TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
April 27, 2017 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators: (Authority: Government Code, Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: CNA		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2017		
	d. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) (3 Matters)		
	e. Approval of prior Closed Session Minutes		

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

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

	Agenda Item	Time Allotted	Requestor
	f. Conference with Legal Counsel – Existing Litigation (Authority: Government Code, Section 54956.9(d)1, (d)4 (1) Francisco Valle vs. TCHD Case No. 37-2015-00015754-CU-OE-NC (2) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (3) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523		
	g. Public Employee Evaluation: General Counsel (Authority: Government Code, Section 54957)		
	h. Public Employee Evaluation: Chief Compliance Officer (Authority: Government Code, Section 54957)		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) .		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Introductions 1) Michael Pietila, M.D. 2) Wilson Liu, M.D.	5 min.	CSO
13	Special Presentations – 1) Gifts for Patients - Evie Cunnington – 8th Grade Vista Student Community Project 2) Resolution No. 784, A Resolution of the Board of Directors of Tri-City Healthcare District Recognizing the Food & Nutrition Services Staff	5 min. 5 min.	CNE Chair
14	Community Update – a) Allied Health Presentation	10 min.	Chief of Staff
15	Report from TCHD Auxiliary– Pat Morocco – Auxiliary President	5 min.	Standard
16	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
17	Report from Chief Executive Officer	10 min.	Standard
18	Report from Acting Chief Financial Officer	10 min.	Standard
19	New Business		
	a. Approval of a Recruitment Agreement with Dr. Yu-Po Lee, Orthopedic Surgeon – Spine and Orthopedic Specialist of North County.	10 min.	FOP Comm.
	b. Consideration to award bid for Design Build RFP Vendor Selection	5 min.	COO
	c. Consideration to appoint a Delegate and Alternate Delegate to ACHD for the purpose of considering their newly Amended and Restated Association Bylaws	5 min.	Chair
	d. Board Contract Overview Discussion	10 min.	Director Reno
	e. Consideration to appoint Chief Rick Robinson to the Community Healthcare & Alliance Committee Oceanside Police/Fire representative position as recommended by the committee	5 min.	CHAC Comm.
18	Old Business		
	a. Board Portal Update	5 min	Director Mitchell
19	Chief of Staff a. Consideration of April 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals b. Consideration of Cardiothoracic Privilege Card c. Consideration of Medical Staff Bylaws	10 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled <u>require a second</u>.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 (No meeting held in April, 2017) **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 (No meeting held in April, 2017) **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)*	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of an agreement with Kingsbridge Healthcare for a copier equipment lease for a term of 60 months, beginning May 1, 2017 through April 30, 2022 for an annual cost of $371,112, and a total cost for the term of $1,855,560. 2) Approval of a supply spend agreement with Vyaire Medical, Inc. for the no charge use of loaned ventilator heated humidifiers for a term of 35 months, beginning May 1, 2017 through March 31, 2020 for an annual cost of $95,868 and a total cost for the term of $279,615. 3) Approval of an agreement with Manish Sheth for Co-Medical Directorship for a term of three years, beginning July 1m 2017 through June 30m, 2020 for an hourly rate of $140, an annual maximum cost of $58,080 and a total cost for the term of $174,240. 4) Approval of an agreement with Dr. Dennis Ordas, Co-Medical Director of Outpatient Behavioral Health for a term of three (3) years, beginning July 1, 2017 through June 30, 2020 for an hourly rate of $140, an annual cost of $59,760 and a total cost for the term of $179,280. 5) Approval of an agreement with Cardiology physicians, Drs. Kenneth Carr, Karim El-Sherief and David Spiegel for the Cardiology-General/STEMI ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 through June 30, 2018, for general cardiology at a daily rate of $200, for a total term cost of $73,000 and $600 per day for STEMI, for an annual cost of $219,000 for a total annual and term cost of $292,000. 6) Approval of an agreement with Cardiology physicians Drs. Oscar Matthews and Mohammad Pashmforoush as the Cardiology-General ED Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 through June 30, 2018 at a daily rate of $200, for a total annual and term cost of $73,000. 7) Approval of an agreement with Drs. Daniel Gramins, Eugene Golts, Steven Howe, Michael Madani, Anthony Perricone, Travis Pollema, Gert Pretorium, Patricia Thistlethwaite and Theodore Folkerth as ED On Call Coverage physicians for Cardiothoracic Surgery for a term of 12 months, beginning July 1, 2017 through June 30, 2018 at a daily rate of $375 for an annual cost of $136,875 and $375 per day for Thoracic Surgery for an annual cost of $136,875 for a total term of $273,750. 8) Approval of an agreement with Dr. Donald Ponec, Medical Director for the Cardiovascular Institute for a term of 12 months, beginning July 1, 2017 through June 30, 2018, not to exceed an average of eight (8) hours per month or 96 hours annually, at an		FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	hourly rate of $210 for an annual cost for the term of $20,160. 9) Approval of an agreement with Drs. Deemer, Folkerth, Paveglio and Spiegel as the Specialty Medical Directors of the Cardiovascular Health Institute for a term of 12 months, beginning July 1, 2017 through June 30m 2018, not to exceed an average of 48 hours per month or 576 hours annually, at an hourly rate of $210 for an annual cost of $120,960 and a total cost for the term of $120,960. 10) Approval of an agreement with Drs. Folkerth, Jamshidi-Nezhad and Spiegel as the Coverage Physicians for the Cardiovascular Health Institute Operations Committee for a term of 12 months beginning July 1, 2017 through June 30, 2018, not to exceed an average of six (6) hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120 and a total cost for the term of $15,120. 11) Approval of an agreement with Drs. Kroener, Paveglio and Ponec as the Coverage Physicians for the Cardiovascular Health Institute Quality Committee beginning July 1, 2017 through June 30, 2018, not to exceed an average of six (6) hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120 and a total cost for the term of $15,120. 12) Approval of an agreement with Dr. Henry Showah as the Coverage Physician for Inpatient Wound Care for a term of 12 months, beginning May 1, 2017 through April 30, 2018, not to exceed an average of six (6) hours a month at an hourly rate of $180 for a total cost for the term of $12,960. 13) Approval of an agreement with Dr. Henry Showah as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2017 through April 30, 2018, not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200. 14) Approval of an agreement with Dr. Sharon Slowik as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2017 through April 30, 2018, not to exceed an average of 14 hours a month, at an hourly rate of $180, for a total cost for the term of $30,240. 15) Approval of an agreement with Dr. Sharon Slowik as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months beginning May 1, 2017 through April 30, 2018, not to exceed an average of 30 hours a month, at an hourly rate of $180, for a total cost for the term of $64,800. 16) Approval of an agreement with Regents of the University of California, San Diego School of Medicine Department of Reproductive Medicine for Perinatology Medical Director and Physician Services for a term of 12 months, beginning May 1, 2017 through April 30, 2018 for an annual/total cost of $78,280.		

	Agenda Item	Time Allotted	Requestor
	E. Professional Affairs Committee Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* **1) <u>Patient Care Services</u>** a. Admission Criteria Policy b. Admixture, Intravenous Procedure c. Blanket Warmers Policy d. Code Status/ Do Not Resuscitate DNR 312 e. Determination of Brain Death f. Food and Nutrition Relationships with Other Departments Policy g. Glucose Monitoring During Exercise Therapy for Diabetic Patients h. Meals, Patients- Times, Menus, Substitutions and Nourishments Policy i. Medication Recall Policy j. Outpatient Summary List Procedure k. PureWick Female Urinary Incontinence Management l. Research Activity Investigational Drugs Policy **2) <u>Administrative Policies and Procedures</u>** a. EMTALA- Emergency Medical Screening 506 **3) <u>Unit Specific</u>** **A. Education** 1. ACLS Fee Waiver Policy 2. AHA Reciprocity Statement Policy 3. AHA Role of TCMC AHA Training Center Policy **B. Medical Staff** 1. Conflict of Interest 8710-555 2. Conflict Resolution Policy 8710-562 3. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523 4. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A 5. Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550 6. Credentialing Policy, Processing Medical Staff Applications 8710-543 7. Credentialing Standards Catheter-Based Peripheral Vascular Interventional Procedure 8710-504 8. Documentation Requirements for Emergency Department Residents 8710-532 9. Election Process Members at Large MEC 8710-531 10. Emergency Room Call Duties of the On-Call Physician 8710-520 11. Liability Insurance Requirements 8710-558 12. Management of Conflicts Between Medical Staff and MEC 8710-567 13. Medical Record Documentation 8710-518 14. Medical Staff Governance Documents Development and Review and Approval Mechanisms 8710-500		PAC

	Agenda Item	Time Allotted	Requestor
	15. Name Tags for Health Practitioners 8710-521 16. Peer Review Process: OPPE and FPPE 8710-509 17. Physician Orders/ Family Members 8710-529 18. Physician/ Podiatrist Surgical Assistant 8710-536 19. Physician Well Being Policy 8710-511 20. Professional Behavior Policy and Committee 8710-570 21. Requests for New Privileges/ Technologies New to TCMC 8710-526 22. Standards for Endovascular Repair of Aortic Aneurysms 8710-503 23. Supervision of Residents/Fellows/ Medical Students 8710-513 24. Surgical Assistance 8710-545 25. Suspension for Delinquent Medical Records and Fine Process 8710-519 26. Temporary Privileges 8710-515] 27. Unintended Intraoperative Awareness During Anesthesia 8710-546 **C. NICU** 1. Peripherally Inserted Central Catheters and Midline Catheters Insertion **D. Surgical Services** 1. Anesthesia Type, Location and Monitoring Policy 2. Anticoagulation Management During Cardiopulmonary Bypass Procedure 3. Disinfection of Stockert Heater-Cooler System 3T Tanks Procedure 4. Donor Corneas, Transplant Preparation Procedure 5. Eye Laser Patient Management Procedure 6. Heart Lung Machine Procedure 7. Heart Valves Thawing (Cyropreserved) procedure 8. Laser Safety Management Procedure 9. Mira Cryo Unit Set-Up Procedure 10. Patient Transportation in the Perioperative Environment Procedure **E. Women's and Newborn Services** 1. Amnioinfusion 2. Cord Gas Collection 3. Elective Delivery Under 39 Weeks 4. HIV Intrapartum Management 5. HIV Newborn Management 6. Misoprostol (Cytotec) 7. Shoulder Dystocia 8. Standards of Care : Antepartum 9. Umbilical Cord Blood Banking Private Collection **F. Formulary Requests** 1. Acetaminophen 2. Artificial Saliva 3. Meperidine Oral Tablets 4. Tobramycin Nebulized Solution **G. Pre-Printed Orders**		

	Agenda Item	Time Allotted	Requestor
	1. Discharge Referral Services Orders 8711-4539 **F. Governance & Legislative Committee** Director Dagostino, Committee Chair Open Community Seats - 1 (No meeting held in April, 2017) **G. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 (No meeting held in April, 2017) (2) Minutes – Approval of: a) Regular Board of Directors Meeting – March 30, 2017 (3) Meetings and Conferences – NONE (4) Dues and Memberships - NONE		Audit, Comp. & Ethics Comm. Standard
22	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
23	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (March, 2017) (d) Reimbursement Disclosure Report – (March, 2017) (e) Seminar/Conference Reports: 1) Director Schallock – CHA Leg Days 2) Director Nygaard – ACHD Leg Days	0-5 min.	Standard
24	Legislative Update	5 min.	Standard
25	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
26	Additional Comments by Chief Executive Officer	5 min.	Standard
27	Board Communications (three minutes per Board member)	18 min.	Standard
28	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2.75 hours	
29	Oral Announcement of Items to be Discussed During Closed Session		
30	Motion to Return to Closed Session (if needed)		
31	Open Session		
32	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
33	Adjournment		

Curriculum Vitae

MICHAEL A PIETILA, M D

mprp05@sbcglobal.net
760-712-7420

CURRENT EMPLOYMENT

Kaiser Permanente Medical Group, 1/14/13--9/8/16

Duties--Continuing care department. Work included full time nursing home care for short term skilled patients--ranging from 20-40 and long term care for custodial patients--averaging 40-50. Supervised nurse practitioners and RN case managers in the nursing home. Covered 4 nursing homes and took call 2 weekdays per month and one weekend day every 6 weeks. First 2 yrs included Hospice and Palliative care for Kaiser patients. Would do home initial consults including history and physicals for both Hospice and Palliative care patients throughout north county. Was involved in Palomar hospital to nursing home discharge and medicine improvement committee. Worked on improving discharge summaries as well as an accurate medicine list at time of discharge from acute hospital to nursing home. Worked with clinical pharmacist at Palomar hospital to improve medication list to be sent to skilled nursing facility.

Scripps Coastal Medical Center, 9/14/96--12/31/12 (Formerly Sharp Mission Park Medical Group until 8/08)

Duties--Full spectrum Family Practice office work, including minor surgery, flexible Sigmoidoscopies. Worked in the Urgent Care one weekend shift a month from 1996-2001. Half time--Skilled Nursing Team Physician for the medical group. Attended to patients in 12 local skilled nursing facilities including skilled and long term patients. Did admissions, weekly visits and notes as well as discharge summaries. Took call once a week on week days and once a month on a weekend. Made patient visits to multiple residential care facilities for the elderly (RCFE's). Supervised physician assistants and nurse practitioners in the practice. Patient home visits--twice a month from 1996-2003. Was on the Quality improvement committee for Sharp Mission Park.

Life Care Center of Vista, 2002-2012

Duties--Medical Director for the 135 bed skilled nursing facility. Met with the administrator, director of nursing, and department heads to problem solve and improve quality. Attended monthly regulatory meetings to improve patient care. Was the attending physician for all "no doctor" patients--largely medical patients who were admitted from the acute hospital. Attended yearly medical director meetings at corporate headquarters in Tennessee.

Pleasant Care Nursing Facility, 2001-2011 (presently Astor nursing facility in Vista)

Duties--Medical Director for the 195 bed skilled nursing facility with locked unit for dementia patients. Met with the administrator, director of nursing, and department heads to problem solve and improve quality. Attended monthly Regulatory meetings to improve patient care and care for long term dementia patients. Met with consultant pharmacist monthly to review patients medications in an attempt to reduce any unnecessary medications. Was the attending physician for all "no doctor" patients--largely medical patients who were admitted from the acute hospital

Rancho Vista Nursing Facility, 2003-2008
Duties--assistant medical director. Attended monthly regulatory meetings to improve patient care. Followed "no doctor" patients--largely medical patients as well as clinic patients.

Hospice of the sea, 8/99-12/12
Duties--Medical Director. Attended monthly interdisciplinary team meetings, assessed need for patients to qualify for hospice care. Conducted patient home visits and coordinated care with hospice RN following patients at home or in nursing homes.

SPECIALTY CERTIFICATION--diplomate, American board of Family Medicine. Initial certification 7/96, recertified, 7/03, 7/10 and presently certified in good standing.

EDUCATION AND POST GRADUATE TRAINING

Good Samaritan Hospital Phoenix, AZ--Family Practice program--internship and residency 1993-1996. Was trained in full spectrum of Family Medicine from infants to adults, including OB (delivered 70 babies, did prenatal care), minor surgery training. 3 years of following and managing office patients. Worked at Grand Canyon clinic providing care for tourists. Worked at a local urgent care clinic 4 times a month serving north phoenix patients. Worked one weekend every other month at Williams AZ. urgent care clinic Friday pm to Sunday pm.

Loyola University Stritch School of Medicine--1989-1993 Chicago, IL. Graduated with M.D. degree. Was involved in Christian Medical and Dental Society met on regular basis to discuss ways to care for underprivileged patients.

Grossmont hospital--worked 1/89-6/89 as radiology tech assistant. Was responsible to transfer patients from ER or their room to get xrays and help the xray tech.

Point Loma Nazarene University--1984-1988 Dec.
Bachelor degree in Biology. Member of Urban ministries-- worked with homeless and served at several soup kitchens. Spent one spring break in San Francisco helping the homeless and serving in soup kitchens.

Grossmont College--1983-1984
Completed general education classes to transfer to Point Loma Nazarene University.

Monte Vista High School--1979-1983 earned high school diploma. Participated in numerous sports.

LICENSURE
Arizona--Issued 6/93 M.D. DEA License issued 6/93-to present
California--Issued 6/96 M.D.- to present. BLS certified 6/93-present.

PROFESSIONAL ORGANIZATIONS
American Medical Director's Association
California Association of Long Term Care Medicine (CALTCM)
San Diego County Medical Society

HOSPITAL AFFILIATIONS--Scripps memorial hospital encinitas 8/08-12/12.
Palomar Hospital--1/13-09/16.

VOLUNTEER WORK

Medical ministry international--Medical ministry trips

Tampico, Mexico--1988--worked with surgeons and in medical clinic providing care for the poor. Salsado, Ecuador--2007--provided care to several surrounding poor villages with other doctors and volunteers. Colinas, Honduras, 2008--provided care for poor patients in remote villages my wife worked in pharmacy clinic on trip. Banos, Ecuador, 2009 provided care for poor patients who had no access to medical care. My wife and daughter worked in pharmacy clinic on trip.

Reaching the Hungry

Rancho poiema, Ensenada, Mexico--2012 provided medical care to the poor who have no access to medical care 2 of our kids helped. Tijuana, Mexico--2013 provided medical care to the poor and wife and 3 kids helped with hair cutting and sports ministry. Tijuana, Mexico--2014 provided medical care to the poor and wife and kids participated. Ensenada, Mexico--2016 provided care to the poor and wife and son participated

Bread of life Oceanside--homeless shelter and soup kitchen, helped give medical advice and serve meals to homeless 2009-present

WILSON LIU, M.D.

4330 Cereda Lane, Fairfield CA 94534
cell: (760) 809-2390
email: wlljazz58@gmail.com

PROFILE

Board certified family physician, encompassing pediatrics, adult, geriatrics

EXPERIENCE

Sutter Health Medical Group — 8/2014 - present
Vallejo, California

U.S. Naval Branch Health Clinic, Yokosuka — 7/2011- 1/2014
Sasebo, Japan

Waikiki Health Center — 7/2009 - 1/2011
Honolulu, Hawaii

Private Practice — 7/2004 - 6/2009
Solo
Carlsbad, California

Private Practice — 4/1994 - 7/2004
Partnership with Carl and Christopher Bengs, M.D.
Carlsbad, California

Harbor Family Medical Group — 10/1993 - 2/1994
Harbor City, California

Quick Care/California Medical Center and California Pediatric & Family Center — 7/1992 - 9/1993
Moonlighting during residency
Los Angeles, California

HOSPITAL POSITIONS

Staff Physician, Tri-City Medical Center — 4/1994 - 6/2009
Oceanside, California
Admission and inpatient care of patients
Emergency room call duty

Physician Well-Being Committee, Tri-City Medical Center — 7/2008 - 6/2009

Quality Review Committee, Family Medicine Department, Tri-City Medical Center — 7/2007 - 7/2008

EDUCATION AND POST GRADUATE TRAINING

USC/CALIFORNIA MEDICAL CENTER 7/1990 - 7/1993
Family Practice Internship and Residency
Los Angeles, California

THE CHICAGO MEDICAL SCHOOL 7/1986 - 6/1990
Doctor of Medicine
North Chicago, Illinois

UNIVERSITY OF CALIFORNIA, SAN DIEGO 9/1982 - 6/1986
Bachelor of Arts, General Biology
La Jolla, California

PROFESSIONAL CERTIFICATION AND LICENSURE

American Board of Family Medicine 7/1993 - 12/2017

State of California 4/1991 - 4/2017

DEA 4/1991- 4/2018

LANGUAGES

Spanish, Taiwanese, Japanese

INTERESTS

Swimming, Martial Arts, Jazz music, Cooking, Gardening

RESOLUTION NO. 784

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT RECOGNIZING THE TRI-CITY MEDICAL CENTER'S FOOD & NUTRITION STAFF

WHEREAS, Food and Nutrition Services is a vital service to our patients and consistently stands out as a top performing department;

WHEREAS, on February 27, 2017, the kitchen pipes burst, placing the safety of our patients and staff at risk.

WHEREAS, under the leadership of Kelly Gecewicz, the team sprang into immediate action to stabilize kitchen services in what was considered an internal disaster;

WHEREAS, this team flawlessly executed the coordination of community resources to continue to provide nutrition support to our patients while operating under makeshift conditions;

WHEREAS, this team implemented to perfection the countless hours of disaster drilling that prepared them for such a catastrophe;

NOW THEREFORE, BE IT RESOLVED:

The Tri-City Healthcare District Board of Directors extends a heartfelt thanks to the Food & Nutrition staff for their contributions during the hospital's time of need.

The Tri-City Healthcare District Board of Directors is extremely proud of the team's actions and is inspired by their unselfish dedication.

ADOPTED, SIGNED AND APPROVED THIS 27TH DAY OF APRIL, 2017.

_____
James J. Dagostino
Chairperson

ATTEST:

_____
Laura E. Mitchell
Secretary

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Physician Recruitment Proposal – Orthopedic Surgeon-Spine

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

Physician Name: Yu-Po Lee, M.D.
Areas of Service: Orthopedic Surgeon - Spine

Key Terms of Agreement:

Effective Date:	June 1, 2017 or the date Dr. Lee becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff
Community Need:	TCHD Physician Needs Assessment shows significant community need for Orthopedic Surgery
Service Area:	Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients
Income Guarantee:	$445,000 annually ($890,000 for two-years with a three-year forgiveness period)
Sign-on Bonus:	$25,000
Total Not to Exceed:	$915,000 (Loan Amount)

Unique Features: Dr. Lee will join the group practice of Orthopedic Specialist of North County, in Oceanside, CA.

Requirements:

Business Pro Forma: Must submit a two-year business pro forma for TCHD approval relating to the addition of this physician to the medical practice, including proposed incremental expenses and income. TCHD may suspend or terminate income guarantee payments if operations deviate more than 20% from the approved pro forma and are not addressed as per agreement.

Expenses: The agreement specifies categories of allowable professional expenses (expenses associated with the operation of physician's practice and approved at the sole discretion of TCHD) such as billing, rent, medical and office supplies, etc. If the incremental monthly expenses exceed the maximum, the excess amount will not be included.

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Wayne Knight, Chief Strategy Officer

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $915,000 in order to facilitate this Orthopedic Surgeon physician practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) with Orthopedic Specialist of North County and Dr. Yu-Po Lee, M.D.

Yu-Po Lee

Board Certified Orthopaedic Surgeon
Subspecialty in Spine Surgery

UC Irvine Medical Center
101 The City Drive South, Pavilion 3
Orange, CA 92868
(619) 672-1036
E-mail: yupo90025@yahoo.com

Faculty Positions

2015-Present **UC Irvine Department of Orthopaedic Surgery**
Clinical Professor

2005-2015 **UCSD Department of Orthopaedic Surgery**
Associate Clinical Professor

Fellowship

2004-2005 **Cleveland Clinic Spine Fellowship**

Residency

1998-2004 **UCLA Orthopaedic Surgery Residency Program**

Education

1993-1998 **UCLA School of Medicine**

1988-1993 **University of California at Los Angeles**
B.S., Physiological Science, *cum laude*

Honors and Awards

2001 **Charles H. Herndon Residency Research Award**

Society Membership

1. Member of the North American Spine Society 2007 – Present

2. Member of the American Association of Orthopaedic Surgeons 2006 – Present

3. Member of the Western Orthopaedic Association 2007 – Present

4. Member of the Society for Minimally Invasive Spine Surgery 2006 – Present

5. Member of the International Society for the Advancement of Spine Surgery 2008 – Present

Committees and Positions held

1. CME director for UCSD Department of Orthopaedic Surgery Residents 2007 – Present

2. Director of UCSD Spine Surgery Clinical Trials Program 2005 – Present

3. UCSD Spine Fellowship Director 2008 – Present

Publications

1. Lieberman JR, Daluiski A, Stevenson S, Wu L., McAllister P, **Lee YP**, Kabo JM, Finerman GA, Berk AJ, Witte ON. ***The effect of regional gene therapy with bone morphogenetic protein-2-producing bone-marrow cells on the repair of segmental femoral defects in rats.*** *J Bone Joint Surg Am. 1999 Jul;81(7):905-17.*

2. Abe N, **Lee Y**, Sato M, Zhang Z, Wu J, Mitani K, Lieberman J. ***Enhancement of Bone Repair with a Helper-Dependent Adenoviral Transfer of Bone Morphogenetic Protein-2.*** *Biochem Biophys Res Commun. 2002 Sep 27;297(3):523-7.*

3. Berger F, **Lee Y**, Leoning A, Chatziioannou A, Tso C, Freedland S, Leahy R, Lieberman J, Beldegrun A, Sawyers C, Gambhir S. ***Whole body skeletal imaging in mice utilizing MicroPET and MicroCAT: new tools for small animal bone imaging.*** *European Journal of Nuclear Medicine & Molecular Imaging. 2002 Sep;29(9):1225-36.*

4. **Lee Y**, Wang J, Kanim L, Jo M, Davies M, Lieberman J. ***The direct comparison of different commercially available demineralized bone matrix substances in an athymic rat model.*** *The Spine Journal Volume 2, Issue 2, Supplement 1 4 March 2002 Pages 25-*

26. (Abstract)

5. **Lee Y**, Kanim L, Wang J. ***Comparing human "local" bone versus human cancellous bone for spinal fusion in an athymic rat model.*** *The Spine Journal Volume 2, Issue 2, Supplement 1 4 March 2002 Page 25. (Abstract)*

6. **Lee Y**, Schwarz E, Davies M, Jo M, Zhang X, Gates J, Wu J, Lieberman J. ***The use of zoledronate to treat osteoblastic versus osteolytic lesions associated with prostate tumors in a SCID mouse model.*** *Cancer Res. 2002 Oct 1;62(19):5564-70.*

7. **Lee Y**, Schwarz E, Davies M, Jo M, Gates J, Wu J, Zhang X, Lieberman J. ***The cytokine profile associated with osteolytic versus osteoblastic prostate cancer metastases to bone.*** *Journal of Orthopaedic Research, 2003 Jan 8; 21: 62-72.*

8. Davies MR, **Lee YP**, Lee C, Zhang X, Afar DE, Lieberman JR. ***Use of a SCID mouse model to select for a more aggressive strain of prostate cancer.*** *Anticancer Res. 2003 May-Jun;23(3B):2245-52.*

9. Severns AE, **Lee YP,** Nelson SD, Johnson EE, Kabo JM. ***Metabolic measurement techniques to assess bone fracture healing: a preliminary study.*** *Clin Orthop. 2004 Jul;(424):231-8.*

10. Dragoo JL, Lieberman JR, Lee RS, Deugarte DA, **Lee Y**, Zuk PA, Hedrick MH, Benhaim P. ***Tissue-engineered bone from BMP-2-transduced stem cells derived from human fat.*** Plast Reconstr Surg. 2005 May;115(6):1665-73.

11. **Lee Y**, Jo M, Luna M., Chien B., Lieberman J., Wang J. ***The efficacy of different commercially available demineralized bone matrix substances in forming a spinal fusion in an athymic rat model.*** J Spinal Disord Tech. 2005 Oct;18(5):439-44.

12. Gamradt SC, Abe N, Bahamonde ME, **Lee YP**, Nelson SD, Lyons KM, Lieberman JR ***Tracking Expression of Virally Mediated BMP-2 in Gene Therapy for Bone Repair.*** Clin Orthop Relat Res. 2006 May 11

13. Wang ML, Massie J, Allen RT, **Lee YP**, Kim CW. ***Altered bioreactivity and limited osteoconductivity of calcium sulfate-based bone cements in the osteoporotic rat spine.*** Spine J. 2008 Mar-Apr;8(2):340-50.

14. Allen RT, **Lee YP**, Stimson E, Garfin SR. ***Bone morphogenetic protein-2 (BMP-2) in the treatment of pyogenic vertebral osteomyelitis.*** Spine. 2007 Dec 15;32(26):2996-3006.

15. Kim CW, **Lee YP**, Taylor W, Oygar A, Kim WK. ***Use of navigation-assisted fluoroscopy to decrease radiation exposure during minimally invasive spine surgery.*** Spine J. 2008 Jul-Aug;8(4):584-90.

16. Ghofrani H, **Lee YP**. ***Bone Graft Substitutes and Extenders***. Contemporary Spine Surgery. April 2008.

17. Regev GJ, Chen L, Dhawan M, **Lee YP**, Garfin SR, Kim CW. ***Morphometric analysis of the ventral nerve roots and retroperitoneal vessels with respect to the minimally invasive lateral approach in normal and deformed spines.*** Spine (Phila Pa 1976). 2009 May 20;34(12):1330-5.

18. Regev GJ, **Lee YP**, Taylor WR, Garfin SR, Kim CW. ***Nerve injury to the posterior rami medial branch during the insertion of pedicle screws: comparison of mini-open versus percutaneous pedicle screw insertion techniques.*** Spine (Phila Pa 1976). 2009 May 15;34(11):1239-42.

19. **Lee YP**, Ghofrani H. ***Degenerative Scoliosis.*** Contemporary Spine Surgery May 2010.

20. Regev GJ, Haloman S, Chen L, Dhawan M, **Lee YP**, Garfin SR, Kim CW. ***Incidence and prevention of intervertebral cage overhang with minimally invasive lateral approach fusions.*** Spine (Phila Pa 1976). 2010 Jun 15;35(14):1406-11.

21. **Lee YP**, Robertson C, Mahar A, Kuper M, Lee D, Regev G, Garfin S. ***Biomechanical evaluation of transfacet screw fixation for stabilization of multi-level cervical corpectomies.*** Journal of Spinal Disorders and Techniques. Accepted for publication.

22. Regev GJ, Kim CW, Tomiya A, **Lee YP**, Ghofrani H, Garfin SR, Lieber RL, Ward SR. ***Psoas Muscle Architectural Design, In Vivo Sarcomere Length Range, and Passive Tensile Properties Support its Role as a Lumbar Spine Stabilizer***. Spine (Phila Pa 1976). 2011 Mar 14.

23. **Lee YP**, Ghofrani H, Regev GJ, Garfin SR. ***A retrospective review of long anterior fusions to the sacrum***. Spine J. 2011 Apr;11(4):290-4.

24. Vinko Zlomislic , **Y Lee**, Alexandra Schwartz, Steven Garfin. ***Management of sacroiliac joint dysfunction***. Contemporary Spine Surgery April 2011.

25. Webb J, Gottschalk L, **Lee** YP, **Garfin** S, Kim C. Surgeon Perceptions of Minimally Invasive Spine Surgery. SAS J. 2008 Sep 1;2(3):145.

26. **Lee YP**, Regev G, Chan J. ***Evaluation of hip flexion strength following lateral lumbar interbody fusion.*** Spine J. 2013 Oct;13(10):1259-62.

27. Anubhav Jagadish, Douglas Chang, **Yu-Po Lee**. ***Use of Bisphosphonates in Spine Surgery*** Contemporary Spine Surgery. Publication pending.

28. AnubhavJagadish, Sreeharsha V. Nandyala, AlejandroMarquez-Lara, Kern Singh, and **Yu-Po Lee.** ***Spinal Interventions-The Role in the Athlete.*** Operative Techniques in Sports Medicine

29. **Yu-Po Lee**, Joseph Sclafani. ***Lumbar iatrogenic spinal instability.*** Seminars in Spine Surgery. Volume 25, Issue 2, June 2013, Pages 131–137.

30. Chen F, **Lee YP**. ***Vertebral Augmentation.*** Contemporary Spine Surgery. 14(8):1-7, August 2013.

31. Nandyala, Sreeharsha V.; Marquez-Lara, Alejandro; **Lee, Yu-Po.** ***Strategies to Prevent Infection after Spine Surgery.*** Contemporary Spine Surgery. 15(6):1-5, June 2014.

32. Ghofrani H, Nunn T, Robertson C, Mahar A, **Lee** Y, Garfin S. **An evaluation of fracture stabilization comparing kyphoplasty and titanium mesh repair techniques for vertebral compression fractures: is bone cement necessary?** Spine (Phila Pa 1976). 2010 Jul 15;35(16):E768-73.

33. Tatsumi R, **Lee YP**, Khajavi K, Taylor W, Chen F, Bae H. **In vitro comparison of endplate preparation between four mini-open interbody fusion approaches**. Eur Spine J. 2015 Apr;24 Suppl 3:372-7.

34. **Lee YP**, Ihn HE, McGarry MH, et al. **Biomechanical Analysis of an S1 Pedicle Screw Salvage Technique via a Superior Articulating Process Entry Point.** Spine (Phila Pa 1976). 2015 Dec 14.

35. Allison DW, Allen RT, Kohanchi DD, Skousen CB, Lee YP, Gertsch JH. **Vasculopathy, Ischemia, and the Lateral Lumbar Interbody Fusion Surgery: Report of Three Cases.** J Clin Neurophysiol. 2015 Dec;32(6):e41-5.

36. Lee, Yu-Po; Allen, R. Todd. **Proximal Junctional Kyphosis.** Contemporary Spine Surgery. June 2016 - Volume 17 - Issue 6. pp: 1-6.

37. Jagadish, Anubhav; Nandyala, Sreeharsha V.; Marquez-Lara, Alejandro; Chang, Douglas G.; Lee, Yu-Po. **Use of Bisphosphonates in Spine Surgery.** Contemporary Spine Surgery. 16(5):1-5, May 2015.

38. Yu-Po Lee, Jeffrey Gertsch, William Taylor, David Allison, John Attenello, Kara Nepomuceno, Miguel Nepomuceno and Nitin Bhatia. **The Reliability of Neuromonitoring to Detect Neurologic Injury during Lateral Interbody Fusion.** Spine Research. Vol. 1 No. 1:5. Pg. 1-5.

39. Yu-Po Lee, Alex Dohrmann, Douglas Kiester, Nitin Bhatia. **ICD10 and its relevance to Spine Surgeons** in Contemporary Spine Surgery. Accepted. Publication pending.

40. Nitin Bhatia, Asheen Rama, Brandon Sievers, Ryan Quigley, Michelle H. McGarry, Yu-Po Lee, Thay Q Lee. **Biomechanical Evaluation of Unilateral Versus Bilateral C1 Lateral Mass-C2 Intralaminar Fixation.** Global Spine Journal. Accepted for publication. Publication pending.

Presentations

1. Sinel M, Goldstein T, Deutsch A, Mink J, **Lee Y**, Jackson K. Conservative management of large lumbar disc extrusions: an MRI study. American Academy of Orthopaedic Surgeons. 66th, Annual Meeting, Anaheim, 1999.

2. **Lee Y**, Kanim L, Jo M, Luna M, Wang J. The efficacy of local bone versus iliac crest bone in forming a spinal fusion in an athymic rat model. Poster presentation. Orthopaedic Research Society. 43rd Annual Meeting, San Francisco, 2001.

3. **Lee Y**, Schwarz E, Davies M, Jo M, Zhang X, Gates J, Wu J, Lieberman J. The use of zoledronate to treat osteoblastic versus osteolytic lesions associated with prostate tumors in a SCID mouse model. Poster presentation. American Society of Bone and Mineral Research. 23rd Annual Meeting, Phoenix, 2001.

4. **Lee Y**, Schwarz E, Davies M, Jo M, Zhang X, Gates J, Wu J, Lieberman J. The use of zoledronate to treat osteoblastic versus osteolytic lesions associated with prostate tumors in a SCID mouse model. Poster presentation. Orthopaedic Research Society. 44th Annual Meeting, Dallas, 2002.

5. **Lee Y**, Schwarz E, Davies M, Jo M, Zhang X, Lieberman J. The cytokine profile associated with osteolytic versus osteoblastic prostate cancer metastases to bone. Poster presentation. Orthopaedic Research Society. 44th Annual Meeting, Dallas, 2002.

6. Severns AE, **Lee Y**, Martin DE, Botzler TM, Nelson SD, Johnson EE, Kabo JM. Healing of bone fractures assessed using metabolic measurement techniques. Poster presentation. Orthopedic Research Society. 45th Annual Meeting, New Orleans, 2003.

7. **Lee Y**, Kanim L, Jo M, Luna M, Wang J. The efficacy of local bone versus iliac crest bone in forming a spinal fusion in an athymic rat model. Podium presentation. North American Spine Society. 16th Annual Meeting, Seattle, 2001.

8. **Lee Y**, Kanim L, Jo M, Wang J. The efficacy of different commercially available demineralized bone matrix substances in forming a spinal fusion in an athymic rat model. Podium presentation. North American Spine Society. 16th Annual Meeting, Seattle, 2001.

9. **Lee, Y**, Ward, W, Kelly, C, Kabo, JM, Dorey, F, Eckardt, J. Rotating hinge knee mechanisms and tumor endoprostheses. Poster presentation. Musculoskeletal Tumor Society. 2003 Annual Meeting, Chicago.

10. **Lee, Y**, Ward, W, Kelly, C, Kabo, JM, Dorey, F, Eckardt, J. Rotating hinge knee mechanisms and tumor endoprostheses. Poster presentation. American Academy of Orthopaedic Surgery. 2004 Annual Meeting, San Francisco.

11. Lee, Y. Lieberman, I. The use of pull-out resistant nuts in spine surgery. Poster presentation. International Meeting for Advanced Spinal Techniques. 2005 Annual Meeting, Banff, Canada.

12. Massie J., **Lee Y.**, Kim C., Acheson W., Garfin S. The effect of glucosamine and betamethasone on disc degeneration. Poster Presentation. North American Spine Society. 22nd Annual Meeting, Austin, 2007.

13. **Lee Y**, Robertson C, Mahar A, Kuper M, Lee D, Regev G, Garfin S. Biomechanical evaluation of transfacet screw fixation for stabilization of multi-level cervical

corpectomies. Poster presentation. Orthopaedic Research Society. Annual Meeting, San Francisco, 2008.

14. **Lee Y**, Robertson C, Mahar A, Kuper M, Lee D, Regev G, Garfin S. Biomechanical evaluation of transfacet screw fixation for stabilization of multi-level cervical corpectomies. Poster presentation. North American Spine Society. 24th Annual Meeting, San Francisco, 2009

15. Gilad J. Regev, Lina Chen, Mallika Dhawan, **Yu-Po Lee**, Steven R. Garfin, Choll W. Kim. Morphometric Analysis of the Ventral Nerve Roots and Retroperitoneal Vessels With Respect to the Minimally Invasive Lateral Approach in Normal and Deformed Spines. Podium Presentation. Lumbar Spine Research Society. 1st Annual Meeting, Chicago, IL, 2009.

16. **Yu-Po Lee**, Cary Templin, Tudor Hughes,Choll Kim, Michael Gulian, Michael Chang, Robert Eastlack, Steven Garfin. The Accuracy of the Pedicle Probe. Podium Presentation. Lumbar Spine Research Society. 1st Annual Meeting, Chicago, IL, 2009.

17. Gilad J. Regev, Lina Chen, Mallika Dhawan, **Yu-Po Lee**, Steven R. Garfin, Choll W. Kim. Morphometric Analysis of the Ventral Nerve Roots and Retroperitoneal Vessels With Respect to the Minimally Invasive Lateral Approach in Normal and Deformed Spines. Oral Poster Presentation. Spine Arthoplasty Society. 9th Annual Meeting, London, 2009.

18. Gilad J. Regev, William R. Taylor, **Yu Po Lee**, Steven R. Garfin, Choll W. Kim. Nerve Injury to the Posterior Rami Medial Branch During the Insertion of Pedicle Screws: Comparison of Mini-Open vs. Percutaneous Pedicle Screw Insertion Techniques. Oral Poster Presentation. Spine Arthoplasty Society. 9th Annual Meeting, London, 2009.

19. **Lee Y.**, Schwartz A., Girard P., O'Brien J., Ghofrani H., Garfin S. Analysis of orthopaedic residents' in-training scores and complications before and after the 80 hour work rule. Podium Presentation. American Academy of Orthopaedic Surgeons. 2009 Annual Meeting. New Orleans.

20. **Lee Y.**, Ghofrani H., Regev G., Gulian M., Kim C., Garfin S. Evaluation of Hip Flexion Strength Following Extreme Lateral Lumbar Interbody Fusion: Is the Psoas Muscle Seriously Injured? Oral Poster. Spine Arthoplasty Society. 10th Annual Meeting, New Orleans, 2010.

21. **Lee Y.**, Schwartz A., Girard P., O'Brien J., Ghofrani H., Garfin S. Analysis of orthopaedic residents' in-training scores and complications before and after the 80 hour work rule. Poster Presentation. American Orthopaedic Association. 123rd Annual Meeting, San Diego, 2010.

22. **Lee Y.**, Ghofrani H., Regev G., Gulian M., Kim C., Garfin S. Evaluation of Hip Flexion Strength Following Extreme Lateral Lumbar Interbody Fusion: Is the Psoas

Muscle Seriously Injured? Podium Presentation. North American Spine Society. 25th Annual Meeting, Orlando, 2010

23. **Lee Y.**, Ghofrani H., Garfin S. Evaluation of the Functional Anesthetic Discogram as a Screening Tool for Lumbar Fusion to Treat Degenerative Disc Disease. Poster Presentation. North American Spine Society. 25th Annual Meeting, Orlando, 2010

Book Chapters

1. Cervical Lateral Mass Screws in *Tricks of the Trade*, Ed. Alex Vaccaro, 2009

2. Arthritides of the Spine in *AAOS Board Review*. Ed. Jeffrey Wang, 2009

5. Novel Intraoperative Imaging Modalities in Spine Surgery in *Seminars in Spine Surgery*. Ed. Alex Vaccaro.

6. Deformity in *Curbside Consults*. Ed. Bernie Bach.

7. Thoracolumbar Fractures in *Skeletal Trauma*, 4th edition. Ed. Browner, Jupiter, Levine, Trafton

8. Templin, C.R, Lee, Y.L, Garfin, S.R. Pathophysiology and Etiology of Lumbar Disc Herniation. *The Lumbar Intervertebral Disc*. Phillips, F., Lauryssen, C., ed. Thieme Publications.

9. Vertebral Augmentation in *Spine Trauma - Surgical Techniques*. Ed. Vikas Patel. Springer publications.

10. Percutaneous Pedicle Screws in *Advanced Reconstruction: Spine (AAOS)*. Ed. Jeffrey Wang.

11. Cervical Epidural Abscess in *Prove It*. Ed. Christopher Bono. 2010.

12. Cervical Spondylosis–Spinal Stenosis: Laminoplasty Versus Laminectomy and Fusion. BEST EVIDENCE FOR SPINE SURGERY: 20 Cardinal Cases. Ed. Rahul Jandial. 2010.

13. Yu-Po Lee, Joseph Sclafani, Steven Garfin. Pseudoarthrosis in *Seminars in Spine Surgery*. Volume 23, Issue 4, December 2011, Pages 275–281

14. Costotransversectomy in *Operative Techniques in Spine Surgery*. Ed. John Rhee. 2012

15. Yu-Po Lee, Tanaya Pattnaik, Steven R. Garfin. Biologic Considerations. *extreme*

Lateral Interbody Fusion 2nd Edition.

16. Lateral Interbody Fusion in *Rothman and Simeone*. 2011

17. Lateral Interbody fusion in *Minimally Invasive Spine Surgery an Algorithmic Approach*. Ed. Kern Singh. July 2013.

18. Inflammatory Diseases in *Spine Surgery Current Concepts and Evidence*. 2016

19. Cervical Lateral Mass Screws in *Tricks of the Trade*, Ed. Alex Vaccaro, 3rd edition. 2016

20. Arthritides of the Spine in *AAOS Board Review*. 2nd edition. August 2015

21. Unilteral facet disclocation in Board Review Series, Ed. Chris Bono.

22. Lateral Surgery. Case Based Minimally Invasive Surgery, Ed. Sheeraz Qureshi. 2016.

23. Lateral Interbody Fusion in *Rothman and Simeone*. Pub. Pending.

24. Spinal Infections in *Rothman and Simeone*. Pub. Pending.

25. Vertebral Augmentation in Orthopaedic Knowledge Update 12. Publication Pending.

26. Smith-Peterson and Pedicle Subtraction Osteotomies in Seminars in Spine Surgery. Also Editor for the series. Publication Pending.

27.

Courses Taught

1. AONA ORP Training course. Columbus, OH 2004.

2. San Diego Citywide Spine Conference. San Diego, CA April 29, 2006.

3. Spine Study Group. West Palm Beach, Fl. May 17-21, 2006.

4. Cleveland Clinic Spine Review Course. Cleveland OH. July 17-25, 2006.

5. Spine Study Group. West Palm Beach, Fl. May 2-6, 2007.

6. Critical Care. San Diego, CA July 24-26, 2008.

7. Cervical Spine Stabilization Technique Workshop at NASS Annual Meeting 2008.

8. American Academy of Orthopaedic Surgeons Techniques Workshop. St. Louis, MO. 2009.

9. California Orthopaedic Association. Santa Barbara, CA. May 2009.

10. Spine Study Group. West Palm Beach, Fl. May, 2009

11. Cervical Spine Stabilization Technique Workshop at NASS Annual Meeting, 2009

12. Spine Study Group. West Palm Beach, Fl. May, 2010

13. Cervical Spine Stabilization Technique Workshop at NASS Annual Meeting, 2010

14. Biologics Technique Workshop at NASS Annual Meeting 2011

15. Spine Study Group. West Palm Beach, Fl. May, 2011

16. Spine Study Group. West Palm Beach, Fl. May, 2012

17. Deformity Technique Workshop at NASS Summer Meeting, 2013

18. Spine Study Group. West Palm Beach, Fl. May, 2013

19. Spine Study Group. San Diego, CA. Feb. 2014

20. Deformity Technique Workshop at NASS Summer Meeting, 2014

Teri Donnellan

From: Association of California Healthcare Districts <sheila.johnston@achd.org>
Sent: Wednesday, April 19, 2017 1:29 PM
To: Steven L. Dietlin
Subject: Reminder: Call for Delegates

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Reminder: Appoint your District's Delegates

Based upon the ACHD Board of Director's strategic planning and the recently completed merger of the ALPHA Fund and BETArma, the Board has undertaken a comprehensive review of the Association Bylaws. As a result of their review, the Board will be recommending to the ACHD Members newly Amended and Restated Association Bylaws for approval by the Member Healthcare Districts.

In order to prepare for the election to approve the Amended and Restated Association Bylaws, ACHD requests that Member Healthcare Districts appoint *one delegate* and *one alternate delegate* to represent your Healthcare District. All delegates must be District Trustees. However, alternate delegates may be District Trustees, Administrators, or Chief Executive Officers.

Please complete **this form** *as soon as possible.*
We appreciate your prompt attention to this matter.

ACHD staff will be following up with you on Monday, April 24, 2017, if we have not yet received delegate selections from you.

Staff will provide Members with a separate email pertaining to election materials, logistics, and a hosted webinar to inform the membership of the proposed changes to the Bylaws.

Please contact **Ken Cohen** or **Sheila Johnston** with any questions or concerns.

www.achd.org

ACHD, 1215 K Street, Suite 2005, Sacramento, CA 95814

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Call for Delegates!

*Required Question(s)

In order to prepare for the election to approve the Amended and Restated Bylaws, ACHD requests that Member Healthcare Districts appoint one delegate and one alternate delegate to represent your Healthcare District. All delegates must be District Trustees. However, alternate delegates may be District Trustees, Administrators, or Chief Executive Officers.

* 1. Please provide the name and email address of your Delegate and their title.

50 characters left.

* 2. Please provide the name and email address of your Alternate Delegate and their title.

50 characters left.

* 3. Please provide the name and title of the individual completing this form.

First Name:

Last Name:

Job Title:

Email Address:

emailaddress@xyz.com

Address 1:

Address 2:

City:

Postal Code:

District:

Finish

CITY OF OCEANSIDE

OFFICE OF CITY MANAGER

February 28, 2017

Ms. Susan McDowell
Tri-City Medical Center
Marketing, Communications & Public Affairs
2095 W. Vista Way, Ste 214
Vista, CA 92083

Re: Community Healthcare Alliance Committee (CHAC)

Dear Ms. McDowell:

This letter will serve to request that Oceanside Fire Chief Rick Robinson be considered as an appointment to the CHAC Committee. Chief Robinson would be proud to represent Oceanside's Police and Fire community.

Chief Robinson's contact information is as follows:

Fire Chief Rick Robinson
Oceanside Fire Department
300 North Coast Highway
Oceanside, CA 92054
760-435-4088
rwrobinson@ci.oceanside.ca.us

Thank you for contacting my office and providing information regarding Tri-City's CHAC Committee.

Sincerely,

Michelle Skaggs Lawrence
City Manager

cc: Fire Chief Robinson

Confirmed CHAC mtg 3/16/17

300 NORTH COAST HIGHWAY • OCEANSIDE, CA 92054-2885 • TELEPHONE (760) 435-3065 • FAX (760) 435-3078

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
April 12, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 4/28/2017-3/31/2019)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 4/28/2017 through 3/31/2019:

- **CHOW, Chien-Hsiang M.D. / Anesthesiology (Anesthesia Service Medical Group)**
- **GRANT, Colette M.D. / Pediatrics (Children's Primary Care Medical Group)**
- **MAC EWAN, Jennifer M. D. / Otolaryngology (Rancho ENT)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
April 12, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 5/01/2017 -4/30/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 5/01/2017 through 4/30/19, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- ANSARI, Rashad, MD/Rheumatology/Consulting
- ARGOUD, Georges, MD/Endocrinology, Diabetes & Metabolism /Consulting
- BODDU, Navneet, MD/Anesthesiology/Active
- DELGADO, George, MD/Family Medicine/Provisional
- GILBOA, Ruth, MD/Dermatology/Affiliate
- HARTMAN, Andrew, MD/Orthopedic Surgery/Active
- LEE, Margaret, MD/Diagnostic Radiology/Active
- MANOS, Paul, DO/Family Medicine/Active
- NICPON, Gregory, MD/Diagnostic Radiology/Active
- RODRIGUEZ, Madeline, MD/Obstetrics & Gynecology/Active
- RYPINS, Eric, MD/General Surgery/Active
- WANG, Anchi, MD/Neurology/Active
- WARDA, Gregory, MD/Neonatology/Provisional

RESIGNATIONS: (Effective date 4/28/2017 unless otherwise noted)

Voluntary:

- BERKOWITZ, Alan MD/Psychiatry
- DESADIER, Jason DO/Emergency Medicine

Attachment B

- **OBLON, David MD/Oncology**
- **PATEL, Yogesh MD/Anesthesiology**
- **TARR, Leanne PAC/General/Vascular Surgery**

CORRECTIONS:

BIENNIAL REAPPOINTMENTS: (Effective Dates 04/01/2017 -03/31/2019)

The following application was recommended for reappointment to the medical staff office effective 04/01/2017 through 3/31/19:

- **MUHTASEB, Talal, MD/Obstetrics & Gynecology/Active**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
April 12, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 4/30/17, unless otherwise specified)

• BHARNE, Anjali MD	Oncology
• BROWN, Rica MD	Emergency Medicine
• CAPELLA, Marina MD	Pediatrics
• GOELITZ, Brian MD	Radiology
• KOCH, Richard MD	Emergency Medicine
• BROWN, Rica MD	Emergency Medicine
• LUDEMAN, Lori MD	Emergency Medicine
• MCCAMMACK, BRADLEY MD	Pediatrics
• SEIDEN, Grant MD	Orthopedic Surgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 12, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 4/30/2017.

- GANDHI, Dhruvil MD — Colon & Rectal Surgery
- JUREWITZ, William MD — OB/GYN
- MCCAMMACK, Bradley MD — Pediatrics
- MILLER, Jeffrey MD — Diagnostic Radiology
- SHAPIRO, Mark MD — Nephrology

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by October 31, 2017 would result in these privileges automatically relinquishing.

- COOPERMAN, Andrew MD — Orthopedic Surgery
- DAUGHERTY, David MD — Orthopedic Surgery
- GARNER, Darin MD — Emergency Medicine
- PARKER, Sherine MD — Pediatrics
- SHOWAH, Henry MD — Emergency Medicine

ADDITIONAL PRIVILEGE REQUEST (Effective 4/30/2017, unless otherwise specified)

The following practitioners requested the following privileges

- KELLY, Jon MD — Orthopedic Surgery
- TERRAMANI, Thomas MD — General/Vascular Surgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 12, 2017

CHANGE IN PRIVILEGE CARD (Effective 4/30/2017, unless otherwise specified)
The following practitioners are transitioning to the new version of the Neurosurgery Privilege Card.

- JONES, Pamela, MD — Neurosurgery
- KHALESSI, Alexander MD — Neurosurgery
- MARCISZ, Thomas MD — Neurosurgery

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 4/30/2017, unless otherwise specified)

The following practitioners are voluntarily relinquishing the following privileges.

- WILTSE, Lise MD — Anesthesiology

STAFF STATUS CHANGES

None.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
April 11, 2017

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following AHPs have met the basic requirements of staff and are therefore recommended for appointment effective 4/28/2017 through 3/31/2019:

- **FROST, Robert, Physician's Assistant/Allied Health Professional (UCSD)**
- **HARTIG, Margaret Nurse Practitioner/Allied Health Professional (The Neurology Center)**
- **NAST, Daniel Audiologist/Allied Health Professional (Specialty Care)**
- **PERLMAN, Tamara Certified Nurse Midwife/Allied Health Professional (No. County Health Svcs.)**
- **STABLER, Holly Physician's Assistant/ Allied Health Professional (Tri City Emergency Medical Group)**
- **VIERRA, Erin Nurse Practitioner/Allied Health Professional (Coastal Hospital Medical Assoc.)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
April 11, 2017

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 5/1/2017 – 4/30/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 5/1/2017 through 4/30/2019, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- ALLEN, Matthew, PAC/Allied Health Professional
- BAYUDAN INOCELDA, Andrew, PAC/Allied Health Professional
- BRADY, Kristina, AuD/Allied Health Professional
- BROCKMAN, Joe, PAC/Allied Health Professional
- BROWNSBERGER, Richard, PAC/Allied Health Professional
- CRESPO, Christopher, PAC/Allied Health Professional
- FOLKERTH, Jean, RN, CNOR, CRNFA/Allied Health Professional
- HERMANSON, Kathleen, PAC/Allied Health Professional
- JENKINS-SEBASTIANI, Christina, AuD/Allied Health Professional
- LISTER, Crystal, CNM/Allied Health Professional
- MCDONALD, April NP/Allied Health Professional
- MCNALLY, Paul NP/Allied Health Professional
- PREGERSON, Heather, PAC/Allied Health Professional
- GARBACZEWSKI, Stephanie, PAC/Allied Health Professional
- WEARY, Yong, CNM/Allied Health Professional

RESIGNATIONS:

No resignations

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
April 11, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 4/30/17, unless otherwise specified)

- SCOTT, Katie PAC — Emergency Medicine
- WEARY, Yong CNM — OB/GYN

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
April 11, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

ADDITIONAL PRIVILEGE REQUEST (Effective 4/30/2017, unless otherwise specified)
The following practitioners requested the following privileges

- **TAYLOR, Phyllis NP** **Medicine**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 4/30/2017, unless otherwise specified)

The following practitioners are voluntarily relinquishing the following privileges.

None.

STAFF STATUS CHANGES

None.

Tri-City Medical Center

Delineation of Privileges

Cardiothoracic Surgery - 6/07

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Division of Cardiothoracic Surgery consists of physicians who are Board Certified or are in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Cardiothoracic Surgery, or able to demonstrate comparable ability, training and experience.
ASSIST IN SURGERY: Cardiothoracic Surgeons are able to assist in Cardiac or Thoracic Surgery without proctoring.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Assist in Surgery

___ Admit Patients ___

___ Consultation, including via telemedicine (F) ___

___ Perform medical history & physical, including via telemedicine (F) ___

___ **CARDIAC SURGERY** ___
Initial: A total of (6) cases from this category must be submitted to initially be granted privileges from this category of procedures.
Proctoring: A total of (6) procedures from this category must be proctored. Assisting in Cardiac Surgery performing specific procedures will be accepted for Cardiac Surgery proctoring.
Proctoring for UCSD Cardiac Surgeon: A total of (4) procedures from this category must be proctored.
Reappointment: A total of (24) procedures from this category are required for recredentialing of the entire category of procedures.

___ Intra-Cardiac and Valve Surgery ___

___ Extra-Cardiac Surgery for Traumatic Injury Repair (Thoracic) ___

___ Thoracic Aneurysmectomy ___

___ Coronary Artery Bypass Procedure ___

___ Infarctectomy ___

OTHER:

___ Convergent Procedure for AFIB
Initial: A certificate of training must be submitted to initially be granted privileges for this procedure.

___ **THORACIC SURGERY** ___
Initial: A total of (5) cases from this category must be submitted to initially be granted privileges from this category of procedures.
Proctoring: A total of (5) procedures from this category must be proctored. Assisting in Cardiac Surgery performing specific procedures will be accepted for Thoracic Surgery proctoring.
Proctoring for UCSD Thoracic Surgeon: A total of (2) procedures from this category must be proctored.
Reappointment: A total of (6) procedures from this category are required for recredentialing of the entire category of procedures.

___ Trachea and bronchi - All procedures ___

___ Thorax - Chest Wall Aspiration ___

___ Thorax - Chest Wall Drainage ___

Tri-City Medical Center
Delineation of Privileges
Cardiothoracic Surgery - 6/07

Provider Name:

Request	Privilege	Action MSO Use Only
___	Thorax - Major Excisional procedure of the Chest Wall	___
___	Diaphragm - All procedures	___
___	Esophagus - All procedures	___
___	Lungs - All procedures	___
___	Mediastinum - Excision of tumors, cysts, etc.	___
___	Heart and Pericardium - Repair of Wounds	___
___	Pericardium - All procedures	___
___	Placement of Permanent Epicardial and Endocardial Pacing Systems	___
	OTHER:	
___	Thoracoscopy and Video assisted Thoracic Surgery Initial: A total of (2) cases must be submitted to initially be granted privileges for this procedure. Proctoring: (2) cases must be proctored. Reappointment: (10) cases required per every two year reappointment cycle.	___
___	Intra-Cardiac Cardio-converter Defibrillator Initial: A total of (2) cases must be submitted to initially be granted privileges for this procedure. Proctoring: (2) cases must be proctored. Reappointment: (2) cases required per every two year reappointment cycle.	___
___	Laser Surgery (YAG; CO2) to include TMR Initial: Proof of (2) completed cases required for initial appointment. Proctoring: (2) cases need to be proctored.	___

Physicians applying for privileges to use the laser in surgery must submit:
1.) A certificate indicating successful completion of a laser surgery course that should provide at least two hours of hands-on use of the laser equipment. Separate training must be documented for each wavelength of laser for which the physician is applying for privileges.
2.) Copies of two previous procedures performed with any type of surgical laser, if available.
3.) First two (2) laser cases must be proctored by a physician who holds unrestricted laser privileges.
4.) Proctor reports will be reviewed by Chief of Cardiothoracic Surgery and then reported to the Department of Surgery.
5.) Transmyocardial Laser Revascularization (TMR): Completion of an FDA approved instruction course on the use of CO2 Laser for TMR.

CORE ROBOTIC-ASSISTED SURGERY CRITERIA (da Vinci) (Refer to Credentialing Policy, Robotic Assisted Surgery #8710-563):

Surgeons with prior da Vinci experience:
Initial:
1. Physicians must have privileges to perform the underlying procedure as an open and thoracoscopic procedure.
2. If residency/fellowship training included robotic surgery training, provide:
a. Letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device as primary surgeon; and
b. Documentation of ten (10) da Vinci cases as primary surgeon (may be core or advanced cases, see CTS Rules & Regulations).
c. Proctoring: One (1) case within a one-hundred-eighty (180) day period must be proctored by a robotic-credentialed surgeon (preferably in their field). Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

Tri-City Medical Center
Delineation of Privileges
Cardiothoracic Surgery - 6/07

Provider Name:

Request	Privilege	Action MSO Use Only

Surgeons with prior da Vinci experience at an outside institution, provide:
a. Documentation of ten (10) cases as primary surgeon beyond proctoring and within the previous 24-month period (see CTS Rules and Regulations)
b. Proctoring: A minimum of one (1) case must be concurrently proctored by a robotic-credentialed surgeon (preferably in their field).

3. The above-listed proctoring requirements are waived for any surgeon on the Intuitive Surgical List of Approved Proctors.

Surgeons without prior da Vinci experience:
Initial:
1. Privileges to perform the underlying procedure either as an open or laparoscopic procedure.
2. Completion of an Intuitive Training Program or comparable program, which includes didactic and hands-on training including cadaver, animal lab, or simulator (See Phase II-Preparation and System Training of Surgeon Clinical Pathway-Intuitive Surgery). A minimum of one (1) live case observation.
3. Proctoring: Four (4) cases within a one hundred eighty (180) day period must be concurrently proctored by a robotic-credentialed surgeon (preferably in their field). Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

Reappointment: Ten (10) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present. (If less than 10 cases, refer to Policy 563)

(Select the procedures below)

___	**Robotic Surgery (da Vinci) - CORE PRIVILEGES**	___
___	**Closed Cardiac Cases**	___
___	Epicardial pacer lead placement	___
___	Left internal mammary artery/right internal mammary artery takedown, off-pump coronary artery bypass graft	___
___	Transmyocardial laser revascularization	___
___	Pericardial window	___
___	**Basic Thoracic Cases**	___
___	Thymectomy	___
___	Lung biopsy	___
___	Mediastinal exploration (lymph nodes, mass)	___
___	Pericardial cysts	___
___	Diaphragm plication	___
___	Esophageal myotomy for achalasia	___
___	**Robotic Surgery (da Vinci) - ADVANCED PRIVILEGES** Initial: See privileges below for specific criteria Proctoring: See privileges below for specific criteria Reappointment: Ten (10) Advanced Cardiac/Ten (10) Advanced Thoracic cases per two-year reappointment	___

Tri-City Medical Center
Delineation of Privileges
Cardiothoracic Surgery - 6/07

Provider Name:

Request	Privilege	Action MSO Use Only

cycle

___ **ADVANCED CARDIAC** ___

___ ASD/Cardiac tumor resection ___
Initial:
1. Unrestricted CORE privileges and
2. Training in Aortic Endo-Balloon (if technique to be used)
3. Endoscopic Suturing Skills Training (simulator or live case)
Proctoring: First 1 case.
Reappointment: See ADVANCED PRIVILEGE criteria above

___ Mitral valve repair ___
Initial:
1. Unrestricted CORE privileges
2. Case log of ten (10) successful mitral repairs (non-robotic)
3. Traning in Aortic Endo-Balloon (if technique used)
4. Endoscopic Suturing Skills Training (simulator or live case)
Proctoring: First 3 cases.
Reappointment: See ADVANCED PRIVILEGE criteria above

___ **ADVANCED THORACIC** ___
Initial: Unrestricted CORE privileges
Proctoring: First 1 case
Reappointment: See ADVANCED PRIVILEGE criteria above

___ Pulmonary Resection (other than wedge resection) ___

___ Esophageal resection (other than enucleation) ___

Assist in da Vinci robotic surgery for MD/DO, PA, RNFA Criteria (Refer to Credentialing Policy, Robotic-Assisted Surgery #8710-563):
Initial:
1. Unrestricted surgical assisting privileges
2. Documented experience in robotic assisting or completion of Intuitive Training Program for assistants on-line module
3. Documented on-site training by Intuitive or a robotics-trained assistant
Proctoring: Six (6) cases must be proctored by the primary surgeon

Reappointment: Ten (10) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present. (If less than 10 cases, refer to Policy 563)

(Select the procedure below)

___ Assist in robotic surgery (da Vinci) ___

___ Moderate Sedation - Refer to Medical Staff policy 8710-517 ___

___ Deep Sedation (Policy #517) - Refer to Medical Staff policy 8710-517 ___

_____
Print Applicant Name

_____
Applicant Signature

Tri-City Medical Center

Delineation of Privileges

Cardiothoracic Surgery - 6/07

Provider Name:

Request	Privilege	Action MSO Use Only

_____

Date

_____

Division/Department Signature

_____

Date

TRI-CITY HOSPITAL DISTRICT

MEDICAL STAFF BYLAWS

~~August 2013~~
February 2017

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Tri-City Hospital District and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the ~~Board of Directors~~Governing Body, and relations with applicants to and members of the Medical Staff. The organized Medical Staff both enforces and complies with these Medical Staff bylaws.

These bylaws recognize that the organized Medical Staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide policy, involving the oversight of care, treatment, and services provided by members and others in the hospital. The Medical Staff is also responsible for and involved with all aspects of delivery of health care within the hospital including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review.

These bylaws acknowledge that the provision of quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the hospital governing board for the proper performance of their respective obligations.

DEFINITIONS

1. CHIEF EXECUTIVE OFFICER means the person appointed by the ~~Board of Directors~~Governing Body to serve in an administrative capacity.

2. AUTHORIZED REPRESENTATIVE or the HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

3. ~~BOARD OF DIRECTORS~~GOVERNING BODY means the ~~governing body~~ Board of Directors of the Hospital.

4. CHIEF OF STAFF means the chief officer of the Medical Staff elected by members of the Medical Staff.

5. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to Medical Staff members to provide patient care and includes unrestricted access to those Hospital resources (including equipment, facilities, and Hospital personnel) that are necessary to effectively exercise those privileges.

6. HOSPITAL means Tri-City Hospital District.

7. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, of a concern or a complaint raised against a member of the Medical Staff, and does not include activity of the Physician Well Being Committee.

8. MEDICAL BOARD OF CALIFORNIA means the agency responsible for the licensing of physician members of the Medical Staff holding a M.D. degree.

9. OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA means the agency responsible for the licensing of physician members of the Medical Staff holding a D.O. degree.

10. MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff~~, which shall constitute the governing body of the Medical Staff as described in these Bylaws~~.

11. MEDICAL STAFF or STAFF means those physicians, dentists, and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

12. MEDICAL STAFF YEAR means the period from July 1 to June 30.

13. MEMBER means, unless otherwise expressly limited, any physician, dentist, or podiatrist holding a current license to practice within the scope of his or her license that is a member of the Medical Staff.

14. PHYSICIAN means an individual with a M.D. or D.O. degree or their equivalent. "Their equivalent" shall mean any degree (i.e., foreign) recognized by the licensing boards in the State of California to practice medicine.

15. PRACTITIONER means an individual licensed to practice one of the professions eligible for membership in the Medical Staff.

16. IN GOOD STANDING means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules, and regulations or policy of the Medical Staff.

17. SELF GOVERNANCE DOCUMENTS means documents that supplement the bylaws (i.e., rules and regulations and policies).

ARTICLE I: NAME

The name of this organization is the Tri-City Hospital District Medical Staff.

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital or via telemedicine unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Medical Staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists, or podiatrists who:

(a) Document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, and (6) not currently excluded from any governmental healthcare program, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonable expect to receive quality medical care.

(b) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work co-operatively with others so as not to adversely affect patient care, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

(c) Maintain ~~in force~~current professional liability insurance coverage in accordance with ~~a carrier that is approved by the California State Insurance Commission~~Board Policy 14-038. Minimum coverage will be established by the Medical Executive Committee with the concurrence of the ~~Board of Directors.~~ Governing Body. Coverage must extend to all clinical privileges sought to be exercised. For physicians with "claims made malpractice insurance," prior acts coverage must be secured by the physician, i.e. tail and/or nose coverage must be documented. With respect to initial applicants, the prior acts coverage requirement may be waived or modified on a case-by-case basis by the Medical Executive Committee acting through the Chief of Staff or his or her designee.

(d) Shall be deemed to possess basic qualifications for membership in the Medical Staff, except for the honorary staff category in which case these criteria shall only apply as deemed individually applicable by the Medical Staff.

2.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for membership on the Medical Staff, except for the honorary staff, must hold a M.D. or D.O. degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Board of California or the ~~Board of~~ Osteopathic ~~Examiners of the State~~Medical Board of California. The applicant must present evidence of completion of a residency approved by the ~~Council on~~Accreditation Council for Graduate Medical Education. If the applicant has not completed a residency as outlined above, he or she must prove that his or her training is equivalent. The applicant must also hold a valid and unsuspended certificate to

practice medicine issued by the Medical Board of California or ~~Board of~~ Osteopathic ~~Examiners of the State of~~ Medical Board of California.

(b) Limited License Practitioners

(1) Dentists: An applicant for dental membership on the ~~medical~~Medical Staff, except for the honorary staff, must hold a D.D.S., D.M.D. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Board of Dental Examiners of California and must also hold a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of the State of California.

(2) Podiatrists: An applicant for podiatric membership on the Medical Staff, except for the honorary staff, must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Medical Board of California and must hold a valid and unsuspended certificate to practice podiatry issued by the ~~Medical~~California Board of ~~California~~Podiatric Medicine.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation or other organization or in contracts with a third party which contracts with this Hospital. Medical Staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the members professional or business interests.

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, ~~or~~ national origin, ~~or~~ physical or mental impairment or sexual orientation that does not pose a threat to the quality of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary staff, the ongoing responsibilities for each member of the Medical Staff include:

(a) Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital and Hospital policies and procedures.

(b) Abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations and Medical Staff Policies and Procedures~~.~~, and Hospital Policies and Procedures.

(c) Discharging in a responsible and cooperative manner, such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments.

(d) Preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the Hospital.

(e) Abiding by the lawful ethical principles of the American Medical, Dental, and Podiatry Associations.

(f) Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel.

(g) ~~Working cooperatively with members~~Abide by the Medical Staff's Professional Behavior Policy, and Tri-City Healthcare District's Code of Conduct working cooperatively with fellow medical staff members, Allied Health Professionals, nurses, Hospital Administration, and others and refraining from any abusive or disruptive behavior, which could adversely affect the delivery of patient care.

(h) Making appropriate arrangements for the continuous and uninterrupted coverage for his or her patients as determined by the Medical Staff, as reflected in Medical Staff Rule and Regulation number 3.

(i) Refusing to engage in improper inducements or fee splitting for patient referral.

(j) Participating in continuing education programs as determined by the Medical Staff.

(k) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff. Abide by EMTALA requirements. Additional on-call coverage may be mandated only upon majority vote of the Medical Staff.

(l) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

(m) Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.1-3, and those, which are the subject of a hearing pursuant to Article VII.

(n) Notify the Medical Staff Office upon notification of:

(1) Any past ~~or~~ pending or current sanctions by the ~~Medical Board~~applicable licensing/certifying entity, the DEA or exclusions from a federal health care program;

(2) Any convictions or guilty pleadings to a criminal offense(s) (i.e., a felony or misdemeanor other than traffic violations) and/or any deferred adjudication or probation for a criminal offense(s) (including accusation(s) of sexual misconduct) within thirty (30) days of final written resolution; (3) any current or pending enrollment in a drug or alcohol treatment program (voluntary or involuntary) within thirty (30) days of enrollment.

(o) Participating in an Organized Health Care Arrangement (OHCA) as established between the hospital and the Medical Staff to expedite the sharing of data for improvement of patient care and operations.

~~2.6 HARASSMENT PROHIBITED~~

2.6 ~~Harassment~~STANDARD OF CONDUCT

2.6-1 As a condition of membership and privileges, a Medical Staff member shall continuously meet the requirements for professional conduct established in these Bylaws and as further described in the Medical Staff's Professional Behavior policy and Tri-City Healthcare District's Code of Conduct.

2.6-2 Prohibited conduct affects or could affect the quality of patient care at the hospital and includes:

~~2.6-1~~(a) Discrimination, which is defined as conduct by a Medical Staff member against any individual (e.g., against another Medical Staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation ~~shall not be tolerated~~.

~~2.6-2~~(b) "Sexual harassment" is an unwelcome verbal or physical conduct of a sexual or gender-based nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment also includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment.

(c) Behavior that undermines a culture of safety (also sometimes referred to as disruptive behavior), as described in the Medical Staff's Professional Behavior policy.

~~2.6-3 Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct, which indicates that employment, and/or employment benefits are conditioned upon acquiescence in sexual activities.~~

~~2.6-4~~2.6-2 All allegations of ~~sexual harassment~~such prohibited conduct shall be immediately investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of Medical Staff privileges or membership, if warranted by the facts.

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: ~~active, consulting, associate, courtesy~~Active, Active Affiliate, Refer and Follow, provisional, and honorary~~, temporary and affiliate~~. Each time membership is granted or renewed, the member's staff category shall be determined.

3.2 ACTIVE STAFF

Are practitioners who are involved in at least 12 patient care or Medical Staff activities per year; these may consist of admissions, assisting at surgeries, consultations, other patient care procedures and/or active service on Medical Staff committees.

3.2-1 QUALIFICATIONS

The active staff shall consist of members who:

(a) Meet the general qualifications for membership set forth in Section 2.2.

(b) Have offices or residences, which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide continuity of quality care.

~~(c) Are involved in at least 12 patient care or Medical Staff activities per year; these may consist of admissions, assisting at surgeries, consultations, other patient care procedures and/or active service on Medical Staff committees.~~

~~(d)~~(c) Have satisfactorily completed their designated term in the provisional staff category.

3.2-2 PRIVILEGES

Except as otherwise provided, the PRIVILEGES of an active staff member shall be to:

(a) Exercise such clinical privileges as are granted pursuant to Article V.

(b) Attend and vote on Medical Staff bylaws and amendments and all other matters presented at general and special meetings of the Medical Staff and of departments and committees of which he or she is a member.

(c) Hold staff, division, or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof so long as the activities required by the position fall within the member's scope of practice as authorized by law.

Active staff members must provide emergency service coverage on a rotating panel unless specifically exempted by the Medical Executive Committee.

3.2-3 TRANSFER OF ACTIVE STAFF MEMBERS

After one staff year in which a member of the active staff fails to regularly care for patients in accordance with Section 3.2-1(c), or be regularly involved in Medical Staff functions as

determined by the Medical Executive Committee, that member shall be automatically transferred to the appropriate category if any, for which the member is qualified.

~~CONSULTING~~

3.3 ACTIVE AFFILIATE STAFF

Are practitioners who are considered to be in good standing and who may admit or otherwise be involved in the care of patients at TCMC, documenting a minimum of twelve (12) patient care activities within a two (2) year time period, or are telemedicine-only providers.

3.3-1 QUALIFICATIONS

~~Any member of the Medical Staff in good standing may consult in his or her area of expertise; however, the consulting Medical Staff shall~~Shall consist of such practitioners who:

(a) Are not otherwise members of the Medical Staff and meet the general qualifications set forth in Section 2.2~~, except that this requirement shall not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee~~.

~~(b) May provide Telemedicine services.~~

~~(b)~~(c) Possess adequate clinical and professional expertise.

~~(c)~~(d) Are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence.

~~(d)~~(e) Are members in good standing of the active Medical Staff of another health care facility ~~whose quality assurance and Focused Practitioner Performance Review activities are sufficient to assure current clinical competence.~~.

~~(e)~~(f) Have satisfactorily completed their designated term in the provisional category.

3.3-2 PRIVILEGES

The ~~consulting~~Active Affiliate staff shall be entitled to:

~~(a) Exercise such clinical privileges as are granted pursuant to Article V, but shall not admit patients.~~

(a) Admit patients without limitation, except as otherwise provided in the Medical Staff Rules & Regulations, or by specific privilege restriction.

(b) Attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

~~Consulting~~Active Affiliate staff members shall not be eligible to hold office in the Medical Staff organization, but may serve committees.

3.4 ~~ASSOCIATE~~REFER AND FOLLOW STAFF

Are practitioners who maintain membership limited to contracted administrative processes without other obligations, or have an active community office practice and routinely utilize TCMC's outpatient and inpatient referral services and wish to maintain medical staff membership status;

3.4-1 QUALIFICATIONS

The ~~associate~~Refer and Follow staff shall consist of members who:

(a) Meet the general qualifications set forth in Section 2.2.

~~(b) Are part-time Hospital based physicians.~~

~~(c) Provide telemedicine services~~

~~(d) Are physicians, dentists, or podiatrists who infrequently work for Medical Staff members. Physicians who regularly admit or treat patients on an ongoing basis at this medical center, as a part of the private medical practice, shall not be eligible for this status.~~

~~(e) Are physicians functioning only as surgical assistants. The surgical assistants may not admit patients or write orders.~~

~~(f) Have satisfactorily completed appointment in the provisional staff category. Dues may be waived for associate staff members at the discretion of the Medical Executive Committee. Associate staff members are not required to attend meetings nor participate in emergency service coverage. However, such members are welcome to attend Medical Staff meetings in a non-voting capacity.~~

3.4-2 PRIVILEGES

(a) Refer and Follow staff members do not have privileges to admit or otherwise provide patient care but are still required to maintain malpractice insurance;
(b) Will be responsible to pay any annual or reappointment fees.
(c) Has "view only" access to their patient's Health information record, and will not be allowed to enter orders in the patient's health record.
(d) Shall not nominate or vote on any matters presented at general or special meeting of the Medical Staff or any Committee or the Department of which they are members.
(e) May attend a General meeting of the Medical Staff and Department of which they are appointed and any Educational program offerings.

~~3.5 COURTESY STAFF~~

~~3.5-1 QUALIFICATIONS~~

~~The courtesy staff shall consist of members who:~~

~~(a) Meet the general qualifications set forth in Section 2.2.~~

~~(b) Are involved in not more than 12 patient care activities including admissions, assisting in surgeries, consultations, or other patient care procedures but at least two (2) patient care and/or Medical Staff activities as defined in Section 3.2-1 (c) per year.~~

~~(c) Are members in good standing of the active Medical Staff of another health care facility whose quality assurance and Focused Practitioner Performance Review activities are sufficient to assure current clinical competence.~~

~~(d) Have successfully completed their designated term in the provisional staff category.~~

~~3.5-2 PRIVILEGES~~

~~Except as otherwise provided, the courtesy Medical Staff member shall be entitled to:~~

~~(a) Participate in the care of patients within the limitations of Section 3.5-1 (b) and exercise such clinical privileges as are granted pursuant to Article V.~~

~~(b) Attend, in a non-voting capacity, meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and education programs.~~

~~(c) Serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.~~

~~Courtesy staff members shall not be eligible to hold office in the Medical Staff.~~

~~3.5-3 LIMITATION~~

~~Courtesy staff members who admit or regularly care for more than twelve patients in a Medical Staff year shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.~~

(c)

~~2.63.5~~ PROVISIONAL STAFF

Is a temporary category which all newly appointed ~~physicians~~practitioners with clinical privileges must be assigned for observation to demonstrate proficiency and competency.

~~3.6-13.5-1~~ QUALIFICATIONS

The provisional staff shall consist of all members who:

(a) Meet the general Medical Staff membership qualifications set forth in Section 2.2.

(b) Immediately prior to their application and appointment, were not members of the Medical Staff.

~~3.6-23.5-2~~ PRIVILEGES

The provisional staff member shall:

(a) Exercise such clinical privileges as are granted pursuant to Article V.

(b) Attend meetings of the Medical Staff and the department of which he or she is a member, including committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

(c) Be entitled to serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.

(d) Provisional staff members shall not be eligible to hold office in the Medical Staff organization.

~~3.6-33.5-3~~ OBSERVATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The observation shall be to evaluate the member's:

(a) Proficiency in the exercise of clinical privileges initially granted; and

(b) Over-all eligibility for continued staff membership and advancement within staff categories.

Observation of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chairman to the Medical Executive Committee.

~~3.3-43.5-4~~ TERM OF PROVISIONAL STAFF STATUS

A member shall be eligible to request advancement from provisional staff after a minimum period of six (6) months if the member's proctoring is fully completed. Otherwise, a member

remains in the provisional staff for a period of 24 months unless that status is extended by the Medical Executive Committee upon determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.6-53.5-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active or Active Affiliate~~, active, consulting, associate, or courtesy~~ staff, as appropriate, upon recommendation of the Medical Executive Committee.

(b) In all other cases, the appropriate department shall advise the Medical Executive Committee which, in turn, shall make its recommendation to the ~~Board of Directors~~ Governing Body regarding a modification or termination of clinical privileges

3.73.6 HONORARY STAFF

~~3.7-1~~9.1-1 ~~QUALIFICATIONS~~

The honorary staff shall consist of physicians, dentists and podiatrists who do not actively practice at the Hospital but whom the Medical Executive Committee deems deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital and who continue to exemplify high standards of professional and ethical conduct.

3.7-23.6-1 PRIVILEGES

Honorary staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff meetings and educational programs.

~~3.8 ADMINISTRATIVE STAFF~~

~~3.8-1 QUALIFICATIONS~~

~~Administrative staff category membership shall be held by any physician who is not otherwise eligible for another category of membership and who is retained by the Medical Staff or hospital solely to perform ongoing medical administrative activities.~~

~~The administrative staff shall consist of members who:~~

~~(a) Are charged with assisting the Medical Staff in carrying out medical-administrative functions, including but not limited to quality assessment, quality improvement, and utilization review;~~

~~(b) Document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties;~~

~~(c) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.~~

3.8-2 PREROGATIVES

The administrative staff shall be entitled to attend meetings of the Medical Staff and various departments, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.

Administrative staff members shall not be eligible to (1) hold office in the Medical Staff organization, (2) admit patients, (3) exercise clinical privileges, (4) appeal rights, hearings, and appellate reviews. They shall not be required to carry professional liability insurance in connection with their activities for the Medical Staff or hospital. Medical staff dues shall be reduced by one-half for this category of membership.

3.9 TEMPORARY STAFF

3.9-1 QUALIFICATIONS

The temporary staff shall consist of physicians, dentists and podiatrists who do not actively practice at the Hospital but are important resource individuals for Medical Staff quality assurance or patient care activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff.

3.9-2 PRIVILEGES

(a) Temporary Medical Staff members who are appointed to engage in quality assurance activities, Focused Practitioner Performance Review and or related functions without clinical privileges shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assurance functions. They shall have no privileges to perform clinical services in the Hospital. They may not admit patients to the hospital, or hold office in the Medical Staff organization. They may, however, serve on designated committees with or without vote at the discretion of the Medical Executive Committee. They may attend other Medical Staff meetings upon invitation.

3.10 AFFILIATE STAFF

3.10-1 QUALIFICATIONS

The Affiliate Staff shall consist of members who:

(a) The affiliate staff shall consist of physicians / dentists, podiatrists who do not actively practice at the hospital but are an important resource for the Medical Staff.

3.10-2 PRIVILEGES

The Affiliate Staff member shall:

(a) Are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in the Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs.

(b) Shall pay dues.

~~(c) Will not have any hearing / or appeal rights.~~

~~(d) Not be subject to the requirement for Provisional Staff term described in Section 3.6 of these Bylaws.~~

~~3.11 LIMITATION OF PRIVILEGES~~

~~The privileges set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff Rules and Regulations.~~

~~3.12~~3.7 GENERAL EXCEPTIONS TO PRIVILEGES

Regardless of the category of membership in the Medical Staff, unless otherwise required by law, limited license members:

(a) Shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chairman of the meeting, subject to final decision by the Medical Executive Committee.

(b) Shall exercise clinical privileges only within the scope of their licensure and set forth in Section 5.4.

~~3.13~~3.8 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, or upon recommendation of a specific department, or pursuant to a request by a member under Section 4.6-1 (b), or upon direction of the ~~Board of Directors~~ Governing Body and the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

~~3.14~~3.9 ALLIED HEALTH PROFESSIONALS

Refer to Rules and Regulations for Allied Health Professionals.

ARTICLE IV: MEMBERSHIP AND MEMBERSHIP RENEWAL

4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital or via telemedicine unless and until he or she applies for and obtains membership on the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for membership or membership renewal, the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist and as they may be modified from time to time. Membership to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for membership, membership renewal, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent of the law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee.

4.3 MEMBERSHIP AUTHORITY

Memberships, denials and revocations of memberships to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff as set forth in Section 4.5-6 and 4.5-7.

4.4 DURATION OF MEMBERSHIP AND MEMBERSHIP RENEWAL

Except as otherwise provided in these Bylaws, initial membership to the Medical Staff shall be for a period of up to twenty-four months. Membership renewal shall be for a period of up to two years.

4.5 APPLICATION FOR INITIAL MEMBERSHIP AND MEMBERSHIP RENEWAL

4.5-1 APPLICATION FORM

An application form shall be developed by the Medical Executive Committee. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA (Drug Enforcement Administration) registration, continuing medical education information related to the clinical privileges to be exercised by the applicant, and documentation of the results of a current tuberculosis skin test. The requirement for DEA registration may be waived on the recommendation of the Credentials Committee to practitioners who do not need such prescriptive authority.

(b) At least (3) peer references familiar with the applicant's professional competence and ethical character.

(c) Requests for membership ~~categories~~category, departments, and clinical privileges.

(d) Past or pending professional disciplinary action, voluntary or involuntary relinquishment of Medical Staff membership or privileges or any license or registration, licensure limitations, and related matters. For the purposes of this section, voluntary actions shall only include those taken while under investigation for possible incompetence ~~of~~or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted.

(e) Final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending.

(f) Physical and mental health status.

(g) Professional liability insurance coverage as required.

Each application for initial membership to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, he or she shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and summaries of other applicable policies relating to clinical practice in the Hospital, if any.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1, by applying for membership to the Medical Staff each applicant:

(a) Signifies his or her willingness to appear for interviews in regard to the application.

(b) Authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications and ability to carry out clinical privileges requested, and authorizes such individuals and organizations to candidly provide all such information.

(c) Consents to inspection of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying, releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.

(d) Releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant.

(e) Consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law.

(f) Acknowledges responsibility for timely payment of any Medical Staff dues payable, if any.

(g) Agrees to provide for continuous and quality care for his or her patients.

(h) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

(i) Pledges to be bound by the Medical Staff bylaws, rules and regulations, and policies.

(j) Recognizes that applicant has no procedural rights in connection with an application ~~rejected~~deemed voluntarily withdrawn for incompleteness.

(k) Agrees that if membership and privileges are granted, and for the duration of Medical Staff membership, the member has an ongoing and continuous duty to report to the Medical Staff office within ten (10) days any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication when such correction, change, modification or addition may reflect adversely on current qualifications for membership or privileges.

4.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the ~~Chief Executive Officer or~~ Medical Staff Credentials Coordinator with payment of application fee, if any is required. ~~The application and all supporting materials then available shall be transmitted to the chairman of each department in which the applicant seeks privileges and to the Credentials Committee. The Credentials Committee shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.~~ If all references and other information required to process the application are not received within ninety (90) days from the date application was first submitted, the application is automatically deemed to be incomplete and ~~rejected~~deemed to be voluntarily withdrawn for that reason. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s). The completed application and all supporting materials then available shall be made available for review to the chairman of each department in which the applicant seeks privileges and to the Credentials Committee. The medical staff Credentials Coordinator shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.

4.5-4 DEPARTMENT ACTION

After receipt of the application, the chairman or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his or her discretion. The chairman or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a written report and recommendation as to membership and, if membership is recommended, as to membership

category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chairman may also request that the Medical Executive Committee defer action on the application.

4.5-5 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, evaluate, and verify the supporting documentation, the department chairman's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the membership. The committee may also recommend that the Medical Executive Committee defer action on the application.

4.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Chief Executive Officer, for prompt transmittal to the ~~Board of Directors~~Governing Body, a written report and recommendations as to Medical Staff membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted and any special conditions to be attached to the membership. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the ~~Board of Directors~~Governing Body.

(b) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the ~~Board of Directors~~Governing Body and the applicant shall be promptly informed by written notice from the Chief Executive Officer. The applicant shall then be entitled to the procedural rights as provided in Article VII, except as provided in Section 4.5-3.

4.5-8 ACTION ON THE APPLICATION

The ~~Board of Directors~~Governing Body may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on applications:

(a) If the Medical Executive Committee issues a favorable recommendation, ~~the Board of Directors shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.~~and

(1) If the ~~Board of Directors~~Governing Body concurs in that recommendation, the decision of the ~~Board~~Governing Body shall be deemed final action.

(2) If the tentative recommendation of the ~~Board of Directors~~Governing Body is unfavorable, the Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If the applicant waives his or her procedural rights, the decision of the ~~Board~~Governing Body shall be deemed final action.

(b) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VII shall apply.

(1) If the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the ~~Board for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence~~Governing Body for final action.

(2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 4.5-8(b) or an adverse ~~Board of Directors~~Governing Body tentative final action pursuant to 4.5-8(a)(2), the ~~Board of Directors~~Governing Body shall take final action only after the applicant has exhausted his or her procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the ~~Board~~Governing Body shall make a final decision ~~and shall affirm the decision of the Judicial Review Committee, if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.~~. The ~~Board's~~Governing Body's decision shall be in writing and shall specify the reasons for the action taken.

(3) ~~If a hearing is requested and the decision of a Judicial Review Committee is favorable to the applicant and if the Board of Directors concurs in the unfavorable recommendation of the Medical Executive Committee following an appeal pursuant to Article VII, the decision of the Board shall be deemed final action. However, if the tentative action of the Board of Directors is favorable to the applicant, the matter shall be referred to the Professional Affairs Committee of the Board for consideration and resolution within fifteen (15) days and such committee shall have access to all records from the hearing and appeal. The decision for the Professional Affairs Committee of the Board shall be in writing within thirty (30) days of receipt of the matter unless extended by that committee for good cause. The decision shall specify the reasons for the action taken. The decision of the Board of Directors shall constitute final action.~~

4.5-9 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the chairman of each department concerned, the applicant, and the Chief Executive Officer.

(b) A decision and notice of initial membership or membership renewal shall include, if applicable: (1) the staff category to which the applicant is assigned membership; (2) the department to which he or she is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the membership.

4.5-10 REAPPLICATION AFTER ADVERSE MEMBERSHIP DECISION

An applicant who has received a final adverse decision regarding membership shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5-11 TIMELY PROCESSING OF APPLICATIONS

Applications for staff membership shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute a good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

(a) Evaluation, review, and verification of application and all supporting documents by the Medical Staff office: thirty (30) days from receipt of all necessary documentation.

(b) Review and recommendation by department(s): sixty (60) days after receipt of all necessary documentation from the Medical Staff office.

(c) Review and recommendation by Credentials Committee: thirty (30) days after receipt of all necessary documentation from the department(s).

(d) Review and recommendation by Medical Executive Committee: thirty (30) days after review of all necessary documentation by the Credentials Committee and appropriate department(s).

(e) Final action: thirty (30) days after conclusion of action in 4.5-11 (a through d) above or conclusion of hearings.

4.6 MEMBERSHIP RENEWAL AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 APPLICATION

(a) At least ninety (90) days prior to the expiration date of the current staff membership, a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the member. At least forty-five (45) days prior to the expiration date, each Medical Staff member shall submit to the Credentials Committee the completed application form for renewal of membership to the staff ~~for the new two years~~, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3. If an application has not been received forty-five (45) days prior to a staff member's expiration date, a written notice should be promptly sent to the applicant by certified mail, advising that the application has not been received.

(b) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time to the Credentials Committee in the form prescribed for applications for renewal of membership, except that such application may not be filed within six (6) months of the time a similar request has been denied.

4.6-2 EFFECT OF APPLICATION

The effect of an application for membership renewal or modification of staff status and privileges is the same as set forth in Section 4.5-2.

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits ~~the first~~an application for ~~membership renewal, and every two years thereafter~~reappointment, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in depth review, generally following the procedures set forth in Section 4.5-3 through Section 4.5-11. ~~If an Active Staff or a Courtesy Staff member had no Hospital activity during the two years preceding membership renewal and, therefore, has no basis on which professional performance can be reviewed, he or she will be recommended for renewal of membership to the Affiliate Staff.~~

~~4.6-4 EXTENSION OF MEMBERSHIP~~

~~If it appears that an application for membership renewal will not be fully processed by the expiration date of the member's membership, for reasons other than due to the re-applicant's failure to return documents or otherwise timely cooperate in the membership renewal process, the Medical Executive Committee and the Board of Directors (or its duly appointed committee in expedited cases) shall approve a time and member-specific extension of the member's status and clinical privileges. With respect to such delays not caused by the staff member, if for any reasons the Medical Executive Committee and/or Board of Directors (or its duly appointed committee in cases eligible for expedited processing) fails to approve an extension or the extension time runs out prior to completion of membership renewal procedures, the member's membership and privileges shall be temporarily re-granted without interruption until processing of the reapplication is completed. Any extension of membership pursuant to this Section does not create a vested right in the member for continued membership through the entire next term but only until such time as processing of the application is concluded. The member shall continue to be subject to the reapplication review process as outlined in Sections 4.5-3 through 4.5-11. Failure by the member to timely complete and return the membership renewal application form or provide other documentation or cooperation will result in termination of the member's membership.~~

~~4.6-5~~4.6-4 FAILURE TO FILE MEMBERSHIP RENEWAL APPLICATION

Failure without good cause to timely file a completed application for renewal of membership shall result in the ~~automatic suspension of the member's admitting~~ member being deemed to have resigned membership and privileges ~~and expiration of other practice privileges and prerogatives at the~~ as of the end of the current staff ~~membership~~appointment~~, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. If the member fails to submit a completed application for membership renewal within 30 days past the date it was due, the member shall be deemed to have resigned membership in the Medical Staff.~~. In the event membership ~~terminates~~and privileges terminate for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed two (2) years~~.~~ or duration of current appointment, whichever is first. During the period of the leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, and membership renewal as specified in section 4.4, shall continue unless waived by the Medical Executive Committee.

4.7-2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedures provided in Sections 4.1 through 4.5-11 shall be followed.

4.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement in a timely fashion shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and privileges.

A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial membership.

4.7-4 MEDICAL LEAVE OF ABSENCE

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

4.7-5 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of 4.7-2 and 4.7-3, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee.

ARTICLE V: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member providing clinical services at this Hospital or via telemedicine shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Hospital specific, within the scope of any license authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the Rules and Regulations of the clinical departments and the authority of the department chairman and the Medical Staff. Medical Staff privileges may be granted, continued, modified, or terminated by the ~~Board of Directors~~Governing Body ~~of this Hospital~~ only ~~upon recommendation of the Medical Staff, only for reasons directly related to quality of care and other~~in a manner consistent with these ~~provisions of the~~ Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

Each application for initial membership or renewal of membership to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 BASIS FOR PRIVILEGES DETERMINATION

(a) Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and proctoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

(b) No specific privilege may be granted to a member if the task, procedure, or activity constituting the privilege is not available within the hospital despite the member's qualifications or ability to perform the requested privilege. Refer to Medical Staff Policy, Requests for *Privileges New to Tri-City Medical Center, 8710-526.*

5.2-3 CRITERIA FOR "CROSS-SPECIALTY" PRIVILEGES WITHIN THE HOSPITAL

Any request for clinical privileges that are either new to the hospital or that overlap with more than one department shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. The Medical Executive Committee shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad-hoc committee with representation from all appropriate departments.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

~~Except as otherwise determined by the Medical Executive Committee, all~~All initial appointees to the Medical Staff who are granted privileges and all members granted new clinical privileges shall be subject to a period of focused evaluation that may include proctoring in accordance with the applicable departmental proctoring policy. Members who have had their privileges restricted and who are applying for the reinstitution of those privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases, as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chairman of the department, or the chairman's designee, during the period of proctoring specified in the department's Rules and Regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chairman or his designee. Refer to Medical Staff Policy *Focused Professional Practice Evaluation/Proctoring, 8710-542.*

5.3-2 FAILURE TO OBTAIN PROCTORING CERTIFICATION

Refer to Medical Staff Policy, *Focused Professional Practice Evaluation/Proctoring, 8710-542.*

~~5.3-3 MEDICAL STAFF ADVANCEMENT~~

~~The failure to obtain certification for any specific clinical privilege shall not, of itself, preclude advancement in Medical Staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified period of time. Refer to Medical Staff Policy, *Focused Professional Practice Evaluation/Proctoring, 8710-542.*~~

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSION

When dentists, oral surgeons, or podiatrists who do not hold history and physical privileges who are members of the Medical Staff admit patients, a physician member of the Medical Staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, oral surgery, or podiatry) and assume responsibility for the care of the patient's medical problems present at the time of admission, or which may arise during hospitalization, which are outside of the limited license practitioner's lawful scope of practice.

5.4-2 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chairman of the Department of Surgery or the chairman's designee.

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a

physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the chairman of the appropriate department(s).

5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges are allowed under two circumstances only; (1) to address a patient care need and (2) to finalize a pending application.

5.5-1 PATIENT CARE NEEDS

(a) Care of a Specific Patient

Temporary clinical privileges may be granted for a specified period not to exceed sixty (60) days where good cause exists, to a physician, dentist or podiatrist for the care of a specific patient, provided that the procedure described in Section 5.5-~~2~~(a)(1) has been followed and Medical Staff Policy, *Temporary Privileges, 8710-515,* has been followed. No individual shall be granted such privileges for more than 120 days per calendar year.

(b) Locum Tenens

Following the procedures in Section 5.5-~~2~~(a)(1), temporary privileges may be granted to a person serving as a locum tenens for a current member of the Medical Staff. Such person may attend only patients of the member(s) for whom he or she is providing coverage. Such privileges shall be granted for a period not to exceed sixty (60) days, unless the Medical Executive Committee recommends a longer period not to exceed beyond 120 days for good cause. The locum tenens physician must apply for the appropriate category of staff membership if a longer period of coverage is requested

(c) Disaster Privileges

Disaster privileges may be granted when TCMC Emergency Management Plan has been activated. The CEO, Chief of Staff, or designee may grant such privileges in accordance with Medical Staff Policy, *Disaster Privileges, 8710-553.*

5.5-2 PENDING APPLICATION FOR ~~PERMANENT~~ MEDICAL STAFF MEMBERSHIP

Temporary clinical privileges may be granted while that person's application for ~~permanent~~ Medical Staff membership and privileges are pending Medical Executive Committee and ~~Board of Directors~~ Governing Body approval provided that the procedure described in Section 5.5-4 (a) (2) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of Medical Staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 120 days.

~~5.5-3 TEMPORARY MEMBERSHIP AND TEMPORARY PRIVILEGES NOT CO-EXTENSIVE~~

~~Temporary members of the Medical Staff pursuant to Section 3.8 are not, by virtue of such membership, granted temporary clinical privileges.~~

~~5.5-4~~ 5.5-3 APPLICATION AND REVIEW

(a) Upon receipt of a completed application and all required fees and supporting documentation, including responses to all requests for information, from a physician, dentist or podiatrist who is authorized to practice in California, ~~and who meets one of the requirements of Section 5.5-1,~~ the CEO, or designee, upon recommendation of the Department Chair and the Chief of Staff, may grant temporary privileges to an individual who appears to have qualifications, ability and judgment consistent with Section 2.2 (Particular Qualifications), but only~~:~~ after a National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified, and:

(1) With respect to applications by locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or

~~(2) With respect to a new applicant awaiting review and approval of the Medical Executive Committee and the governing board in compliance with requirements in section 5.5-2, after the following has been completed:~~

~~a. The National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.~~

~~(3)~~(2) ~~The~~With respect to both types of applicant, the appropriate department chairperson(s) or designee has reviewed the application and has ~~reviewed~~verified the practitioner's current competency by reviewing the peer reference of at least one person who:

a. Has recently worked with the applicant;

b. Has directly observed the applicant's professional performance over a reasonable time; and

c. Provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care.

d. ~~Has~~If the Medical Staff has followed Medical Staff Policy, *Temporary Privileges,* 8710-*515*.

~~(4)~~(3) The applicant's file, including the recommendation of the ~~department chairperson of the~~ applicable department ~~when available~~ chairperson and Chief of Staff, is reviewed;

~~(5)~~(4) The Chief of Staff recommends and the ~~Board of Directors~~Governing Body, through the Chief Executive Officer, concurs in the granting of temporary privileges

~~(6)~~(5) In the event of a disagreement between the ~~Board~~Governing Body and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be ~~resolved~~ referred to ~~by~~ the ~~Professional Affairs~~Joint Conference Committee ~~of the Board~~.

(b) The omission of any information, response, or recommendation specified in this Section shall preclude the granting of temporary privileges.

~~5.5-5~~5.5-4 GENERAL CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chairman to which the applicant has been assigned, and shall ensure that the chairman, or the chairman's designee, is kept closely informed as to his or her activities within the Hospital.

(b) Temporary privileges shall automatically expire at the end of the designated period, unless earlier terminated by the Medical Executive Committee upon recommendation of the department or Credentials Committee or unless affirmatively renewed following the procedure as set forth in Section 5.5-~~2~~4.

(c) Requirements for proctoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Chief of Staff after consultation with the department chairman or his designee.

(d) A person shall not be entitled to the procedural rights afforded by Article VII~~.~~ because of the automatic expiration of temporary privileges pursuant to 5.5-3(b).

~~(e) Because of the automatic expiration of temporary privileges pursuant to 5.5-3(b).~~

(e) . All persons requesting or receiving temporary privileges shall be bound by the Bylaws ~~and~~, Rules ~~and~~& Regulations of the Medical Staff.

~~(f)~~

5.6 EMERGENCY PRIVILEGES

(a) In the case of an emergency involving a particular patient, any member of the Medical Staff, to the degree permitted by his or her scope of license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm. The member shall make every reasonable effort to communicate promptly with the appropriate department chairman concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chairman with respect to further care of the patient at the Hospital.

(b) In the event of an emergency under subsection (a), any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes available.

(c) Emergency privileges under subsection (a) shall not be used to force members to serve on emergency department call panels providing services for which they do not hold delineated clinical privileges

5.7 HISTORY AND PHYSICAL PRIVILEGES

Histories and physicals can be conducted or updated only pursuant to specific privileges granted upon request to qualified physicians and other practitioners who are members of the Medical Staff or seeking temporary privileges, acting within their scope of practice.

Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education, and have been determined by the Medical Staff to be competent to do so, may be granted the privileges to perform a history and physical examination related to oral and maxillofacial surgery. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the Medical Staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

Every patient receives a history and physical within Twenty-four (24) hours ~~of~~after admission, unless a previous history and physical performed within thirty (30) days ~~of~~before admission is on record, in which case that history and physical will be updated within twenty-four (24) hours ~~of~~after admission. Every patient admitted for surgery must have a history and physical within twenty-four (24) hours prior to surgery, unless a previous history and physical performed within thirty (30) days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four (24) hours ~~of~~prior to the surgery. Refer to Medical Staff Policy, *Medical Record Documentation Requirements, 8710-518.*

5.8 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 4.6-1(b), the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s), of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to proctoring in accordance with procedures similar to those outlined in Section 5.3-1 (General Provisions).

5.9 ~~LAPSE~~VOLUNTARY WITHDRAWAL OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information necessary to evaluate the request, the application shall ~~automatically lapse~~be deemed voluntarily withdrawn, and the applicant shall not be entitled to a hearing as set forth in Article VII.

ARTICLE VI: EVALUATION AND CORRECTIVE ACTION

Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.

6.1 EVALUATION OF MEMBERS

All members are subject to evaluation based on Medical Staff peer review criteria, consistent with these bylaws. Evaluation results are used in privileging, system improvement, and when warranted, corrective action.

6.1-1 PEER REVIEW CRITERIA

Departments shall develop and routinely update peer review criteria based on current practices and standards of care, which shall be the sole criteria used in evaluating the performance of members and privileges holders. Included in the departmental peer review criteria are the types of data to be collected for evaluation. Department criteria are subject to the approval of the Medical Executive Committee. Approved criteria as updated are made known and accessible to all members. Refer to Medical Staff Policy, *Ongoing Professional Practice Evaluation/Peer Review Process, 8710-509.*

6.1-2 REVIEW OF INITIAL MEMBERS

All initial granting of privileges shall be subject to proctoring under these bylaws and otherwise reviewed for compliance with the relevant departmental peer review criteria. Refer to Medical Staff Policy, *Focused Professional Evaluation/Proctoring, 8710-542.*

6.1-3 REVIEW OF MEMBERS

All members and privilege holders ~~not otherwise subject to initial review~~ are reviewed for compliance with the relevant department peer review criteria on an on-going basis. In addition to information gathered under routine screening, complaints and concerns are analyzed in light of the department peer review criteria using mechanisms determined by the department. Members are kept apprised of reviews of their performance. Performance monitoring, corrective action or other measures are implemented or recommended.

6.1-4 FOCUSED REVIEW

The Medical Executive Committee shall define, on a continuing basis, the circumstances warranting further intensive review of a member or other practitioner's services provided under privileges held, and establish the parameters for participation of the subject under review in the focused review process. Focused review may result in recommendations for changes to improve the member's performance, or a request for investigation or corrective action, or other action as indicated. Refer to Medical Staff Policy, *Ongoing Professional Practice Evaluation/Peer Review Process, 8710-509.*

6.1-5 EXTERNAL REVIEW

External peer review may be used to perform Medical Staff peer review as delineated under these bylaws.

The Credentials Committee or Medical Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member, may obtain external peer review in the following circumstances:

(a) Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action or are not reasonably supported by the facts or evidence of the matters or cases being reviewed;

(b) No current Medical Staff member can provide necessary expertise in the clinical procedure or area under review;

(c) To promote impartial peer review;

(d) Upon reasonable request of the practitioner.

6.2 CORRECTIVE ACTION

6.2-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a ~~members~~member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) disruptive; (4) contrary to the Medical Staff Bylaws or Rules and Regulations; (5) below applicable professional standards, corrective action against such member may be requested by any officer of the Medical Staff, by the chairman of any department, by the member's division chief, by the chairman of any standing committee of the Medical Staff, or by the Medical Executive Committee.

6.2-2 INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate record of the reasons.

6.2-3 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff department, standing or ad hoc committee of the Medical Staff, or appropriate expert(s) outside the Medical Staff. Failure to cooperate with an investigation or accept an external reviewer(s) shall be automatic grounds for termination of staff membership. The investigation, whether delegated to an officer, committee, Medical Executive Committee or outside expert(s) shall be accomplished in a prompt manner and a written report shall be forwarded to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and the general nature and subject matter of the investigation. The member shall be given a reasonable opportunity to provide information. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.2-4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall meet. The member under investigation shall be given notice of the meeting, as well as the grounds for the corrective action, and shall have time to prepare a response before the meeting is held. The Medical Executive Committee shall take action, which may include, without limitation:

(a) Determining no corrective action is taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information in the member's file.

(b) Deferring action for a reasonable time where circumstances warrant.

(c) Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude a department ~~head~~chair from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response, which shall be placed in the member's file.

(d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or proctoring.

(e) Recommending reduction, modification, suspension, or revocation of clinical privileges.

(f) Recommending reduction of membership status or limitation of any privileges directly related to the member's delivery of patient care.

(g) Recommending suspension, revocation, or probation of Medical Staff membership.

(h) Taking other actions deemed appropriate under the circumstances.

6.2-5 SUBSEQUENT ACTION

~~(a)~~ If corrective action as set forth in Section 7.2(a)-(k) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the ~~Board of Directors~~Governing Body for final action unless the member requests a hearing, in which case no final action will be taken until the member exhaust his remedies.

~~(b) So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.~~

6.2-6 INITIATION BY ~~BOARD OF DIRECTORS~~GOVERNING BODY

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of evidence, the ~~Board of Directors~~Governing Body may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. If the Medical Executive Committee fails to take action in response to the ~~Board of Directors~~Governing Body direction, the ~~Board of Directors~~Governing Body may initiate corrective action, but this corrective action must comply with Articles VI and VII of these Medical Staff Bylaws.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3-1 CRITERIA FOR INITIATION

Whenever a member's conduct or physical condition, ~~including but not limited to temporary impairment due to the consumption of alcohol or chemicals, appears to require~~is such that ~~immediate~~failure to take action ~~be taken to protect the life or well being of patient(s) or to reduce a substantial and~~ may result in an imminent ~~likelihood of significant impairment of the life, danger to the~~ health~~, or safety~~ of any ~~patient, prospective patient, or other person~~individual, the Chief of ~~the Medical~~ Staff, the Chief of Staff-elect ~~of the Medical Staff~~, or the immediate Past Chief of Staff ~~of the Medical Staff ,~~, or Chair of the applicable Department , together with either a member of the ~~Board of Directors~~Governing Body or the Chief Executive Officer acting in his capacity as an agent of the ~~Board of Directors~~Governing Body, shall conjointly have the authority to summarily restrict or suspend the Medical Staff privileges of a member and such summary suspension shall become effective immediately upon imposition. The person or body responsible shall promptly give written notice to the member, the ~~Board of Directors~~Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The summary restriction or suspension may be limited in duration and may be based upon the member's refusal to submit to a blood or urine test to detect the presence of alcohol or chemicals. The summary suspension shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chairman or by the Chief of Staff, considering where feasible the wishes of the patient in the choice of a substitute member.

6.3-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one (1) working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the Medical Executive Committee may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action).

6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The member shall be given notice of the meeting, as well as of the grounds for the summary restriction or suspension, and shall have time to prepare a response before the meeting is held. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two working days of the meeting.

6.3-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension before it becomes reportable to the Medical Board of California or the National Practitioners Data Bank, the member shall be entitled to the procedural rights afforded by Article VII.

6.3-5 INITIATION BY ~~BOARD OF DIRECTORS~~GOVERNING BODY

If the Chief of Staff, members of the Medical Executive Committee and the Chair of Department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the ~~Board of Directors~~Governing Body (or designee) may immediately suspend a member's privileges if a failure to summarily suspend these privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the ~~Board of Directors~~Governing Body (or designee) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the ~~head of the~~ department chair (or designee) before the suspension. Such a suspension is subject to ratification of the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.2 of these Bylaws will apply. ~~In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.~~

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership shall be suspended or limited as described, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred:

6.4-1 LICENSURE

(a) Revocation, ~~and~~ Suspension, and Expiration: Whenever a member's license or other legal credential authorizing practice in this State is revoked, ~~or~~ suspended, or expired, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action become effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.4-2 CONTROLLED SUBSTANCES

(a) Whenever a member's DEA certificate is revoked, limited or suspended, the member shall automatically and correspondingly be suspended of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

(c) Expiration: Whenever a member's DEA certificate is expired or evidence of renewal has not been received, the member's right to prescribe such medication shall automatically be suspended until such time as evidence of current DEA certificate is received.

6.4-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member, without good cause, to appear and satisfy the requirements of Section 11.2-4 shall be a basis for corrective action.

6.4-4 MEDICAL RECORDS

Medical Staff members are required to complete medical records within the time frame prescribed by the Medical Executive Committee. Failure to timely complete medical records shall result in a limited suspension after notice is given by the Chief of Staff pursuant to Medical Staff Policy, *Delinquency Status, 8710-519.* Such limited suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or has scheduled to treat or to perform any invasive procedure. Bona fide vacation or illness may constitute an excuse subject to the approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available. The suspension shall continue until the medical records are completed or suspension lifted by the Chief of Staff or his designee.

6.4-5 TUBERCULIN TESTING DOCUMENTATION

The admitting and clinical privileges of any member who fails to provide documentation of Tuberculin Testing in accordance with Medical Staff Policy, *Tuberculosis Screening of Licensed Independent Practitioners and Allied Health, 8710-538,* shall be automatically suspended. Such limited suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or has scheduled to treat or to perform any invasive procedure. Members whose privileges have been suspended for failing to provide documentation of a Tuberculin Test may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available. The suspension shall continue until the Tuberculin Test is provided, or suspension lifted by the Chief of Staff or his designee.

6.4-6 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a member's clinical privileges, and if within ninety (90) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the membership shall automatically expire.

6.4-7 EXCLUSION FROM GOVERNMENTAL HEALTHCARE PROGRAM

In the event a member is excluded from participation in a government healthcare program, the member shall be automatically suspended. Such suspension shall remain in place until the member submits a plan, acceptable to the Medical Executive Committee and the Governing Body, which permits the member to exercise privileges without subjecting the hospital to sanctions or denial of payment. Failure to submit an acceptable plan within ninety (90) days after written notice of suspension shall result in automatic termination.

6.5 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Sections ~~6.3-1(b) or (c), Sections 6.3-2, 6.3-3, 6.3-4, or 6.3-5~~6.4, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 6.2.

~~6.6 PROFESSIONAL LIABILITY INSURANCE~~

~~Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a member's clinical privileges, and if within ninety days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the membership shall be automatically terminated.~~

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Section 6.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term "member" may include "applicant" as it may be applicable under the circumstances, unless otherwise stated.

7.1-3 SUBSTANTIAL COMPLIANCE

Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these bylaws shall not be grounds for invalidating any action taken.

7.2 GROUNDS FOR HEARING

Any one or more of the following actions, if taken or recommended based upon conduct that is reasonably likely to be detrimental to patient safety or the delivery of patient care, shall constitute grounds for hearing if such action(s) or recommendation(s), if sustained, are required by law to be reported to the Medical Board of California and/or the National Practitioners Data Bank.

(a) Denial of Medical Staff membership.

~~(b) Denial of requested advancement in staff membership status or category.~~

~~(c)~~(b) Denial of Medical Staff reappointment.

~~(d) Demotion to lower Medical Staff category.~~

~~(e)~~(c) Suspension of Medical Staff membership.

~~(f)~~(d) Revocation of Medical Staff membership.

~~(g)~~(e) Denial of requested clinical privileges.

~~(h)~~(f) Involuntary reduction of current clinical privileges.

~~(i)~~(g) Suspension of clinical privileges.

~~(j)~~(h) Termination of all clinical privileges.

~~(k)~~(i) Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to provisional status and Section 5.3).

7.3 REQUEST FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, said person or body shall give the member prompt written notice of the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code; notice of the right to request a hearing pursuant to Section 7.3-2; that such hearing must be requested within thirty (30) days; and a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws. If the recommendation or final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, said written notice shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the proposed report.

7.3-2 REQUEST FOR HEARING

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing, addressed to the Medical Executive Committee, with a copy to the ~~Board of Directors.~~Governing Body. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and to have accepted the recommendation or action involved.

7.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing, and within fifteen (15) days give notice to the member of the time, place and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall not be less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

7.3-4 NOTICE OF CHARGES

Together with the notice stating the place, time and date of the hearing, the Medical Executive Committee shall state clearly and concisely in writing the reasons for the adverse final proposed action taken or recommended, including the acts or omissions with which the member is charged and a list of the charts in question, where applicable, as well as a list of all witnesses the Medical Executive Committee expects to call at the hearing.

7.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee which shall be composed of not less than five (5) members of the Medical Staff who shall gain no direct financial benefit from the outcome, and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively

participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. The Medical Executive Committee may appoint members from either staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chairman. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused and, where feasible, include an individual practicing in the same specialty as the member. All other members shall have M.D. or D.O. degrees. At the discretion of the Medical Executive Committee, an arbitrator or arbitrators, selected by a process mutually agreeable to the individual and the Medical Staff, may be utilized rather than a judicial review committee.

7.3-6 FAILURE TO APPEAR OR PROCEED

Failure without good cause of a member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be granted upon agreement of the parties, or by the Hearing Officer in consultation with the chairperson of the Judicial Review Committee upon a showing of good cause. The Medical Executive Committee shall exercise ongoing oversight over the hearing to ensure the timely resolution of issues.

7.4 HEARING PROCEDURE

7.4-1 PRE-HEARING PROCEDURE

(a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the Hospital or Medical Staff, and all evidence which will be made available to the Judicial Review Committee.

(b) The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his or her possession or control as soon as practicable after receiving the request.

(c) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

(d) The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the Focused Practitioner Performance Review process and justice requires. In so doing, the Hearing Officer shall consider:

(1) Whether the information sought may be introduced to support or defend the charges;

(2) The exculpatory or inculpatory nature of the information sought, if any;

(3) The burden imposed on the party in possession of the information sought, if access if granted; and

(4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding

(e) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee member or the Hearing Officer shall be ruled on by the Hearing Officer prior to the commencement of the hearing.

(f) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chairman of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

(g) The Medical Executive Committee shall not be represented by an attorney at law if the member is not so represented.

7.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. The member shall be entitled to representation by legal counsel in any phase of the hearing at the member's expense, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. The Medical Executive Committee shall not be represented at the hearing by an attorney at law if the member is not so represented. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing by an individual of the member's choosing who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present it's action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee representative may be accompanied and assisted by an employee of the Medical Staff Office. The foregoing rules should not be deemed to deprive the member or the Medical Executive Committee of the right to legal counsel in connection with preparation for any and all aspects of the hearing or appellate review, or to be represented by legal counsel at any appellate review.

7.4-3 THE HEARING OFFICER

Concurrent with his/her notice of appeal, the member shall submit a list of at least three (3) qualified persons the member would accept as a Hearing Officer. If none of the persons

suggested by the member is acceptable to the Chief of Staff, the Chief of Staff shall within seven (7) days provide the member with the names of at least three (3) qualified persons to serve as a Hearing Officer. The member shall have seven (7) days to select a Hearing Officer from one of the names provided by the Chief of Staff. If the member fails to make a selection within the said seven (7) days, the Chief of Staff may select the Hearing Officer from his/her list. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, with prior experience as a Hearing Officer in a hospital peer review matter, where feasible. Absent stipulation by the Chief of Staff and the member, attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer, nor shall a person who has served as a Hearing Officer at the Hospital in the prior two-year period. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. If a Hearing Officer selected by this process is disqualified for any reason, a replacement will be chosen by repeating the process described in this section.

The Hearing Officer shall preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed hearing panel members of the Hearing Officer.

The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence; provided that any rulings by the Hearing Officer are subject to review and reconsideration by the Judicial Review Committee upon request by the member or the Medical Executive Committee's representative. If requested by the Judicial Review Committee, the Hearing Officer may participate in the deliberations of such committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and those pre-hearing proceedings deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such an oath.

7.4-5 RIGHTS OF THE PARTIES

Both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The Hearing Officer, in consultation with the Judicial Review Committee, may place reasonable limits on the time and scope of the examination of any witness by either side and/or the introduction of documentary evidence. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of his/her qualifications by producing information, which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of evidence, that its action or recommendation was reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chairman of the Judicial Review Committee, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-9 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws~~, but shall otherwise be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure~~.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Chief Executive Officer, the ~~Board of Directors~~Governing Body, and to the member. The report shall contain a concise statement of

the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Medical Board of California [and shall state the text of the report as agreed upon by the committee]. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws, but shall otherwise be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of DirectorsGoverning Body as the final action if, in the Governing Body's independent judgment, the decision it is supported by substantial the evidence, following a fair procedure.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; (c) the text of the report to be filed to the National Practitioner Data Bank is not accurate.

7.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice; provided, however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 APPEAL BOARD

The Board of DirectorsGoverning Body may sit as the appeal board, or it may appoint an appeal board, which shall be composed of not less than three (3) members of the Board of Directors.Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a

prior hearing on the same matter. The appeal board shall select a Hearing Officer to assist in the proceeding, if requested by the appeal board. The Hearing Officer for the appeal shall generally have the qualifications and exercise the same duties and powers as set forth in the in Section 7.4-3 of these Bylaws. Any decision of the appeal Hearing Officer that affects the substantive rights of the parties to the appeal is subject to review and reconsideration by the appeal board.

7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review hearing; or the appeal board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal, to present a written statement in support of his/her position on appeal and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the ~~Board of Directors~~Governing Body its written recommendations as to whether the ~~Board of Directors~~Governing Body should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the ~~Board of Directors~~Governing Body shall render a final decision and shall affirm the decision of the Judicial Review Committee if, in the Governing Body's independent judgment, it is supported by the evidence, following a fair procedure~~the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure~~.

(b) Should the ~~Board of Directors~~Governing Body determine that the Judicial Review Committee decision is not supported by ~~substantial~~ the evidence, the ~~Board~~Governing Body may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendation to the ~~Board of Directors.~~Governing Body. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree for good cause as jointly determined by the Chairman of the ~~Board of Directors~~Governing Body and the Judicial Review Committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank, if any, and shall be forwarded to the Chief of Staff, the Medical Executive Committee, the subject of the hearing, and the Chief Executive Officer, at least ten (10) days prior to submission to the Medical Board of California.

7.5-7 RIGHT TO ONE HEARING

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter, which shall have been the subject of adverse action or recommendation.

7.6 EXCEPTIONS TO HEARING RIGHTS

7.6-1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS

Members who are directly under contract with the Hospital have the same appellate and hearing rights as outlined in Article VII, except as pertains to contract negotiations between the contract physicians and the ~~Board of Directors~~Governing Body.

7.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or DEA certificate has been revoked or suspended as set forth in Section 6.3-1 (a). In other cases, described in Section 6.3-1 and 6.3-3, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA was unwarranted, but only whether the member may continue practice in the Hospital with those limitations imposed.

~~7.7 EXPUNCTION OF DISCIPLINARY ACTION~~

~~Upon petition, the Medical Executive Committee, in its sole discretion, may expunge previous disciplinary action upon a showing a good cause or rehabilitation.~~

~~7.8~~7.7 NATIONAL PRACTITIONER DATA BANK REPORTING

~~7.8-1~~7.7-1 ADVERSE ACTIONS

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the ~~Board of Directors.~~Governing Body. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the chair of the subject's department, and the Hospital's authorized representative, or their respective designee. If a hearing was held, the dispute process shall be deemed to have been completed.

~~7.8~~7.7-2 DISPUTING REPORT LANGUAGE

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report-dispute-meeting shall not constitute a hearing, and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the chair of the subject's department, and the hospital's authorized representative, or their respective designees.

If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE VIII: OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the (1) Chief of Staff-elect (Vice President), (2) Chief of Staff (President), (3) Immediate Past Chief of Staff (Treasurer and Credentials Committee Chairman), and (4) Past Chief of Staff (Secretary).

8.2 QUALIFICATIONS OF OFFICERS

Officers must be Active members of the Medical Staff for five (5) years preceding their nomination and election and must remain Active members in good standing during their term of office. Failure to maintain such status shall result in a forfeiture of office and a successor shall be nominated by the Nominating Committee and elected by majority of the Medical Executive Committee. Officers must have two (2 ~~years~~) years' experience as a Chair of a Medical Staff Committee, Department, or Chief of a Division prior to their nomination and election. All officers of the Medical Staff must be licensed by the California Medical Board or California Osteopathic Medical Board as licensed physicians and surgeons. The Chief of Staff must be a Medical Doctor or a Doctor of Osteopathy.

8.3 ELECTION OF OFFICER

(a) Officers shall be elected at the annual meeting of the Medical Staff. Only members of the ~~active~~Active Medical Staff shall be eligible to vote. The vote shall be by secret ballot, and there shall be successive balloting as necessary until one candidate receives an absolute majority of those present and voting. Successive balloting shall occur, with the name of the candidate receiving the fewest votes being omitted from each successive slate until a majority vote is obtained by one candidate. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

(b) The Nominating Committee shall consist of the Medical Executive Committee and the four (4) immediate past ~~chiefs~~Chiefs of ~~staff~~Staff.

(c) Nominations may also be made by petition, provided that the name of the candidate is submitted in writing to the chairman of the Nominating Committee and bears the candidate's written consent. These nominations shall be delivered to the chairman of the Nominating Committee as soon as reasonably practicable, but at least twenty (20) days prior to the date of election. If any nominations are made in this manner, the voting members of the Medical Staff shall be advised by notice, delivered or mailed at least ten (10) days prior to the meeting.

(d) Nominations from the floor will be recognized if the nominee is present and consents, and is seconded by ten percent (10%) of the ~~active~~Active Medical Staff present.

8.4 TERM OF OFFICE

(a) Each officer shall serve a (2) two-year term from his/her election date or until a successor is elected. Officers shall take office on the first day of July following their election. At the end of his/her term of office, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff (Treasurer), and the Chief of Staff-elect shall automatically assume the office of Chief of Staff. At the end of his/her term of office, the Immediate Past Chief of Staff shall automatically assume the office of the Past Chief of Staff (Secretary).

8.5 VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the Medical Executive Committee ~~of the Medical Staff~~. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff-elect shall immediately assume the office of Chief of Staff and serve out the unexpired term of the Chief of Staff, plus the full term as Chief of Staff he/she would have otherwise served in the prescribed succession. He/she shall immediately request the Nominating Committee to decide promptly upon a nominee for the office of Chief of Staff-elect. Such nominee shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting.

If there is a vacancy in the office of Chief of Staff-elect, the Nominating Committee shall promptly report a nominee for the office of Chief of Staff-elect to the Medical Executive Committee and the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. At that time nominations from the floor shall be recognized as outlined in Section 8.3(d).

8.6 DUTIES OF OFFICERS

8.6-1 CHIEF OF STAFF (PRESIDENT)

The Chief of Staff shall serve as chief officer of the Medical Staff. The duties of the Chief of Staff shall include but not be limited to:

(a) Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.

(b) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff.

(c) Serving as chairman of the Medical Executive Committee.

(d) Serving as ex-officio member of all staff committees without vote unless his or her membership in a particular committee is required by these Bylaws.

(e) Interacting with the Chief Executive Officer and the ~~Board of Directors~~Governing Body in all matters of mutual concern within the Hospital.

(f) Appointing committee members for all standing and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designated the chairman of these committees.

(g) Representing the view and policies of the Medical Staff to the ~~Board of Directors~~Governing Body and to the Chief Executive Officer.

(h) Being a spokesman for the Medical Staff in external professional and public relations.

(i) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee

(j) Serving on liaison committees with the ~~Board of Directors~~Governing Body and Administration, as well as outside licensing or accreditation agencies.

(k) Attending all meetings of the ~~Board of Directors of the Tri-City Hospital Medical District~~Governing Body.

(l) Relieving any staff member, which he has appointed to a committee position for any reason.~~; and shall supervise the professional work in the Hospital.~~

8.6-2 CHIEF OF STAFF-ELECT (VICE PRESIDENT)

The Chief of Staff-Elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff-Elect shall be a member of the Medical Executive Committee and the Credentials Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

8.6-3 IMMEDIATE PAST CHIEF OF STAFF (TREASURER)

The immediate past Chief of Staff shall automatically become the Treasurer of the Medical Staff. He shall be a member of the Medical Executive Committee and chair of the Credentials Committee. He shall collect all dues and assessments from members and will send notices to members in arrears. He shall make all payments and in general manage the fiscal affairs of the Medical Staff.

8.6-4 PAST CHIEF OF STAFF (SECRETARY)

The Secretary shall attend all meetings of the Medical Staff and shall keep the minutes. He shall be custodian of all records and papers belonging to the Medical Staff. He shall keep a correct list of all members and record their attendance at meetings. At the end of each year he shall make certain that all amendments to the Bylaws and Rules and Regulations that have been made during the year were added to the Bylaws and Rules and Regulations. The Secretary shall be a member of the Medical Executive Committee of the Medical Staff and shall act as its recorder. He/She shall be a member of the Credentials Committee.

8.6-5 ~~IMMEDIATE PAST CHIEF OF STAFF (TREASURER)~~

~~The immediate past Chief of Staff shall automatically become the Treasurer of the Medical Staff. He shall be a member of the Medical Executive Committee and chair of the Credentials Committee. He shall collect all dues and assessments from members and will send notices to members in arrears. He shall make all payments and in general manage the fiscal affairs of the Medical Staff.~~

8.7 COMPENSATION OF MEDICAL STAFF

Medical Staff officers shall be compensated for their work spent representing and leading the Medical Staff. Such compensation shall come from the Medical Staff treasury, for which the Medical Staff has sole responsibility. The payment to individual physicians shall be in the amount determined by the Medical Executive Committee. Payment to each physician under this provision shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole determination of the Medical Executive Committee.

8.8 RECALL OF OFFICERS

8.8-1 INITIATION OF RECALL ACTION

Action for recall of an officer may be instituted by the Medical Executive Committee or may be initiated by petition signed by at least one third (1/3) of the practitioners of the ~~active~~Active Medical Staff, for valid cause, including but not limited to gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall shall be considered in a special meeting called for that purpose, held within thirty (30) days subsequent to the receipt of such a petition. Recall may be effected by a two thirds (2/3) vote of the ~~active~~Active Medical Staff who actually cast votes at the special meeting in person or by mail ballot received prior to the meeting. Such votes shall be by secret written ballot. The meeting shall have a quorum.

8.8-2 REPLACEMENT OF OFFICER

If a petition for recall is submitted to the Chief of Staff, he shall request the Nominating Committee to have ready a name to be nominated as replacement in the event of a successful recall action. Election of the replacement officer shall take place at the recall meeting and will be held in conformance with Article(s) 8.2 and ~~Article~~ 8.3.

ARTICLE IX: CLINICAL DEPARTMENTS AND DIVISIONS

9.19.2 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall be organized into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chairman selected and entrusted with the authority, duties and responsibilities specified in Section 9.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in Section 9.7. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions. Departments and Divisions shall meet at least annually and as requested by the Department Chairman or the Division Chief.

9.20.3 CURRENT DEPARTMENTS AND DIVISIONS

The current departments and divisions are:

(a) Department of Anesthesiology

(b) Department of Family Medicine

(c) Department of Emergency Medicine

(1) Occupational Medicine Division

(d) Department of Medicine

(1) Cardiology Division

~~(2) Dermatology & Allergy Division~~

~~(3)~~(2) Gastroenterology Division

~~(4)~~(3) Internal Medicine Division

a. Allergy & Immunology
b. Dermatology
c. Endocrinology
~~d.~~ Infectious Disease

~~e.~~ Nephrology

~~f.~~ Physiatry (Physical Medicine & Rehabilitation)
g. Rheumatology

~~(5)~~(4) Oncology Division

~~(6)~~(5) Psychiatry Division

~~(7)~~(6) Pulmonary Division

~~(8)~~(7) Neurology Division

(e) Department of Obstetrics-Gynecology

(f) Department of Pathology

(g) Department of Pediatrics

(1) Neonatology Division

(h) Department of Radiology

(i) Department of Surgery

(1) General and Vascular Surgery Division

(2) Cardiothoracic Surgery Division

(3) Subspecialty Surgery Division

a. Plastic and Reconstructive Surgery

b. ~~Otorhinolaryngology~~Otolaryngology, Head and Neck Surgery

c. Oral and Maxillofacial Surgery and Dentistry

(4) Neurosurgery Division

(5) Ophthalmology Division

(6) Orthopedic Surgery Division

(7) Podiatric Surgery Division

(8) Urology Division

9.39.4 ASSIGNMENT OF DEPARTMENTS AND DIVISIONS

Each member shall be assigned membership in one department, and to a division, if any and if applicable, within such department, but also may be granted membership and/or clinical privileges in other departments or divisions consistent with practice and privileges granted.

9.49.5 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting timely patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect information about important aspects of patient care provided in the department, periodically and timely access this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department.

(b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

(c) Conducting ongoing professional practice evaluations, and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

(d) Conducting, participating in and making recommendations regarding continuing education programs pertinent to departmental clinical practice.

(e) Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures; (2) sound principles of clinical practice.

(f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services.

(g) Submitting timely minutes to the Quality Assurance/Performance Improvement/Patient Safety and Medical Executive Committees concerning: (1) the department's review and evaluation activities, action taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and Hospital.

(h) Meeting for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions. For departments with more than one division, the division chiefs shall meet as often as necessary, ~~but at least quarterly,~~ with the department chairman.

(i) Establishing such committees or other mechanisms as may be necessary or appropriate to perform departmental functions, including proctoring.

(j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

(k) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department.

(l) Formulating recommendations for departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities. No such recommendations shall become effective until approved by the Medical Executive Committee and the ~~Board of Directors.~~Governing Body. No such recommendations may be submitted to the Medical Executive Committee unless ~~it has~~they have received the favorable votes of a majority of the voters eligible to vote on the matter.

(m) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

(n) Evaluation of the accuracy, timeliness and completion of medical records.

~~9.59.6~~ FUNCTIONS OF DIVISIONS

Subject to approval of the Medical Executive Committee, each division shall perform the functions assigned to it by the department chairman. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, evaluation of the accuracy, timeliness, and completion of medical records, credentials review, and privileges delineation, and continuing education programs. The division shall also formulate recommendations for divisional Rules and Regulations reasonably necessary for the proper discharge of the functions assigned to it by the department chairman. No such rule or regulation shall become effective until approved by the appropriate department chair (or, by majority vote, the department chair may elect to require voting on proposed division rules and regulations by all eligible members of the applicable department), the Medical Executive Committee and the ~~Board of Directors~~Governing Body. To be considered, any such recommendation must receive the favorable votes of a majority of the voters eligible to vote on the matter. The division shall meet at least annually and as requested by the Division Chief and shall transmit reports to the department ~~chairman~~chair and the Quality Assurance/Performance Improvement and Medical Executive Committees on the conduct of its assigned functions.

~~3.6~~9.7 DEPARTMENT ~~CHAIRMAN~~CHAIR

~~9.6-1 QUALIFICATIONS~~

~~3.14-1~~9.7-1 QUALIFICATIONS

Each department shall have a chairman and, at the discretion of each department, a vice-chairman who shall be members of the ~~active~~Active Medical Staff and shall be qualified by experience and demonstrated ability in at least once of the clinical areas covered by the department. Department chairs must be licensed by the California Medical Board and be certified by an appropriate specialty board or must demonstrate comparable competence.

~~9.6-2~~9.7-2 SELECTION

Department chairmen and vice-chairmen shall be elected every year by those members of the department who are eligible to vote for general officers of the Medical Staff. Elections shall be held at the department meetings (or by mail ballot). Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

~~9.6-3~~9.7-3 TERM OF OFFICE

Each department chairman and vice-chairman shall serve a ~~one~~two (2) year term which coincides with the Medical Staff year unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

~~9.6-4~~9.7-4 REMOVAL

After election, removal of department chairmen or vice-chairmen from office may occur for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude by a two-thirds (2/3) vote of the Medical Executive Committee and a two-thirds (2/3) vote of the department members eligible to vote on departmental matters who cast votes.

~~9.6-5~~9.7-5 DUTIES

Each chairman shall have the following authority, duties and responsibilities, and the vice-chairman, in the absence of the chairman, shall assume all of the duties and otherwise perform such duties as may be assigned to him:

(a) Acting as presiding officer at department meetings.

(b) Report to the Quality Assurance/Performance Improvement/Patient Safety Committee, the Medical Executive Committee, and the Chief of Staff regarding all professional and administrative activities within the department.

(c) Being responsible for the clinically related activities of the department.

~~(c)~~(d) Generally and continuously ~~monitor~~assess, with the focus on improvement of, the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; ~~oversee and maintain~~maintain the quality control programs, as appropriate, which includes overseeing and maintaining the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities.

(e) Continuously surveilling the professional performance of all individuals in the department that have delineated clinical privileges.

~~(d)~~(f) Develop and implement departmental programs for timely and effective retrospective patient care review, on-going monitoring of practice, credentials review and privileges delineation, medical education, utilization review, and quality assessment, improvement, and all other clinically related activities of the department.

~~(e)~~(g) Be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding his or her department.

~~(f)~~(h) Transmit to the Credentials Committee the department's recommendations concerning practitioner criteria for clinical privileges, proctoring of specified services, and corrective action, with respect to persons with clinical privileges in his or her department.

~~(g)~~(i) Endeavor to enforce the Medical Staff Bylaws, Rules and Regulations and departmental policies within his or her department.

~~(h)~~(j) Implement within his or her department appropriate actions taken by the Medical Executive Committee.

~~(i)~~(k) Participate in every phase of administration of the department with activities including:

(1) Recommending a sufficient number of qualified and competent persons to provide quality care and treatment of patients;

(2) Recommending the appropriate services to be provided by the department;

(3) ~~Insuring~~Recommending adequate space, supplies, and other resources ~~are allocated to~~needed by the department;

(4) Cooperating with the nursing service and administration in evaluating personnel matters of qualifications and the competence of individuals who are not licensed independent practitioners and who provide patient care, treatment, and services;

(5) Providing input regarding supplies, special regulations, standing orders, and techniques to be employed.

~~(j)~~(l) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his department as may be required by the Medical Executive Committee.

~~(k)~~(m) Assess and recommend to the ~~Board of Directors~~Governing Body external sources for needed patient care, treatment, and services not provided by the department or the hospital;

~~(l)~~(n) Integrate the department or service into the primary functions of the hospital, and coordinate and integrate interdepartmental and intradepartmental services;

~~(m)~~(o) Develop and implement departmental policies and procedures that guide and support the provision of care, treatment, and services in the department;

~~(n)~~(p) Provide orientation and continuing education of applicable persons in the department or service;

~~(o)~~(q) Recommend delineated clinical privileges for each member of the department; and

~~(p)~~(r) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

~~9.7-6~~ COMPENSATION OF DEPARTMENT CHAIRS

Department Chairs shall be compensated for their work spent representing and leading the Medical Staff. Such compensation shall come from the Medical Staff treasury, for which the Medical Staff has sole responsibility. The payment to individual physicians shall be in the amount determined by the Medical Executive Committee. Payment to each physician shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole ~~determination~~province of the Medical Executive Committee.

~~9.79.8~~ DIVISION CHIEFS

~~9.7-9.8-1~~ QUALIFICATIONS

Each division shall have a chief who shall be a member of the active Medical Staff and a member of the division which he or she is to head, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

~~9.7-9.8-2~~ SELECTIONS

Each division chief shall be ~~selected~~elected by a majority vote of the members of the division. If a majority fails to be reached, a division chief shall be selected by the department chairman. If there is a vacancy due to any reason, the ~~Department Chairman~~department chairman shall designate a new chief, or call a special election.

9.7-39.8-3 TERM OF OFFICE

Each division chief shall serve a ~~one~~(2) two-year term that coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign or be removed from office or lose Medical Staff membership or clinical privileges in that division. Division chiefs shall be eligible to succeed themselves.

9.7-49.8-4 REMOVAL

After ~~appointment~~election, a division chief may be removed by the department chairman, for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude with ratification by the Medical Executive Committee.

9.7-59.8-5 DUTIES

Each division chief shall:

(a) Act as presiding officer at division meetings.

(b) Assist in the development and implementation, in cooperation with the department chairman, of programs to carry out the quality review, and evaluation and proctoring functions assigned to the division.

(c) Evaluate the clinical work performed in the division.

(d) Conduct investigations and submit reports and recommendations to the department chairman regarding the clinical privileges to be exercised within his division by members of or applicants to the Medical Staff.

(e) Perform such other duties commensurate with the office as may be delegated by the department chairman, including, but not limited to, designating individuals to serve as Emergency Department call panels, evaluating and making recommendations regarding requests for clinical privileges including temporary privileges, and determining satisfactory completion of proctoring requirements.

9.8 MEMBER-AT-LARGE, JOB DESCRIPTION

~~3.14-2~~ QUALIFICATIONS

Member-at-Large will be a member of the Active Medical Staff, meet all requirements for medical staff membership and be a member in good standing.

SELECTIONS

Each Member-At-Large will be elected by a majority vote of the medical staff members. If there is a vacancy due to any reason, the MEC shall designate a new member-at-large to serve the remaining term, or call a special election.

TERM OF OFFICE

Each Member- At-Large shall serve a one-year term that coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign or be removed from office or lose Medical Staff membership or clinical privileges.

REMOVAL

After election, a Member-At-Large may be removed by the Chief of Staff, for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude with ratification by the Medical Executive Committee.

DUTIES

Each Member-At Large shall:

(a) Attend the Medical Executive Committee Meetings

(b) Perform such other duties as may be delegated by the Chief of Staff/MEC

ARTICLE X: COMMITTEES

10.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee as need to perform specified tasks. The chairman and members of all committees shall be the only voting members thereof (ref. Section 11.2-2(b). The chairman and members of each committee shall be appointed by and may be removed by the Chief of Staff. Medical Staff committees shall be responsible to the Medical Executive Committee. Committees shall meet as specified herein or at more or less frequent intervals, if so directed by the Medical Executive Committee.

10.2 GENERAL PROVISIONS

10.2-1 TERM OF COMMITTEE

Unless otherwise specified, committee members shall be appointed for a term of one year and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. Committee members may serve consecutive terms.

10.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if there is valid cause, including but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude, that member may be

removed by the Chief of Staff. Removal of the chairman of a committee against the chairman's wishes must be ratified by a majority vote of the Medical Executive Committee.

10.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee ~~shall~~may be filled ~~in the same manner in which an original appointment to such committee is made; provided, however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected~~ by the Chief of Staff or his/her designee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the officers of the Medical Staff, the department chairman of each clinical department, and others as follows:

(a) Chief of Staff (President of the Medical Staff)

(b) Chief of Staff-elect (Vice President of the Medical Staff)

(c) Immediate Past Chief of Staff (Treasurer, Credentials Committee Chairman)

(d) Past Chief of Staff (Secretary of the Medical Staff)

(e) Chairman of the Department of Anesthesiology

(f) Chairman of the Department of Emergency Medicine

(g) Chairman of the Department of Family Medicine

(h) Chairman of the Department of ~~Hospital Based Physicians~~Radiology

(i) Chairman of the Department of Medicine

(j) Chairman of the Department of Obstetrics and Gynecology

(k) Chairman of the Department of Pathology

~~(k)~~(l) Chairman of the Department of Pediatrics

~~(l)~~(m) Chairman of the Department of Surgery

~~(m)~~(n) Chairman of the QA/PI/ Quality ~~Assurance/Performance Improvement/Patient Safety~~Peer Review Committee

~~(n)~~(o) Chairman of the Professional Behavior Committee

~~(o) Up to two Members-at-Large, of any discipline or specialty, which are members of the organized Medical Staff are eligible for membership on the Medical Executive Committee. Refer to Medical Staff Policy, *Election Process, Members-at-Large/Medical, 8710-531*, for Member-at-Large election process.~~

~~Members of the Medical Executive Committee cannot serve in more than one capacity on the Medical Executive Committee.~~

(p) ~~Regular attendees~~Up to two Members-at-Large.

Ex-Officio members of the Medical Executive Committee, without vote, shall be as follows:

~~(a)~~(c) Chief Executive Officer of the Hospital

~~(b)~~(d) Chief Operating Officer

~~(c)~~(e) Chief Nurse Executive

~~(d)~~(f) Representative of the ~~Board of Directors~~Governing Body

Division chiefs and committee chairmen may attend Medical Executive Committee meetings as ex-officio members without vote. Other persons and/or staff members may be invited to attend Medical Executive Committee meetings by the Chief of Staff.

10.3-2 DUTIES

The duties of the Medical Executive Committee as delegated by the Medical Staff are:

(a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings within the scope of its responsibility as defined by the Medical Staff and subject to such limitations as may be imposed by these Bylaws.

(b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff that are not otherwise the responsibility of the departments.

(c) Receiving and acting upon reports and recommendations of Medical Staff departments, divisions, committees, and assigned activity groups.

(d) Providing liaison between the Medical Staff, the Chief Executive Officer, and the ~~Board of Directors~~Governing Body.

(e) Recommending action to the Chief Executive Officer and ~~Board of Directors~~Governing Body on matters of a medical-administrative nature.

(f) Establishing the structure of the Medical Staff, the mechanism for reviewing credentials and delineating clinical privileges, establishing appropriate criteria for cross-specialty privileges in accordance with Section 5.2-3, the organization of quality assurance activities and mechanisms, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff.

(g) Evaluating the medical care rendered to patients in the Hospital.

(h) Participating in the development of Medical Staff and Hospital policy, such as long-range planning.

(i) Approval of Medical Staff Self-Governance documents that supplement the Bylaws (i.e. Rules and Regulations, standardized procedures, protocols, and policies).

(j) Assuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.

(k) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members, including the initiation and participation in Medical Staff corrective review measures when warranted.

(l) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members and making recommendations to the ~~Board of Directors~~Governing Body regarding staff membership and renewal of membership, assignments to departments, clinical privileges, and corrective action.

(m) Providing for the preparation of meeting programs, including continuing medical education, either directly or through delegation to a committee or other agent.

(n) Reporting to the Medical Staff at each general staff meeting.

(o) Designating such special or ad hoc committees as may ~~seem~~deemed necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.

(p) Reviewing the quality and appropriateness of services provided by contract physicians.

(q) Reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes.

(r) Developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster.

(s) Establishing a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient.

(t) Affirmatively implementing, enforcing, and safeguarding the self-governance rights of the Medical Staff to the fullest extent permitted by law, such rights of the Medical Staff including but not limited to the following:

(1) Initiating, developing, and adopting Medical Staff bylaws, rules or regulations, and amendments thereto, subject to approval of the hospital governing board, which approval shall not be unreasonably withheld;

(2) Selecting and removing Medical Staff officers in accordance with the provisions of these Bylaws;

(3) Assessing ~~Medical Staff dues~~ and utilizing ~~the~~ Medical Staff dues as appropriate for the ~~purposed~~purposes of the Medical Staff;

(4) The ability to retain and be represented by ~~the~~ independent legal counsel at the expense of the Medical Staff;

(5) Establishing~~, in Medical Staff bylaws, rules or regulations~~, criteria and standards for Medical Staff membership and privileges, and for enforcing those criteria and standards;

(6) Establishing~~ in Medical Staff bylaws, rules and regulations,~~ clinical criteria and standards to oversee and manage quality assurance, utilization review and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments, and review and analysis of patient medical records;

(7) Taking such action as appropriate to enforce Section 13.11 (Retaliation Prohibited) of these bylaws regarding prohibition ~~against~~of retaliation directed towards a member;

(u) Taking such other steps as appropriate to meet and confer in good faith to resolve disputes with the ~~governing body~~Governing Body, or any other person or entity, regarding any self-governance rights of the Medical Staff.

(v) After having met and conferred in good faith to remedy any dispute under ~~subsection(s) of~~ this section, exercising its discretion as appropriate to resolve the dispute, up to and including ~~resort to~~ resolution of the matter in the courts as permitted by law.

(w) Reviewing the job description (e.g., qualifications, responsibilities, and reporting relationships) of medical directorships in the hospital both to assure their adequacy for Medical Staff purposes, and to avoid a conflict of duties between the medical director and any Medical Staff leader;

(x) Participating in the interview and review of candidates for position of medical director in the hospital, and in approving or vetoing the selection of any such candidate, with any veto being binding upon the hospital;

(y) Reviewing the performance of the hospital's medical directors periodically and transmitting the results of that review to the hospital board for its consideration;

(z) Fulfilling such other duties as the Medical Staff has delegated to the Medical Executive Committee in these bylaws.

(aa) Making recommendations to the Governing Body about the process to be used by Medical Staff to review credentials and delineate privileges.

~~(cc)~~(bb) By action of 2/3 of the Medical Staff members present and entitled to vote, the Medical Staff may, at a regular or special meeting at which a quorum is achieved, remove and reassign a duty or duties delegated to the Medical Executive Committee for a stated period of time, for a reason identified and supported by the meeting.

~~(bb) Establishing appropriate criteria for cross specialty privileges in accordance with section 5.2-3 (Criteria for "Cross Specialty" Privileges within the Hospital).~~

~~(cc) Making recommendations to the Board of Directors about the process to be used by Medical Staff to review credentials and delineate privileges.~~

The Chief of Staff may assign any of the above duties to a Subcommittee of the Medical Executive Committee for detailed recommendation to the committee as a whole for the Medical Executive Committee's final action.

The Medical Executive Committee is empowered to act ~~for~~on behalf of the organized Medical Staff between meetings of the organized Medical Staff.

10.3-3 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least ten (10) times per year, and shall maintain a permanent record of its proceedings and actions.

10.4 CREDENTIALS COMMITTEE

10.4-1 COMPOSITION

The Credentials Committee shall consist of at least four~~,~~ (4), and ~~up to~~no more than six (6) members of the Active Medical Staff. They shall comprise the three (3) most recent past Chiefs of Staff, and the then current Chief. The Chair of this Committee may appoint up to two additional members to the Committee. The two (2) additional members shall be selected only from the pool of Active Medical Staff members who have previously served as Chiefs of Staff. The committee chair shall be the Immediate Past Chief of Staff (Treasurer of the Medical Staff).

10.4-2 DUTIES

The Credentials Committee shall:

(a) Review and evaluate the qualifications and competence of each practitioner applying for initial appointment and reappointment to the Medical Staff and for clinical privileges or modification of clinical privileges. Applicants for initial appointment may be interviewed by the Credentials Committee.

(b) Obtain and consider the recommendations of the appropriate departments concerning appointment, reappointment, and clinical privileges.

(c) Submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations to the Medical Executive Committee with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions.

(d) Investigate, review, and report on matters referred by the Chief of Staff, the Medical Executive Committee, or the Quality Assurance/Performance Improvement~~/Patient Safety~~ Committee regarding the qualifications, conduct, professional character, or competence of any applicant or Medical Staff member.

(e) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications for initial appointment, reappointment, and clinical privileges.

10.4-3 MEETINGS

The Credentials Committee shall meet as often as necessary, but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions.

10.5 BIOETHICS COMMITTEE

10.5-1 COMPOSITION

The Bioethics Committee shall be chaired by a member of the medical staff, and shall consist of physicians and such other staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the ~~Board of Directors~~Governing Body, although a majority shall be physician members of the Medical Staff.

10.5-2 DUTIES

The Bioethics Committee may participate in development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; education of the Hospital staff on bioethical matters; and oversee the development and implementation of policies related to patient rights and self-determination.

10.5-3 MEETINGS AND REPORTING

The Bioethics Committee shall meet as often as necessary but at least quarterly and maintain a permanent record of its proceedings and actions. The committee shall report to the Medical Executive Committee.

10.6 BLOOD UTILIZATION REVIEW COMMITTEE

10.6-1 COMPOSITION

The committee shall consist of members of high blood utilization groups, including a surgeon, anesthesiologist, internist/oncologist, obstetrician-gynecologist, and the Transfusion Services Director. Ancillary members may include Transfusion Service Supervisor and a QA representative. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.6-2 DUTIES

Duties: To monitor blood utilization to include:

(a) Observing transfusion and component-utilization practices

(b) Usage ~~(~~, including discard of components~~)~~, following professional judgement & industry best practices;

(c) Appropriateness of use

(d) Blood Administration Policies

(e) Transfusion Reactions

(f) Ability of Service to meet patient need

(g) Compliance with Focused Practitioner Performance Review recommendations

10.6-3 MEETINGS

The committee shall meet at least quarterly and submit written reports to the Quality Assurance/Performance Improvement and Medical Executive Committees.

10.7 BYLAWS COMMITTEE

10.7-1 COMPOSITION

The committee shall consist of at least two members of the Medical Staff, at least one of whom shall be a prior Chief of Staff. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.7-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) Conducting an annual review of the Medical Staff bylaws, as well as the rules and regulations, policies and forms promulgated by the Medical Staff, its departments and divisions;

(b) Developing and submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect or improve current Medical Staff practices;

(c) Receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a); and

(d) Reviewing the hospital bylaws and policies for inconsistencies and conflicts with Medical Staff documents and reporting issues and recommendations to the Medical Executive Committee for its review.

10.7-3 MEETINGS

The committee shall meet as often as necessary, but at least annually, and report its findings and activities in written form to the Medical Executive Committee.

10.8 CANCER COMMITTEE

10.8-1 COMPOSITION

The committee shall include a general surgeon, a medical oncologist, a diagnostic radiologist, a radiation oncologist, a pathologist, a pain management specialist, and the Cancer Liaison Physician. It shall also include the cancer program administrator, an oncology nurse, a social worker/case manager, a performance improvement/quality management professional, and the certified tumor registrar. Others may be appointed as the Medical Executive Committee or its designee may deem appropriate, ~~which may include a dietary/nutrition specialist, pharmacist, pastoral care representative,~~ and in conformance with the membership requirements of the American College of Surgeons' Commission on Cancer ~~Society representative~~. To assure continuity and to facilitate planning, the members shall be appointed to serve for a period of three (3) years and may serve consecutive terms.

10.8-2 DUTIES

The Cancer Committee shall be responsible for:

(a) Planning, initiating, implementing, evaluating, improving, and setting goals regarding all cancer related activities within the Hospital.

(b) Scheduling and conducting multi-disciplinary educational cancer conferences, the intent of which will be to provide consultative services in the form of a Tumor Board.

(c) Developing and carrying out a system of quality care evaluation with documentation of its operation.

10.8-3 MEETINGS

The committee shall meet at least quarterly ~~for the purpose of policy decisions and for patient care evaluation~~. Written minutes of the meetings shall be kept and submitted to the Quality Assurance/Performance Improvement and Medical Executive Committees.

10.9 CONTINUING MEDICAL EDUCATION COMMITTEE

10.9-1 COMPOSITION

The committee shall consist of at least five (5) members of the Medical Staff. The members and chairman ~~shall~~ may be appointed by the Chief of Staff for a term of three (3) years. Two members ~~shall~~ may be replaced annually. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate. ~~The Mission of Tri-City Medical Center's Continuing Medical Education Program is to provide quality educational opportunities that enhance the knowledge base and clinical competency of practicing, teaching, and research physician affiliated with Tri-City Medical Center, thus enabling physicians to practice more effectively and efficiently in today's healthcare environment.~~

10.9-2 DUTIES

The committee shall:

(a) Submit a budget annually to the Medical Executive Committee for its approval, action, and disbursement of funds.

(b) Assist departments and divisions in planning and scheduling educational programs.

(c) Plan education programs for staff meetings and educational conferences.

(d) Approve all requests for CME credit for educational programs. Each request must include:

(1) Demonstration of need.

(2) Statement of objectives.

(3) Assessment of improvement.

(e) Be responsible for arranging staff education programs for training in cardiopulmonary resuscitation if requested by the Medical Executive Committee.

(f) Keep attendance records and provide each member with a report of credit hours on the member's request.

(g) Publish a monthly schedule of educational programs.

10.9-3 MEETINGS

The committee shall meet quarterly and submit written reports of its activities to the Quality Assurance/Performance Improvement and Medical Executive Committees.

10.10 CRITICAL CARE COMMITTEE

10.10-1 COMPOSITION

The committee shall consist of at least one representative of the following specialties: family medicine, internal medicine, infectious diseases, cardiothoracic surgery, neurosurgery, pulmonary medicine, cardiology, general surgery, anesthesia, and gastroenterology. The committee shall also include the pulmonary function laboratory supervisor, the cardiac catheterization laboratory supervisor, the critical care unit head nurse(s), the telemetry unit supervisor, and the critical care education nurse. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.10-2 PURPOSE AND DUTIES

The purpose of the committee shall be to optimize care in the acute cardiac care setting.

The committee shall:

(a) Establish, review, and update drug administration protocols.

(b) Establish, review, and update standing treatment orders utilized in the critical care unit.

(c) Update and streamline Code Blue carts, including the addition of new and appropriate drugs and the deletion of old and inappropriate drugs.

(d) Establish, update, and revise Medical Staff protocols for various procedures.

(e) Make recommendations concerning nursing personnel utilization, particularly as relates to the manipulation of central lines.

(f) Revise and update admission and discharge criteria from the critical care unit, and revise and update transfer criteria from the critical care unit to outsider care facilities.

(g) Make recommendations concerning bed utilization in the critical care unit.

(h) Make recommendations concerning equipment procurement, utilization, and procedure protocols.

(i) Mediate Medical Staff-Nursing problems.

(j) Perform such other duties as assigned by the Medical Executive Committee.

10.10-3 MEETINGS

The committee shall meet quarterly and submit written reports to the Quality Assurance/Performance Improvement and Medical Executive Committees.

10.11 GRADUATE MEDICAL EDUCATION COMMITTEE

10.11-1 COMPOSITION

The Graduate Medical Education (GME) Committee shall consist of at least one supervising Medical Staff Member for each area where residents, medical students and/or fellows serve in rotation. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.11-2 DUTIES

The duties of the GME Committee shall include:

(a) Oversight of residents, medical students and/or fellows who rotate throughout patient care areas per Medical Staff Policy, *Supervision of Residents/ Fellows/Medical Students, 8710-513*, and *Supervision of Residents in Emergency Medicine, 8710-571*.

(b) Maintenance of appropriate schedules and policies and procedures pertaining to the residents, medical students and/or fellows.

(c) Review of quality of care provided to the patients by the residents, medical students and/or fellows.

10.11-3 MEETINGS

The GME Committee shall meet at the discretion of the Chairman, ~~and~~on an as needed basis or at least ~~twice per year.~~ annually. The GME shall provide a report to the Medical

Executive Committee regarding the safety, quality of care, performance, supervision and ongoing education needs of these practitioners.

10.12 INFECTION CONTROL COMMITTEE

10.12-1 COMPOSITION

The committee shall consist of at least one representative from each department of the Medical Staff, and a representative from each of the following areas: Administration, the nursing service, laboratory microbiology section, environmental services, central supply, engineering, dietary, pharmacy, operating room, and the infection control practitioner. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.12-2 DUTIES

Infections acquired in the Hospital or from the community are potential hazards for all persons having contact with the Hospital. Effective measures must be developed to prevent, identify, and control such infections. The Infection Control Committee shall recommend corrective action based on records and reports of infections and infection potentials among patients and Hospital personnel.

Basic elements of the program shall include:

(a) Definition of nosocomial infections.

(b) A system for reporting, evaluating, and maintaining records of infection among patients and personnel.

(c) Ongoing review of all aseptic and sanitation techniques in the Hospital.

(d) Specific written infection control policies and procedures for all services in the Hospital.

(e) Preventive surveillance and control procedures relating to the inanimate environment.

(f) Input into the content and scope of the employee health program.

(g) Coordination with the Medical Staff on actions relative to the findings from regular review of clinical use of antibiotics.

(h) Orientation and education of all Hospital personnel relative to infection prevention and control.

(i) Action as required to assess the effectiveness of the infection control program.

The committee or infection control nurse, consulting with the chairman, may institute measures or control measures where there is reasonably considered to be a danger to any patient or to Hospital personnel from infectious diseases in hospitalized patients after discussing the action with the attending staff member.

Any patient admitted to the Hospital with a diagnosis requiring isolation, as determined by a previously approved list of isolatable diseases, will be admitted directly to appropriate isolation. Any patient who is found to have an isolatable disease after admission will be placed in appropriate isolation by either the attending physician or the infection control nurse with the supervision of a physician member of the Infection Control Committee. If there is a disagreement between the attending physician and infection control nurse as to the level of

appropriate isolation, arbitration and final decision shall be by the chairman of the committee.

10.12-3 MEETINGS

The committee shall meet not less than quarterly, maintain a record of its proceedings and activities, and report to the Quality Assurance/Performance Improvement and Medical Executive Committees quarterly.

10.13 JOINT CONFERENCE COMMITTEE OF THE MEDICAL STAFF

10.13-1 COMPOSITION

The committee shall be composed of: (a) five physician members of the active medical staff to be appointed for terms of two years by the Medical Executive Committee (MEC), and who may be reappointed for additional terms; (b) two members of the ~~District Board of Directors~~Governing Body, to be ~~appointed~~recommended by the ~~Board~~Governing Body Chair for ~~a term of~~ one year terms; and (c) three members of hospital administration to be appointed by, and for a term determined by, the Chief Executive Officer. The medical staff members shall include: (1) a hospitalist, (2) one physician chosen from another hospital-based specialty, and (3) the Chief of Staff. The immediate past Chief of Staff shall serve as an alternate physician member.

10.13-2 DUTIES

The committee shall constitute a forum at which representatives drawn from the medical staff, the ~~District Board of Directors~~Governing Body, and hospital administration shall meet and confer on any issues that are of importance to any of the parties, to allow for open and fruitful discussion of respective positions, and for resolution of differences.

The committee is to have wide scope, and, amongst its other activities, it:

(a) Shall assist in the development of policy;

(b) Shall consider plans for future growth, or changes in hospital organization;

(c) Is intended to facilitate open communication, particularly as it relates to actions contemplated or taken;

(d) Shall discuss quality-of-care issues, or any matters of importance to the delivery of patient care;

(e) Shall discuss problems that may arise among the parties;

(f) Shall function as a liaison to facilitate communication on any matter among the ~~Board of Directors~~Governing Body, the medical staff, and administration;

(g) Shall satisfy the meet and confer requirements of California Business & Professions Code Section 2282.5.

The committee shall reach its positions by a process of consensus, without the necessity of a formal vote. However, it may elect to do so by a decision of the committee in-toto.

10.13-3 MEETINGS

The committee shall meet as often as necessary to fulfill its responsibilities, but at least quarterly. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee. Any member of the committee may call for a meeting by contacting the Secretary of the committee, who shall then convene a meeting at the earliest opportunity of the members.

At its first meeting, and annually thereafter, the committee by consensus shall appoint a member to serve as its Secretary, who shall (1) anchor the meetings; (2) act as the recorder of its findings; and (3) prepare its written reports. The Secretary shall coordinate meetings, prepare agendas when applicable, and be the committee's contact individual for its members between meetings.

The Secretary shall prepare minutes of meetings when requested, to be later approved by the committee at-large at its next meeting. He/she shall transmit written reports of the committee's activities to the MEC and the ~~Board of Directors~~Governing Body at the direction of, and with the content specified by, the committee.

10.14 QUALITY REVIEW COMMITTEES

10.14-1 COMPOSITION

With the approval of the Medical Executive Committee, Medical Staff departments may individually or jointly form one or more Quality Review Committees to perform all quality assessment and improvement activities as specified in Section 9.4. Members of a quality review committee shall be appointed from active members of the involved department(s) by the chairperson(s) of the involved department(s), subject to the approval of the Medical Executive Committee. Each Quality Review Committee shall be composed of at least four members. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate. The chairman of each QRC shall serve as its department's representative on the Medical Staff Quality Assurance/Performance Improvement~~/Patient Safety~~ Committee.

10.14-2 DUTIES

In addition to performing the quality assessment and improvement function specified in Section 9.4, each Quality Review Committee shall:

(a) Involve department members in identifying important aspects of care, including the indicators used to monitor care;

(b) Communicate, at least quarterly to the members of their departments, the relevant and significant findings, conclusions, recommendations, and actions taken by the Quality Review Committee.

10.14-3 MEETINGS

Quality Review Committees shall meet as often as necessary but at least quarterly. The committee shall report to the represented department chairpersons and the Medical Executive Committee through the Quality Assurance/Performance Improvement~~/Patient Safety~~ Committee at least quarterly.

10.15 LIBRARY COMMITTEE

10.15-1 COMPOSITION

The committee shall consist of ~~a representative from each department~~three (3) members of the Medical Staff. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.15-2 DUTIES

The committee will identify needed library services, and act as an advocate to assure that these programs are enacted or supported. Committee members will assist the librarian to develop the library's book and periodical collections, identify subject area priorities, and provide expertise in various specialties and disciplines.

10.15-3 MEETINGS

The committee shall meet as needed and transmit written reports of its activities to the Quality Assurance/Performance Improvement and Medical Executive Committees.

10.16 NOMINATING COMMITTEE

10.16-1 COMPOSITION

The Medical Executive Committee and the four most recent past chiefs of staff shall serve as the Nominating Committee. The Immediate Past Chief of Staff shall serve as the chairman of the Nominating Committee.

10.16-2 DUTIES

The committee shall nominate, from members of the active staff, a candidate for the biennial election of the Chief of Staff-elect (Vice President) of the Medical Staff.

10.16-3 MEETINGS

The committee shall meet biennially or as needed, and report the nominees for Medical Staff offices for announcement prior to the annual Medical Staff meeting. ~~Elections are conducted at the annual Medical Staff meeting.~~

10.17 OPERATING ROOM COMMITTEE

10.17-1 COMPOSITION

The committee shall consist of the Chairman of the Department of Surgery and three other members of the Department of Surgery appointed by the Chief of Staff; the Chairman of the Department of Anesthesia and one other member of the Department of Anesthesia appointed by the Chief of Staff; a member of the Department of Obstetrics and Gynecology appointed by the Chief of Staff; a management representative of the Operating Room to be appointed by Administration; and a consultant from Administration to be appointed by the

Chief Executive Officer. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

Chairmanship of the committee shall be alternated between the Surgery and Anesthesia Departments on alternate years. Members of the committee shall serve for a period of two years. Each physician member shall vote with decisions of the committee effective immediately subject to later ratification, revision, or revocation by the Medical Executive Committee.

10.17-2 DUTIES

The committee shall:

(a) Conduct a periodic review of policies governing the scheduling of elective and emergency procedures, and submit recommendations for change to the Medical Executive Committee.

(b) Investigate and evaluate individual infractions of established policies.

(c) Function as liaison between Operating Room personnel and Medical Staff members in operational matters such as scheduling, equipment, and other matters affecting the proper and efficient functioning of the Operating Rooms.

10.17-3 MEETINGS

The committee shall meet at least every other month in addition to any meetings called by a minimum of two committee members. Written reports shall be transmitted to the Quality Assurance/Performance Committee and Medical Executive Committees.

10.18 PHARMACY AND THERAPEUTICS COMMITTEE

10.18-1 COMPOSITION

The committee shall consist of at least ~~one member from each department~~ five (5) members of the Medical Staff, one or more members from (a) the pharmacy service, (b) nursing administration, (c) the Chief Nurse Executive or representative, (d) the Infection Control Practitioner, and (e) the Hospital Chief Executive Officer or representative. Other staff members may be appointed as the Medical Executive Committee or its designee deem appropriate.

10.18-2 DUTIES

(a) Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard.

(b) Assist in the formation of broad professional policies regarding the evaluation, appraisal,

(c) Serve as an advisory group to the Hospital staff and the pharmacist on matters pertaining to the choice of available drugs.

(d) Make recommendations concerning drugs to be stocked on nursing units and by other services.

(e) Develop and periodically review a formulary or drug list for use in the hospital.

(f) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

(g) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(h) Establish standards concerning the use, control, and proctoring of investigational drugs and research in the use of recognized drugs.

(i) Review all significant untoward drug reactions.

(j) Review the appropriateness of empiric and therapeutic use of drugs.

(k) Review of antibiogram and appropriate antibiotics for the formulary.

(l) Responsible for the analysis of individual or aggregate patterns of drug practice.

10.18-3 MEETINGS

The committee shall meet at least quarterly and submit written reports of its activities to the Quality Assurance/Performance Improvement and Medical Executive Committees.

10.19 PHYSICIANS' WELL BEING COMMITTEE

10.19-1 PURPOSE

~~The committee's purpose is to assure that patients being treated at Tri-City Medical Center will, as much as humanly possible, not be under the jeopardy of an impaired member; and further, to assure that an impaired member will be no danger to himself and to make every attempt to encourage and support his or her recovery.~~

~~The purpose of this committee is to establish guidelines and strategies for providing assistance for those members who are experiencing problems, which might impair their function and the function of their families. Experience of medical staffs and societies indicates that these dysfunctions may involve the abuse of mood altering chemicals, including alcohol, and psychiatric or physical disorders of members.~~

~~This committee will provide strategies, which are most efficacious in working with these members and their families. Medical doctors must identify, in a timely manner, cases of member dysfunction in order for the committee to intervene early and assist the member's~~

~~return to an appropriate level of practice.~~ The Medical Staff recognizes its obligation to protect patients, its members, and other persons in the hospital from harm. This Committee is designed to provide education about member health; address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of members who suffer from a potentially impairing condition. The purpose of the process is to facilitate the rehabilitation by assisting a member to retain and to regain optimal professional functioning consistent with the protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a member is unable to safely perform the privileges granted, the matter is forwarded for appropriate corrective action. Refer to Medical Staff Policy, *TCMC Well-Being Policy, 8710-511*.

~~10.19-2 OBJECTIVES~~

~~The objectives of the committee are to:~~

~~(a) Identify and verify the dysfunctional member while assuring maximum confidentiality. Confidentiality of any informant will be maintained, and any retaliation will not be tolerated (refer to Policy 511.1).~~

~~(b) Motivate him or her to voluntarily enter treatment.~~

~~(c) Refer him or her to the best-equipped facilities, organizations, and services to give them the best chance for recovery and maintenance of recovery.~~

~~(d) Assume an advocacy role on his or her behalf.~~

~~(e) Aid his or her re-entry into professional activities after the recovery from various sources.~~

~~(f) Provide the means of protecting (1) the member's patients, (2) his or her medical colleagues, (3) the member's family, and (4) the member himself from the consequences of non-treatment, incomplete treatment, or the failure of perfectly adequate treatment but inadequate recovery. The member's genuine desire to maintain recovery for the rest of his or her professional life is vitally necessary.~~

~~10.19-3~~ 10.19-2 COMPOSITION

The committee will consist of at least four ~~to six~~(4) members of the Medical Staff who are ~~not only~~ well read and well versed in the problems of the well being of members, ~~but who are also willing to execute discipline at the request of the Medical Executive Committee. They must assure ongoing help to the impaired colleague after the execution of this discipline.~~ Appointment of a member to the Committee may be done only after consultation with the Chair of the Committee. In so far as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

~~10.19-4~~ 10.19-3 FUNCTIONS

The committee's functions are to:

~~(a) Inform the impaired member, as well as the Medical Staff, of the availability of various facilities, organizations, and services that have the best personnel and equipment to help recover and maintain recovery of the impaired colleagues.~~

~~(b) Establish an effective outreach program, which will include a plan of education regarding problems of member dysfunction.~~

(a) Educate members and hospital staff about illness and impairment recognition issues specific to members.

(b) Receive self-referrals by members.

(c) Verify reported problems suggesting member dysfunction, make assessments of the validity of evidence, and as directed by the Well Being Committee Chairman, report those findings to the Medical Executive Committee~~.~~ when the practitioner is providing or at risk of providing, unsafe treatment. Receive referrals by others and maintain informant confidentiality.

~~(c)~~

(d) Assure the protection of the public at large, as well as the impaired member. This will be done by making appropriate recommendations to the Medical Executive Committee. Refer members to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

(e) Evaluate the credibility of a complaint, allegation, or concern.

(f) Monitor the member and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

~~(e)~~(g) Report quarterly to the Medical Executive Committee and the ~~Board of Directors~~Governing Body instances in which a member is providing unsafe treatment.

(h) Initiate appropriate actions when a member fails to complete the required program.

10.20 MEDICAL QUALITY ~~ASSURANCE/PERFORMANCE IMPROVEMENT~~ PEER REVIEW COMMITTEE

~~10.10-5~~10.20-1 COMPOSITION

The committee shall consist of a physician chairman, selected by the Chief of Staff; and a member and an alternate member elected by each department. The alternate member shall attend Medical Quality ~~Assurance/Performance Improvement/Patient Safety~~Peer Review Committee meetings in the member's absence. All department chairmen, Medical Staff committee chairmen, and the Director of Patient Care Review will be asked to attend and participate in committee functions when appropriate and will serve in an ad hoc capacity.

With the approval of the Chief of Staff, up to two additional physicians may be appointed by the committee chair to promote committee priorities. The Chief of Staff shall have the authority to remove the chairman and appoint a new chairman prior to expiration of the one (1) year term, subject to approval of the Medical Executive Committee.

10.19.610.20-2 DUTIES

The Medical Quality Peer Review Committee shall perform the following duties:

~~The Quality Assurance/Performance Improvement (QA/PI) Committee shall perform the following duties:~~

(a) Accept responsibility and accountability for that portion of the overall quality assurance/performance improvement program developed by the ~~Board of Directors~~Governing Body and Administration, which is related to the Medical Staff including but not limited to, evaluation of the accuracy, timeliness and completion of medical records.

~~(b)~~(a) Recommend plans for improving and sustaining quality patient care on an ongoing basis within the Hospital to the Medical Executive Committee for approval. These may include mechanisms to:

(1) Evaluate opportunities for improvement in patient care and patient safety (medical errors).

(2) Evaluate priorities for action on opportunities for improvement.

~~(1)~~1) ~~Establish systems to identify opportunities for improvement in patient care and patient safety (medical errors).~~

~~(2)~~1) ~~Set priorities for action on opportunities for improvement.~~

~~(3)~~(1) Refer opportunities for improvement for assessment and for corrective action to appropriate departments, divisions, or committees.

~~(4)~~(1) ~~Track and analyze~~Evaluate the results of quality assurance, performance improvement, safety activities, and patient satisfaction throughout the Hospital to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements.

~~(5)~~(1) Review and track medical errors and adverse patient events. Causal factors related to the Medical Staff are referred per # 3.

~~(6)~~(1) Review and evaluate the activities of subcommittees for department and division quality review and hospital-wide quality assessment and performance improvement activities, directly or through its subcommittee(s).

(1) Evaluate the quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.

~~(7)~~1) ~~Coordinate quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.~~

~~(c)~~(a) Submit regular confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality review activities conducted.

~~(d) Receive reports of the Quality Outcomes Committee, a subcommittee of the QA/PI Committee with representation from medical staff, nursing, ancillary, and administration as determined by the QA/PI Chair in consultation with the Chief of Staff, and with specific responsibilities as delegated by the QA/PI Committee.~~

(a) Delegate specific responsibilities to and receive reports from the Quality Assessment/Performance Improvement Committee.

~~10.19-7~~10.20-3 MEETINGS

The committee shall meet as often as necessary at the call of its chairman, but at least ten times annually. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and ~~Board of Directors~~Governing Body, except that routine reports to the ~~Board~~Governing Body shall not include Focused Practitioner Performance Review evaluations related to individual Medical Staff members.

~~10.20~~10.21 QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT COMMITTEE

10.21-1 COMPOSITION

The committee shall consist of the Medical Peer Review Committee physician chairman with representation from medical staff, nursing, ancillary, and administration as determined by the Medical Quality Peer Review Committee Chair in consultation with the Chief of Staff.

10.21-2 DUTIES

The Quality Assurance/Performance Improvement (QA/PI) Committee shall perform the following duties:

Recommend plans for improving and sustaining quality patient care on an ongoing basis within the Hospital to the Medical Quality Peer Review Committee for approval. These may include mechanisms to:

~~(1)~~1) Establish systems to identify opportunities for improvement in patient care and patient safety (medical errors).

~~(2)~~1) Set priorities for action on opportunities for improvement.

1) Refer opportunities for improvement.

2) Track, analyze and submit the results of quality assurance, performance improvement, safety activities, and patient satisfaction throughout the Hospital to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements.

3) Review adverse patient events.

~~(3)~~4) Coordinate quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.

1) Accept specific responsibilities as delegated by the Medical Quality Peer Review Committee.

8) Submit regular confidential reports to the Medical Quality Peer Review Committee on quality review activities conducted.

10.21-3 MEETINGS

The committee shall meet as often as necessary at the call of its chairman, but at least ten times annually. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Quality Peer Review Committee.

~~10.21~~10.22 TISSUE COMMITTEE

~~10.21-1~~10.22-1 COMPOSITION

The committee shall consist of a pathologist, a radiologist, a gynecologist, a general surgeon, and at least two representatives of other surgery subspecialties. Other staff members may be appointed as the Medical Executive Committee or its designee deem appropriate.

~~10.21-2~~10.22-2 DUTIES AND RESPONSIBILITIES

The committee shall be responsible for:

(a) Reviewing all surgical cases in which a specimen (tissue or non-tissue) is removed, as well as all cases in which no specimen is removed.

(b) Evaluating the pre-operative and post-operative diagnosis and referring cases in which discrepancies occur to the appropriate department for review resolution.

(c) Maintaining written evidence of tissue review findings.

(d) Referring pertinent problem cases to the Medical Executive Committee.

~~10.21-3~~10.22-3 MEETINGS

The committee shall meet at least quarterly and submit written reports to the Quality Assurance/Performance Improvement and Medical Executive Committees.

~~10.22~~10.23 UTILIZATION~~/DRG~~ REVIEW COMMITTEE

~~10.22-1~~10.23-1 COMPOSITION

The committee shall consist of at least five (5) members of the Medical Staff.

~~10.22-2~~10.23-2 DUTIES

The duties of the committee shall be to:

(a) Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services, and related factors which may contribute to the effective utilization of services.

(b) Work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital.

(c) Communicate the results of its studies and other pertinent data to the Quality Assurance/Performance Improvement and Medical Executive Committees. It shall make recommendations to these committees for the optimum utilization of Hospital resources and facilities commensurate with maintenance of high quality patient care.

~~10.22-2~~10.23-3 MEETINGS

The committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a quarterly report thereof to the Quality Assurance/Performance Improvement and Medical Executive Committees.

~~10.23~~10.24 INTERDISCIPLINARY PRACTICE COMMITTEE

~~10.23-1~~10.24-1 COMPOSITION

The committee shall ~~consist~~ include as a minimum of the chairman, the Chief Nurse Executive or designee, the Chief Executive Officer or designee and an equal number of physicians appointed by the ~~Chief of Staff and~~Medical Executive Committee and registered nurses appointed by the Chief Nursing Executive. Additionally, ~~an equal number of~~ licensed or certified health professionals who are performing functions requiring standardized procedures ~~will~~may be appointed by the Chief of Staff or his designee.

~~10.23-2~~10.24-2 DUTIES

The Interdisciplinary Practice Committee (IPC) shall perform functions consistent with the requirements of law and regulation. The IPC shall routinely report to the ~~Board of Directors~~Governing Body through the Medical Executive Committee and, in addition, shall submit an annual report to the ~~Board of Directors~~Governing Body and the Medical Executive Committee.

The IPC shall establish written policies and procedures for, but not limited to:

(a) Reviewing and approving standardized procedures in accordance with Section 2725 of the Business and Professions Code.

(b) Approving recommendation from Department(s) and Division(s) for adding Allied Health Professional Categories within their respective rules and regulations.

(c) Reviewing as appropriate any clinical care provided to patients by an Allied Health Professional to ensure competency.

(d) Intended line of approval for each recommendation of the committee.

(e) The committee shall be responsible for identifying functions and/or procedures, which require the formation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by Registered Nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this Section.

(f) The committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to Registered Nurses and to Physician Assistants, whether or not employed by the facility, and to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in a licensed health facility.

10.23-310.24-3 MEETINGS

The IPC shall meet at the call of the chairman at such intervals as the chairman of the Medical Executive Committee may deem appropriate, but at least annually.

10.2410.25 PROFESSIONAL BEHAVIOR COMMITTEE

10.24-410.25-1 COMPOSITION

The committee shall act as a sub-committee appointed by the Medical Executive Committee as per the Medical Staff Professional Behavior Policy.

10.24-210.25-2 DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Professional Behavior Committee are defined in Medical Staff Policy, *TCMC ~~Well-Being~~Professional Behavior Policy, 8710-511*, and include, but are not limited to:

(a) Reviewing all documentation and determining appropriate action(s) regarding issues not resolved by prior interventions as defined in *Professional Behavior Policy, 8710-570*;

(b) Recommending any such appropriate action(s) to the Medical Executive Committee;

(c) Maintaining confidential records of recommendations, and;

(d) Providing non-confidential feedback as appropriate.

(e) Reporting periodically to the Medical Executive Committee.

10.24-310.25-3 MEETINGS

The committee shall meet as necessary.

ARTICLE XI: MEETINGS AND ATTENDANCE

11.1 MEDICAL STAFF MEETINGS

11.1-1 REGULAR MEETINGS

An annual staff meeting shall be held within thirty (30) days of the end of the staff year (the staff year ends June 30). The agenda for such meetings shall include reports of review and evaluation of the work done in the clinical departments and the performance of required Medical Staff functions. If the Medical Staff chooses, they may conduct regular meetings on a more frequent basis.

11.1-2 SPECIAL MEETINGS

The Chief of Staff or the Medical Executive Committee may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within fifteen (15) days after receiving a written request for same signed by not less than one-fourth of the members of the active staff and stating the purpose of such meeting. The Chief of Staff shall designate the time and place of any special meeting, after consultation with the Medical Executive Committee. Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the active staff not less than one week nor more than one month before the day of such meeting by, or at the direction of, the Chief of Staff or other persons authorized to call the meetings. If mailed, the notice of the meeting shall be deemed delivered if deposited, postage prepaid, in the United States mail and addressed to each staff member.

11.1-3 QUORUM

The presence of twenty-five (25%) percent of the total membership of the active staff at any regular or special Medical Staff meeting shall constitute a quorum.

11.1-4 VOTING

For regular and special Medical Staff meetings, Medical Staff members entitled to vote may do so either in person or by written proxy executed by the person and filed with the Medical Staff Office, provided, however, that no voting member shall enter into a proxy arrangement with any person other than another licensed physician entitled to vote.

11.2 MEETINGS OF DEPARTMENTS, DIVISIONS AND COMMITTEES

11.2-1 SPECIAL MEETINGS

Special meetings may be called in addition to the regular meetings as provided in the Bylaws. A special meeting of any department, division, or committee may be called by or at the request of the chairman, or by one-third of the members, but not by less than two members. Notice of such meeting shall be as provided above for the Medical Staff meeting notices.

11.2-2 QUORUM

(a) Definition of a Quorum

~~Twenty-five percent (25%) of the active Medical Staff members of the committee or department, but not less than two members, shall constitute a quorum at any meeting.~~ At special meetings of the Medical Staff and at the General Medical Staff meetings, fifty-one percent (51%) of those Active members present shall constitute a quorum to vote on an action item. Quorum requirements for the MEC and QAPI Committee shall require at least 51% of voting members to vote on an action. Quorum requirement for all other medical staff meeting shall be recognized when at least 3 voting members are present to vote on an action item.

(b) Voting Rights

Persons serving under these Bylaws as ex officio members of a committee have all rights and privileges of regular members except that they shall not be counted in determining the existence of a quorum and shall have no vote.

11.2-3 MINUTES

Minutes of each regular or special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on the matter. The minutes shall be signed by the presiding officer or member secretary and copies thereof shall be submitted to the Medical Staff office and then forwarded to the Medical Executive Committee.

11.2-4 REQUIRED ATTENDANCE

At the discretion of the chairman, when a member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

11.2-5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference or other electronic communication which shall be deemed to constitute a meeting for the matters discussed in that telephone conference or other electronic communication. Valid action may be taken

without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least a simple majority of the members voting.

11.2-6 RIGHTS OF EX-OFFICIO MEMBERS

Except as otherwise provided in these Bylaws, persons serving as ex-officio members of a Committee shall have all privileges of regular members except they shall not vote or be counted in determining a quorum.

ARTICLE XII: CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital an applicant:

(a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.

(b) Authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff.

(c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this Article.

(d) Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

(a) Records and proceedings of all Medical Staff committees have the responsibility for evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article X, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to Section 10.1) or by departments (pursuant to Section 9.4 (i), and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

(b) The Medical Staff shall develop a "Medical Staff Focused Practitioner Performance Review Activity Confidentiality Agreement" and require each member who is asked to participate in Focused Practitioner Performance Review activities on behalf of the Medical Staff to execute such an agreement if, in the opinion of the Medical Executive Committee, such an agreement is necessary to preserve the confidentiality of the Medical Staff information.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective ~~Focused Practitioner Performance~~Peer Review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be

based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other hospitals, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or Hospital.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

12.3-3 LIABILITY INSURANCE COVERAGE

The Tri-City Hospital District shall, at its expense, provide liability insurance coverage for all acts of duly appointed officers and committee members performed in good faith in an amount not to be less than $1,000,000.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

The confidentiality and immunity provided by this article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) Applications for appointment, reappointment, or clinical privileges.

(b) Corrective action.

(c) Hearings and appellate reviews.

(d) Utilization reviews.

(e) Other department, or division, committee, or Medical Staff activities related to proctoring and maintaining quality patient care and appropriate professional conduct.

(f) Focused Practitioner Performance Review organizations, Medical Board of California, and similar reports.

12.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 INDEMNIFICATION

The Tri-City Healthcare District shall defend, indemnify, and hold harmless the Medical Staff and its individual members from and against attorneys' fees, judgments, settlements (to which the Tri-City Healthcare District has agreed), and court-awarded costs incurred or suffered by reason of or based upon any claim, action, special proceedings, administrative proceeding, or arbitration brought by a third party relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities on behalf of the Tri-City Healthcare District, including, but not limited to, service (1) as a member of or witness for a Tri-City Healthcare District Medical Staff department, service, committee or hearing panel, (2) as a member of or witness for the Tri-City Healthcare District ~~board~~Board of directors or any Tri-City Healthcare District hospital task force, group, or committee, and (3) as a person providing information to any Tri-City Healthcare District hospital or Medical Staff officer or committee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member, past Medical Staff member, or applicant with respect to any Tri-City Healthcare District medical facility or operation. The Medical Staff or member may seek defense and indemnification for such losses and expenses in accordance with this bylaw provision and Tri-City Healthcare District policy. Payment of any losses or expenses as set forth herein by the Medical Staff or member is not a condition precedent to the Tri-City Healthcare District's defense and indemnification obligations hereunder.

The Tri-City Healthcare District's indemnification obligation shall include payment of any part of a judgment that is for punitive or exemplary damages if the Tri-City Healthcare District ~~Board of Directors~~, acting in its sole reasonable discretion and exercising independent judgment after providing the Medical Staff member a reasonable opportunity to present relevant evidence and information on the issues, finds the following:

(a) The judgment is based on an act or omission of the Medical Staff or member acting within the course and scope of peer review or quality assessment activities as defined above; and

(b) At the time of the act or omission giving rise to the liability, the Medical Staff's or member's act or omission was in good faith, without actual malice and in the apparent best interests of the Tri-City Healthcare District; and

(c) Payment of the claim or judgment would be in the best interests of the Tri-City Healthcare District.

Any dispute between the Medical Staff or member and the Tri-City Healthcare District regarding defense and indemnification under this bylaw provision and/or District policy shall be resolved by binding arbitration pursuant to the laws of the State of California, Code of Civil Procedure § 1280 et. seq. The parties agree that the arbitrator shall interpret this bylaw provision and District policy as a whole and not inconsistent with each other to the greatest extent possible.

ARTICLE XIII: GENERAL PROVISIONS

13.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such rules and regulations as it may deem desirable for the proper conduct of its work and shall review every two years and revise (if necessary) its Rules and Regulations to comply with current Medical Staff practice. Upon the request of (1) the Medical Executive Committee, or the Chief of Staff or the bylaws committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least 10% of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of Medical Staff rules and regulations. Such action shall be taken at a regular or special meeting of the Medical Staff, provided notice of the next regular or special meeting at which action is to be taken included notice that a rules or regulations change would be considered. The notice shall include the exact wording of the existing language of the rule(s) or regulation(s), if any, and the proposed change(s) and that there be a 30-day period for responding to submission of petitions. Following adoption such rules and regulations shall become effective upon approval of the ~~Board of Directors~~Governing Body, which approval shall not be withheld unreasonably~~, or automatically after 60 days if no action is taken by the Board of Directors. In the latter event, the Board of Directors shall be deemed to have approved the rule(s) and regulation(s) adopted by the Medical Staff~~. Neither body may unilaterally amend the Rules and Regulations. "Temporary Rules and Regulations" may be put into place by the Medical Executive Committee while waiting for a vote by the Medical Staff. This will allow changes to be made when necessary, but subject to final approval by the Medical Staff.

Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between Bylaws and the Rules and Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations. Members of the Medical Staff shall be given written notice of new adopted Rules and Regulations.

13.2 DUES ASSESSMENTS

Reasonable dues shall be assessed members of the Medical Staff in an amount to be determined by the Medical Executive Committee each year. The Medical Staff will use such dues as appropriate for its purposes. Such dues shall be due and payable at the time of each member's biennial reappointment. Application for reappointment will be considered as incomplete if dues (or other fines or assessments) are not paid within the time frame described in Section 4.6-5 and the member is deemed to be voluntarily resigned without the rights to a hearing as described in Section VII. If a delinquent staff member is voluntarily resigned for non-payment of dues, he will incur the cost and process of a new application should he desire to reinstate his membership.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of the Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

13.4 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

13.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

13.6 NOTICES

Except where specific notice provisions are otherwise provided in the Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof shall be addressed as following:

Name and proper title of addressee, if known or applicable
Name of Department, Division~~,~~ or Committee
c/o Medical Staff ~~Coordinator,~~Manager / Chief of Staff
Tri-City Medical Center
4002 Vista Way
Oceanside, California 92056

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

13.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of the election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

13.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state and national Hospital Medical Staff sections should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by the Nominating Committee.

13.9 MEDICAL STAFF CREDENTIALS FILES

13.9-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

(a) As stated previously in Section 6.1-1, any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

(b) When a request is made for insertion of adverse information into the Medical Staff member's credentials file, the respective department chairman, and Chief of Staff shall review such a request.

(c) After such review a decision will be made by the respective department chairman and Chief of Staff to:

(1) Not insert the information;

(2) Notify the member of the adverse information by a written summary and offer him the opportunity to rebut this assertion before it is entered into this file; or

(3) Insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Section 6.1-2 of these Bylaws.

(d) If adverse information is inserted into a member's file, the member shall be promptly notified and shall have an opportunity to address the Medical Executive Committee and submit contrary information. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions by a majority vote.

13.9-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

The following applies to the review of adverse information in the Medical Staff member's credential's file at the time of reappraisal or reappointment.

(a) Prior to recommendation on reappointment, the Credentials Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

(b) Following this review, the Credentials Committee shall determine whether documentation in the file warrants further action.

(c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.

(d) However, if an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.

(e) No later than sixty (60) days following final action on reappointment, the Medical Executive Committee shall, except as provided in (g):

(1) Initiate a request for corrective action, based on such adverse information and on the credential's committee's recommendation relating thereto, or

(2) Cause the substance of such adverse information to be summarized and disclosed to the member.

(f) The member shall have the right to respond thereto in writing, and the Medical Executive Committee may elect to remove such adverse information on the basis of such response.

(g) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the Medical Executive Committee, by a majority

vote, determines that such information is required for continuing evaluation of the member's:

(1) Character;

(2) Competence; or

(3) Professional performance.

13.9-3 CONFIDENTIALITY

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the ~~Board of Directors~~Governing Body of the Hospital or its appointed representatives—in order that the ~~Board of Directors~~Governing Body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.

(d) Information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff, professional licensing board, or as required by law.

(e) A Medical Staff member shall be granted access to his own credentials file, subject to the following provisions:

(1) Timely notice of such shall be made by the member to the Chief of Staff or his designee;

(2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information-including Focused Practitioner Performance Review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member in writing by the designated officer of the Medical Staff within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized.

(3) The review by the member shall take place in the Medical Staff office during normal work hours, with an officer or designee of the Medical Staff present.

13.9-4 MEMBERS' OPPORTUNITY TO REQUEST CORRECTION/DELETION AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) When a member has reviewed his file as provided under Section 13.8-3(e), he may address to the Chief of Staff a written request for correction or deletion of information in

his credentials file. Such request shall include a statement of the basis for the action requested.

(b) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation by a majority vote.

(c) The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

(d) In any case, a member shall have the right to add to his own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

13.10 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

13.10-1 In the event of a disagreement between the Medical Executive Committee and the Hospital regarding an exclusive contract arrangement, the Medical Executive Committee may review and make recommendations to the ~~Board of Directors~~Governing Body regarding all quality of care issues related to exclusive arrangements for physician and/or professional services. Such arrangements include:

(a) execution of an exclusive contract in a previously open department or service;

(b) renewal or modification of an exclusive contract in a department or service;

(c) termination of an exclusive contract in a department or service; and

(d) the execution, renewal, or termination of any exclusive vendor or prime vendor contract for medical supplies or equipment.

13.10-2 The Medical Executive Committee may conduct a notice and comment hearing to assess the quality of care issues related to such arrangement. The results of any such hearing shall be reported to the ~~Board of Directors~~Governing Body.

13.10-3 The ~~Board of Directors~~Governing Body shall give great weight to the recommendations of the Medical Executive Committee on quality of care issues; and

~~(a) In the event that any proposed exclusive arrangement will result in termination or limitation of any Medical Staff membership and/or privilege for reasons related to professional conduct or competence, all adversely affected individuals shall be entitled to the procedural rights afforded by Article VII. All proceedings pursuant to Article VII arising from a specific proposed exclusive arrangement may be consolidated.~~

13.11 RETALIATION PROHIBITED

(a) Neither the Medical Staff, its members, committees or department ~~heads~~chairs, division chiefs, the ~~governing board~~Governing Body, its chief administrative officer, or any other employee or agent of the hospital or Medical Staff, may engage in any punitive or retaliatory action against any member of the Medical Staff because that

member claims a right or privilege afforded by or seeks implementation of any provision of these Medical Staff bylaws.

(b) The Medical Staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients. No person, including but not limited to the Medical Staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict, or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.

(c) This section does not preclude corrective and/or disciplinary action as authorized by these Medical Staff bylaws.

13.12 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the Medical Staff, or of the Medical Executive Committee acting on its behalf, the Medical Staff may retain and be represented by independent legal counsel.

ARTICLE XIV: ADOPTION AND AMENDMENT OF BYLAW

14.1 PROCEDURE

Upon the request of the Bylaws Committee, the Chief of Staff, ~~the~~and Medical Executive ~~Committee, the Bylaws~~ Committee, or upon timely written petition signed by at least 10% of the members of the Medical Staff in good standing who are entitled to vote at Medical Staff meetings, consideration will be given to the recommendation to the Governing Body regarding the adoption, amendment, or repeal of these Bylaws. Such adoption, amendment, or repeal of the Bylaws may be acted upon following introduction of the proposed action at a Medical Staff meeting or by ~~mailing~~mail ballot or by electronic method the proposed action to each staff member entitled to vote ~~thirty (30)~~ at least 10 days prior to a scheduled staff meeting. Such introduction shall include the exact wording of existing Bylaws language, if any, and the proposed change(s).

14.2 ACTION OF BYLAW CHANGE

Discussion and vote on adoption, amendment, or repeal of Bylaws shall take place at the next Medical Staff meeting following introduction as outline in 14.1. ~~A~~In this instance, a quorum of voting members must be present for the purpose of enacting a Bylaws change. ~~The change shall require an affirmative vote of two-thirds (66 2/3%) of the members voting in person or by written absentee ballot that must be received prior to the meeting.~~ In addition, and as an alternative method, balloting may occur electronically by the use of a verifiable e-mail sent to the Director of the Medical Staff Office ~~by the voting member personally, or by the facsimile transmission of a written signed ballot from the voting member to the same Office. An~~. The change shall require an affirmative majority vote ~~of two-thirds (66 2/3%)~~ of the members voting ~~via this alternative method is required.~~at a meeting in person or by electronic ballot .

14.3 APPROVAL

Bylaws changes adopted by the Medical Staff shall become effective following ~~either~~ approval by the ~~Board of Directors~~Governing Body, which approval shall not be withheld unreasonably ~~or automatically within sixty (60) days if no action is taken by the Board of Directors~~. Neither body may unilaterally amend the Medical Staff Bylaws. If approval is withheld, the reasons for doing so shall be specified by the ~~Board of Directors~~Governing Body in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee, and the Bylaws Committee.

14.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 UPDATING BYLAWS AND RULES AND REGULATIONS

At the end of each year the staff secretary shall make certain that all amendments to the Bylaws and Rules and Regulations, which have been made during the year, are added to the Bylaws and Rules and Regulations. Review of the Medical Staff Bylaws and Rules and Regulations should also ascertain that they do not conflict with the ~~governing body's~~Governing Body's bylaws.

14.6 EFFECT OF THE BYLAWS

Upon adoption and approval as provided in Article XIV, in consideration of the mutual promises and agreements contained in these bylaws, the hospital and the Medical Staff, intending to be legally bound, agree that these bylaws constitute part of the contractual relationship existing between the hospital and the Medical Staff members, both individually and collectively.

14.7 SUCCESSOR IN INTEREST/AFFILIATIONS

14.7-1 Successor in Interest

These bylaws, and privileges of individual members of the Medical Staff accorded under these bylaws, will be binding upon the Medical Staff, and the ~~Board of Directors~~Governing Body of any successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the Medical Staff shall work together to develop new bylaws, which will govern the combined medical staffs, subject to the approval of the hospital's ~~Board of Directors~~Governing Body or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

14.7-2 Affiliations

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

TRI-CITY MEDICAL CENTER
RULES AND REGULATIONS

1. Meetings of the Medical Staff shall be held annually in June, unless otherwise designated by the Chief of Staff. There will be one additional General staff Meeting per Medical Staff year, to be held in the month of January.

2. Autopsies shall be performed by the Hospital pathologists at the request of the attending staff member. The following criteria identify deaths in which an autopsy may be encouraged:
   (a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
   (b) Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.
   (c) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
   (d) Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
   (e) All obstetrical deaths.
   (f) All pediatric deaths.
   (g) All cases of unusual death and of medical-legal and educational interest.

   Securing an autopsy will be performed according to the Patient Care Services Policy Manual, policy *Autopsy, Authorization of,* IV.P.4.

   It is the attending physicians responsibility upon notification of death to explain to the family the benefits and rational of an autopsy, the associated cost and offer them the opportunity to request or deny an autopsy.

   Refer to Department of Pathology Rules and Regulations for the Notification guidelines for an autopsy.

3. Patients shall be attended by their own private practitioners, who are members of the Medical Staff. Each attending member shall provide the name of an alternate who shall be a member of the Medical Staff qualified to manage the care/treatment needs of the attending member's patients. Assent of the named alternate will be obtained by the Medical Staff office. Applicants shall name an alternate as part of the application process. Patients requiring admission with no attending member shall be assigned to the physician on Emergency Department call that day. Members are not permitted to sign out to the Emergency Department.

4. Each department shall formulate its own Rules and Regulations, policies and procedures for approval by the Medical Executive Committee.

5. All orders for treatment shall be in writing. Medical Staff Policy *Medical Record Documentation Requirements, 8710-518*, sets forth in detail the standard for this regulation.

6. The Safety Officer will report at least annually, and more often as needed, to the Medical Executive Committee regarding Mass Casualty and/or Disaster Planning. His report will include recommended responsibilities of members of the Medical Staff. The Medical Executive Committee will inform the members of the Medical Staff at least annually of these assignments.

7. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded by the admitting member as soon after admission as possible.

8. Members admitting private patients shall give such information as is necessary to assure the protection of other patients from those who are a source of danger.

9. The Hospital shall admit patients suffering from all types of diseases except for those specifically excluded by state and county laws relative to a general hospital not having facilities for isolation of communicable diseases. Neuropsychiatric patients may be admitted only when proper facilities and care may be available.

10. A.M. admissions and outpatient surgery admissions must be arranged in accordance with the Hospital's Policies and Procedures.

11. Patients shall be discharged only on order of the attending member or his designee.

12. The attending member shall be held responsible for the preparation of a complete medical record for each patient as defined by the medical records committee. An abbreviated form, for transient admissions not exceeding 48 hours for minor procedures, may be used. For all other patients, a complete medical record shall include a discharge summary, which shall be completed within two weeks following the patient's discharge.

~~13. A complete history and physical examination shall, in all cases, be written or dictated by an oral maxillofacial surgeon or other qualified individual in accordance with state law and hospital policy within 24 hours of admission of the patient, except for transient admissions as defined above. An H&P older than 24 hours yet within 30 days of admission must be accompanied by an interim note which documents any changes to the history and/or physical exam. A previous history and physical is sufficient for a patient readmitted within 30 days for the same condition. A copy of the old H&P must accompany the new chart in these cases and a documented update noted is to be recorded to reflect the patient's physical status upon readmission. It is the physician's responsibility to request the old H&P from Medical Records. An H&P dictated over 30 days prior to admission is not valid and must be re-dictated or rewritten. Prior to commencing a procedure, an interval medical history and physical examination is performed and recorded within the previous 24 hours.~~

~~14.~~13. When ~~such~~the history and physical examination are not recorded on the chart before the time stated for the operation, ~~the~~a scheduled operation shall be canceled ~~unless the attending member states, in writing, that such a delay would constitute a hazard to the patient~~.

~~15.~~14. All original records are the property of the Hospital and shall not be taken away except for court order, subpoena, or statute. In cases of readmission of a patient, all previous records shall be available for the use of the attending member. This shall apply whether he is attended by the same member or not. When patients request a copy of their medical records, either a copy of the record or a pertinent summary may be provided.

~~16.~~15. ~~Free access~~Access to ~~all~~ medical records ~~of all patients shall be afforded to~~for staff members in good standing for bona fide study and research~~, consistent~~ shall be done in accordance with ~~preserving~~ the ~~confidentiality of personal information concerning the individual patients~~Hospital's HIPAA policies. Subject to the discretion of the Chief Executive Officer and the Chief of Staff, former members of the Medical Staff shall be permitted ~~free~~ access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

~~17.~~16. All surgical operations and diagnostic procedures shall be performed with informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title 22.

~~18.~~17. All operations performed shall be fully described by the operating surgeon in his operative report, describing the technical procedures used, findings, the specimens removed, the postoperative

diagnosis, and the name of the primary surgeon and any assistants. The operative report shall be written or dictated immediately after surgery and is to be subsequently signed by the surgeon. If the operative report is dictated, a summary progress note must be written in the medical record immediately after the surgery to be available for the next level of care.

~~18.~~18. All tissues, foreign bodies~~,~~ or devices removed at operation shall be sent to the Hospital pathologist, who shall make such examination as he may consider necessary to establish his findings and/or arrive at a diagnosis. His authenticated report shall be made a part of the patient's medical record.

~~19.~~19. One member shall be designated as attending physician for each inpatient. The attending physician has overall responsibility for the medical care of his patient. When clinically appropriate, the attending physician may transfer his responsibilities to another qualified physician member. The attending physician may also delegate specific aspects of the medical evaluation and treatment of his patient to another member. The attending physician documents the transfer or delegation of these responsibilities by written orders on the medical record. When care is transferred or delegated to a member for the performance of a surgery or procedure, post-operative care is also transferred or delegated. However, anesthesiologists may also appropriately participate in postoperative care.

~~20.~~20. Consultations:

Consultants

(a) A consultant must be qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of individual training, experience, and competence. The consultant must be a member of the Medical Staff or have Temporary Privileges.

(b) Essentials of a Consultation

A satisfactory consultation includes examination of the patient and medical records. An opinion signed by the consultant must be in the medical record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.

(c) Responsibility for Requesting Consultations

The attending member is responsible for requesting consultation when indicated. It is the duty of the Medical Staff, through its committees and departments, to make certain that members of the staff do not fail in the matter of calling consultants when needed. The member requesting consultation shall write his reasons for same on the order sheet or progress notes. If the consultant is to assume management of the case, this must be so designated on the order sheet.

(d) To assure that each patient is treated appropriately the following conditions will require a consultation from a qualified physician who is credentialed:

1. 5150 holds
2. Drug Overdoses
3. Suicide Attempts

Around-the-clock sitters are required for patients in categories (a) through (c) above, unless, in the opinion of the primary member of psychiatric consultant, such sitters are not required.

4. All patients on a ventilator for more than 48 hours must have a consultation by an intensivist or pulmonologist.

5. Hemorrhagic Strokes & Ischemic Strokes

~~22.~~21. Drugs used shall meet the standards of the Pharmacopoeia. and National Formulary. New and unofficial drugs, with the exception of drugs for bona fide clinical investigations, may not be used. Exceptions to this rule shall be well justified and approved by the department and the Medical Executive Committee.

~~23.~~22. Rules and Regulations regarding stop orders on dangerous drugs and narcotics shall be formulated by the Pharmacy and Therapeutics Committee, with the approval of the Medical Executive Committee, and shall be found in the standing orders of the Hospital.

~~24.~~23. In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease or when the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

~~25.~~24. The member is in complete charge of the medical care and treatment given to his patient while in the Hospital. The Hospital has set certain guidelines and rules for the member to work within, and these have been established by the physicians themselves to insure a good level of patient care. However, the Hospital also has a responsibility to the patient, to all the doctors, and to the ~~Board of Directors~~Governing Body to insure that these guidelines are followed for the good of all concerned.

If a Registered Nurse has concern regarding an attending member's care or treatment of a Hospital patient, or if an attending member cannot be located within a reasonable time, she should notify her Nursing Supervisor or the Nursing Supervisor on duty.

After notification, the Nursing Supervisor will first discuss this with the attending member if available, or his designee. She will then use her judgment as to whether the information should go to the Director of Nursing Service and/or Executive Medical Staff, utilizing the following order:

First: Chairman of Department(s) involved
Second: Chief of Staff
Third: Immediate Past Chief of Staff
Fourth: Chief of Staff-elect

The Nursing Supervisor will always notify the Director of Nursing Service of her actions directly or in writing.

~~26.~~25. Each member shall be required to attend 25 hours of CMA Category I education programs and submit a record to the Continuing Medical Education Committee annually as determined by the Credentials Committee.

~~27.~~26. ~~Physicians with~~ Practitioners sixty (60) years of age or older~~,~~ and with at least 5 years of staff membership, or practitioners with twenty-five (25) years of staff membership at Tri-City Medical Center, may be exempted from the ED call with the approval of the Division Chief, Department Chair and the Medical Executive Committee.

~~28.~~27. Respiratory therapists designated by an associate director of the Cardiopulmonary Division may take telephone orders from staff members related to oxygen administration, inhalation therapy, ventilator adjustments, auctioning, and chest physical therapy. Orders transmitted by phone will be written on the patient order sheet with the respiratory therapist's signature and the printed name of the physician as soon as practical. The charge nurse will be informed of the new order immediately.

~~29.~~28. A member unable to practice because of physical or mental illness will notify his department chairman. Inability to practice for a period of three months will automatically result in a leave of absence status as defined in Section 4.7 of the Medical Staff Bylaws.

~~30.~~29. Non-approved symbols and abbreviations may not be used in patient charts. The Medical Records Department maintains the non-approved listing.

~~31.~~30. Member privileges for treating patients in the intensive care units are identical to their privileges throughout the Hospital. Generally, these admission criteria include patients requiring monitoring, as well as those non-monitored patients who require continuous observation and skilled, specialized nursing care.

~~32.~~31. Daily progress notes must be written by the attending member on all acute patients in the acute care setting. Refer to Medical Staff Policy, *Medical Record Documentation Requirement Policy, 8710-518*, or its successors.

An exception to the above rule will be mental health unit patients, on whom progress notes will be written six days per week by the attending member.

~~33.~~32. When serving on the Emergency Department call roster, each member shall respond to requests from the Emergency Department as referenced in Medical Staff Policy, *Emergency Room Call: Duties of the On-Call Physician, 8710-520.* Each department/division may specifically define the Emergency Department call for its area of specialty in its own department/division rules and regulations.

~~34.~~33. Sedation shall be a specifically delineated privilege as moderate or deep sedation. Any and all members of the Medical Staff shall be granted and re-granted privileges to perform sedation in accordance with the Medical Staff Policy, *Criteria for Granting Adult and Pediatric Sedation/Analgesia Privileges Policy and Procedure, 8710-517.*

~~35.~~34. Prior to either side asserting its legal rights under section 2282.5 of the Business and Professional Code with respect to any dispute arising under this section, the Medical Staff and the hospital governing board shall meet and confer in good faith to resolve the dispute. Furthermore, if the dispute is not resolved prior to seeking court intervention, the parties will submit the dispute to non-binding mediation, the procedure of which will be explained in supplemental regulations.

~~36.~~35. Maximal sterile precautions will be used during insertion of Central Venous Catheters (including Peripherally Inserted Central Catheters) or guidewire exchanges. Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet.

~~37.~~36. In addition to physicians, the following persons may perform Medical Screening Exam as that term is defined in the Medical Staff Policy *Emergency Room Call: Duties of the On-Call Physicians, 8710-520*:

(a) In the Emergency Department: by a Physician Assistant who has been determined to be qualified and experienced and as delegated by the supervising physician.

(b) In the Labor and Delivery Unit: by a Registered Nurse who has determined to be qualified and experienced in obstetrical nursing and who is required to follow standardized procedures as approved by the Medical Staff.

BYLAWS: Revised ~~05/2013~~ February 6, 2017

ADOPTED by the Tri-City Medical Staff on:

Date: ~~08/15/2013~~

APPROVED by the ~~Board of Directors~~Governing Body on:

Date: ~~08/29/2013~~

Human Resources Committee
(No meeting held in
April, 2017)

Employee Fiduciary Subcommittee
(No meeting held in
April, 2017)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 20, 2017

MEMBERS PRESENT: CHAC Chair Julie Nygaard, BOD Chair Jim Dagostino, Director Larry Schallock; Dr. Victor Souza, MD; Gigi Gleason, Guy Roney, Linda Ledesma, Marge Coon, Mary Lou Clift, Sandy Tucker, Ted Owen, Audrey Lopez, Dung M. Ngo

MEMBERS ABSENT: Barbara Perez, Bret Schanzenbach, Carol Herrera, Danielle Pearson, Jack Nelson, Marilou de la Rosa Hruby, Mary Donovan, Mary Murphy, Rick Robinson, Roma Ferriter, Rosemary Eshelman, Scott Ashton, Xiomara Arroyo

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; David Bennett, Chief Marketing Officer; Cheryle Bernard-Shaw, CCO; Kapua Conley, COO

NON-VOTING MEMBERS ABSENT: Fernando Sanudo

OTHERS PRESENT: Wayne Knight, CSO; Brian Greenwald, Celia Garcia, CHAC Coordinator, Director Laura Mitchell, Lonny Harper, Oceanside PD; Josh Ferry, Oceanside PD

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The April 20, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:31 pm by Director and CHAC Chair Julie Nygaard.		
Approval Of Meeting Agenda	Director Dagostino motioned to approve the April 20, 2017 meeting agenda. The motion was seconded by Ted Owen and unanimously approved.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
April 20, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Jim Dagostino motioned to approve the March 16, 2017 CHAC meeting minutes. The motion was seconded by Gigi Gleason and approved.		
Presentation: Lonny Harper and Josh Ferry, Oceanside Police H.O.T. Team	Officers Lonny Harper and Josh Ferry presented information about the OPD Homeless Outreach Team as follows: • The purpose of the OPD Homeless Outreach Team is to connect the homeless population with appropriate resources. • The program is run and managed by officers Josh Ferry and Lonny Harper. • In 2011 the department received 1,508 calls from those needing help. By 2014 the amount of calls increased to 2,741. • The expense to taxpayers for homelessness averages $50,000.00 per person, per year. • The major problems not being addressed are basic needs, mental health, addiction, disability, employment, elderly, and housing. • The H.O.T. team has many community partnerships within Oceanside and North County.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Lonny Harper and Josh Ferry, Oceanside Police H.O.T. Team (Con't)	H.O.T. is a referral source only – they do not provide housing, they are not a discharge plan, and they are not social workers.		
CEO Update Steve Dietlin	CEO Steve Dietlin updated the group as follows: • Steve expressed his appreciation to Josh and Lonny for the information they shared and noted that this issue directly affects many patients at Tri-City Medical Center. • Surveyors were present at the hospital last week and will be presenting their findings in the near future. Steve noted that one surveyor relayed to him that TCMC is one of the best run hospitals in the State. • Steve stated that TCMC is working towards another "A" from Leapfrog in the Fall season. • April is Donate Life month. Last year, TCMC impacted 16,000 lives through organ donation. • April 5th was National Walking Day. Many from TCMC participated in the walk at the Wellness Center, with 300-350 ppl participating in total.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (Con't)	• Steve encouraged participation in the September 30th North County Health Walk. TCMC is partnering with the American Heart Association to make this event very well received in North County. The event will begin at the Oceanside pier. • Repairs to the broken pipe line are complete. Steve noted that food operations during the repairs were a challenge, but were handled with little to no effect on the patients.		
COO Update Kapua Conley	Chief Operating Officer Kapua Conley reported as follows: • Construction projects are on target, some may even be ahead of schedule. • The PERT team participated in a good meeting on April 19th and the work is showing in improved ER turnaround times and increased utilization of the Crisis Stabilization Unit. • TCMC is working with the Oceanside Police Department in the potential development of a police sub-station on campus.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Chief Marketing Officer Update David Bennett	Chief Marketing Officer David Bennett reported as follows: • David stated that the Marketing Department will be focusing future commercials and advertising on individual districts using local ad publishers and groups. • The department will be highlighting the newly remodeled NICU and TCMC's standing as the only level III NICU in North San Diego County. • The Marketing Department is managing multiple events in the months of April and May. • Recently, Board Member Larry Schallock was highlighted on TV to promote the upcoming National Prescription Drug Take Back Day on April 29th from 10-2p. This program will collect any outdated or unused drugs and dispose of them properly. Director Schallock noted that over 900,000 lbs of prescription drugs were turned in nationally in 2016.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

April 20, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Coloring Book	Chair Dagostino noted that at the next BOD meeting, the BOD will be recognizing an 8th grader from Vista, Evie Cunnington, who had the initiative to create a coloring book that assisted in the healing efforts of a relative who had suffered a stroke. Copies of the coloring book were provided to TCMC.		
Grant Review Meeting	Gigi Gleason updated the group on the recent Grant Review Committee meeting, noting that 30 requests were received, 18 were considered and 16 were recommended. Gigi will be updating the CHAC Committee further at the May meeting.		
Public Comments	There were no public comments.		
Tails on the Trails	Chair Julie Nygaard announced the upcoming Tails on the Trails Charity Dog Walk scheduled for Saturday, May 20, 2017. Flyers were provided to the group and additional registrations are needed.		
Committee Vacancies	Chair Julie Nygaard noted that there are two vacancies on the Committee that need to be filled. Each are Mayoral appointments – Oceanside District Resident and Vista District Resident.		
Next Meeting	The next CHAC meeting is scheduled for Thursday, May 18, 2017.		
Adjournment	The April 20th, 2017 CHAC meeting was adjourned at 1:39pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
April 18, 2017

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Kathleen Mendez, Carlo Marcuzzi, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO
Others	Director James Dagostino, David Bennett, Tom Moore, Norma Braun, Glen Newhart, Sharon Schultz, Sarah Jayyousi, Jane Dunmeyer, Sherry Miller, Susan Hadley, Charlie Nickell (Vereco), Mary Diamond, Eric White, Charlene Carty, Sharon Davies, Jeremy Raimo, Chris Miechowski, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Wayne Knight, Dr. John Kroener, Dr. Frank Corona, Tim Keane

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:32 p.m.		
2. Approval of Agenda		**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved to accept the agenda of April 18, 2017.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of March 21, 2017	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Mitchell, Director Kellett seconded, that the minutes of March 21, 2017, are to be approved without any requested**	

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		modifications. Ms. Mendez, Mr. Marcuzzi and Mr. Lingenfelter abstained.	
5. Old Business			
6. New Business			
a. Copier Lease Proposal • Kingsbridge Healthcare Financial	Tom Moore shared that this proposal was a replacement lease for copier equipment, which includes a reduction of lease interest rate to 3.74% from 4.67%. There is no increase in cost to TCMC, and includes new equipment and technology. This write-up to be amended to reflect a change in response from no to yes in the table on the write-up document where it notes "Document Submitted to Legal".	**MOTION** **It was moved by Dr. Contardo, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Kingsbridge Healthcare Finance for a copier equipment lease for a term of 60 months, beginning, May 1, 2017 – Ending, April 30, 2022, for an annual cost of $371,112, and a total cost for the term of $1,855,560.** Write up to be amended by Barbara Hainsworth.	Thomas Moore
b. Ventilator Heater Proposal • Vyaire Medical, Inc.	Tom Moore conveyed that this proposal was a loan agreement for respiratory therapy heated humidifiers at no cost in exchange for committed supply purchases from this vendor. These supplies are already being used at TCMC, and would require no product conversions. This write-up to be amended to reflect a change in response from no to yes in the table on the write-up document where it notes "Document Submitted to Legal".	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the committed supply spend agreement with Vyaire Medical, Inc. which will provide the no charge use of loaned ventilator heated humidifiers for a term of 35 months, beginning, May 1, 2017 and ending, March 31, 2020 for an annual cost of $95,868, and a total cost for the term of $279,615.** Write up to be amended by Barbara	Thomas Moore

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Hainsworth.	
c. Co-Medical Director Agreement – Outpatient Behavioral Health • Manish Sheth, M.D.	Sarah Jayyousi presented this agreement for Dr. Manish Sheth to continue as a co-director for Outpatient Behavioral Health Services. She stated it is a renewal for 36-months, with a new hourly rate. This write-up to be amended to reflect a change in response from yes to no in the table on the write-up document where it notes "Document Submitted to Legal". A standard template was used, and does not require submission to legal.	**MOTION** **It was moved by Director Kellett, Ms. Mendez seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Dr. Manish Sheth for Co-Medical Directorship for a term of three years, beginning July 1, 2017 and ending June 30, 2020 for an hourly rate of $140, an annual maximum cost of $58,080, and a total cost for the term of $174,240.** Write up to be amended by Barbara Hainsworth.	Sarah Jayyousi
d. Co-Medical Director Agreement – Outpatient Behavioral Health • Dennis Ordas, M.D.	Sarah Jayyousi presented this agreement for Dr. Dennis Ordas to continue as a co-director for Outpatient Behavioral Health Services. She stated it is a renewal for 36-months, with a new hourly rate. This write-up to be amended to reflect a change in response from yes to no in the table on the write-up document where it notes "Document Submitted to Legal". A standard template was used, and does not require submission to legal.	**MOTION** **It was moved by Director Kellett, Ms. Mendez seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Dr. Dennis Ordas for Co-Medical Directorship for a term of three years, beginning July 1, 2017 and ending June 30, 2020 for an hourly rate of $140, an annual cost of $59,760, and a total cost for the term of $179,280.** Write up to be amended by Barbara Hainsworth.	Sarah Jayyousi
e. Physician Agreement for ED On-Call Coverage – Cardiology-General/STEMI • Kenneth Carr, M.D.	Sherry Miller presented this renewal agreement for 12 months, for ED On-Call Coverage – Cardiology-General/STEMI with the rate	**MOTION** **It was moved by Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the**	Sherry Miller

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Karim El-Sherief, M.D. • David Spiegel, M.D.	remaining the same.	**Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Cardiology physicians Kenneth Carr, M.D., Karim El-Sherief, M.D., and David Spiegel, M.D. as the Cardiology-General/STEMI ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018, for general cardiology at a daily rate of $200, for a total term cost of $73,000, and $600 per day for STEMI, for an annual cost of $219,000, for a total annual and term cost of $292,000. Director Kellett abstained from the vote.**	
f. Physician Agreement for ED On-Call Coverage – Cardiology-General • Oscar Matthews, M.D. • Mohammad Pashmforoush, M.D.	Sherry Miller presented this renewal agreement for ED On-Call Coverage – Cardiology-General for 12 months, with the rate remaining the same.	**MOTION** **It was moved by, Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Cardiology physicians Oscar Matthews, M.D. and Mohammad Pashmforoush, M.D. as the Cardiology-General ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018, at a daily rate of $200, for a total annual and term cost of $73,000.**	Sherry Miller
g. ED On-Call Coverage – Cardiothoracic Surgery • Daniel L. Grammins, M.D. • Eugene Golts, M.D.	Sherry Miller presented this renewal agreement for ED On-Call Coverage - Cardiothoracic Surgery for 12 months, with the rate remaining the same.	**MOTION** **It was moved by, Dr. Contardo Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning**	Sherry Miller

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Steven Howe, M.D. • Michael Mandani, M.D. • Anthony Perricone, M.D. • Travis Pollema, M.D. • Gert Pretorius, M.D. • Patricia Thistlethwaite, M.D. • Theodore Folketh, M.D.		**Committee recommend that the TCHD Board of Directors authorize physicians Daniel L. Gramins, M.D.; Eugene Golts, M.D.; Steven Howe, M.D.; Michael Madani, M.D.; Anthony Perricone, M.D.; Travis Pollema, M.D.; Gert Pretorius, M.D.; Patricia Thistlethwaite, M.D. and Theodore Folkerth, M.D. as ED On-Call Coverage physicians for Cardiothoracic Surgery for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $375 for an annual cost of $136,875, and $375 per day for thoracic surgery for an annual cost of $136,875, for a total term cost of $273,750.**	
h. Cardiovascular Health Institute: • Medical Directorship Agreement	Jeremy Raimo conveyed that this agreement was a renewal at the same rates.	**MOTION** **It was moved by Dr. Contardo, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Ponec as the Medical Director for a term of 12 months, beginning July 1, 2017 - ending June 30, 2018. Not to exceed an average of 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual cost of $20,160, and a total cost for the term of $20,160.**	Jeremy Raimo
• Specialty Medical	Jeremy Raimo conveyed that this	**MOTION**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Directorship Agreements	agreement was a renewal at the same rates.	**It was moved by Dr. Contardo, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Deemer, Folkerth, Paveglio, and Spiegel as the Specialty Medical Directors for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 48 hours per month or 576 hours annually, at an hourly rate of $210 for an annual cost of $120,960, and a total cost for the term of $120,960.**	
• Operations Committee Agreements	Jeremy Raimo conveyed that this agreement was a renewal at the same rates.	**MOTION** **It was moved by Dr. Contardo, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Folkerth, Jamshidi-Nezhad, and Spiegel as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120, and a total cost for the term of $15,120.**	
• Quality Committee Agreements	Jeremy Raimo conveyed that this agreement was a renewal at the same rates.	**MOTION** **It was moved by Dr. Contardo, Director Mitchell seconded, and it was unanimously approved that the**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Drs. Kroener, Paveglio, and Ponec as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120, and a total cost for the term of $15,120	
i. Physician Agreement for Covering Physician – Inpatient Wound Care • Henry Showah, M.D.	Sharon Schultz conveyed that this was a renewal agreement for Dr. Showah to act as a covering physician for wound care inpatients, with new rates.	**MOTION** **It was moved by Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 6 hours a month, at an hourly rate of $180 for a total cost for the term of $12,960.**	Sharon Schultz
j. Physician Agreement for Covering Physician – Outpatient Wound Care / HBO Center • Henry Showah, M.D.	Sharon Schultz explained that this was a renewal agreement for Dr. Showah to act as a covering physician for outpatient wound care/HBO patients, with new rates.	**MOTION** **It was moved by Dr. Contardo, Ms. Mendez seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2017, and ending April**	Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		30, 2018. Not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.	
k. Physician Agreement for Covering Physician – Inpatient Wound Care • Sharon Slowik, M.D.	Sharon Schultz conveyed that this was a renewal agreement for Dr. Slowik to act as a covering physician for wound care inpatients, with new rates.	**MOTION** **It was moved by Director Kellett, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 14 hours a month, at an hourly rate of $180 for a total cost for the term of $30,240.**	Sharon Schultz
l. Physician Agreement for Covering Physician – Outpatient Wound Care / HBO Center • Sharon Slowik, M.D.	Sharon Schultz explained that this was a renewal agreement for Dr. Slowik to act as a covering physician for outpatient wound care/HBO patients, with new rates.	**MOTION** **It was moved by Director Kellett, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 30 hours a month, at an hourly rate of $180 for a total cost for the term of $64,800.**	Sharon Schultz
m. Physician Recruitment Proposal – Orthopedics Surgeon-Spine • Yu-Po Lee, M.D.	Jeremy Raimo relayed that this write-up was for a physician recruitment agreement with Dr. Yu-Po Lee, who is slated to join the	**MOTION** **It was moved by Director Kellett, Ms. Mendez seconded, and it was unanimously approved that the**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	orthopedic physicians group Orthopedic Specialist of North County.	**Finance, Operations and Planning Committee recommend that the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $915,000 in order to facilitate this Orthopedic Surgeon physician practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) with Orthopedic Specialist of North County and Dr. Yu-Po Lee, M.D.**	
n. Perinatal Services Proposal • Regents of the University of California, San Diego School of Medicine Department of Reproductive Medicine	Sharon Davies presented the write-up for Perinatal Services with Regents of the University of California, School of Medicine-Department of Reproductive Medicine. This proposal to include a medical director services as well as physician on-call and on-site consultations.	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Regents of the University of California, San Diego School of Medicine Department of Reproductive Medicine for Perinatology Medical Director and Physician Services for a term of 12 months, beginning May 1, 2017, and ending April 30, 2018 for an annual/total cost of $78,280.**	
o. Financials	Ray Rivas presented the financials ending March 31, 2017 (dollars in thousands) **TCHD – Financial Summary Fiscal Year to Date**		Ray Rivas

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Operating Revenue $ 251,660 Operating Expense $ 253,117 EBITDA $ 11,534 EBITDA Excl. Finance Chg. / 25 yrs. $ 14,937 EROE $ 138 EROE Excl. Finance Chg. / 25 yrs. $ 3,542 **TCMC – Key Indicators – FYTD** Avg. Daily Census 181 Adjusted Patient Days 84,445 Surgery Cases 4,752 Deliveries 1,979 ED Visits 47,248 **TCHD-Financial Summary – Current Month** Operating Revenue $ 29,352 Operating Expense $ 29,409 EBITDA $ (1,630) EBITDA Excl. Finance Chg. / 25 yrs. $ 1,774 EROE $ (2,912) EROE Excl. Finance Chg. / 25 yrs. $ 492 **TCMC – Key Indicators – Current Month** Avg. Daily Census 174 Adjusted Patient Days 9,330 Surgery Cases 583 Deliveries 202 ED Visits 5,420 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 43.1 Days in Net A/R Avg. 49.8 **Graphs:**		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	• TCMC-Net Days in Patient Accounts Receivable • TCMC – Adjusted Patient Days • TCMC-Acute Average Length of Stay • TCMC-Emergency Department Visits		
p. Work Plan – Information Only	Director Nygaard reported that these agenda items were for review only, but Committee members were welcome to ask questions.		Chair
• Wellness Center	David Bennett briefly reviewed the update document, and responded to questions and suggestions from committee members. In addition, David requested that the Wellness Center reporting period be changed from quarterly to semi-annually.	The Committee declined to recommend a change in the reporting period at this time. It will remain scheduled for a quarterly updates on the Work Plan.	David Bennett
• Finance, Operations & Planning Charter	Director Nygaard conveyed that the Finance, Operations and Planning Charter had received Board approval on January 26, 2017, and would be up for review again in 3-years (2020).	The Work Plan to be modified to reflect that this item would be placed on the agenda for review in April 2020.	Chair
• Construction Report	Kapua Conley gave a brief overview of the Construction Report. No Discussion		Kapua Conley / Chris Miechowski
• Dashboard	Mary Diamond gave a short PowerPoint presentation reflecting the outcome performance metrics		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Medical Director, Surgery	for Monthly First Case-On Time Starts, Total Block Utilization Percentage by Month and the Monthly Average Turnover & Close to Cut Intervals.	Committee Chair Nygaard solicited feedback from Committee members, with regard to changing the reporting period from quarterly to semi-annually for this item. All agreed that this reporting period change should be undertaken. **Barbara Hainsworth will edit the Work Plan to reflect this change.**	Mary Diamond
7. Comments by Committee Members		None	Chair
8. Date of next meeting	May 16, 2017		Chair
9. Community Openings (none)			
10. Adjournment	Meeting adjourned 1:36 pm		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
COPIER LEASE PROPOSAL

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

Vendor's Name: Kingsbridge Healthcare Finance

Area of Service: Lease Finance for Copier Fleet

Term of Agreement: 60 months, Beginning, May 1, 20017 – Ending, April 30, 2022

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$30,926	$371,112	$1,855,560

Description of Services/Supplies:

- Replacement lease schedule for copier equipment
- Using existing TCMC lease finance vendor
- Reduction of lease interest rate to 3.74% from 4.67%
- No increase in cost for TCMC, new equipment and technology
- Copier vendor selected and managed by Vereco, Inc.
- Lease payments made by Vereco, Inc, but agreement remains in TCHD's name, in case we part ways with Vereco, Inc.

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

Person responsible for oversight of agreement: Thomas Moore, Director of Purchasing / Ray Rivas, Acting Chief Financial Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Kingsbridge Healthcare Finance for a copier equipment lease for a term of 60 months, beginning, May 1, 2017 – Ending, April 30, 2022, for an annual cost of $371,112, and a total cost for the term of $1,855,560.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
VENTILATOR HEATER PROPOSAL

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

Vendor's Name: Vyaire Medical, Inc.

Area of Service: Respiratory Therapy Ventilator Heated Humidifier Loan Agreement

Term of Agreement: 35 months, Beginning, May 1, 2017 – Ending, March 31, 2020

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$7,989	$95,868	$279,615

Description of Services/Supplies:

- Committed supply spend agreement in exchange for loaned use of ventilator heated humidifiers at no cost
- Commitment level is based upon 90% of current spend volume
- No increase in current spend for TCMC
- This agreement avoids the need for TCMC to spend capital funds to purchase ventilator humidifiers
- The supplies stated in the agreement are directly related to the ventilator humidifier and currently already being used at TCMC. No product conversions are necessary.

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

Person responsible for oversight of agreement: Thomas Moore, Director of Purchasing / Ray Rivas, Acting Chief Financial Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the committed supply spend agreement with Vyaire Medical, Inc. which will provide the no charge use of loaned ventilator heated humidifiers for a term of 35 months, beginning, May 1, 2017 and ending, March 31, 2020 for an annual cost of $95,868, and a total cost for the term of $279,615.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Co-Medical Director Agreement - Outpatient Behavioral Health

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

Physician Name: Manish Sheth, M.D.

Area of Service: Outpatient Behavioral Health

Term of Agreement: 36 months, Beginning, July 1, 2017 – Ending, June 30, 2020

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

Hourly Cost	Monthly Cost	Annual Cost	Total Term Cost
$140 / 31 Hours	$4,340	$52,080	$156,240
	$500 Vacation Coverage	$6,000 Vacation Coverage	$18,000 Vacation Coverage
	Total: $4,840	**Total: $58,080**	**Total: $174,240**

This agreement adds on-call coverage and increases the rate from $125 to $140 per hour.

Description of Services/Supplies:

- Provide professional guidance and oversight for the Outpatient Behavioral Health department, including, Intensive Outpatient Program, Dual Recovery, and afternoon programs.
- Provide supervision for the clinical operation of the department and programs.
- Provide patient and staff education and educate providers and community members on availability of efficacy of Intensive outpatient Program services.
- Respond to insurance authorization calls and complete reports requested by patients
- Facilitate weekly treatment team meetings and evaluate appropriateness for continued stay.

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sarah Jayyousi, Operations Manager, Outpatient Behavioral Health / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Manish Sheth for Co-Medical Directorship for a term of three years, beginning July 1, 2017 and ending June 30, 2020 for an hourly rate of $140, an annual maximum cost of $58,080, and a total cost for the term of $174,240.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Co-Medical Director Agreement - Outpatient Behavioral Health

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

Physician Name: Dennis Ordas, M.D.

Area of Service: Outpatient Behavioral Health

Term of Agreement: 36 months, Beginning, July 1, 2017 – Ending, June 30, 2020

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

Hourly Cost	Monthly Cost	Annual Cost	Total Term Cost
$140 / 32 hours	$4,480	$53,760	$161,280
	$500 Vacation Coverage	$6,000 Vacation Coverage	$18,000 Vacation Coverage
	Total: $4,980	**Total: $59,760**	**Total: $179,280**

This agreement reduces hours from 48 to 32 per month, adds on-call coverage and increases rates from $125 to $140.

Description of Services/Supplies:

- Provide professional guidance and oversight for the Outpatient Behavioral Health department, including, Intensive Outpatient Program, Dual Recovery, and afternoon programs.
- Provide supervision for the clinical operation of the department and programs.
- Provide patient and staff education and educate providers and community members on availability of efficacy of Intensive outpatient Program services.
- Respond to insurance authorization calls and complete reports requested by patients
- Facilitate weekly treatment team meetings and evaluate appropriateness for continued stay.

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sarah Jayyousi, Operations Manager, Outpatient Behavioral Health / Sharon Schultz, Chief Nurse Executive

Motion:

Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Dennis Ordas for Co-Medical Directorship for a term of three years, beginning July 1, 2017 and ending June 30, 2020 for an hourly rate of $140, an annual cost of $59,760, and a total cost for the term of $179,280.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology-General/STEMI

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

Physician's Name: Kenneth Carr, M.D.; Karim El-Sherief, M.D.; David Spiegel, M.D.

Area of Service: Emergency Department On-Call: Cardiology - General and STEMI

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage:

Rate/Day	Panel Days per Year	Panel Annual Cost
$200 - General	365	$73,000
$600 - STEMI	365	$219,000
	Total Cost:	**$292,000**

Position Responsibilities:

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

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Cardiology physicians Kenneth Carr, M.D., Karim El-Sherief, M.D., and David Spiegel, M.D. as the Cardiology-General/STEMI ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018, for general cardiology at a daily rate of $200, for a total term cost of $73,000, and $600 per day for STEMI, for an annual cost of $219,000, for a total annual and term cost of $292,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology-General

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

Physician's Name: Oscar Matthews, M.D.; Mohammad Pashmforoush, M.D.

Area of Service: Emergency Department On-Call: Cardiology-General

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage:

Rate/Day	Panel Days per Year	Panel Annual Cost
$200	365	$73,000

Position Responsibilities:

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

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Cardiology physicians Oscar Matthews, M.D. and Mohammad Pashmforoush, M.D. as the Cardiology-General ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018, at a daily rate of $200, for a total annual and term cost of $73,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiothoracic Surgery

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

Physician's Names: Daniel L. Gramins, M.D.; Eugene Golts, M.D.; Steven Howe, M.D.; Michael Madani, M.D.; Anthony Perricone, M.D.; Travis Pollema, M.D.; Gert Pretorius, M.D.; Patricia Thistlethwaite, M.D.; Theodore Folkerth, M.D.

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

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

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

For entire Current ED On-Call Area of Service Coverage: Cardiothoracic Surgery

Rate/Day	Panel Days per Year	Panel Annual Cost
Cardiac: $375	365	$136,875
Thoracic: $375	365	$136,875
	Total Cost:	**$273,750**

Position Responsibilities:

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

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physicians Daniel L. Gramins, M.D.; Eugene Golts, M.D.; Steven Howe, M.D.; Michael Madani, M.D.; Anthony Perricone, M.D.; Travis Pollema, M.D.; Gert Pretorius, M.D.; Patricia Thistlethwaite, M.D. and Theodore Folkerth, M.D. as ED On-Call Coverage physicians for Cardiothoracic Surgery for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018 at a daily rate of $375 for an annual cost of $136,875, and $375 per day for thoracic surgery for an annual cost of $136,875, for a total term cost of $273,750.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Cardiovascular Health Institute - Medical Directorship Agreement

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

Physician's Name: Donald Ponec, M.D., Cardiovascular Institute

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	8	96	$1,680	$20,160	$20,160

Position Responsibilities:

Physician shall serve as Institute Medical Director and shall be responsible for the medical direction of the Institute and the performance of the other medical administrative services as outlined in the previously approved Co-Management Agreement for the Institute.

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Ponec as the Medical Director for a term of 12 months, beginning July 1, 2017 - ending June 30, 2018. Not to exceed an average of 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual cost of $20,160, and a total cost for the term of $20,160.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Cardiovascular Health Institute - Specialty Medical Directorship Agreements

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

Physician's Name: Andrew Deemer, M.D., Vascular Surgery
Theodore Folkerth, M.D., Cardiothoracic Surgery
Kathleen Paveglio, M.D., Non-Invasive Cardiology
David Spiegel, M.D., Invasive Cardiology

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	48	576	$10,080	$120,960	$120,960

Position Responsibilities:

Physicians shall serve as Medical Director and shall be responsible for the medical direction of the listed Specialty Area and the performance of the other medical administrative services as outlined in the previously approved Co-Management Agreement for the Institute.

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Deemer, Folkerth, Paveglio, and Spiegel as the Specialty Medical Directors for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 48 hours per month or 576 hours annually, at an hourly rate of $210 for an annual cost of $120,960, and a total cost for the term of $120,960.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Cardiovascular Health Institute - Operations Committee Agreements

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

Physician's Name: Theodore Folkerth, M.D.
Mohammad Jamshidi-Nezhad, M.D.
David Spiegel, M.D.

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	6	72	$1,260	$15,120	$15,120

Position Responsibilities:

Physicians shall serve as Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Folkerth, Jamshidi-Nezhad, and Spiegel as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120, and a total cost for the term of $15,120.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
Cardiovascular Health Institute - Quality Committee Agreements

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

Physician's Name: John Kroener, M.D.
Kathleen Paveglio, M.D.
Donald Ponec, M.D.

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	6	72	$1,260	$15,120	$15,120

Position Responsibilities:

Physicians shall serve as Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

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

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Wayne Knight, Chief Strategy Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Kroener, Paveglio, and Ponec as the Coverage Physicians for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 6 hours per month or 72 hours annually, at an hourly rate of $210 for an annual cost of $15,120, and a total cost for the term of $15,120.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for Covering Physician - Inpatient Wound Care

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

Physician's Name: Henry Showah, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2017- Ending, April 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	6	72	$1,080	$12,960

Position Responsibilities:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 6 hours a month, at an hourly rate of $180 for a total cost for the term of $12,960.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for Covering Physician - Outpatient Wound Care/HBO Center

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

Physician's Name: Henry Showah, M.D.

Area of Service: Outpatient Wound Care/HBO

Term of Agreement: 12 months, Beginning, May 1, 2017- Ending, April 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	20	240	$3,600	$43,200

Position Responsibilities:

- Provide supervision of staff and patients undergoing HBO
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Design Quality Assurance and Performance Improvement program.
- Creates criteria for medical audits
- Timely communication with primary care physicians and/or other community health resources
- Audits patient care and records of care for opportunities in case delivery.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, and QAPI: Actively participate in Hospital's Medical Staff utilization review, quality, performance improvement and risk programs.
- Attends monthly QAPI meetings

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Henry Showah as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 20 hours a month, at an hourly rate of $180 for a total cost for the term of $43,200.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for Covering Physician - Inpatient Wound Care

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 12 months, Beginning, May 1, 2017- Ending, April 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	14	168	$2,520	$30,240

Position Responsibilities:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Inpatient Wound Care for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 14 hours a month, at an hourly rate of $180 for a total cost for the term of $30,240.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PHYSICIAN AGREEMENT for Covering Physician - Outpatient Wound Care/HBO Center

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Outpatient Wound Care/HBO

Term of Agreement: 12 months, Beginning, May 1, 2017- Ending, April 30, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	12 month (Term) Cost
$180	30	360	$5,400	$64,800

Position Responsibilities:

- Provide supervision of staff and patients undergoing HBO
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Design Quality Assurance and Performance Improvement program.
- Creates criteria for medical audits
- Timely communication with primary care physicians and/or other community health resources
- Audits patient care and records of care for opportunities in case delivery
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, and QAPI: Actively participate in Hospital's Medical Staff utilization review, quality, performance improvement and risk programs.
- Attends monthly QAPI meetings

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon Slowik as the Coverage Physician for Outpatient Wound Care/HBO for a term of 12 months from May 1, 2017, and ending April 30, 2018. Not to exceed an average of 30 hours a month, at an hourly rate of $180 for a total cost for the term of $64,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: April 18, 2017
PERINATAL SERVICES PROPOSAL

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

Vendor's Name: Regents of the University of California, San Diego School of Medicine Department of Reproductive Medicine

Area of Service: Perinatology

Term of Agreement: 12 months, Beginning, May 1, 2017 – Ending, April 30, 2018

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

	Hourly Rate	**5 Months May - September 2017**	**7 Months October 17 – April 2018**	**12 month Cost**
Medical Director	$150	$12,750	$17,850	$30,600
Physician On-Call	$100	$8,667	$12,133	$20,800
Physician On-Site	$120	0	$26,880	$26,880
		$21,417	**$56,863**	**$78,280**

Description of Services/Supplies:

- Provide Medical Director and perinatology consultation services and outpatient fetal diagnostic services beginning 5/1/2017
- Provide assistance by telephone to obstetrical medical staff in management of high risk pregnancy beginning 5/1/2017
- Provide on-call/telephone consultation services 24 hours per day, 7 days per week beginning 5/1/2017
- Provide up to two 4 hour sessions (or 8 hours per week) on a schedule as mutually agreed to by the parties, beginning 10/1/2017

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

Person responsible for oversight of agreement: Wayne Knight, Chief Strategy Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Regents of the University of California, San Diego School of Medicine Department of Reproductive Medicine for Perinatology Medical Director and Physician Services for a term of 12 months, beginning May 1, 2017, and ending April 30, 2018 for an annual/total cost of $78,280.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
April 20, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino and Dr. Johnson.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director of Regulatory Compliance, Kathy Topp, Kevin McQueen, Sherry Miller, Aimee Hardt, Nancy Myers, Sharon Davies, Mary Diamond, Oska Lawrence, Merebeth Richns, Linda Sprague, Priscilla Reynolds, Tori Hong, Manuel Escobar, Scott Livingstone, Patricia Guerra and Karren Hertz.

Members Absent: Director Leigh Anne Grass, Dr. Gene Ma, Dr. Scott Worman and Dr. Marcus Contardo.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 8:39 AM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications. Due to a lack of quorum, Sharon Schultz was appointed by the committee as a voting member for this month's meeting.	Motion to approve the agenda was made by Director Dagostino and seconded by Dr. Johnson.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of March 2017.	Director Mitchell called for a motion to approve the minutes from March 9, 2017 meeting.	The minutes were ratified and was unanimously approved by the group. Director Dagostino moved and Dr. Johnson seconded the motion to approve the minutes from March 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Admission Criteria Policy 2. Admixture, Intravenous Procedure 3. Blanket Warmers Policy 4. Code Status/ Do Not Resusciate DNR 312 5. Determination of Brain Death	 There was a recommendation to remove the the AHP (Allied Health Practitioner) term in this policy. A clarification was made on the use of filter needles when using ampules. There were three stipulations that will be added on the use of blanket warmers as recommended by Safety Officer Kevin Mcqueen. Director Mitchell had a question regarding the surrogate decision maker; committee had a short discussion. It was noted that there is a separate policy addressing End of Life issues. There was no discussion on this policy.	 **ACTION:** The Patient Care Services policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval with the appropriate corrections noted by the Committee members.	 Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
6. Food and Nutrition Relationships with Other Departments Policy	Director Mitchell recommended to take out the section (i) preparing infant formulas for the obstetrical nursery since the hospital does not practice that anymore.		
7. Glucose Monitoring During Exercise Therapy for Diabetic Patients	This policy is geared solely for diabetics; and this premise needs to be confirmed by the diabetic's PCPs.		
8. Meals, Patients—Times, Menus, Substitutions and Nourishments Policy	It was noted that there is a separate policy addressing food brought from outside.		
9. Medication Recall Policy	There was no discussion on this policy.		
10. Outpatient Summary List Procedure	There was no discussion on this policy.		
11. Purewick Female Urinary Incontinence Management	There was no discussion on this policy.		
12. Research Activity Investigational Drugs Policy	There was an indication that there are a lot of changes in this policy; the reason being is because the hospital didn't have an investigational research in the past. Director Mitchell suggested to have a Glossary placed at the beginning of the policy for better awareness of the abbreviated terms contained in the whole policy.		
Administrative Policies and			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Procedures: 1. EMTALA- Emergency Medical Screening 506	There was no discussion on this policy.	**ACTION:** The Administrative policy and procedure was approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Unit Specific Education 1. ACLS Fee Waiver Policy 2. AHA Reciprocity Statement Policy 3. AHA Role of TCMC AHA Training Center Policy 4. AHA TC Course Content Requirements Policy 5. AHA TC Dispute Resolution- Disciplinary Action Policy	Forensics should be replaced with PCU. All the TCMC should be taken out and replaced with THCD.	**ACTION:** The Education policies were approved as moved by Director Dagostino and seconded by Sharon Schultz.	Patricia Guerra
Medical Staff 1. Conflict of Interest	This policy will be reviewed further by the Chief Compliance Officer Cheryle Bernard-Shaw. References will also be updated.	**ACTION:** The Medical Staff policies were approved. Director Dagostino moved and Sharon Schultz seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Conflict Resolution Policy	There was no discussion on this policy.		
3. Credentialing Criteria, Chronic Non-Healing Wound Care	Physician assistant will be replced with AHP (Allied Health Practitioner).		
4. Credentialing Criteria,	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Hyeprbaric Medicine Oxygen Therapy			
5. Credentialing Policy, Expedited Credentialing and Privileging Process	The committee had a discussion to change the person responsible for granting expedited credentialing in certain emergent cases. Instead of this committee, it was agreed that the Board, or the CEO or a designee shall be the one who will be responsible for this .		
6. Credentialing Policy, Processing Medical Staff Applications	There was no discussion on this policy.		
7. Credentialing Standards Catheter-Based Peripheral Vascular Interventional Procedure	It was noted by the group that the applicant for credentialing peripheral vascular physicians are required to have certification in fluoroscopy.		
8. Documentation Requirements for Emergency Department Residents	Since residents usually come from another facility, they are required to do their documentation the way it is done at TCMC. Guidance will be provided for dictation documentation.		
9. Election Process Members at Large MEC	There was no discussion on this policy.		
10. Emergency Room Call Duties of the On-Call Physician	Certain information was refreshed in this policy.		
11. Liability Insurance Requirements	The liability information was updated in this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
12. Management of Conflicts Between Medical Staff and MEC	There is no discussion on this policy.		
13. Medical Record Documentation	All sections that still have Tri-City Medical Center should be changed to Tri-City Healthcare Ditrict.		
14. Medical Staff Governance Documents Development and Review	There is no discussion on this policy.		
15. Name Tags for Health Practitioners	There is no discussion on this policy.		
16. Peer Review Process: OPPE and FPPE	Refrences will be updated for this policy.		
17. Physician Orders/ Family Members	There was no discussion on this policy.		
18. Physician/ Podiatrist Surgical Assistant	The approval dates contained in this policy will be updated.		
19. Physician WellBeing Policy	There was no discussion on this policy.		
20. Professional Behavior Policy and Committee	There was no discussion on this policy.		
21. Requests for New Privileges/ Technologies New to TCMC	Sherry Miller said that a new website link was added to this policy indicating the status of a technology procedure which is used in credentialing process.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
22. Standards for Endovascular Repair of Aortic Aneurysms	There was no discussion on this policy.		
23. Supervision of Residents/ Fellows/ Medical Students	There was no discussion on this policy.		
24. Surgical Assistance	Bariatric and robotic cases were added to the areas needing surgical assistance.		
25. Suspension for Delinquent Medical Records and Fine Process	There was no discussion on this policy.		
26. Temporary Privileges	Jody Root recommended to take out the Section number when referring to the Medical Staff bylaws as some of these numbers are constantly changing and might not be accurate at a certain time.		
27. Unintended Intraoperative Awareness During Anesthesia	There was no discussion on this policy.		
NICU			
1. Peripherally Inserted Central Catheters and Midline Catheters Insertion		**ACTION:** The NICU procedure was approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the procedure moving forward for Board approval.	Patricia Guerra
Surgical Services			
1. Anesthesia Type, Location and Monitoring Policy	There were no discussion on the policies for Surgical services.	**ACTION:** The Surgical Services Services policies were approved.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Anticoagulation Management During Cardiopulmonary Bypass Procedure 3. Disinfection of Stockert Heater-Cooler System 3T Tanks Procedure 4. Donor Corneas, Transplant Preparation Procedure 5. Eye Laser Patient Management procudre 6. Heart Lung Machine Procedure 7. Heart Valves Thawing (Cyropreserved) Procedure 8. Laser safety Management Procedure 9. Mira Cryo Unit Set-Up Procedure 10. Patient Transportation in the Perioperative Environment Procedure		Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	
Women's and Newborn Services			
1. Amnioinfusion	This policy is being deleted as it is in Mosby's already.	**ACTION:** The Women's and Children's Services policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Cord Gas Collection	The cord gas collection information will be in the newborn record and not in the mother's medical record.		
3. Elective Delivery Under 39 Weeks	It was noted that the figures for this population is getting better over time.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. HIV Intrapartum Management	There was no discussion on this policy.		
5. HIV Newborn Management	There was no discussion on this policy		
6. Misoprostol	There was no discussion on this policy.		
7. Shoulder Dystocia	This is being deleted; all information is in Mosby's		
8. Standards of Care: Antepartum	There was no discussion on this policy.		
9. Umbilical Cord Blood Banking Private Collection	Sharon Davies reiterated that for the umbilical cord collection, the patient has to bring her own kit since TCMC is not sanctioning any companies offering that kind of service.		
Formulary Requests 1. Acetaminophen 2. Articial Saliva 3. Meperidine Oral Tablets 4. Tobramycin Nebulized Soluntion	The committee had a short discussion on these formulary requests but all of them were approved to move forward for Board approval.	**ACTION:** The formulary rtequests were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve these requests moving forward for Board approval.	
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 9:30 AM.	Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
8. Return to Open Session	The Committee return to Open Session at 11:01AM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:11 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE

~~April 14, 2017~~ April 20, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Admission Criteria Policy	Practice Change	Forward to BOD for approval with Revisions
2. Admixture, Intravenous Procedure	3 Year Review, Practice Change	Forward to BOD for approval
3. Blanket Warmers Policy	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
4. Code Status / Do Not Resuscitate DNR 312	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
5. Determination of Brain Death	NEW	Forward to BOD for approval
6. Food and Nutrition Relationships with Other Departments Policy	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
7. Glucose Monitoring and Exercise Therapy for Diabetic Patients	NEW	Forward to BOD for approval
8. Meals, Patients - Times, Menus, Substitutions, & Nourishments Policy	3 Year Review	Forward to BOD for approval
9. Medication Recall Policy	3 Year Review	Forward to BOD for approval
10. Outpatient Summary List Procedure	DELETE	Forward to BOD for approval
11. PureWick Female Urinary Incontinence Management	NEW	Forward to BOD for approval
12. Research Activity Investigational Drugs Policy	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
Administrative Policies & Procedures		
1. EMTALA_Emergency Medical Screening 506	3 Year Review	Forward to BOD for approval
Unit Specific		
Education		
1. ACLS Fee Waiver Policy	3 Year Review	Forward to BOD for approval
2. AHA Reciprocity Statement Policy	3 Year Review	Forward to BOD for approval
3. AHA Role of TCMC AHA Training Center Policy	3 Year Review	Forward to BOD for approval
4. AHA TC Course Content Requirements Policy	3 Year Review	Forward to BOD for approval
5. AHA TC Dispute Resolution - Disciplinary Action Policy	3 Year Review	Forward to BOD for approval
Medical Staff		
1. Conflict of Interest 8710-555	3 Year Review	Forward to BOD for approval
2. Conflict Resolution Policy 8710-562	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
3. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
4. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A	3 Year Review	Forward to BOD for approval
5. Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550	3 Year Review	Forward to BOD for approval with Revisions

PROFESSIONAL AFFAIRS COMMITTEE

~~April 14, 2017~~ April 20, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
6. Credentialing Policy, Processing Medical Staff Applications 8710-543	3 Year Review	Forward to BOD for approval
7. Credentialing Standards Catheter-Based Peripheral Vascular Interventional Proc 8710-504	3 Year Review	Forward to BOD for approval
8. Documentation Requirements for Emergency Department Residents 8710-532	3 Year Review, Practice Change	Forward to BOD for approval
9. Election Process Members at Large MEC 8710-531	3 Year Review	Forward to BOD for approval
10. Emergency Room Call Duties of the On-Call Physician 8710-520	3 Year Review	Forward to BOD for approval with Revisions
11. Liability Insurance Requirements 8710-558	3 Year Review	Forward to BOD for approval
12. Management of Conflicts between Medical Staff and MEC 8710-567	3 Year Review	Forward to BOD for approval
13. Medical Record Documentation Requirements 8710-518	3 Year Review	Forward to BOD for approval
14. Medical Staff Governance Documents Development and Review and Approval Mechanism 8710-500	3 Year Review	Forward to BOD for approval
15. Name Tags for Health Practitioners 8710-521	3 Year Review	Forward to BOD for approval
16. Peer Review Process: OPPE and FPPE 8710-509	3 Year Review	Forward to BOD for approval with Revisions
17. Physician Orders_Family Members 8710-529	3 Year Review	Forward to BOD for approval
18. Physician Surgical Assistant 8710-536	3 Year Review	Forward to BOD for approval
19. Physician Well Being Policy 8710-511	3 Year Review	Forward to BOD for approval
20. Professional Behavior Policy 8710-570	3 Year Review	Forward to BOD for approval
21. Requests for Privileges New to TCMC 8710-526	3 Year Review	Forward to BOD for approval
22. Standards For Endovascular Repair of Aortic Aneurysms 8710-503	3 Year Review	Forward to BOD for approval
23. Supervision of Residents/Fellows/Medical Students 8710-513	3 Year Review	Forward to BOD for approval
24. Surgical Assistance 8710-545	3 Year Review, Practice Change	Forward to BOD for approval
25. Suspension for Delinquent Medical Records 8710-519	3 Year Review	Forward to BOD for approva
26. Temporary Privileges 8710-515	3 Year Review	Forward to BOD for approval with Revisions
27. Unintended Intraoperative Awareness During Anesthesia 8710-546	3 Year Review	Forward to BOD for approval
NICU		
1. Peripherally Inserted Central Catheters and Midline Catheters Insertion	3 Year Review, Practice Change	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE

~~April 14, 2017~~ April 20, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
	Surgical Services		
1.	Anesthesia Type, Location and Monitoring Policy	3 Year Review, Practice Change	Forward to BOD for approval
2.	Anticoagulation Management During Cardiopulmonary Bypass Procedure	DELETE	Forward to BOD for approval
3.	Disinfection of Stockert Heater-Cooler System 3T Tanks Procedure	DELETE	Forward to BOD for approval
4.	Donor Corneas, Transplant Preparation Procedure	DELETE	Forward to BOD for approval
5.	Eye Laser Patient Management Procedure	DELETE	Forward to BOD for approval
6.	Heart Lung Machine Procedure	DELETE	Forward to BOD for approval
7.	Heart Valves Thawing (Cryopreserved) Procedure	DELETE	Forward to BOD for approval
8.	Laser Safety Management Procedure	DELETE	Forward to BOD for approval
9.	Mira Cryo Unit Set-Up Procedure	DELETE	Forward to BOD for approval
10.	Patient Transportation in the Perioperative Environment Procedure	DELETE	Forward to BOD for approval
	Women & Newborn Services		
1.	Amnioinfusion	DELETE	Forward to BOD for approval
2.	Cord Gas Collection	3 Year Review, Practice Change	Forward to BOD for approval
3.	Elective Delivery Under 39 Weeks	3 Year Review	Forward to BOD for approval
4.	HIV Intrapartum Management	3 Year Review, Practice Change	Forward to BOD for approval
5.	HIV Newborn Management	DELETE	Forward to BOD for approval
6.	Misoprostol [Cytotec]	3 Year Review, Practice Change	Forward to BOD for approval
7.	Shoulder Dystocia	DELETE	Forward to BOD for approval
8.	Standards of Care: Antepartum	3 Year Review, Practice Change	Forward to BOD for approval with Revisions
9.	Umbilical Cord Blood Banking Private Collection	3 Year Review	Forward to BOD for approval
Formulary Requests			
1.	Acetaminophen	Practice Change	Forward to BOD for approval
2.	Artificial Saliva	Addition to Formulary	Forward to BOD for approval
3.	Meperidine Oral Tablets	Remove from Formulary	Forward to BOD for approval
4.	Tobramycin Nebulized Solution	Remove from Formulary	Forward to BOD for approval
Pre-Printed Orders			
1.	Discharge Referral Services Orders 8711-4539	DELETE	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 03/02	**SUBJECT: Admission Criteria**
REVISION DATE: 10/02; 6/03, 5/05, 12/05, 5/09, 2/12, 08/12	**POLICY NUMBER: VI.A**

Department Approval:	06/16
Clinical Policies & Procedures Committee Approval:	~~09/14~~08/~~16~~02/17
Nurse Executive Council Approval:	~~10/14~~02/17
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/14~~03/17
Professional Affairs Committee Approval:	~~01/15~~04/17
Board of Directors Approval:	01/15

A. **PURPOSE:**

1. To provide guidelines for the medical staff, nursing personnel, ancillary disciplines, and admitting personnel to ensure:
   a. A consistent process for admission of patients
   b. An appropriate level of care is based on patient's needs/situation

B. **POLICY:**

1. Admission Requirements:
   a. Hospital admission requires a physician's ~~or Allied Health Professional (AHP)~~ order.
   b. Patients may be admitted to inpatient or observation status per current InterQual guidelines.
      i. Patients must be 14 years of age or older to be admitted.
         1) Patient must be 18 years and above to be admitted to the Progressive Care Unit (PCU) or Behavioral Health Services (BHS) including the Crisis Stabilization Unit (CSU) and Inpatient Behavioral Health Unit (IBHU).
         ~~i.~~**2) Refer to Women and Newborn Services Neonatal Intensive Care Unit (NICU) Policy: Admission and Discharge Criteria for the NICU regarding infants up to adjusted 44 week post conceptual age**
   ~~b.~~**c.** The attending physician~~/AHP~~ shall be designated by the admitting physician~~/AHP~~ at the time of patient admission.
   ~~c.~~**d.** The Administrative Supervisor (AS) /Assistant Nurse Manager (AN~~M~~**M**~~N~~) or designee assigns a bed based upon patient diagnosis, acuity, age, bed availability and physician/~~provider~~ ~~AHP~~ request.
   ~~d.~~**e.** Additional considerations:
      i. The decision to admit a patient continues to be the responsibility of the treating **physician/**~~AHP~~~~provider~~.
         1) If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case shall be referred for secondary review per chain of command.
      ii. Each unit may have limitations of ability to care for certain types of patients in terms of physical layout, environment, equipment, staff expertise, availability, or patient acuity.
      iii. Temporary staffing adjustments shall be made for those patients whose acuity level exceeds established guidelines.

1) If patient admission requirements exceed hospital bed and/or staffing capacity, AS collaborates with ANM, Charge Nurses and/or Managers, then forwards the request to hold admissions to the Clinical Operations On Call if deemed necessary.

~~c.~~**f.** Admission of patients to the nursing units may occur by any of the following methods:

i. Direct Admissions:

1) Patients may come directly from a physician's~~/AHP's~~ office, their home, a long-term care facility or outpatient department as ordered by a physician~~/AHP~~.
2) The physician~~/AHP~~ calls the AS for a bed assignment per Patient Care Services **(PCS)** Policy Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC).
3) The AS shall conduct a telephone triage on the patient to assess status. Admission ~~borders~~ **orders** are required for each patient~~ prior to admission~~. **The Registered Nurse will call the admitting physician for orders once the patient arrives to the nursing unit.** Orders may **also** be faxed to Registration Department at 760-940-4016**, entered electronically** or sent with the patient.
4) The AS assigns the patient to the appropriate unit and informs the ANM/relief charge.
5) Ambulatory patients report to the Registration Department between the hours of 0500-1800 and to the Emergency Department between the hours of 1800-0500.
6) The Registrar notifies the unit that the patient has arrived. Patients admitted via Registration may be escorted to the nursing unit by the office staff or volunteer personnel.
7) Patients unable to complete the registration process in one of the registration areas due to severity of illness or discomfort shall be escorted directly to the nursing unit. These patients shall be registered at the bedside by a registrar or by a family member/conservator/designee in the registration office.
8) Patients experiencing acute symptoms shall be triaged in the Emergency Department (ED) prior to being escorted by clinical staff to the respective nursing units.
9) If an inpatient bed is unavailable, the patient may be:
   a) Admitted to the ED for evaluation and treatment.
   b) Requested to remain in physician's~~/AHP's~~ office until bed available.
   c) Requested to remain home until bed available.

ii. Admissions to Acute Rehabilitation:

1) When a physician~~/AHP~~ orders an inpatient be evaluated for admission to Acute Rehab, the Rehab Coordinator will determine if the patient meets the admission criteria.

~~**All patients being admitted to Acute Rehabilitation (Rehab) are direct admissions.**~~

~~**When a physician/AHP orders an inpatient be transferred to Rehab, the Rehab Coordinator will determine if the patient meets the criteria to be admitted to Acute Rehab.**~~

2) Once approval is obtained, the patient must be discharged from the inpatient unit and ~~re~~admitted as a direct admit to Rehab with a new financial account number (FIN#) when a bed is available.
   a) The inpatient unit secretary will request a Rehab bed in Aionex
   b) The RN will complete the Depart process including all required documentation.

c) A Cerner communication notice will be sent to Registration upon transfer.

~~a)~~**i) Registration will create the new FIN#.**

~~ii.~~**iii.** Emergency Admission:

1) ED admission to an inpatient unit:

a) After a physician**/~~AHP~~** determines that an Emergency Department patient will be admitted, the ED unit secretary will enter the bed request into Aionex, AS**/ANM or designee** will assign the bed in Aionex, and inputs the bed number into FirstNet.

2) ED patients being admitted to the ~~I~~BHS~~U~~ are converted to an Inpatient status with the same FIN # when a bed is available.

3) ED patients being admitted to the CSU are to be discharged from the ED and readmitted to CSU with a new FIN# when a bed is available.

a) **If the patient is admitted to IBHU or must return to the ED, the patient is to be discharged from the CSU and a new account with new FIN# must be created.**

~~iii.~~**iv.** Transfer Admission:

1) The AS shall arrange patient transfers from another in-house patient care unit or outside facility.

~~iv.~~**v.** Surgical Admission:

1) Surgery patients are pre-scheduled through Surgery Scheduling.
2) Surgery Scheduling schedules the appointment for pre-admission procedures and teaching.
3) Surgery Scheduling generates a computerized list of pre-scheduled surgical admissions and forwards the list to the AS.
4) The AS assigns the bed and notifies the nursing unit.

~~v.~~**vi.** Outpatient Admissions:

1) Registration processes all outpatient admissions.

~~vi.~~**vii.** Boarders:

1) WNS - Boarders are newborn infants admitted after delivery and not discharged with their mother. Boarders **may be~~are~~** admitted to the newborn nursery **or NICU based on infant status~~ only~~.**

~~1)~~**2) ED – Boarders are patients with admission orders greater than four (4) ~~two (2)~~ hours after a bed has been requested for inpatient admission or observation.**

~~vii.~~**viii.** The following departments coordinate admissions to their unit(s), see department specific admission criteria:

1) ~~Behavioral Health,~~ **BHS – Inpatient or ~~Crisis Stabilization Unit~~ (CSU) – Outpatient Observation.**
2) Neonatal Intensive Care Unit (NICU),
3) **Acute** Rehabilitation Unit (**ARU or** Rehab)
4) Women and Newborn Services
~~3)~~**5) Progressive Care Unit (PCU)**

2. Unit Specific Criteria:

a. Intensive Care Unit (ICU) (1 East, 1 West):

i. This level is appropriate to use when the patient has an acute cardiac, medical, surgical, or trauma event, along with any of the following:~~.~~

1) Invasive hemodynamic monitoring
2) Urgent temporary pacemaker insertion
3) Urgent cardioversion
4) Intra-aortic Balloon pump (IABP)
5) Continuous cardiac monitoring
6) Acute intubation and mechanical ventilation management
7) Sepsis
8) Therapeutic Hypothermia

9) Dialysis
10) Coronary Bypass Surgery
11) Advanced Hemodynamic monitoring

ii. The following patients shall not be managed on this unit due to the lack of available resources:
1) Undergoing organ transplants
2) Requiring specialized burn treatments
3) Under the age of 14 or less than 35kg

b. Telemetry (2 East, 2 West, ~~3 East,~~ 4 East, 4 West, 3 Pavilion):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available **cardiac** monitored beds.
1) Continuous cardiac monitoring
2) Continued mechanical ventilation with stable ABG's and extended ventilator weaning
3) Stable temporary pacemaker insertion or transcutaneous pacing
4) See Telemetry Policy: Admission and Discharge Criteria

c. Progressive Care Unit (3 North, 3 South)
i. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
1) Continuous Cardiac Monitoring
2) Chemotherapy Administration ~~Chemotherapy Administration Policy)~~
3) Acute rehabilitation
4) Ante-partum care
5) Post-partum care
6) Medical-Surgical

~~c.~~**d.** Acute Care Services (1 North, 2 Pavilion, ~~3 Pavilion~~, 4 Pavilion and Acute Rehabilitation):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available beds.
1) Post critical care or Telemetry monitoring
2) Procedures requiring inpatient hospitalization
3) IV medications requiring hospitalization for initial therapy
4) Designated inpatient post surgical~~/delivery~~ care.

ii. 1 North/Ortho (Ortho and Medical/Surgical Patients)
1) This unit specializes in nursing care for patient's ages 14 years of age and older suffering from diseases, injuries or conditions of the human musculoskeletal system.
2) Orthopedic diagnoses are emphasized with an emphasis on orthopedic surgeries including total joint replacement, spinal surgeries and hip replacements.

iii. 2 Pavilion (Oncology and Medical/Surgical Patients)
1) This unit provides nursing care for adolescent patients (ages 14 years to 21 years) or adult patients (age 22 years and older).
a) Patients receiving chemotherapy must be age 18 or older.
2) Oncological diagnoses are emphasized~~;~~ along with women's surgeries and ~~the daVinci Robotic Surgery patients, in addition to~~ general medical surgical diagnosis.

~~iv. 3 Pavilion (Adolescents Adult Medical/Surgical Patients overflow)~~
~~a) Adolescent (ages 14 to 21 years) medical/surgical patients~~
~~b) Adult patients (ages 22 and older) medical/surgical patients~~

v. 4 Pavilion (Dialysis, Rate Monitoring for Medical/Surgical patients, ~~and~~ Designated Stroke Unit**, and Epilepsy Monitoring Unit [EMU]**)
1) This unit specializes in nursing care for patients ages 14 years of age and older:
a) Medical/Surgical patients requiring rate monitoring
b) Hemodynamically stable patients status post CVA
c) Visual monitoring of stable epilepsy patients **(EMU)**

vi. Acute Rehabilitation Unit (ARU)
~~ii.~~1) The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services.

~~d.~~**e.** Emergency Services:
i. This unit provides nursing care for patients of all ages that:
1) Require medical care and are in stable, mild, moderate, or acute status.
2) Are afflicted with conditions involving major trauma, major burns, or requiring hyperbaric therapy, and pediatric intensive care services that can be stabilized to the degree medically feasible and subsequently transferred to facilities providing these specialty services in compliance with EMTALA regulations.

f. Women and Newborn Services:
i. This unit specializes in nursing care for:
1) Perinatal patients who have conditions associated with antepartum, intrapartum and/or postpartum management needs to include surgical requirements related to perinatal care.
2) **Neonates born in the hospital that may need resuscitation, stabilization and ongoing evaluation**

C. **RELATED DOCUMENTS:**
1. Behavioral Health Unit Inpatient Policy: Inpatient Unit Admission Criteria
2. Patient Care Services Policy: Transferring of Patients and Recovering Patients from Outside ~~Tri City Medical Center~~**TCMC**
3. PCS Policy: Transfer of Patients, Intra Facility
4. Surgery Policy: Scheduling Surgical Procedures
~~4.~~5. Telemetry Policy: Admission and Discharge Criteria
~~Women and Newborn Services Policy: Admission Policy~~
~~5.~~6. Women Newborn and Services~~Neonatal Intensive Care Unit~~ (~~NICU~~) Policy: Admission and Discharge Criteria for NICU

Tri-City Medical Center	Distribution: Patient Care Services

PROCEDURE:	ADMIXTURE, INTRAVENOUS
Purpose:	To outline the responsibilities and technique for Registered Nurses (RNs) in compounding sterile intravenous admixture preparations in patient care areas to prevent harm that could result from microbial contamination (non-sterility), excessive bacterial endotoxins, and large content errors in strength of correct ingredients, and incorrect ingredients in compounded sterile preparations (CSP).
Supportive Data:	Aseptic technique refers to performing a procedure in a manner that minimizes the chance of contamination caused by the introduction of microorganisms. Because contaminants may be introduced from the environment, equipment, supplies, or personnel, it is essential to control these different sources of contamination at the time **an** aseptic **procedure**~~technique~~ is **performed**~~carried out~~. Touch contamination by the person performing a procedure is the most frequent cause of contamination, occurring when proper control over manipulation is not maintained. Good technique in the preparation of **intravenous (**IV**)** admixtures is critical to producing a sterile product. All objects that come in contact with the drug additive or IV solution must be sterile, or contamination will result.
Equipment:	~~A.~~**1.** Admixture (medication) ~~B.~~**2.** IV solution ~~(refer to TCMC Standard Concentrations for specialty areas to identify correct solution and volume: Attachment 1)~~ ~~C.~~**3.** Sterile syringe: appropriate size based on the volume of solution to be measured and the graduation marks on the syringe. (The smallest size syringe should be selected, but should not be filled to capacity **or the** plunger may become dislodged). Selecting the smallest size syringe allows the volume of solution to be measured most accurately. ~~D.~~**4.** Sterile needles for transfer; not less than 19 gauge recommended (*filtered needles or filter straws are needed to draw any medication from ampules)* ~~E.~~**5.** 70% alcohol swabs/wipes

A. **POLICY:**

1. Pre-mixed standard concentration infusions shall be utilized whenever possible.
~~1. When an on-site licensed pharmacist is available; sterile medications, intravenous admixtures, and other drugs shall be compounded or admixed in the pharmacy.~~
2. Intravenous admixture of pharmaceutical products which require the measured addition of a medication to a 50 mL or greater bag or bottle of IV fluid ~~u~~must be compounded in the pharmacy except:
   a. Emergencies when nursing staff may need to prepare a dose of a sterile product for immediate use.
      i. Medications for immediate use shall have administration started within one hour of preparation. If administration is not started within one hour the dose must be discarded.
   b. Product stability is of short duration.
3. Compounding personnel must visually confirm that ingredients measured in syringes match the written order.
   a. All admixtures shall be visually examined for the presence of particulate matter and not administered or dispensed when such matter is observed.
4. **All IV solutions mixed by nursing must be discarded within 24 hours of spiking.**
5. All CSP labels shall include:
   a. Patient name
   b. Correct names and amounts or concentrations of ingredients
   c. Total volume

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/06, 9/08, 6/11, 4/12, **09/16**	4/12, **10/16**	4/12, **01/17**	**11/16, 02/17**	5/12, **03/17**	06/12, **04/17**	06/12

d. Date and time of preparation
e. Beyond use date (BUD) and time is 1 hour from time of preparation. ~~Expiration date and time, 24 hours from time of preparation unless indicated by pharmacy~~
i. Medication must be administered or have infusion initiated prior to BUD time.
f. Initials of the compounding nurse

B. **DEFINITIONS:**

1. Admixture:— One or more drugs are commonly added to the intravenous solution to prepare the final sterile product. The drug is referred to as the additive and the final product is referred to as the admixture. This does not include the drawing up of medication into a syringe and/or adding medication to a buretrol or intravenous line.

C. **PROCEDURE:**

1. Assess designated preparation area for cleanliness and gather all appropriate supplies prior to beginning admixture procedure. If admixture area is visibly soiled, clean with hospital-approved **disinfectant**~~antibacterial cleaner~~.
2. Perform hand hygiene.
3. Use of Needle and Syringe for Transfer:
   a. Open the syringe and needle using proper aseptic technique, do not allow syringe package to come in contact with the syringe, since the outside surface is contaminated.
   b. Remove the protective cover over the syringe tip by twisting.
      i. When a needle is to be added to a syringe, the needle package must be opened before removing the protective cap.
   c. Remove the protective cover over the syringe tip by twisting.
   d. Insert the tip of the syringe into the hub of the needle. The needle may be held on by friction or by a locking mechanism. The finger should be held well back from the point of attachment of the needle to the syringe.
   e. Leave needle guard in place until just before use. To remove the guard, pull it straight off or twist very gently.
4. Use of Ampules:— When preparing sterile products contained within an ampule container, special precautions should be taken to avoid glass fragments from entering the final sterile product. Even tiny glass fragments entering the circulatory system can cause great damage to vital organs or carry contaminants that cause infection.
   a. Tap or shake all the liquid into the bottom half of the ampule.
   b. Wipe the ampule neck with an alcohol swab and break it at a horizontal angle away from you. Discard the wipe and the ampule neck immediately to prevent accumulation of glass particles in the CSP area.
   c. Choose an appropriate size syringe and attach a *filter straw or filter needle*.
   d. Hold the ampule at a nearly horizontal angle to ensure proper airflow around the neck area. Tip the ampule downward as necessary to keep the tip of the straw below fluid level.
   e. Withdraw the contents of the ampule with the syringe. When pulling back the plunger of the syringe, the fingers should not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand. Contamination of the medication can occur in some procedures if the plunger is touched with the fingers.
   f. ~~Withdraw the contents of the ampule with the syringe.~~ Remove the filter needle or filter straw and replace it with a needle.
   g. Tap the air bubbles from the syringe barrel, bring the liquid to the correct volume, squirt any excess liquid into the ampule, and deliver the liquid.
5. Use of Vials:
   a. Remove the protective cap from the vial and scrub the diaphragm with alcohol swab**, and allow to air dry before piercing the vial.**~~.~~
   b. Draw the volume of air equivalent to the volume of solution that will be withdrawn from the vial into the syringe. **When pulling back the plunger of the syringe, the fingers should**

not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand.~~The syringe plunger should not be contaminated by contact with the hands.~~

c. Hold the vial~~ at an angle;~~ **and** insert the needle **at 45 degree angle with bevel up** into the vial, taking care to prevent coring of the closure.

d. Hold the vial in a vertical position (inverted) and force air into the vial, withdraw slightly more than the required amount of fluid.

e. With the vial in the vertical (inverted) position and the needle in the diaphragm, tap the barrel of the syringe to remove air bubbles and bring the syringe to the proper volume. Read the volume of solution by aligning the rubber end of the plunger with the graduation marks on the barrel of the syringe. Squirt excess liquid back into the vial.

6. To Reconstitute and Transfer a Drug from a Vial:— Some drugs inside a vial may be in powder or liquid form. If the drug is in powder form, an extra step – reconstitution - must be performed before it can be added to the IV solution. Diluents such as sterile water for injection, bacteriostatic water for injection, or bacteriostatic 0.9% sodium chloride injection are usually used to reconstitute powdered drugs. The volume of a suitable diluent is specified in the package insert and frequently on the vial itself.

a. Remove the protective tab and swab the top surface of the rubber closure of each vial with alcohol swab**, and allow to air dry before piercing the vial**.

b. Determine the correct volume of suitable diluent to reconstitute the powdered drug.

c. Inject a volume of air equal to the volume of solution to be removed from the diluent vial using a needle and syringe, and then remove the diluent from the vial. (Hold the diluent vial in an inverted position).

d. Inject the diluent into the medication vial.

e. Remove the needle and shake the vial until the drug is dissolved unless shaking is not recommended.

f. Reinsert the needle and remove the proper volume of drug solution. Do not inject air before withdrawing the drug solution unless air was withdrawn before the needle was removed.

g. Remove all air bubbles from the syringe so the volume can be read accurately.

7. Drug Transfer into a Plastic Bag:– A syringe and needle are generally used to transfer a drug additive from a vial or ampule to a plastic bag. It is recommended the needle gauge be not less than 19 to ensure resealing of the protective rubber cover. The needle must be at least ½ inch long to penetrate the inner diaphragm.

a. Remove the plastic IV from the outer wrap.

b. Assemble the needle and syringe.

c. Swab the medication vial or ampule with alcohol swab and withdraw the necessary amount of drug solution. If the drug is in powder form, reconstitute it with the recommended diluent. (See previous section of procedure).

d. Swab the medication port of the plastic IV bag with an alcohol swab**, and allow to air dry before piercing the port**.

e. Insert the needle into the medication port and through the inner diaphragm. The medication port should be fully extended to minimize the chance of going through the side of the port.

f. Remove the needle and dispose of in appropriate sharps container.

g. Shake and inspect the admixture.

8. In Emergency Situations**:**

a. The RN **may**~~shall~~ prepare the first infusion bag using aseptic technique for the following but not limited to: phenylephrine, nitroprusside, norepinephrine, epinephrine, epinephrine/calcium, diltiazem, aminocaproic acid, and labetolol.

~~a.~~**b. Label the compounded product appropriately**

~~a. On pharmacist PharmNet order entry, an initial label is printed and the nurse completes the "IV Drip Request Form" for number of bags needed at the designated delivery times. (see attachment A)~~

~~b. The medication is administered based on a new written order by the physician or a PRN order. For "PRN" orders, the nurse shall call their unit pharmacist when the IV is started after it is made on the unit. This eliminates duplicate IV preparation.~~

D. **REFERENCES:**

1. USP General Chapter. Pharmaceutical Compounding-Sterile Preparations. 797th ed: USP/NF,2004. Print .
2. Buchanan, C.E., and P.J. Schneider. Compounding Sterile Preparations 2nd Ed.: American Society of Health-System Pharmacists, 2005. Print.
3. Contianment Technologies Group, Pharmacopeal Form, August 2003. <http.//www.mic4.com/regulations/USP-797.pdf>.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 02/09	**SUBJECT: Blanket Warmers**
REVISION DATE: ~~08~~5/12	**POLICY NUMBER: IV.OO**

Department Approval:	**03/17**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~03/17**
Nursing Executive Council Approval:	**~~06/12~~03/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee	**~~07/12~~ n/a**
Professional Affairs Committee Approval:	**~~08/12~~04/17**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. To ensure blanket warmers are maintained according to manufacturer's recommendations.

B. **POLICY:**

1. Blankets are stored in the blanket storage compartment of the warmer unit.
2. The warmer is not to be overfilled. Leave approximately two inches between stack of blankets and the roof and walls of the blanket warmer.
3. Blanket warmers **thermostats** shall be set to a maximum temperature of 130°F. ~~Blanket warmer temperature shall be monitored and recorded daily by department personnel for adherence to the temperature recommendation of 110°-130°F~~.
   - **a. The temperature should be monitored any time a blanket is removed. Staff should assess the temperature gauge prior to removing blankets from the warmer.**
   - **b. If blanket warmer gauge is found to be above 131 degrees, then Engineering should be notified.**
   - **~~3.~~i. Blankets above 130 degrees may pose a potential risk of skin burns.**

   ~~a. If the temperature falls outside the correct range:~~
   - ~~i. The department personnel shall correct any situation causing an obvious deviation from accepted temperature range (i.e., close the warmer door if it is found ajar).~~
   - ~~ii. If the temperature is not corrected within one hour after correcting the problem, Engineering shall be notified at extension 7148 and a work order entered.~~
   - ~~iii. Corrective actions shall be documented on the Blanket Warmers Temperature Monitoring Log.~~
4. Blanket warmers shall be used for clean blankets only.

~~B. FORMS:~~

~~1. Blanket Warmer Temperature Monitoring Log located on the Intranet~~

C. **REFERENCES:**

1. **ECRI Institute Continues to Recommend Maximum Temperature Setting of 130 Degrees Fahrenheit for Blanket Warming Cabinets: https://www.ecri.org/components/PSOCore/Pages/PSMU040114_ecri.aspx**
2. **AORN Environment of Care: What are the appropriate temperature settings for blanket warming cabinets?: https://www.aorn.org/guidelines/clinical-resources/clinical-faqs/environment-of-care**
3. **~~1.~~3. The Joint Commission: Medical Equipment-Blanket Temperature Risk Assessment: https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1132&ProgramId=46**

BLANKET WARMER TEMPERATURE MONITORING LOG

Year: ____ Month: _____ Location: _____

Definition: The blanket warmer temperature shall be monitored daily and maintained at a temperature of 100°-130°F.
Blanket Warmer: Maximum 130° F

Guideline: Mark an "X" in the corresponding box for the observed temperature daily.
Shaded area indicates that the temperature is outside the range.
If temperature is outside the range:

1. Take action to correct any obvious reason for out of range temperature (i.e. close the door if found ajar)
2. If not correct notify Engineering @ext. 7148.
3. Relocate contents to an alternate location with appropriate temperature control.
4. Record actions taken and resolution

Temperature (°F)

138																														
136																														
134																														
132																														
130																														
128																														
126																														
124																														
122																														
120																														
118																														
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114																														
112																														
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108																														
106																														
104																														
102																														
100																														
Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Problem/Action Resolution Documentation – Record with reference to above date.

Date	Problem	Action Taken	Resolution Achieved

Tri-City Health Care District
Oceanside, California

~~Administrative Policy Manual~~PATIENT CARE SERVICES

ISSUE DATE: 10/88

SUBJECT: Code Status / Do Not Resuscitate (DNR) / Withholding or Withdrawing Life Sustaining Treatment

REVISION DATE: 9/91; 8/94; 12/96; 11/06; 11/09

POLICY NUMBER: 8610-312

~~Administrative Policies & Procedures Committee Approval:~~	~~11/09~~
Clinical Policies and Procedures Committee Approval	09/15
~~Operations Team Committee Approval~~	~~12/09~~
Nursing Executive Committee Approval:	09/15
Critical Care Committee Approval:	~~06/16~~02/17
Medical Executive Committee Approval:	03/17
Professional Affairs Committee Approval:	~~01/10~~04/17
Board of Directors Approval:	01/10

A. **PURPOSE:**

1. To outline the policy ~~and procedure~~ for withholding and/or withdrawing life sustaining treatment during hospitalization **including code status orders**.
2. **To provide direction to all personnel and medical staff members who may be involved in the care of a patient for whom life-sustaining treatment is withheld or withdrawn during hospitalization.**
~~1.~~3. **This policy conforms with the decision of the California Court of Appeal, Second Appellate District, in Barber Vs. Superior Court, 147 Cal. APP 3d 1006 (1983), which established guidelines for decisions to withhold or withdraw life-sustaining treatment. These guidelines address all situations in which life-sustaining treatment may be discontinued, including but not limited to cases of irreversible coma and brain death.**

B. **DEFINITION(S):**

1. **Advanced health care directive or advance directive — Designation of an agent (surrogate) appointed by the patient to make medical decisions for him/her should the patient no longer have the capacity to express his/her wishes.**
~~A.~~2. **Brain Death:~~–~~ See Patient Care Services Policy, Determination of Brain Death.**
3. **Capacity~~:~~: The patient's decision making ability to understand the consequences of his/her decisions. Capacity is commonly secured by determining the patient's ability to understand basic information about his/her condition and prognosis, the nature of a proposed intervention, the alternatives, the risks and benefits, and the consequences of his/her decisions.**
~~1.~~4. **Code Status:**
   a. Full Code~~–~~**:** A full code is synonymous with "full resuscitation" which consists of basic and advanced life support. The patient is a "full code" unless withholding of life sustaining treatment is ordered. Resuscitative measures are defined as: electric defibrillation, chest compressions, mechanical ventilations, endotracheal intubations.
   b. No Code~~–~~**:** A "no code" is synonymous with "no resuscitation" or "do not resuscitate (DNR)". This means that no basic or advanced life support will be administered.
      i. Resuscitative measures do not refer to ordinary or reasonable methods used to maintain the life, health or comfort of a patient such as the administration of pain or other appropriate medications, IV fluids and nutritional support.
      ii. DNR orders are not intended to govern pre-arrest care.
      iii. A patient may decline **basic life support**~~CPR~~ for arrest conditions but may readily agree to mechanical ventilation for a likely reversible respiratory condition (ie., pneumonia, aspiration).
      ~~a.~~**iv.** A patient with ventricular tachycardia, bradycardia or heart block is not

considered arrested. Emergency medications, external pacemaker and/or rapid fluid infusions may be administered as appropriate.

c. **Allow Natural Death (AND):— AND orders are intended for terminally ill patients only. An AND order would ensure that only comfort measures are taken. This would include withholding or discontinuing resuscitation, artificial feedings, fluids, and other measures that would prolong a natural death.**

~~2.~~**5. Incapacitated:— A condition of the patient where the capacity to make informed decisions regarding care is temporarily or permanently lost.**

~~3.~~**6. Individual Health Care Instruction: Designation for a Surrogate – An adult having capacity may give an individual health care instruction orally or in writing. The instruction may be limited to take effect only if a specified condition arises. A patient may also designate an adult as a surrogate to make health care decisions for him/her. The patient must do so by personally informing the supervising health care provider. An oral designation of a surrogate must be promptly recorded on the medical record, and is effective only during the course of treatment in the health care institution when the designation is made.**

~~4.~~**7. Futile Care:— Any health care that the primary physician and his or her consultant(s), consistent with prevailing standards of practice, in good faith believe(s) cannot, within a reasonable possibility, be expected to satisfactorily cure, ameliorate, improve, or restore a quality of life to the patient.**

~~5.~~**8. Permanent Unconscious Condition:— An incurable and irreversible condition that, within reasonable medical judgment, renders the patient in an irreversible coma or persistent vegetative state.**

~~6.~~**9.** POLST Form:— Physician Order for Life Sustaining Treatment form means a request regarding resuscitative measures that direct a health care provider regarding resuscitative and life-sustaining measures. **If a Patient is admitted with completed POLST, POLST order will be honored by staff in accordance with California Assembly Bill 3000, Chapter 266. It is the policy of Tri-City Healthcare District (TCHD) to treat the patient in accordance with a POLST form (Probate Code Sec. 4781.2 (d)). Refer to Patient Care Services Policy POLST.**

~~2.~~**10.** Prehospital DNR:– In cases where there is a completed approved "Emergency Medical Services Prehospital Do Not Resuscitate (DNR) Form" (a written request to limit the scope of emergency medical care), an approved DNR medallion or bracelet, or a valid DNR order from the patients medical record from a nursing facility and the patient experiences a respiratory or cardiac arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated unless the patient or surrogate decision maker instructs us to do otherwise. The Emergency and Attending Physicians will be notified of the existence of the advanced directive and a copy will be placed in the patient's medical record. Documentation in the patient's medical record regarding patient's DNR status will be completed.

~~7. Terminal Illness – an incurable or irreversible condition that, without the administration of life-sustaining treatment will result in death within a relatively short time (Health and Safety Code, Section 718(i).~~

11. Terminal Illness:— means a medical condition resulting in a prognoses of life of one year or less, if the disease follows its natural course (California Health and Safety Code 1746 - p).

~~8.~~**12.** Withdrawing Life Sustaining Treatment: —The discontinuation of specified medical therapies that may be prolonging the patient's death.

~~9.~~**13.** Withholding Life Sustaining Treatment:– The withholding of all or some basic life support (**BLS** ~~CPR~~) and advanced life support interventions in the event that a respiratory and/or cardiac arrest is recognized.

C. POLICY:

~~3.~~**1.** All physician orders regarding **code status,** withholding or withdrawing life sustaining treatments must be ~~in writing on the Physician Order Sheet~~**recorded (written) legibly or entered electronically into the patient's ~~medical~~health record.**

~~4.~~**a.** All withdrawing life sustaining treatment orders must specify which treatments and

devices are to be discontinued (i.e., ventilator support, endotracheal tube, pacemakers, vasoactive drips, parenteral and enteral fluids, parenteral and enteral nutrition) and how they are to be withdrawn.

b. ~~An~~ **Registered Nurse** (RN) may accept verbal/telephone orders; however, another RN must witness the order by having the physician repeat the order to the second RN and then co-signing the receiving RN's transcription of the order.

~~1. All "no code" orders must be renewed every 72 hours UNLESS the attending physician has ordered "no code for duration of hospital stay" or has written specific orders pursuant to an advance directive. A "no code" that requires renewal, but is not renewed will be considered expired and the patient will become a "full code".~~

2. **The treating physician and consulting physicians (if any) shall be responsible for determining the patient's diagnosis, prognosis and providing the patient or the patient's surrogate with the requisite information to enable him/her to evaluate the treatment's benefits and burdens.**

~~a.~~**3.** The decision to withhold or withdraw life-sustaining treatment must be substantiated by physician documentation in the progress notes, which describes the circumstances surrounding the decision to limit or withdraw care.

~~1.~~**4.** Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery/~~ or~~ procedure **and recovery periods**. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the ~~medical~~ **health** record and an appropriate order written.

5. The RN/Respiratory Care Practitioner (RCP) shall follow the physician order for discontinuation of the specified treatment or device.

~~2.~~**a. Every necessary procedure shall be performed to relieve the patient's suffering and to maintain the patient's hygiene and comfort in the setting of DNR and/or withholding/withdrawing treatment orders.**

~~a.~~**b.** Any health care provider who objects to withholding or withdrawing life-sustaining treatment based on the individual's moral, and/or religious beliefs or affiliations should immediately report their ~~conscience~~ objections to their supervisor or manager. Refer to **Administrative Human Resources Policy 480~~.~~, ~~Staff Requests Not to Participate in Care**~~Patient Care Services Policy VIII.J, Staff Requests~~.

~~b.~~**6. The patient shall be the decision – maker whenever possible. If the patient is incapable of making the decision, the health care providers and surrogates shall act in accordance with the patient's desires previously expressed. If a patient is incapable of making the decision because of his/her medical or mental condition, a surrogate decision-maker should be identified.**

a. Parent or Guardian, Attorney-In-Fact, Conservator.

~~5.~~**i. If patient is a minor, his/her parents or guardian must be consulted. If the patient has executed a Durable Power of Attorney for Health Care which remains valid, the designated attorney-in-fact must be consulted. If the patient is an adult for whom a conservator has been appointed with authorization to make health care decisions for the patient, the conservator must be consulted. A copy of the Durable Power of Attorney for Health Care or the certified letters of guardianship or conservatorship must be obtained and placed in the patient's medical record.**

b. Consultations in the event of disagreement.

~~3.~~**i. If the withholding or withdrawal of treatment is appropriate, but a family member or significant other disagrees, the hospital administrator on call shall be contacted and it shall be determined whether court authorization for the issuance of such an order should be sought.**

c. Review if there is no surrogate decision-maker.

~~a.~~**i. If the patient is incompetent, incapacitated and no surrogate decision-maker can be identified, a DNR order may be issued when the treating~~**patient's** **physician determines it is medically appropriate. It is**

advisable that the physician seeks a consultation before issuing the order and notifies hospital administration.

~~b.~~7. When a patient's primary physician believes that further or additional health care would constitute futile care, as defined above, the following steps should be taken:

~~c.~~a. The primary physician shall carefully explain to the patient and/or his or her representative the nature of the ailment, the available treatment options, and the patient's prognosis. The physician shall explain that in no event shall the withholding or withdrawal of health care involve a withdrawal or withholding of comfort, dignity, and psychological care and support.

~~d.~~b. The primary physician shall provide the names of appropriate medical consultants to provide independent opinions concerning the patient's diagnosis, prognosis and available treatment alternatives, if any.

~~e.~~c. The support of TCMC nurses, chaplain, patient care representative, and social services shall be offered to the patient's representative(s). A joint conference or other collaborative communication between these parties and the primary physician and/or the patient or his or her representative(s) may arranged as needed.

~~i.~~d. Adequate time should be given for the patient or his or her representative(s) to consider the information and situation.

~~6.~~e. If the above steps are taken and the patient or his or her representative disagrees with the primary physician as to whether further or additional health care would be futile:

~~7.~~i. The primary physician shall cooperate with the patient or his or her representative in transferring the care of the patient to another qualified physician and/or health facility who will consent to implementation of the patient's or his or her representative's health care wishes. The responsibility for finding such an alternate physician and/or health facility shall lay with the patient or his or her representative, though the primary physician and hospital shall make reasonable efforts to assist such efforts.

~~i.~~ii. If a disagreement persists between the physician and the patient or his or her representative as to the futility of further or additional health care, and the patient cannot be transferred to another physician and/or facility, the physician and/or TCMC shall petition the court to approve or deny the proposed health care~~, as the case may be, pursuant to Health and Safety Code Section 32000~~. In so doing, the physician shall consult with the Bioethics Committee, who shall in turn consult with legal counsel to ensure compliance with applicable laws and regulations. Life-sustaining treatment shall not be withdrawn when a dispute exists under this Section until the dispute is resolved by an order of the court.

~~3.~~8. Incarcerated patients: When the patient is a prisoner at a state correctional facility and the prisoner is incapable of making decisions on their behalf, the attending physician at the hospital should make an attempt to contact the primary care physician at the state correctional facility before determination can be made on withholding or withdrawing life support.

~~4.~~9. The hospital's administrator and/or risk manager shall be consulted before an order to withhold or withdraw treatment is issued whenever:

a. The patient's condition has resulted from an injury which appears to have been inflicted by a criminal act.

b. The patient's injury or condition was created or aggravated by a medical accident

c. The patient is pregnant.

d. The patient is a parent with custody or responsibility for the care and support of young children.

e. A dispute exists regarding the desires or best intentions of an incompetent patient.

~~f.~~ No appropriate legal representative exists.

~~5. t is the policy of TCHD to treat a patient in accordance with a POLST form [Probate Code Sec. 4781.2 (d)]. Refer to Patient Care Services policy POLST.~~

~~D. PROCESS:~~

~~1. The physician shall be responsible for issuing all orders to withhold treatment that is usually automatically initiated or withdraw life-sustaining treatment in accordance with policy statement C.3. The physician shall complete the documentation in the Progress Notes in accordance with policy statement C.4.~~

~~2. Withholding Life Sustaining Treatment - the RN shall transcribe the "No Code" order into the electronic health record (EHR).~~

~~3. Withdrawing Life Sustaining Treatment - the RN shall follow the physician order for discontinuation of the specified treatment or device.~~

~~4. Every necessary procedure shall be performed to relieve the patient's suffering and to maintain the patient's hygiene and comfort in the setting of DNR and/or withholding/withdrawing treatment orders.~~

~~5.~~D. RELATED DOCUMENT(S):

1. **Administrative Human Resources Policy 480: Staff Requests Not to Participate in Care**
2. **Patient Care Services ~~Administrative~~ Policy 354: Advance Health Care Directive**
3. **Patient Care Services Policy: End of Life/Comfort Care Policy**
4. **Patient Care Services ~~Administrative~~ Policy 393: Physicians Orders for Life Sustaining Treatment (POLST)**

E. FORM(S) ~~REFERENCED WHICH CAN BE LOCATED ON THE INTRANET~~:

1. Pre-Hospital Do Not Resuscitate (DNR) FORM **Sample**

~~2. Physician Order for Life Sustaining Treatment Form (POLST)~~

F. REFERENCES:

1. Consent Manual, California Hospital Association, ~~2009~~**20152016**

~~2. Administrative Policy #354, Advance Health Care Directive~~

~~3. Patient Care Services Policy POLST~~

~~4. California Probate Code, Sections 4600-4806, Health Care Decisions.~~

EMERGENCY MEDICAL SERVICES
PRE-HOSPITAL DO NOT RESUSCITATE (DNR) FORM SAMPLE

An Advanced Request to Limit the Scope of Emergency Medical Care

1._____requests limited emergency care as herein described.
(Print Name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.
I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital emergency medical care personnel and/or medical care directed by a physician prior to my death.
I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.
I give permission for this information to be given to the pre-hospital emergency care providers, doctors, nurses, or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate _____ Date _____

Surrogate's Relationship to Patient _____

Witness Signature _____ Print Name _____ Date _____

I affirm this directive is the expressed wish of the patient/surrogate, is medically appropriate, and a copy of this form is in the patient's permanent medical record.
In the event of a cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiotonic medications are to be initiated.

Physician's Signature _____ Date _____

Print Name _____

Address _____ Phone Number _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY.

PRE-HOSPITAL DNR REQUEST FORM
Approved by the San Diego Medical Society
P.O. Box 23581
3702 Ruffin Rd
San Diego, CA 92193-3581
(619) 569-1334

White Copy: To be kept by patient
Canary Copy: To be kept in Patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to:
Medic Alert Foundation, Turlock, CA 95381

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT: Determination of Brain Death**

REVISION DATE:

Department Approval	**09/15**
Clinical Policies & Procedures Committee Approval:	**09/15**
Nurse Executive Committee Approval:	**09/15**
Critical Care Committee Approval Date(s):	**06/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval:	**10/16**
Professional Affairs Committee Approval:	**04/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for brain death determination in adult patients (~~18~~ 15 years and older) as a means of standardization of:
   a. Criteria for the diagnosis of brain death
   b. Medical decision making
   c. Health record documentation.

B. **DEFINITIONS:**

1. Brain death: An irreversible cessation of all functions of the entire brain, including the brain stem (Health and Safety Code§ 7180). A physician may determine an individual has suffered brain death (as defined by statute). Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code§ 7181). Patient time of death is recorded at the time the second physician confirms brain death. These physicians:
   a. May not participate in procedures for removing or transplanting part(s)
   b. Must document in the health record procedures used to determine the death and factual basis for determination of death.
   c. Must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.

C. **POLICY:**

1. Determination of Death: Based on current medical standards (California Code, Health and Safety Code § 7180 of The Uniform Determination of Death Act), an individual who has sustained either of the following is dead:
   a. Irreversible cessation of circulatory and respiratory functions or
   b. Irreversible cessation of all functions of the entire brain, including those of the brain stem.
2. A determination of brain death must be made in accordance with accepted medical standards, at this time considered to be those standards outlined in the American Academy of Neurology Guidelines.
3. The declaration of brain death should not be given as a choice for families.
   a. Testing should be performed when clinical signs and symptoms suggest brain death has occurred.
   b. Appropriate efforts should be made to discuss the patient's medical condition and the process of determining death with family or surrogate decision-makers prior to evaluating whether or not the patient is dead.
      i. Family/surrogate must be provided with the policy if requested.
   c. Determination of death should be accomplished as early as practical in the patient's clinical course, for the benefit of both family/surrogate decision makers and staff.

4. Declaration of brain death by neurological criteria is outlined in the 2010 American Academy of Neurology (AAN) Guidelines,reaffirmed on April 30, 2014, and is reflected in *Declaration of Brain Death, Physician Progress Note* which should be used for documentation. Brain death by neurologic criteria requires the following evaluations:
   a. Clinical reflexes
   b. Apnea testing
   c. If one of the evaluations cannot be completed, ancillary testing should be considered.
5. Two licensed physicians must independently confirm the diagnosis of brain death, (California Health and Safety code, § 7181).
   a. Each physician must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.
   b. One physician should be an active member of the patient's care team.
   c. One physician must actively participate in the clinical evaluation of any patient where declaration of brain death is determined. This participation must include an appropriate clinical exam performed by the physician to include being present during the apnea test if performed to observe for respiratory movement, and documenting the results of the exam in the patient's health record.
   d. The time of brain death must be recorded as the time the second physician confirms brain death diagnosis.
   e. A physician involved in the declaration of death must NOT participate in the procedure for organ/tissue procurement or transplantation.
6. The Care Team will follow California Health and Safety Code § 1254.4 requiring that a reasonably brief period of accommodation be provided for family or next-of-kin to gather at the bedside after the determination of death has been made through the discontinuation of cardio pulmonary support.
   a. The period of reasonable accommodation is generally not greater than 24 hours after brain death has been declared.
   b. Reasonable accommodation also may include the hospital's consideration of the needs of other patients and prospective patients in urgent need of care.
   c. The care team shall make reasonable efforts to accommodate the religious/cultural practices and concerns of the family.
7. Required Notification to provide for option of Donation of Organ and Tissue.
   a. If imminent death criteria are present and/or brain death is being considered, validate that the Organ Procurement Organization (OPO) has been notified. The OPO will be responsible for the evaluation of potential organ and tissue donation options.
   b. The OPO is responsible for verifying death in any patient where organ donation is being considered or is authorized. The OPO will review the brain death documentation to validate that it meets the requirements set forth in the 2010 AAN Guidelines; this may include a physical assessment of the organ donor patient as well as a review of the brain death declaration documentation.
   c. The OPO will evaluate the declaration of brain death as an element of medical suitability for organ donation. The OPO may ask the hospital for clarification or additional testing if the declaration does not include elements in brain death by neurologic criteria outlined in the AAN Guidelines. The OPO will not participate in the actual brain death declaration process.

D. **FORM(S)**:
1. Declaration of Brain Death Physician Progress Note

E. **RELATED DOCUMENT(S)**:
1. Patient Care Services Policy: Code Status/Do not Resuscitate (DNR)/ Withholding or Withdrawing Life Sustaining Treatment.
2. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes.

F. **REFERENCES**:

1. California Health and Safety Code § 7150.65(c), § 7180-83, § 1254.4
2. Wijdicks, E. F., Varelas, P. N., Gronseth, G. S., and Greer, D. M. Evidence-Based Guideline Update: Determining Brain Death in Adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology (June 8, 2010). *Neurology* (74)23, 1911-1918.
3. Scintigraphic Confirmation of Brain DeathPartha Sinha, MD, and Gary R. Conrad, MD Semin Partha, S., and Conrad, G. R. (2012). Scintigraphic Confirmation of Brain Death. *Seminars in Nuclear Medicine* (42), 27-32.

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Prerequisite	**Yes**	**No**
Evidence of acute CNS catastrophe compatible with brain death		
Exclusions:		
1. Presence of CNS-depressant drug effect by history, drug screen*		
2. Recent administration or continued presence of neuromuscular blocking agent		
3. Electrolyte imbalances, acid-base imbalances or endocrine disturbances		
4. Conditions such as severe facial trauma, preexisting pupillary abnormalities, pulmonary disease resulting in CO_2 retention		
5. Core body temperature less than 32°C (90°F)		

**Calculate drug clearance using 5 times the drug half-life*

Clinical Exam ***Do not proceed with Apnea test if any 1-6 in Clinical Exam PRESENT***	**Yes**	**No**
1. Motor response to pain in extremities (nail-bed pressure; supraorbital pressure; temporomandibular joint compression)		
2. Pupillary response to light		
3. Doll's Eyes movement (oculocephalic reflex) present		
4. Eye movement to ice water calorics (oculovestibular reflex)		
5. Eyelid movement to corneal swab/touch (corneal reflex)		
6. Cough or gag to deep endotracheal suctioning		

Apnea Exam Pre Conditions, ~~Guidance for Testing~~ Inclusion Criteria	**Verified**
1. Normotensive (may require vasopressors, MAP greater than or equal to 60-65mmHg)	
2. Normothermic: (core temp greater than or equal to 36°C)	
3. Normal pCO_2 (35 - 45 mmHg) or at patients documented pCO_2 baseline	
4. pO_2 greater than or equal to 200 mm Hg or ability to pre oxygenate to 200mmHg	
If unable to complete Apnea Exam, proceed with Ancillary Testing	
Apnea Exam:	**Completed**
1. Increase FiO_2 to 100% and PEEP of 5mmHg	
2. Draw baseline ABG	
3. Disconnect patient ventilator	
4. Provide O_2 via cannula at level of carina at 6 L/min (or 1-piece with CPAP at 10 cm H_20)	
5. Observe closely for respiratory movements for approximately 8-10 minutes	
6. Repeat ABG in approximately 8-10 min	
7. Reconnect ventilator	

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Apnea Exam Results						
If pCO_2 is greater than or equal to 60mmHg OR pCO_2 increase is greater than or equal to 20 mmHg over baseline normal pCO_2 WITHOUT respiratory movement noted — patient is apneic and apnea testing is consistent with diagnosis of Brain Death. If respiratory movements are observed, the apnea test result does not support the clinical diagnosis of brain death.						
Test 1—Adult	**pH**	**pO_2**	**pCO_2**	**BP**	**SpO_2**	**Apnea Time**
Baseline Blood Gas						
Apneic Blood Gas						

Ancillary Testing		**Verified**
Cerebral Angiography	Flow absent in all major intracranial vessels consistent with death	
CBF Isotopic Scan	Cerebral perfusion is absent in cortex and brain stem, consistent with death.	
Other		

PHYSICIAN COMPLETING ABOVE DOCUMENTATION:

I have examined the patient, together with the health record and laboratory results and was present and observed the apnea test if performed. I declare that the patient is dead on the basis of this evaluation.

Signed: _____ **Date:** / / **Time:** _____

Print: _____

BRAIN DEATH DECLARATION

Attestation: Physician 2

I have examined the patient _____**together with the health record and laboratory results. This included conducting or reviewing the results of the apnea test and or/any ancillary tests. The patient is declared dead on the basis of this evaluation.**

Signed: _____ **Date:** / / **Time:** _____

Print: _____

This form is a composite drawn from a number of sources, reflecting best practice — and amended in the context of the 2010 AAN Adult and 2011 SPA/SCCM Pediatric guidelines.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 5/78

SUBJECT: Food and Nutrition Relationships with other Departments

REVISION DATE: 4/00, 6/03, 7/05, 7/07, 3/10, 1/13

POLICY NUMBER: I.P

Department Approval:	02/17
Clinical Policies and Procedures Committee Approval:	~~01/13~~03/17
Nursing Executive Committee Approval:	~~01/13~~03/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	~~04/13~~04/17
Board of Directors Approval:	04/13

A. **POLICY:**

1. Food and Nutrition Services is organized, staffed and integrated with other units and departments of the hospital in a manner designed to assure the provision of optimal nutritional care and quality food service. The department maintains operating relationships with most of the medical care and administrative activities of the hospital. Close relationships are maintained with the medical staff on special dietetic needs of patients; with nursing services on provisions of regular and modified diets and between meal nourishments; and with administration on management matters.

B. **NURSING SERVICE:**

1. Food and Nutrition personnel are responsible for:
   a. Preparation and delivery of all trays to patient units, including the provision of nourishment supplies.
   b. Return of soiled trays and dishes to the kitchen on food carts. Check soiled utility room for soiled trays / dishes, put on food carts, and bring back to kitchen.
   c. Dietitians screen and assess nutritional status of patients to provide optimal nutritional care or instruction regarding special dietary needs.
   d. Upon receiving a physician's order, or as deemed appropriate, dietitian instructs patients in maintenance of modified diets at home, prior to discharge.
   e. Visit patients daily to pick up or assist with completion of selective menu for the next day. Both nursing and food service personnel may help the patients with menu selections.
   f. Preparation and delivery of mid-morning, mid-afternoon, and evening nourishments to nursing stations.
   g. Preparation and delivery of enteral feedings.
   h. Preparation, delivery, and service of attractive, nutritional, and satisfying meals under approved standards of sanitation.
   i. The clinical dietician will establish priorities of care, determine nutritional status, and develop nutritional care plans.
   j. Providing in-services on nutrition-related and food and nutrition services related topics as requested.
   k. Communicating with nursing regarding patient's nutritional needs and concerns.
2. Nursing personnel are responsible for:
   a. Obtaining a physician's order for each patient's diet.
   b. Transmitting diet orders to Food and Nutrition Services.
   c. Assisting patients with choices on selective menus.
   d. Preparing patients to receive trays.

e. Pass**ing** trays to patients upon arrival of food carts **under direction of Primary Registered Nurse**.
f. Ensuring two patient identifiers are used when delivering trays and nourishments.
g. Feeding patients who need assistance.
h. Serving special interval nourishments **(for example snacks)**.
~~i. Preparing infant formulas for the obstetrical nursery.~~
~~j.~~**i.** Obtaining height and weight and recording in patient's chart.
~~k.~~**j.** Complete Braden Scale Score and initiate nutrition consult for patients at high risk for skin breakdown.
~~l.~~**k.** Notifying the Food and Nutrition Services Dietitian if a patient is not eating well.
~~m.~~**l.** Transmitting guest tray orders.
m. Collecting finished food trays and placing on food cart if still on floor, or storing in dirty utility room.
~~n.~~**i. Remove protected health information from tray.**
~~o.~~**n.** Completion of patient history related to nutrition risk factors (generating nutrition consults if any risks are identified.)

C. **BUSINESS OFFICE:**
1. Food & Nutrition personnel are responsible for:
   a. Submitting a cafeteria cash report.
2. Business Office personnel are responsible for:
   a. Initiating receipts for cafeteria cash received.

D. **INFORMATION TECHNOLOGY:**
1. Food and Nutrition personnel are responsible for entering physicians' cafeteria charges into the computer at the end of each month.
2. Information Technology personnel are responsible for:
   a. Consulting with Food and Nutrition when initiating new dietary data processing procedures.
   b. Providing the system for receiving patient discharges, admissions, and room changes.
   c. Assisting Food and Nutrition in the use of the computer system.
   d. Providing support for Cerner.

E. **EMPLOYEE HEALTH:**
1. The Employee Health Nurse and/or the Emergency Room handle all Food and Nutrition Services employee accidents, pre-employment physicals, and annual physical reviews.

F. **ENVIRONMENTAL SERVICES:**
1. Food and Nutrition personnel are responsible for:
   a. Returning soiled ~~towels, and~~ mop heads to the laundry.
2. Environmental Services personnel are responsible for:
   a. Providing clean ~~towels and~~ mop heads for use in Food and Nutrition Services.
   b. Cleaning Food and Nutrition offices and carpeted and tiled areas of cafeteria.

G. **FACILITIES MANAGEMENT:**
1. Food and Nutrition personnel are responsible for:
   a. Initiating work requests for repair of equipment.
   b. Reporting hazardous working conditions.
2. Facilities personnel are responsible for:
   a. Preventive maintenance and repair on all Food and Nutrition equipment unless under contract with an outside agency.
   b. Keeping records of preventative maintenance in Facilities Management.
   c. Keeping files on maintenance of Food and Nutrition equipment.

H. **EDUCATION:**

1. Education ~~provides~~ **facilities** in-service education for Food and Nutrition personnel for hospital orientation and other areas as needed and/or requested.

I. **AUXILIARY:**

1. Food and Nutrition Services provides refreshments for Auxiliary meetings.
2. Food and Nutrition Services provides supplies for Auxiliary functions.

J. **PHARMACY:**

1. Pharmacy personnel are responsible for:
   ~~a. Providing updated list of patients receiving total parenteral nutrition (TPN) for Registered Dietician (RD) on daily basis.~~
   ~~b.~~**a.** Conferring with RDs regarding drug-nutrient interactions.
   ~~c.~~**b.** Conferring with RDs regarding best means to achieve nutritional needs via TPN for those patients receiving TPN.
2. Dietitians are responsible for:
   a. Conferring with Pharmacists regarding potential drug -- nutrient interactions.
   b. Conferring with Pharmacists on patients receiving TPN to optimize nutrition support via TPN.

K. **ALL TRI-CITY MEDICAL CENTER DEPARTMENTS:**

1. Food and Nutrition Services provides room set-ups and catering upon request for meetings/events for departments, Board of Directors, and the medical center in general.
   a. Coordination is completed by contacting the Event Coordinator, the Catering/Cafeteria Supervisor, and/or the Operations Manager of Food & Nutrition.
2. Individual departments may request catering with approval from the department director/manager.
3. Individual departments/cost centers are charged for internal catering.
   a. Departments may authorize payment via an external source (i.e. a vendor).

L. REFERENCE(S):

~~a.~~**1. Title 22**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: **Glucose Monitoring During ~~and~~ Exercise Therapy for Diabetic Patients**

REVISION DATE(S):

Department Approval Date(s):	**05/16**
Clinical Policies and Procedures Approval Date(s):	**02/17**
Nurse Executive Committee Approval Date(s):	**02/17**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**03/17**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To provide safe, therapeutic care for **out**patients with diabetes during their exercise training session **in Tri-City Healthcare District (TCHD) rehabilitation facilities**.

B. **POLICY:**

1. All phase 2 patients who are taking insulin or oral diabetes medications will have their blood glucose level checked before and after exercise during their first 3 exercise sessions by **the Registered Nurse RN**~~nursing /~~ **or Respiratory Care Practitioner (**RCP**)** staff trained in the use of the Nova Stat Strip glucose monitoring system.
2. If blood sugars are stable (between 100-300 mg/dL) after 3 visits pre and post exercise, patients will no longer need to continue having checks (unless symptomatic).
3. If blood sugars are unstable (under 100 or over 300 mg/dL) after 3 visits, patient must make an appointment with their **Primary Care Provider (**PCP**)** to have **their**~~his/her~~ medication and diet reviewed. The patient will need to bring back a note from PCP stating he/she is cleared to return to exercise.
4. The **RN**~~nurse~~/RCP will again check blood sugars pre and post exercise over the next 3 visits. If stable (100-300mg/dL), patient does not need to continue being checked. If unstable (below 100 or above 300 mg/dL) patient will again need clearance from PCP to return to exercise. A referral to a diabetes educator will be given to patient, as well as other educational materials.

C. **PROCEDURE:**

1. **RN**~~Nurse~~/RCP on staff shall test diabetic patients' pre and post exercise blood sugars for their first 3 visits ~~Follow~~ **followed** immediately with action based on results.
2. If blood glucose is less than 100 mg/dL, the patient shall eat a pre-exercise snack of 15 grams of carbohydrate which they are instructed to bring to every session. Juice, glucose tabs, and glucose gel are kept in the department in case the patient did not bring his/her own snack. (Examples of fast acting carbohydrate are ½ cup orange juice, 1 cup skim milk, 3-4 glucose tabs or glucose gel equal to 15 grams, 8-10 lifesaver candies).
3. For patients with a pre exercise blood sugar less than 100 mg/dL who have eaten a 15 gram carbohydrate snack, wait 15 minutes after snack and recheck blood sugar. If below 100, repeat treatment. Notify physician for repeated low blood sugar levels.
4. If blood glucose is greater than 300 mg/dL, patient may not exercise that day. Notify physician if patient is unable to exercise due to elevated blood glucose level.

5. If the patient is driving him/herself, the post exercise blood sugar should be 100 mg/dL or greater. If the post exercise blood sugar is less than 100 mg/dL he/she should have a snack of 15 grams carbohydrate and re-check in 15 minutes and repeat until blood sugar is 100 or greater before being discharged home.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**5/78**	**SUBJECT:**	**Meals, Patients – Times, Menus, Substitutions and Nourishments**
REVISION DATE:	**4/00, 6/03, 8/05; 5/08; 02/11**	**POLICY NUMBER:**	**IV.AA**

Department Approval:	**02/17**
Clinical Policies and Procedures Approval:	**~~05/15~~03/17**
Nursing Executive Council Approval:	**~~05/15~~03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~06/15~~04/17**
Board of Directors Approval:	**06/15**

A. **POLICY:**

1. The Food and Nutrition Services Department provides three (3) patient meals daily and offers between-meal nourishments three (3) times daily. No more than 14 hours shall elapse between the serving of the dinner meal and the breakfast meal of the following day.
   a. Patient tray line shall operate according to the following schedule:
      i. Breakfast: 7:00 AM – 8:15 AM
      ii. Lunch: 11:00 AM – 12:15 PM
      iii. Dinner: 4:45 PM – 6:15 PM
      iv. (All finish times are approximate)
   b. Patient trays shall be loaded on food carts and delivered to the nursing units in a predetermined sequence.
2. Meal service shall be provided for patients who are not served meals during normal meal service time.
   a. Delayed trays are ordered via the computer system.
      i. All delayed tray requests shall be filled with a minimum of delay.
      ii. Food & Nutrition personnel trained on special diets shall prepare the tray as listed on the diet slip. Supervisory personnel shall monitor performance.
      iii. All food items shall be covered.
      iv. Normal tray line delivery systems shall be used to ensure maximum temperature retention.
   b. Early breakfast trays are available upon request.
   c. Standard late breakfast trays are served from 8:30 AM until 10:00 AM. Late trays shall be delivered on the half-hour.
   d. From 10 AM to 10:30 AM, Continental-type breakfast may be served.
   e. Standard late lunch trays are served from 12:30 PM until 2:30 PM.
      i. From 2:30 PM until 4:00 PM, soup, sandwich, dessert, and beverage lunch shall be served.
   f. Standard late dinner trays are served from 6:00 PM until 7:00 PM.
      i. From 7:00 PM until 1:30 AM, grilled items and cold sandwiches, appropriate to the patient's diet, can be obtained in the cafeteria.
   g. Late trays served shall comply with the patient's diet order.
   h. Floor stocks are used for after-hours.
3. Most patients receive selective menus from which to make their meal choices. Exceptions are: New admissions, patients who are NPO, patients on liquid diets, severely restricted diets, and those electing not to select.

a. The next day's menu is distributed by a representative from Food & Nutrition. The menu is reviewed with the patient and appropriate selections are made. New admits receive a selective menu by their second meal.
b. Patients willing but unable to fill out the menu by themselves shall receive assistance from family members, Nursing or Food & Nutrition personnel.
c. Upon receipt of a new diet order, the patient shall be visited by a dietitian or food service partner within two (2) meals of receipt of the diet order.
    i. The patient shall receive the house menu prior to visitation.
    ii. Patients with new diet orders received by 8:00 AM shall be allowed to choose a lunch and dinner for that day in addition to the next day's menu.
    iii. Patients with new diet orders received between 8:00 AM and 12:30 PM shall be allowed to choose dinner for that day as well as the next day's menu.
    iv. Patients with new diet orders received between 12:30 PM and 8:00 AM the next day receive a house diet for dinner and breakfast and then are allowed to choose subsequent meals.

4. Menu substitutions are offered to patients who cannot make adequate choices from the printed menu.
    a. Substitutions are offered from the substitution list when the patient asks for other foods due to reasons as stated above.
    b. Suggestions are made based on the reason for patient's request from substitution list.
    c. A two-hour notice is required for staff to request a substitution item.
    d. Production area is alerted by diet clerk if "write-ins" are done on the day food substitutions are to be served.
    e. Patients are familiarized with available menu substitutions.
    f. The hospital cafeteria menu, appropriate to the patient's diet, is made available to patients who request additional selections.
    g. Every effort within reason shall be made to accommodate the patient's nutritional needs.
5. Nourishments or "between meal feedings" shall be recommended and provided to meet the patients' nutritional requirements.
    a. Criteria for recommending/providing supplements or nourishments:
        i. Multiple feeding plans, i.e. IDDM, dumping syndrome, and hypoglycemia.
        ii. Patients' inability to consume daily caloric requirements within a three (3)-meal per day plan.
        iii. Calorie or protein needs are greater than the prescribed diet.
    b. All nourishment orders shall be received and planned by the food service partner or dietitian. The food service partner or the dietitian shall initiate specific nourishment orders.
    c. The dietitian or food service partner shall review patient acceptance and tolerance and revise the nourishment/meal plan as appropriate.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE:	**02/03**	**SUBJECT:**	**Medication Recall**
REVISION DATE:	**06/03, 08/05; 01/06; 03/08; 02/09 07/11**	**POLICY NUMBER:**	**IV.I.9**

Department Approval:	**10/16**
Clinical Policies & Procedures Committee Approval:	**~~05/14~~11/16**
Nurse Executive Council Approval:	**~~05/14~~01/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Committee Approval:	**~~07/14~~02/17**
Medical Executive Committee Approval:	**~~09/14~~03/17**
Professional Affairs Committee Approval:	**~~10/14~~04/17**
Board of Directors Approval:	**11/14**

A. **POLICY:**

1. The Pharmacy Department shall maintain a system whereby drugs subject to recall are immediately identified, removed from active inventory, and sequestered.
2. The Pharmacy Department is notified of manufacturer's or Food and Drug Administration (FDA's) recall or medication discontinuation proceedings through direct mail, wholesaler's notification, written or electronic FDA Safety Alert or Recall Notification.
   a. Chronological files of such notifications, alerts, and recall notices shall be maintained for at least one (1) year.

B. **PROCEDURE:**

1. When the Pharmacy Department receives information about a medication recall or discontinuation by the manufacturer or the FDA for safety reasons:
   a. All individuals ordering, dispensing, and/or administering recalled or discontinued medications are notified.
   b. Patients will be notified of the recall or discontinuation if required by law or regulation.
2. The pharmaceutical buyer or designee shall remove all lots of a recalled drug if found in inventory. Recalled medications are replaced with an unaffected lot number of the same medications or generic equivalent, when available.
   a. A record of actions taken shall be written on the recall notice; including none found in inventory and the date the action was taken.
   b. The notice is forwarded to the Director of Pharmacy or designee upon completion of the recall action.
3. All drug storage areas of the hospital shall be inspected, including satellite pharmacies, surgery and other floor stock areas if applicable.
4. Recalled medications are quarantined in a designated area separate from active stock. This area is clearly identified.
5. Recalled medications are returned in accordance with manufacturers/recall notice specifications.
6. Medications recalled for safety reasons are reported to the Pharmacy and Therapeutics Committee.

Tri-City Medical Center	Distribution: Patient Ca

DELETE – no longer required. Now documented in Cerner

PROCEDURE:	OUTPATIENT SUMMARY LIST PROCEDURE
Purpose:	To provide ongoing documentation for continuity of care for the outpatient population
Supportive Data:	This process is unique to Tri-City Medical Center and is not included in Mosby's Nursing Skills
Equipment:	Outpatient Summary List Form 6185-1002

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

~~1. Tri City Medical Center is committed to providing continuity of care to the outpatient population. The Outpatient Summary List (OPSL) will facilitate this continuity of care over a period of time by keeping current information regarding patient's diagnoses, procedures, medications, and allergies. This information will be available to all caregivers and is quickly and easily available to staff.~~

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

~~1. The OPSL will be used in the following areas:~~
~~a. Outpatient Chemotherapy~~
~~b. Special Procedures Recovery Area (SPRA)~~
~~c. Cath Lab~~
~~d. Interventional Radiology~~
~~e. Dialysis Unit (4 Pavilion)~~

~~2. The registered nurse will complete the Outpatient Summary List (Form #6185-1002) by the patient's third visit (may be completed earlier).~~

~~3. At the completion of the visit, the OPSL will be sent to Medical Records with the patient's medical record and a copy made and placed in unit file.~~

~~4. At each subsequent visit, the registered nurse will retrieve the copy of the OPSL from the unit file and update. Any changes will be lined out with a single line, and additions made as appropriate. The RN shall sign/date the form.~~

~~5. At the completion of the visit, a copy is made of the revised OPSL and placed in the unit file. The revised original shall be sent to Medical Records along with the discharged encounter for scanning.~~

~~6. Units will purge the OPSL file quarterly by shredding.~~

~~7. Other outpatient units not addressed in this procedure will develop and maintain their own forms per their unit specific procedures.~~

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/06; 11/06, 11/07, 7/09; 12/09; 11/12, 12/16	7/09, 1/10;12/12, **02/17**	8/09, 1/10;12/12, **02/17**	8/09, 2/10; 5/13; **03/17**	9/09, 3/10, 6/13, **04/17**	9/09, 3/10, 6/13

Patient Name _____ DOB: _____ HT: _____ WT: _____
Date Summary List Was Initiated _____
Allergies/ Reaction _____

1. Medical Diagnosis and Conditions

Diagnosis and Conditions		Diagnosis and Conditions	
Date		Date	

2. Hospitalizations/Surgeries/Invasive Procedures

Hospitalizations/Surgeries/Invasive Procedures		Hospitalizations/Surgeries/Invasive Procedures	
Date		Date	

3. Home Medications (Including OTC & Herbal)

Medications				Medications			
Name	Dose	Start Date	Stop Date	Name	Dose	Start Date	Stop Date

4. Family History

Family History						
☐ Allergies	☐ Asthma	☐ Bleeding Disorders	☐ Diabetes	☐ High Blood Pressure	☐ Kidney Disease	
☐ Sickle Cell	☐ Seizures	☐ High Cholesterol	☐ Liver Disease	☐ Hearing Loss	☐ Cancer	
☐ Psychological Problems		☐ Heart Disease				

Explain _____
☐ Any Other Problems

RN _____ Date _____ RN _____ Date _____ RN _____ Date _____

5. Date Summary List Was Reviewed (Must be Reviewed Every Outpatient Visit)

Outpatient Summary List Reviewed									
Date	RN Signature	Date	RN Signature	Date	RN Signature	Date	RN Signature	Date	RN Signature

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

6185-1002
(Rev. 11/99)

OUTPATIENT SUMMARY LIST

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PUREWICK FEMALE URINARY INCONTINENCE MANAGEMENT**
Purpose:	To define the appropriate procedure for initiation of urinary incontinence management through implementation of the PureWick system. To define the assessment, monitoring, and maintenance of urinary incontinence management **with**~~through~~ implementation of the PureWick system.
Supportive Data:	Reduces the need for inserting an indwelling urinary catheter for incontinent female patients and avoids the risk associated with catheter-associated urinary tract infections (CAUTI). Keeps patient's skin dry, avoids pressure ulcers, **contact dermatitis**~~rashes~~ from urine, and the need for diapers
Equipment:	PureWick System Wall suction regulator Suction **c**~~C~~anister ~~-~~and ~~-I~~~~L~~iner Suction **t**~~T~~ubing Suction tubing ~~-~~connectors Incontinence ~~P~~**p**ads**, patient undergarments, mesh panties (optional)** Hygiene supplies

A. **DEFINITION(S):**

1. Wick: Disposable, latex free flexible urine collection tube with a vacuum, with cloth material on one side and plastic or tape on the other side that is positioned between the labia and the bottom to collect urine. The wick is designed to connect to the suction regulator via suction tubing. The suction is set at 20mmHg to produce a mild vacuum inside of the wick. Wicks are capable of capturing 100% of urine.

B. **POLICY:**

1. PureWick urine management system may be implemented for female patients with urinary incontinence 24 hours per day and the following:
   a. ~~w~~**W**alking from bed to chair to a toilet is difficult or painful
   b. ~~i~~**I**nability to retain urine
   c. P~~p~~ost-surgical **or procedure** ~~-~~immobility
   d. Accurate urine output measuring
   ~~c.~~**e. Strict intake and output orders**
   ~~d.~~**f.** ~~p~~**P**ressure ulcers or contact dermatitis associated skin injuries related to urine
   ~~e.~~**g. U**~~u~~rine sample, if a sample cannot be obtained from a clean catch
2. The PureWick system is contraindicated for the following:
   a. Male patients
   b. Patients with male genitalia
   c. Patients with urinary retention
   ~~a.~~**d.** Uncooperative patient
      i. Uncooperative patients will remove wicks
   ~~b.~~**e.** Patient gets out of bed without supervision
   ~~c.~~**f.** Bowel incontinence with frequent episodes
3. Precautions for the use of the PureWick system include but are not limited to:
   a. Skin irritation
   b. Pressure from device
   c. Patient discomfort
4. PureWick urine management system will be implemented by a Registered Nurse (RN); **a physician order is not required**. The RN is responsible for:
   a. Identifying patients that will benefit from the use of a PureWick
   b. Maintenance of PureWick.

Department Review	Clinical Policies and Procedures Committee	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/16	01/17	02/17	n/a	03/17	04/17	

c. Documentation in the medical record

5. Each wick may be used for a maximum of 12 hours.
6. Change the wick prior to the end of each shift, as needed (PRN) and if the following occurs: .
   a. Indications for changing the wick
      i. Patient comfort or request
      ii. Skin irritation
      iii. Frequency of urinations
      iv. After each stool
      ~~iv.~~**v. Menstruating**
7. Assessment
   a. Assess the following at least twice per shift and PRN
      i. Urine output, if urine is escaping the wick, refer to the Troubleshooting section below
      ii. Patient's comfort
      iii. Proper placement of the wick at least three times per shift **and with position changes**
      iv. Presence of skin redness or irritation related to the wick location
      ~~iv.~~**v. Ensure patient does not insert the wick into the vagina, anal canal or other body cavities**
8. **Transport On and Off a Unit**
   a. Patients with PureWicks suction will be:
      i. Disconnected from suction prior to transport by RNs and Advanced Care Technicians (ACTs)
      ii. Reconnected to suction by RNs and ACTs when returning from test or procedures

C. **PROCEDURE:**

1. Perform hand hygiene per TCMC policies and procedures
2. Obtain a PureWick Urinary System ~~for the unit supply Pyxis or cart~~
3. Explain procedure to patient
4. Set up suction per manufacturer's instructions
5. Set vacuum pressure i.e., suction to 20mmHg (low setting) continuous suction. -Suction may be increased if required to a maximum of **60**~~40~~ mmHG. **Do not exceed 60 mmHG**
   a. Ensure suction is working by closing and opening the suction tubing end with your thumb or by placing the suction tubing open end in the palm of your hand.
6. Perform hand hygiene and don new gloves.
7. Position patient on their back or ~~side~~**side;** place an incontinence pad under her buttocks to capture urine that escapes the wick.
8. Provide pericare ~~as needed~~
9. Remove wick from the **package**~~plastic bag~~.
10. Peel the PureWick label from bag and wrap it around the suction tubing.
    a. It will serve as a method of identifying the hose when replacing wicks.
11. Insert the plastic **hose** ~~connector~~ on the end of the wick into the connector on the suction tubing
12. **Separate the gluteus muscle and the labia**
~~12.~~**13.** Hold the wick vertically with the connection to the suction tubing on top and the cloth surface facing the patient's perineum.
~~13.~~**14.** Gently place the wick -snugly against the perineum, between the labia and patient's buttocks.
    a. The cloth surface of the wick **(white side)** should be snugly positioned between the labia and close to the urethra.
    b. The wick should touch the perineum between the anus and the pubic bone
    ~~b.~~**i. Failure to properly place the wick will result in urine leakage**
    c. If the patient is lying still, the wick will typically stay in-position.
    d. Assist patient with repositioning at least every 2 hours and PRN.
    e. Mesh stretch panties or the patient's undergarments may be applied to hold the wick in place.

15. Ensure the hose connector is above the pubic bone

~~14.~~**16.** Verify the suction is functioning

~~15.~~**17.** Ensure there are no kinks in the suction tubing

~~16.~~**18.** Maintenance of Suction Canister

a. The suction will stop working when the suction canister is full

b. Change the suction canister when it is ¾ full.

i. The canister may be changed without removing the wick. Disconnect the suction tubing from the plastic connector attached to the wick and change suction canister per manufacture's recommendations.

c. Observe the amount of urine in the canister a minimum of 3 times daily.

D. **OBTAINING A URINE SAMPLE WITH THE PUREWICK:**

1. Set up suction ~~as outlined in C-1-5~~
2. See Online Clinical Skills: **Specimen** Collection: Midstream (Clean-Voided) Urine
3. Female patient

a. Spread or have the patient spread the labia minora with the thumb and forefinger or forefinger and middle finger of the nondominant hand.

b. Use the dominant hand to cleanse the urethral area with antiseptic ~~swabs moving~~**swabs moving** from front (above the urethral orifice) to back (toward the anus).

c. Using a fresh swab each time, employ the front-to-back motion first with the left side, then the right side, and then down the center. Again using a fresh swab each time, repeat the process

d. While continuing to hold the labia apart,

i. Apply **a**~~the~~ PureWick **(do not connect the PureWick to suction)** have the patient initiate a urine stream, discard the PureWick~~, urine, and discard suction liner and tubing~~

~~ii. Place a clean suction liner in the suction canister and suction tubing to collect the specimen.~~

~~iii.~~**ii.** Apply a new PureWick**, connect to suction** ~~-~~and allow patient to void to collect a midstream specimen

~~iv.~~**iii.** After collecting the midstream specimen, disconnect the suction tubing from the suction canisters, close the lids on the liner, ~~remove~~**and remove** the liner.

1) If the PureWick is to remain in place, **a**~~A~~pply a new liner and connect the suction

2) If the PureWick is no longer require remove and discard suction tubing.

~~v.~~**iv.** Pour midstream specimen in a specimen container and label according to TCMC **Specimen Labeling** ~~policy.~~

~~vi.~~**v.** Transport specimen to lab according to TCMC policy

~~vii.~~**vi.** Document in the medical record according to TCMC policy

E. **TROUBLESHOOTING:**

1. If a large amount of urine is escaping from the wick, contributing factors include but are not limited to:

a. The wick is not correctly tucked between the labia and buttocks.

i. The wick must be snugly positioned between the labia with the bottom end between the buttocks.

ii. Ensure the top of the wick reaches just above the pubic bone.

iii. Change the PureWick

~~ii.~~**iv. Apply mesh panties to assist with maintain the PureWick's position**

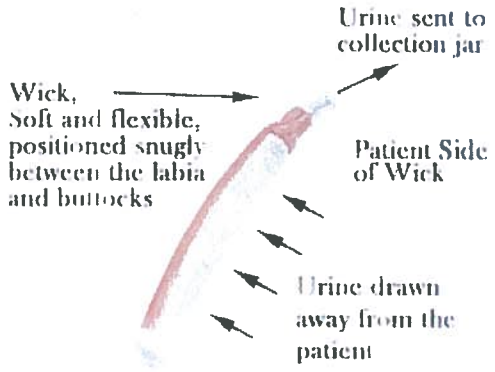
b. No or low suction.

i. Check suction settings and ensure the regulator is set at 20 mmHg

ii. Check for kinks in the tubing or sediments

iii. Ensure the suction canister lid is firmly in place

iv. Verify the suction regulator is functioning
v. Ensure the suction tubing is connected to the wick connector



~~v.~~**vi.**

2. ~~For other troubleshooting assistance, PureWick is available at 619-660-0734.~~

F. **RELATED DOCUMENT(S):**
1. **Clinical Skills (**Mosby's**): Specimen** Collection: Midstream (Clean-Voided) Urine
2. Urine Collection Clean Catch Urine Specimen: TCMC Clinical Laboratory Manual
3. Patient Care Services Policy: Specimen Labeling~~, Nurse Collectibles~~

G. **REFERENCE(S) ~~LIST~~:**
1. PureWick, Inc. (**2016, April**~~n.d.~~).**Instructions for use (in hospital settings).** ~~How does it work. Retrieved from http://www.purewick.com/how-does-it-work-2/~~
2. PureWick, Inc. (n.d.). Successful incontinence management for women. Retrieved from http://www.purewick.com/

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 05/08	**SUBJECT:** Research Activities: Investigational Drugs
REVISION DATE: 09/09; 12/09	**POLICY NUMBER:** IV.I.12

Department Approval:	10/16
Clinical Policies & Procedures Committee Approval:	~~01/10~~11/16
Nurse Executive Council Approval:	01/17
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	02/17
~~**Patient Care Quality Committee Approval:**~~	~~01/10~~
Medical Executive Committee Approval:	03/17
Professional Affairs Committee Approval:	~~02/10~~04/17
Board of Directors Approval:	02/10

A. **PURPOSE:**

1. **To provide guidelines for coordination of medical, nursing, administration, and pharmacy staff in providing for the safe use and dissemination of investigational drugs, biologics and devices within the hospital. More information can be found in the Clinical Research Policies Manual and the Pharmacy sub-manual Investigation Drugs Services Policies and Procedures, both ~~department~~departments – specific manuals.**
2. ~~1.~~ To provide guidelines for coordination of medical, nursing, administration, and pharmacy staff in **hospital-driven research such as Evidenced Based Practice (EBP) and new healthcare research.**~~providing for the following:~~
   - ~~a. Safe use of investigational drugs within the hospital~~
   - ~~b. Adequate overall financial compensation~~
   - ~~c. Development of operational procedures to coordinate investigational studies~~

B. **GLOSSARY:**

1. **CFR: Code of Federal Regulations**
2. **CRC: Clinical Research Coordinator**
3. **CRD: Clinical Research Department**
4. **CUSP: Comprehensive-Unit Based Safety Program**
5. **EBM: Evidence-Based Machine**
6. **ESP: Evidence-Based Practice**
7. **IRB: Investigational Review Board**
8. **PI: Principal Investigator**
9. **SRC: Scientific Review Committee**

~~B.~~C. **DEFINITION(S):**

1. **Clinical Research Coordinator (CRC): The CRC is a Tri-City Healthcare District (TCHD~~MC~~) credentialed clinical trial coordinator employed by the clinical research site conducting the clinical trial or study.**
2. **Clinical Research Site refers to the external organization that is conducting the Clinical Trial or Study.**
3. **Comprehensive-Unit Based Safety Program (CUSP): The Clinical Research Department (CRD) is actively involved in supporting a culture shift towards patient safety via the Pronovost invented CUSP program.**

4. **Evidence-Based Practice (EBP): Evidence-Based Medicine (EBM) aims to apply the best available published evidence gained from the scientific method to clinical decision making and medical intervention. It seeks to assess the strength of evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests as well as drives the support for determining "best practices". This helps clinicians to learn whether a treatment will do more good than harm.**
5. **Exemption Determinations for Research Projects: Research projects *may be* determined exempt from federal oversight and Investigational Review Board (IRB) review under 45 Code of Federal Regulations (CFR) Part 46 if they not involve a Federal Drug Administration (FDA) regulated product such as a drug or device and if prisoners are not included in the research. Exemption Determinations are reviewed by the ~~Tri-City Medical Center (~~TCHD~~MC)~~ CRD and the opinions derived by the TC~~MC~~HD Exemption Determination Committee. The policy number describing exempted research is Clinical Research Exempted Research Policy 8010.021.**
6. **Informed Consent Form (ICF): A document which explains the following:**
   a. **Details of the study**
   b. **The potential risks and benefits**
   c. **Rights and responsibilities**
7. Investigational Drugs **and Biologics** – New drugs **or biologics which**~~, or investigational uses for Food & Drug Administration (FDA) approved drugs that~~ have been issued an Investigational New Drug (IND) number by the FDA. These **medical treatments**~~medications~~ are **for investigational use only**~~not for general use~~
8. **Investigational Devices: New devices which have been designated as a Humanitarian Use Device (HUD) and been issued a Humanitarian Device Exemption (HDE) or have an Investigational Device and been assigned an Investigational Device Exemption (IDE) by the FDA.**
   a. **HUD is as defined in 21 CFR 814.3(n), as a "medical device intended to benefit patients in the treatment or diagnosis of a disease or condition that affects or is manifested in fewer than 4,000 individuals in the United States per year.**
   b. **HDE is defined in 21 CFR 814.3(m), as a "premarket approval application" submitted to FDA pursuant to Subpart A, 21 CFR Part 814 "seeking a humanitarian device exemption from the effectiveness requirements of sections 514 and 515 of the [FD&C Act] as authorized by section 520(m)(2) of the [FD&C Act]."**
   c. **An IDE allows an investigational device (i.e. a device that is the subject of a clinical study) to be used in order to collect safety and effectiveness data required to support a premarket approval (PMA) application or a premarket notification [510(k)] submission to the FDA.**
~~1.~~**9. Investigational Review Board (IRB): An IRB is a committee established to review and approve research involving human subjects. The purpose of the IRB is to ensure that all human subject research be conducted in accordance with all federal, institutional, and ethical guidelines. Western IRB is TC~~MC~~HD's IRB of record.**
10. Principal Investigator **(PI) – Physician(s) with privileges at Tri-City Medical Center (TC~~MC~~HD) who are responsible for the conduct of the clinical study. In the case of drug studies,** the **PI** ~~Tri-City Medical Center (TCMC) approved physician(s)~~**would** sign~~ing~~ **the** FDA Form 1572 **and TC~~MC~~HD would be listed on the Form as a site**~~for obtaining investigational drugs from the study sponsor~~
11. **Publication: Publications shall consist of manuscripts for journal publication, posters and power point presentations aka talks, speaking engagements etc. A completed publication is to be provided to the CRD for approval.**
12. **Research Subject: All patients enrolled in a clinical trial are referred to by trial personnel as a study subject per FDA guidelines.**
13. **Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are**

conducted or supported under a program which is considered research for other purposes.

14. **Scientific Review Committee: The Scientific Review Committee (SRC) serves to assess the scientific, business, contractual, and financial considerations for each clinical research project at TC~~M~~CHD.**

~~2.~~15. **Sponsor: An individual, company, institution or organization which takes responsibility for the initiation, management and/or financing of a clinical trial.**

~~C.~~D. **POLICY:**

1. **All IRB requests are to be made through the TC~~M~~CHD Director of Clinical Research.**

~~1.~~2. **Clinical trials**~~Investigational drugs~~ are administered only in accordance with protocols approved by the **SRC**~~Clinical Research Administrative Review Committee (CRARC) and developed by Performance Improvement,~~. **Representatives from all ancillary services, education** ~~Pharmacy~~, nursing **and physicians**~~, and Lab and Radiology when applicable.~~ **are members of the SRC and play a role in determining whether the study is feasible to be conducted at TC~~M~~CHD and whether there were no regulatory obstacles.**

~~2.~~a. Investigational drugs**, radiation, biologics or devises** shall be used only under the supervision of the principal investigator **and/**or ~~co~~**sub**-investigator, who assumes the burden of **responsibility for the proper conduct of the clinical trial and** securing the necessary **ICF**~~informed~~ consent.

b. The principle or ~~co~~**sub**-investigator must be a member of the Medical Staff of ~~TCMC~~ **TCHD** for all investigational drug protocols approved by the **SRC**~~CRARC~~ of ~~TCMC~~**TCHD**.

~~a.~~c. **Investigational medications are administered only under the supervision of the authorized investigator and according to protocol. They are to be distributed by the IDS Pharmacy.**

3. **The CUSP program may be used to study quality improvement methods or EBP research.**

4. **TC~~M~~CHD has an EBP Committee. This committee is available for teaching or coaching hospital employees who would like to conduct EBP research.**

5. **The CRD will issue a written opinion for a proposed project that may be exempted from Federal Oversight and IRB review under 45 CFR Part 46. The policy describing exempted research is Clinical Research Exempted Research Policy 8010.021.**

6. **TC~~M~~CHD CRD is available to review and assist with manuscript preparation and revision for those discoveries made at TC~~M~~CHD.**

7. **TCHD~~MC~~ conducts various forms of research not based on the reproduction of earlier findings but based on a novel concept that could change medical practice or healthcare workflow. The CRD and EBP Committee are available as a resource.**

~~3. The investigational protocols and a complete TCMC submission packet must be submitted by the principal investigator to the CRARC for review of operational and financial impact.~~

~~a. Approval by CRARC must be granted before patients may enroll.~~

~~b. Investigational medications are administered only under the supervision of the authorized investigator and according to protocol.~~

8. **TCHD~~MC~~'s IDS Pharmacy**~~The Principal Investigator (PI)~~ is responsible for providing information on storage, labeling, ~~and~~ distribution **and waste**~~ to pharmacy~~. **A clinical IDS pharmacist shall review the Investigational Drug Fact sheet with nursing personnel as requested. This is detailed in the Pharmacy IDS Policy and Procedure manual.**

9. **Each hard copy of the patient medical record shall contain a research tab. The signed ICF is to be placed in this section.**

a. **IF THERE IS NO CONSENT and the patient does not have one available, the RN or Healthcare provider needs to call the clinical trial site to obtain a copy.**

b. **No procedures or trial-related medications may be administered until this consent is on file in the Medical Record.**

10. **Prior to the initiation of the clinical research study, sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication. Copies of the orders are to be provided to lab and radiology when appropriate.**

E. ROLES AND RESPONSIBILITIES:

1. **Sponsor:**
   - a. **Provides information on storage, labeling, and distribution to pharmacy**
2. **Principal Investigator:**
   - ~~4.~~a. ~~The PI is also responsible for p~~Provide~~sing~~ a nursing summary and drug fact sheet to the **Nursing Educator group**~~nursing staff~~ in one-page outlines. The ~~minimal~~ information provided shall include:
     - ~~a.~~i. Dosage form
     - ~~b.~~ii. Route of administration
     - ~~c.~~iii. Strength
     - ~~d.~~iv. Actions
     - ~~e.~~v. Uses
     - ~~f.~~vi. Side effects
     - ~~g.~~vii. Adverse effects
     - ~~h.~~viii. Interactions
     - ix. Symptoms of toxicity
   - ~~i.~~b. **Obtains fully executed ICF and places a copy in the medical record.**

~~5. When nurses are required to administer investigational drugs, the study coordinator shall provide the Investigational Drug Fact Sheet (see attached) with the initial dose of study drug.~~

~~a. A clinical pharmacist shall review the Investigational Drug Fact sheet with nursing personnel as requested.~~

- c. **Upon study initiation, the PI shall provide a written order to the IDS pharmacy. If oral study medication has been provided to study subject they may take their own study drug. An order from the PI for the oral drug can be provided by the site or IDS pharmacy.**

3. **Pharmacist**:
   - a. **Prior to study enrollment, the Sponsor or the Contract Research Organization (CRO) shall conduct a site initiation visit (SIV) with the investigational drug service pharmacist**
     - i. **Review study procedures to include randomization, dispensing, blinding and unblinding documentation, and planning for routine monitoring visits.**
     - ii. **Every attempt shall be made to conduct a SIV in the TC~~MC~~HD Pharmacy.**
   - b. **Review the Investigational Drug fact sheet with nursing personnel as requested.**
   - c. **Process all investigational medications**
     - i. **The TC~~MC~~HD Pharmacy address must be listed as the receiving party for all investigational drug study medications.**
     - ii. **Study drug distributor/Sponsor must notify pharmacy as to expected date of receipt, and every attempt must be made by distributor to deliver during normal business hours.**
     - iii. **Once received in the pharmacy, investigational study medications shall be inspected for damage, quantity verified, documented on the study master accountability form, and stored at appropriate temperature by the IDS pharmacist or delegated pharmacist trained on the study.**
       - 1) **If no appropriately trained staff is available to complete the above on the day of receipt, the medications will be sequestered in the investigational drug study room at appropriate storage conditions until above documentation can be completed.**
       - 2) **No study medications shall be removed for patient use unless the above has been completed.**
     - iv. **Investigational study medications shall be stored in a separate locked room within the pharmacy, accessible only to pharmacists and other pharmacy personnel under the supervision of a pharmacist.**
       - 1) **High/low temperature logs shall be maintained in this room for drugs stored under ambient and refrigerated conditions.**

v. Drug receipt shall be logged into appropriate IVRS/IWRS within 24 hours of receipt and all shipping documents processed per study instructions.
vi. An inventory record shall be kept on each investigational drug. A record shall be kept for each dose of investigational drug dispensed.
vii. Inventory of investigational drugs shall be kept and include the following:
1) Quantities dispensed
2) Identities of patients
3) Quantities of medications returned, lost, or destroyed.
viii. Clinical trial materials and/or investigational drugs shall be returned or destroyed per protocol and sponsor direction.
ix. Information on current Drug and Study Protocols is maintained in the Pharmacy IDS locked storage room. Information on closed studies is maintained in the Pharmacy IDS locked storage room for a period of at least one year following the study close-out. After one year, the information may be moved to on-site storage for at least another year before transfer to off-site storage. All IDS study documentations are to be kept permanently.

d. Dispenses Investigational drugs (TC~~M~~CHD licensed pharmacist only)
i. All investigational drugs shall be properly labeled, with auxiliary labeling if necessary:
1) Name of drug or identification of investigational protocol.
2) Strength
3) Expiration date of the drug. If no expiration date is available, a re-test date shall be used as the expiration date. In the event that an expiration or re-test date is not available, a memo from the sponsor shall be obtained stating that they assume responsibility for notifying the pharmacy prior to the drugs expiration date.
ii. For intravenous investigational agents the following process shall be followed:
1) A pharmacist (IDS or IV room pharmacist) shall prepare or directly supervise preparation of all IV investigational infusions.
2) For any IV doses not dispensed during the IV room pharmacist shift, communication will be made to the evening pharmacist of any pending investigational infusions.
3) IV infusions for investigational drugs should be infused via a separate site and clearly labeled as "Investigational Drug" whenever possible. If IV infusions for investigational drugs are infused into a line with other medications, the line must be flushed with normal saline, or flushed per study protocol if specified by the sponsor.
iii. For outpatient study medications, the study site staff will pick up the investigational drug from pharmacy. Pharmacy personnel and study site staff member will sign the transportation log once picked up. The logs will be filed and kept in the IDS storage room.
1) The only exception to this shall be when the study sponsor requires a study-specific dispensing log.
iv. For studies without a study-specific transportation log, a TC~~M~~CHD dispensing/transportation log shall be completed whenever investigational medications are delivered by pharmacy personnel to nursing units. The pharmacy personnel and receiving nurse will sign the log.
v. Procedures pertaining to the disposition of any remaining study drug or study drug preparation shall be determined prior to patient enrollment.
1) Medications not used by the patient shall be returned to the pharmacy or may be retained by the patient per physician's order.
2) When the protocol is closed, the medications shall be returned to the sponsor, physician, or destroyed through standard hospital procedure, as directed by the sponsor or PI.

e. **All pharmacists involved in investigational drug dispensation must complete training by the IDS pharmacist and sign-off that they have received training.**
   i. **Training and delegation logs shall be maintained in the pharmacy study binder.**
   ii. **CV's and California pharmacist license shall be maintained in the pharmacy study binder if required by the sponsor.**
   iii. **Staff education is provided in the departments and to the staff involved**

4. **Study Coordinator**:
   a. **Provides an in-service to the nursing educator group when all items are finalized.**
   b. **Study requirement checklist must be completed by the PI or research coordinator prior to enrollment of patients.**
   c. **Staff education is provided in the departments and to the staff involved.**
      i. **Pharmacists involved in study drug dispensing or monitoring shall be educated on study procedures. This shall include:**
         1) **Documentation**
         2) **Monitoring (if required by the study)**
         3) **Randomization (when pharmacy is the responsible party)**
         4) **Blinding**
         5) **Proper storage, preparation, and dispensing of the study drug.**

5. **Education Group**:
   a. **Reviews orders, the nursing summary, and drug fact sheets**
   b. **Coordinates distribution of the information and in-service education to the nursing staff.**

6. **Nursing:**
   a. **Verifies informed consent.**
      i. **A copy of the consent is retained in the IDS pharmacy and medical record under the research tab**
   b. **Reviews the PPO, drug fact sheet and nursing summary**
   c. **Administers IV infusions for investigational drugs via a separate site and clearly labeled as "Investigational Drug"**
      i. **Investigational drugs can only be infused into a line with other medications with approval from the PI and IDS pharmacist.**

~~6. For patients entering TCMC who are participating in an outside clinical trial (not recognized or approved by the TCMC CRARC), the pharmacy shall adhere to the following:~~
~~a. The PI shall be notified and evaluate the appropriateness of the patient's continuance in the investigational study. If no contraindication exists, the investigational study medications may be continued during hospitalization.~~
~~i. If the PI is not the admitting physician, this information must be communicated to the admitting physician or hospitalist assuming care of the patient.~~
~~b. Physician shall provide a written order for "patient may take own study drug" or similar wording~~
~~c. The PI shall verify identity and confirm study drug~~
~~d. The PI shall complete the Investigational Drug Fact Sheet for nursing and pharmacy.~~
~~e. The CRARC and pharmacy shall accept a copy of original informed consent~~
~~i. A copy shall be placed on the patient's medical chart~~
~~f. Sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication.~~
~~7. All investigational medications must be processed through Pharmacy.~~
~~a. The TCMC Pharmacy address must be listed as the receiving party for all investigational drug study medications.~~
~~b. Study drug distributor must notify pharmacy as to expected date of receipt, and every attempt must be made by distributor to deliver during normal business hours.~~
~~c. Once received in the pharmacy, investigational study medications shall be inspected for damage, counted, and entered on study master accountability form by a pharmacist trained in study procedures.~~

i. ~~If no appropriately trained staff is available to complete the above on the day of receipt, the medications will be sequestered in the investigational study room for no longer than 24 hours.~~
ii. ~~No study medications shall be removed for patient use unless the above has been completed.~~

d. ~~Investigational study medications shall be stored in a separate, locked room within the pharmacy, accessible only to pharmacists and other pharmacy personnel under the supervision of a pharmacist.~~
i. ~~High/Low temperature logs shall be maintained in this room for drugs stored under ambient and refrigerated conditions.~~

e. ~~Drug receipt shall be logged into appropriate IVRS/IWRS within 24 hours of receipt and all shipping documents processed per study instructions.~~

8. ~~The study coordinator or the registered nurse caring for the patient shall provide a written physician's order and a copy of the signed informed consent to obtain study drug.~~
9. ~~An inventory record shall be kept on each investigational drug. A record shall be kept of each dose of the investigational drug. Clinical trial materials and/or investigational drugs shall be returned or destroyed per protocol and sponsor direction.~~
10. ~~Information on current Drug and Study Protocols is maintained in the Pharmacy IV room. Information on closed studies is maintained in the investigational drug storage room for a period of at least one year following study close-out. After one year, the information may be moved to on-site storage for at least another year before transfer to off-site storage. The Investigational Drug Pharmacist shall maintain records of studies sent to storage.~~
11. ~~Investigational drugs shall be dispensed by a TCMC licensed pharmacist.~~
12. ~~IV infusions for investigational drugs should be infused via a separate site and clearly labeled as "Investigational Drug" whenever possible if IV infusions for investigational drugs are infused into a line with other medications, the line must be flushed with normal saline.~~

D. ~~**PROCEDURE:**~~

1. ~~The PI or clinical study coordinator presents the study in person to the CRARC.~~
2. ~~If the study is approved, the following occurs:~~

a. ~~The PI and/or clinical coordinator work with pharmacy to develop study specific pre-printed orders (PPO), drug fact sheet, and nursing summary.~~
i. ~~Copies of the PPO are distributed to the lab and radiology for input if applicable.~~
ii. ~~PPO, drug fact sheet, and nursing summary are distributed to nursing for input.~~

b. ~~When all items are finalized, the study coordinator provides an in-service to the nursing educator group.~~
i. ~~The educator group shall decide who will provide in-service education to the nursing staff.~~

c. ~~Study requirement checklist must be completed by the PI or research coordinator prior to enrollment of patients.~~

d. ~~Prior to study enrollment, the Sponsor or the Contract Research Organization (CRO) shall conduct a site initiation visit (SIV) with the investigational pharmacist to review study procedures to include randomization, dispensing, blinding and unblinding documentation, and planning for routine monitoring visits. Every attempt shall be made to conduct SIV in the TCMC Pharmacy.~~

e. ~~Medications not used by the patient shall be returned to the pharmacy or may be retained by the patient per physician's order.~~

f. ~~Procedures with the disposition of any remaining study drug or study drug preparation shall be determined prior to patient enrollment.~~

g. ~~Inventory of investigational drugs shall be kept and include the following:~~
i. ~~Quantities dispensed~~
ii. ~~Identities of patients~~
iii. ~~Quantities of medications returned, lost, or destroyed.~~

~~h. When the protocol is closed, the medication shall be returned to the company, physician, or is destroyed through standard hospital procedure, as directed by the drug company or PI.~~
~~i. Training and delegation logs shall be maintained in the pharmacy study binder.~~
~~ii. CVs and California pharmacist license shall be maintained in the pharmacy study binder if required by sponsor.~~
~~i. Staff education is provided in the departments and to the staff involved. Pharmacists involved in study drug dispensing or monitoring shall be educated on study procedures. This shall include all documentation, monitoring (if required by the study), randomization (when the pharmacy is the responsible party), blinding, and the proper storage, preparation and dispensing of study drugs.~~
~~j. Consent is obtained and a copy retained in the medical record.~~

~~3. For intravenous investigational agents the following process shall be followed:~~
~~a. A pharmacist (usually the IV room pharmacist) shall prepare all IV investigational infusions.~~
~~b. A second pharmacist shall check and co-sign the final solution after prepared~~
~~i. If no other pharmacist on site, then an IV technician shall check the final product.~~
~~c. For IV doses not dispensed during the IV room pharmacist shift, the IV labels shall be placed in the "Time flag" area with the rest of the IV labels with short stability.~~
~~d. The IV room pharmacist shall communicate to the PM IV technician and either the evening or night pharmacist of the pending investigational infusion(s).~~

~~4. All investigational drugs shall be properly labeled, with auxiliary labeling if necessary:~~
~~a. Name of drug or identification of investigational protocol~~
~~b. Strength~~
~~c. Expiration date of the drug. If no expiration date is available, a re-test date shall be used as the expiration date. In the event that an expiration or re-test date is not available, a memo from the sponsor shall be obtained stating that they assume responsibility for notifying the pharmacy prior to the drug's expiration date.~~

~~5. A dispensing/transportation log shall be completed whenever investigational medications are delivered by pharmacy personnel to nursing units and whenever investigational medications are picked up in the pharmacy by a nurse or study coordinator. The only exception to this shall be when the study sponsor requires a study-specific dispensing log.~~

~~E.~~F. DOCUMENTATION:

1. Documentation in the medical record shall include:
   a. Signed copy of informed consent filed under research tab
   b. Physician's order for the investigational drug including:
      i. Name
      ii. Dose
      iii. Route
      iv. Duration of administration (included on the PPO)
      v. Frequency of administration
      ~~v.~~vi. Acceptable rescue medications for an adverse drug reaction
   c. Order for disposition of any unused medication
   d. Completed Medication Administration Record (MAR)
   e. All side effects and adverse reactions to the investigational drug shall be noted in the nursing notes and reported to the physician.
   f. Results for all tests ordered **at TCM~~C~~HD** as part of the research protocol

G. PATIENTS ENTERING TCHD~~MC~~ WHO ARE PARTICIPATING IN AN OUTSIDE CLINICAL TRIAL:

1. For patients entering TCM~~C~~HD who are in an outside clinical trial (not recognized or approved by the TCM~~C~~HD SRC), the pharmacy shall adhere to the following guidelines:
   a. The PI shall be notified and evaluate the appropriateness of the patient's continuance in the investigational study.

i. If no contraindication exists, the investigational study medications may be continued during hospitalization.
ii. If the PI does not have privileges at TC~~M~~CHD this information must be communicated to the admitting physician or hospitalist assuming care of the patient.

b. The admitting physician or Allied Health Professional (AHP) shall provide a written order for "patient may take own study drug" or similar wording.
c. The IDS pharmacist shall verify identity and confirm the study drug.
d. The PI shall complete the Investigational Drug Fact Sheet for nursing and pharmacy.
e. The TC~~M~~CHD SRC and pharmacy shall accept a copy of the original informed consent
   i. A copy shall be placed on the patient's medical chart
f. Sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication.

H. RELATED DOCUMENT(S):

1. Clinical Research Exempted Research Policy 8010.021

~~F.~~I. REFERENCE(S):

1. http://www.fda.gov/RegulatoryInformation/Guidances/ucm389154.htm
2. https://www.nlm.nih.gov/services/ctconsent.html ~~https://www.google.com/search?sourceid=navclient&aq=&oq=Clinical+Trial+Informed+Consent+Definition&ie=UTF-8&rlz=1T4VRHB_enUS623US624&q=Clinical+Trial+Informed+Consent+Definition&gs_l=hp.....0.0.0.7596.....0.OKAS8cKvMU4#q=IDE+definition+FDA~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 5/00

SUBJECT: EMTALA: Emergency Medical Screening

REVISION DATE: 6/03; 1/06; 8/09; 02/11; 2/17

POLICY NUMBER: 8610-506

Administrative Policies & Procedures Committee Approval:	~~12/10~~ 02/17
Medical Executive Committee Approval:	~~01/11~~03/17
Professional Affairs Committee Approval:	~~02/11~~04/17
Board of Directors Approval:	02/11

A. **PURPOSE:**

1. To ensure compliance with the Federal requirements contained in the Emergency Medical Treatment and ~~Active~~ Labor Act (EMTALA). EMTALA waiver allows hospitals to direct or relocate individuals which would normally be prohibited under EMTALA of individuals with unstable emergency medical conditions if necessitated by the circumstances of the declared emergency. CMS will provide notice of the waiver.

B. **DEFINITION(S):**

1. Individual who presents with an emergency medical condition: An individual who presents with an emergency medical condition anywhere on Tri-City Healthcare District (TCHD) campus, even if the individual presents at a location other than the Emergency Department (ED). TCHD's campus includes ambulatory services departments located on or adjacent to the campus, as well as the medical center parking lots, sidewalks, and access roads.
2. Emergency Medical Condition:
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of an individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; or
   b. With respect to a pregnant woman who is having contractions, there is adequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or her unborn child.
3. Medical Screening Exam (MSE): The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist. MSE requires an evaluation by a qualified medical provider, within the capability of the hospital's ED, to determine whether an emergency medical condition exists, or if the person is in labor. The MSE is a dynamic process and represents a spectrum ranging from a simple process involving only a brief history and physical, to a complex process that involves performing ancillary studies and procedures, depending on the patient's presenting symptoms.
4. Stabilization: Stabilization includes the provision of such medical treatment for the condition, necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or that the woman has delivered the child and placenta. Stabilization may include either stabilization for discharge or stabilization for transfer.
5. Triage: Determines the order in which patients will be seen.

C. **POLICY:**

1. Collection of financial information in the ED must be performed in accordance with this policy.

2. Hospitals may not delay in providing a medical screening examination (MSE) or necessary stabilizing treatment by inquiring about an individual's ability to pay for care. Individuals who have an emergency medical condition must be offered, and if desired, receive a MSE regardless of answers the individual may give to questions asked during the registration process. In addition, a hospital may not delay screening or treatment to an individual while information is verified. However, hospitals may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition. Reasonable registration processes may include requesting information about insurance as long as these procedures do not delay screening or treatment.
3. Each patient seeking treatment in the ED is entitled to an emergency MSE. When collecting financial information in the ED setting, the following guidelines must be followed:
   a. A MSE and necessary stabilization may not be refused by TCHD for any reason, even if a managed care plan refuses to authorize treatment or pay for services **the MSE must be completed despite ability to pay.**
   b. A MSE for an ED patient may not be delayed in order to:
      i. Inquire about an individual's ability to pay
      ii. Inform the patient that he/she must pay a co-pay or deductible if they choose to be treated
      iii. Perform insurance verification and authorization
      iv. Inform the patient that his/her care will be free or at a lower cost if another facility is used
   c. The MSE must be the same for all individuals presenting to the ED with the same condition, regardless of financial status or payment source. Triage does not qualify as an appropriate medical screening exam.
4. The registrar **or Triage RN** must refrain from making any comments that the patient might interpret to mean that services might not be provided based on ability to pay. For example, the registrar must not say, "We don't accept XYZ insurance here."
5. The registrar shall not request co-pays, deductibles, or past due balances from the patient until the MSE and necessary stabilization have occurred.
6. If a patient expresses the intent to leave the ED, the patient shall be encouraged to remain in the ED until the MSE and necessary stabilization are completed. If a patient leaves TCHD as a result of questions asked prior to receiving the MSE, it may be interpreted that the there was a suggestion that the patient leave the ED. **This must be well documented by the Triage RN.**
~~6.~~**7.** If a patient presents to the ED with a life-threatening emergent condition (i.e., patient arrives via ambulance in cardiac arrest) the MSE and necessary stabilization will begin immediately. The registrar may obtain the information identified in C.10 below from a source other than the patient (i.e., next of kin). Otherwise, financial information shall be obtained after the patient has received a MSE and necessary stabilizing treatment. Financial information may be discussed with the patient only after stabilization.
~~7.~~**8.** In case of an emergent situation or active labor identified after the MSE, stabilization and treatment will begin immediately. The registrar may obtain the information identified in C.10 below, as well as insurance verification and authorization, provided that the necessary stabilization and treatment are not delayed. When the physician determines that an emergency medical condition no longer exists, the patient may;
   a. Accept treatment and financial liability.
~~8.~~**9.** If the MSE determines that the patient does not have an emergency medical condition, or the patient is not in active labor, the patient shall be informed of his/her treatment options. The registrar may obtain the information identified in C.10 below, as well as insurance verification and authorization. After the MSE is completed, and once the physician has made the determination that an emergency medical condition does not exist, the patient may be informed of his/her potential financial liability. The patient may;
   a. Accept treatment and financial liability.
   b. Refuse additional treatment. If treatment is refused, the physician may refer the patient to another facility.

~~9.~~**10.** The registration process may be initiated as long as the process does not cause a delay in the provision of a MSE and necessary stabilization for an emergency medical condition. Basic identifying information may be gathered and entered into Affinity to allow for processing of tests in the order entry system. Basic information obtained may include:

a. Patient's full name
b. Patient's date of birth
c. Social Security number
d. Family physician
e. Insurance plan information, if applicable

~~10.~~**11.** If patient's information is already present in Affinity, the registrar will verify the existing information.

~~11.~~**12.** An Advance Beneficiary Notification Notice (ABN) shall not be obtained when rendering emergency medical treatment.

~~12.~~**13.** Signage indicating payment is due at time of service, or indicating that the patient's insurance may not pay for the service may not be placed in the ED lobby or treatment area.

~~13.~~**14.** Registration/ patient access management personnel must educate all registration staff responsible for registering, billing, and maintaining patient records.

~~14.~~**15.** The Registration supervisor shall observe registrars at regular intervals during the orientation period and at least annually thereafter to ensure compliance with this policy. Deviations from the policy will result in corrective action.

D. **REFERENCES:**

1. Social Security Act, Section 1867, 42 U.S.C. 1395dd, Examination and Treatment for Emergency Conditions and Women in Labor.
2. Social Security Act, Section 1867, 42 U.S.C. 1395cc, Emergency Medical Treatment and Active Labor Act.
3. Federal Register 489.24, Special Responsibilities of Medicare Hospitals in Emergency Cases.
4. Federal Register 489.53, Terms of Provider Agreements, Acceptance of Program Beneficiaries.
5. Current California Hospital Association (CHA) Consent Manual – Chapter: Patient Transfer, Discharge, or Temporary Absence
6. EMTALA Answer Book 2016, Author Mark M. Moy

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: ACLS FEE WAIVER

ISSUE DATE: 07/13
REVISION DATE(S):

Department Approval Date(s):	**~~12/16~~02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**07/13**

A. **PURPOSE:**

1. To establish a policy wherein Acute Care Services **Registered Nurses** (RNs) may receive a fee waiver to take the Advanced Cardiac Life Support **(ACLS)** course ~~(hereinafter referred to as ACLS)~~ at Tri-City ~~Medical Center~~**Healthcare District** (~~hereinafter referred to as TCMC~~**TCHD**), when it is not a requirement for their current position. The $50.00 refundable deposit for the ACLS course shall remain in effect.

B. **POLICY:**

1. ACLS is not a requirement for RNs working on 1 North and 2 Pavilion. However, RNs from those departments may receive a fee waiver to take the ACLS Provider Course offered at ~~TCMC~~**TCHD**, subject to approval by their Manager or Assistant Nurse Manager, under the following condition:
   a. After taking the ACLS Provider course and receiving the ACLS Provider card from ~~TCMC~~**TCHD**, RNs will be expected to float to Telemetry, 4Pavilion, and ~~Forensics~~ **Progressive Care Unit** in rotation with the rest of the ACS staff with ACLS Provider certification.

C. **PROCEDURE:**

1. Obtain the ACLS Fee Waiver Form from the Education Department
2. Sign the ACLS Fee Waiver Form.
3. Obtain Manager's or Assistant Nurse Manager's signature on the Form.
4. Turn in the Form to Education when enrolling in the ACLS Course.

D. **FORM(S):**

1. ACLS Fee Waiver

~~E. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

ACLS Fee Waiver Form for ACS RNs (1N/2P)

Instructions: This completed and signed form is to be presented to the Education Department prior to enrolling in the ACLS course. If the form is not presented, a payment must be received in order to enroll in this course. The $50 refundable deposit still applies.

ACLS certification is required for RNs working on 4P. This is not a requirement for other ACS RNs. RNs from 1N and 2P who want to attend the ACLS course must pay for the course, unless a fee waiver form is completed and signed by Management.

The fees for this course will be waived upon successful completion of the ACLS course. Upon completion, there will be the expectation that you will orient and float to Telemetry, 4Pavilion, and Forensics in rotation with the rest of ACS staff with an ACLS provider certification.

ACLS 2 Day Full Provider Course:
Date Classes Scheduled: _____ / _____

I acknowledge and accept the above requirements for Fee Waiver:

_____

Employee Name (Please Print) / Employee ID / Employee signature

_____

Manager or Assistant Nurse Manager Name (Please Print) / Signature

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA: RECIPROCITY STATEMENT

ISSUE DATE: 06/07
REVISION DATE(S): 03/10, 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. **American Heart Association** (AHA) Training Center (TC) Reciprocity Statement
   a. AHA Provider reciprocity is recognized nationally. A current Provider card is valid anywhere in the **United~~.~~ States~~.~~ America**.
   b. Instructor Reciprocity is recognized nationally.
      i. Instructors must align with a ~~Training Center (~~TC~~)~~ in their region.
      ii. An instructor may teach for more than one Training Center but may only align with one primary TC per discipline.
   c. When an instructor moves to another area, he or she must ask the primary TC to transfer records to the new primary TC. The new primary TC must monitor the performance of the Instructor and may impose additional requirements before they can be placed on active status.
      i. TCs are not obligated to accept all instructors who apply for alignment.
   d. **Tri-City Healthcare District (~~TCMC~~ TCHD)** TC will not issue a new Instructor card until satisfactory monitoring of approved course is documented.
   e. Training Center Faculty (TCF) between Training centers in not recognized at the TCF level.
      i. A TCF member who transfers to another TC will need to work within the new TC to establish TCF status.
   f. Regional Faculty Reciprocity- Reciprocity between regions in not recognized at the Regional Faculty level. A Regional Faculty member who moves to another region should contact the Regional **Emergency Cardiovascular Care** (ECC) office in the new Region for specific information.

~~B. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: **AHA: ROLE OF THE TCMC AMERICAN HEART ASSOCIATION (AHA) TRAINING CENTER (TC)**

ISSUE DATE: 07/05
REVISION DATE(S): 05/07, 03/10, 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. The role of the ~~TCMC~~ **Tri-City Healthcare District (TCHD)** American Heart Association (AHA) Training Center (TC) is to provide Basic Life Support (BLS), Advance Cardiac Life Support (ACLS), and Pediatric Advance Life Support (PALS) educational courses and strengthen the AHA Chain of Survival. The TC is responsible for the proper administration and quality of Emergency Cardiovascular Care (ECC) courses as well as the day-to-day management of its local Training Network. The Training Center is considered the principal informational resource, support, and quality control for all AHA ECC Instructors.
2. The TC local Network may be comprised of some or all of the following AHA Job roles:
   a. Regional Faculty is the quality assurance and educational section of the ECC program. These are ACLS, BLS, and PALS instructors appointed as Regional Faculty **(RF)** by the Regional ECC Committee because of the exemplary service. ~~Regional Faculty~~**RF** members are assigned to their TC to serve as outside resource experts on ECC-related issues and to conduct site visits (i.e. Course monitoring and administrative functions). A ~~Regional Faculty~~**RF** member cannot conduct a course monitoring or administrative site visit for their primary TC. RF cannot receive payment for RF activities
   b. Training Center Coordinator (TCC) is a representative of the TC and the primary contact for the AHA. The TC is responsible for selecting the TCC. It is understood that the AHA expects the TCC to have the appropriate skill to either perform or manage all TC responsibilities as describe in the (See Position Description for Training Center Coordinator Attachment A)
   c. Training Center Faculty (TCF), at least one per each discipline the TC teaches. The number of TCF members will be determined by the TC needs based on the number of courses provided. (See Position Description for Training Center Faculty Attachment B).
   d. ACLS/PALS Lead Instructors are responsible for working with the Course Director and staff of the sponsoring institution to ensure quality and to oversee the actual operation of the AHA courses offered by the TC. The Lead Instructor must be present throughout the course to answer questions and resolve logistical problems. (See Position Description for Lead Instructor Attachment C).
   e. Course Instructor is an individual who has received Provider and Instructor training in a specific discipline through the AHA, has been monitored, received an instructor card, and is qualified to teach a Provider Courses to other individuals in this discipline. Before the Instructor can operate as an instructor, they must align with a contracted AHA TC. Any Instructor who is not aligned with an AHA TC is not authorized to act as an AHA Instructor.
3. Operational Responsibilities of the ~~Training Center (~~TC~~)~~ are as follows:

a. Perform all duties in a manner consistent with the AHA mission and guidelines as outlined in the "Emergency Cardiac Care Program Administrative Manual (PAM).
b. Maintains a current signed Agreement with the Regional ECC Office that states the TC will teach all AHA courses in accordance with the AHA science, curriculum, policies, and procedures.
c. Secure and/or maintain general liability insurance in the amount of $1,000,000.00 throughout the term of its Agreement with the AHA ECC.
d. Maintain AHA agreements with Training sites and Instructors. (See Attachment D).
e. Use the most current AHA ECC training materials in all courses and ensure that course participants have the most current course textbooks for use *before, during, and after the course*.
f. Make available to all course Instructors current videos, Instructor toolkits, posters, manikins, and other equipment such as step stools and knee pads to accommodate any participant with physical limitations for use in each course.
g. Assists Instructors develop courses, obtain equipment, and contact assisting Instructors for courses.
h. Maintain complete and accurate Instructors records and contact lists.
i. Provide Instructors with copies of all ECC Training Bulletins and written updates within the time frame outlined in the information accompanying the Training Bulletin/update. (Website access is acceptable.)
j. Transfer Instructor records to other TCs within 30 days of receiving a record transfer request form.
k. Provide at *least one* Training Center Faculty (TCF) per discipline taught through the TC. (Attachment B).
l. Provide adequate administrative capability and space to support the Training Network which includes but not limited to the issuance of cards, maintenance of class rosters, tests, skills check offs and course evaluations, submission of training reports, maintenance of instructor files, etc. (see policy on AHA TC Record Maintenance)
m. Issue the appropriate Provider and Instructor Course completion cards within 30 days of successful completion of AHA ECC courses.
n. Accept all responsibility for the administration, management, and quality assurance, including dispute resolution, for the portion of the ECC Training Network it establishers (e.g.. Training Sites, independent Instructors, etc.).
o. Writes, reviews and revises administrative policies and procedures that address quality assurance, including dispute resolution, card maintenance and issuance, equipment maintenance/decontamination, Training Site management/relations, and management of Instructor communications and updates. These standards must be consistent with current AHA recommendations and guidelines.
p. Strive to expand the AHA ECC training program through number of Instructors as well as course offered in the community.
q. Offer classes to the community through Instructors or directly.
r. Support the Chain of Survival initiatives in its community by maintaining an adequate number of Instructors to meet core requirements.
s. Accept non-employee Instructors and/or Training Sites in its Training Network to help support number 12.
t. Conduct adequate and timely courses/meetings for Instructors and Training Sites to keep them up on any new or updated information about National, Regional, or TC policies, procedures, course content, or course administration that could potentially affect an Instructor in carrying out his/her responsibilities.
u. Monitor and evaluate new (initial) and existing (ongoing) Instructors and Training Sites on a regular basis to assure they perform within all AHA ECC guidelines.

B. **FORM(S):**

1. AHA Position Descriptions of Training Center Coordinator
2. AHA Position Descriptions of Training Center Faculty

3. AHA Position Descriptions of ACLS PALS Lead Instructor
4. AHA Instructor Agreement with TCMC Training Center
5. AHA Lead Instructor Responsibilities
6. AHA Training Center Faculty (TCF) Candidate Application
7. AHA Training Center Course Monitoring Review
8. AHA TCMC Training Center – Fee List
9. AHA Program Administration Manual

~~A. **APPROVAL PROCESS**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA TRAINING CENTER: COURSE CONTENT REQUIREMENTS

ISSUE DATE: 07/05
REVISION DATE(S): 05/07, 03/10; 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. Any **American Heart Association** (AHA) courses will be taught in the manner that upholds the most current AHA core curriculum and guidelines.
2. For each course full or renewal, each student must have access to the current provider manual appropriate for the course before, during and after the course. Textbooks are designed for individual use and are an integral part of the student's learning process. Each student must have access to a computer to complete the online pretest for **Advanced Cardiac Life Support** (ACLS) and **Pediatric Advanced Life Support** (PALS).
3. Instructors must use the most current edition of AHA course materials in all courses.
4. The course Instructor(s) must be a current AHA-recognized Instructor in good standing with their **Training Center** (TC) and the AHA Network.
5. Specialty Faculty (e.g., an anesthesiologist who teach airway) with expertise in a particular content area with prior approval of the course Director or Training Center Coordinator (TCC) may assist AHA Instructors in advanced life support courses (ACLS, **Advanced Cardiac Life Support for Experienced Providers** [ACLS EP], and PALS). Specialty staff may not make up more then 50% of the total Instructors for any Advance life support course.
6. Course Director and/or Lead Instructor is responsible for monitoring the Specialty Faculty.
7. A course evaluation form must be used in all courses to solicit feedback from students on course content and Instructors. The Instructor may use the AHA Course Evaluation Form or prepare its own form containing the same information. Each form must indicate a mechanism for the student to send the form to the Regional **Emergency Cardiovascular Care** (ECC) office.
8. Smoking is prohibited in classrooms and training facilities during all AHA ECC trainings programs.
9. ~~TCMC~~ **Tri-City Healthcare District (TCHD)** TCs offers CE credits for AHA course using ~~TCMC~~ **TCHD** Education provider number as follows:
   a. Full ACLS ~~&~~ **and** PALS course (two days) 12.0 CE
   b. One day ACLS ~~&~~ **and** PALS renewal course 6 CE
   c. Instructor courses 8 CEs
   d. No CEs are awarded for BLS Provider Course
   e. NO CE's are awarded by ~~TCMC~~ **(TCHD)** for online ACLS ~~&~~ **and** PALS courses. The AHA awards CE.
10. Course Equipment should be used according to the course instructor manual for each discipline.
11. All equipment used in an AHA course must be clean, proper working order and good repair.
12. Each AHA course must have a Course Director and/or Lead Instructor; either or both must be physically present on-site throughout the course. The Course Director and/or Lead Instructor are responsible for course logistics and quality assurance.
13. All Course curriculum and objectives must meet with the current guidelines in the course Instructor's manual or the AHA website, http://www.americanheart.org/.

14. Course length and format maybe varied to meet the experience and learning needs of the students as long as all core content and minimum evaluation time requirements outlined in the Instructor manual are meet.
15. All courses should be interactive learning and evaluation. Each student will be offered the opportunity to practice his or her skills under the supervision of an Instructor who will provide ongoing feedback of competency.
16. Student-to-Instructor and Student-to-manikin rations as outlined in the course discipline Instructor's manual will be maintained at all times.
17. Only the most current version of the AHA written exam will be used in any AHA course. These exams are to be given in a traditional instructor-led course, and the exam is to be taken in a proctored setting. Failure to follow these standards of the written testing process may jeopardize the ~~TCMC~~ **TCHD** Training Center (TC) and faculty in their Agreement with the AHA.
18. Students must score 84% or higher on Provider Course written exam for course completion. If a student scores less then 84% they must be given time to study the material and then retake another version of the test.
19. AHA developed computer-based course, testing maybe used in place of the video, Q&A, updates, and written test, but manikin skills check off must still be completed in the presence of an AHA recognized Instructor with the prior consent of the **Training Center Coordinator (**TCC**)**.
20. Each student will be evaluated for his or her didactic knowledge and proficiency in all core skill of the particular course. ACLS and PALS students are expected to be proficient in BLS HCP skills.
21. Successful course completion is achieved when a student meets the course cognitive and skills demonstration required as descried in the Instructor's manual or on the website. It is the responsibility of the Course Director/Lead Instructor to oversee this process and assure that the quality of the core objectives is maintained.
22. AHA clearly states the following regarding course *completion "in no way warrants performance, guarantees future actions, qualifies or authorizes a person to perform any procedures, and is unrelated to licensure."*
23. The goal of an AHA course is to prepare a student to deliver effective resuscitation. If a student does not meet the course objectives, remediation in the deficient areas will be provided during, and if needed after the course.
24. Remediation may be accomplished by monitoring and mentoring the student to identify and resolve weaknesses, requesting additional skills practice, assigning additional reading, referring the student to other course, or having the student retake the examination or assessment stations to the satisfaction of the Course Director.
25. If remediation is unsuccessful, the Course Director may require the student to repeat entire course or refer the student to a different course (a recert candidate may be referred to a repeat a full provider course).
26. AHA renewal interval for all AHA courses is two years.
27. Providers entering a renewal course must show a current provider card as entrance into a renewal course.
28. The Course Director is responsible for allowing a student to proceed in an initial or renewal course if he/she does not have a current Provider card.
29. Students who present an expired Provider card or do not possess an AHA Provider card may challenge a renewal course but will not be given the option of remediation. They will need to repeat the entire Provider Course if they cannot successfully meet the course completion requirements when evaluated.

B. **EXTERNAL LINK(S):**
   1. http://www.americanheart.org/

C. **REFERENCES ~~LIST~~:**
   1. Chapter 7 in of the AHA PAM and AHA Instructor Manuals

~~D. APPROVAL PROCESS~~
~~1. Clinical Policies & Procedures Committee~~

~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: **AHA TRAINING CENTER: DISPUTE RESOLUTION/DISCIPLINARY ACTION**

ISSUE DATE: 07/05
REVISION DATE(S): 06/07, 03/10, 04/13

Department Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**07/13**

A. **POLICY:**

1. All disputes, complaints, or allegations within the ~~TCMC~~ **Tri-City Healthcare District (TCHD)** Training Network are to be handled in a clear, respectful, impartial and organized fashion, consistent with the ethics, values, policies and procedures of ~~TCMC~~ **TCHD** and AHA. Each dispute or complaint will be resolved at the lowest level of the Network.
2. It is the responsibility of ~~TCMC~~ **TCHD Training Center (**TC**)** to manage all aspects for any disputes, complaints, or problems that arise from a course offered by an Instructor employed by or aligned with the TCMC TC.
3. Complaints regarding the issues outlined in section C may be submitted to TCMC TC in writing by:
   a. A student who attended the course in which the problem arose
   b. An Instructor, Course Director, TC Faculty member, or TC with information about the problem.
   c. An AHA volunteer or staff member with information about the problem.
4. ~~TCMC~~ **TCHD** TC will respond back to the individual(s) involved in the dispute, complaint, or problem in question within 5 Business days after receipt of the concern in writing. At this time an action plan or steps of further investigation will be discussed.
5. ~~TCMC~~ **TCHD** TC investigation will involve all individuals felt to have first hand knowledge of the occurrence. All measures will be handled with respect and confidentiality manner to the extent that is appropriate for process of resolution.
6. If a dispute, complaint or problem involves a ~~TCMC~~ **TCHD** employee's performance, ~~TCMC~~ **TCMHD** HR or employee's Clinical Manager will be included in the investigative process as appropriate per TCMC AP 427.
7. If after 30 days of diligent efforts ~~TCMC~~ **TCHD** TC is unable to resolve any problems involving the following the TC must turn the dispute, complaint, or problem over to the AHA:
   a. Course content/curriculum
   b. Instructor qualifications
   c. AHA administrative policies and procedures
   d. AHA **Emergency Cardiovascular Care (**ECC**)** science issues
   e. AHA Training Center agreement and program guidelines
8. ~~TCMC~~ **TCHD** will send a detailed description of the dispute/complaint in writing to the Regional ECC Office (. This written description will include all of the following:
   a. The name and address of the person making the complaint ("complainant"). The AHA will not permit the individual(s) making the complaint to remain anonymous.
   b. The name and address of the person and/or organization against which the complaint is made ("Respondent").

c. A detailed written description of the dispute, complaint, or problem (i.e., who, what, when, where, and why). For TC-related issues, the complaint should contain information on the attempts of the TC to resolve the matter. The TC coordinator must sign the statement.
d. Reference to the appropriate rule, standard, and/or guidelines related to the matter.
e. Copies of all related correspondence, records and other documentation.
f. Within 10 business days after receipt of notification of the dispute, AHA ECC Committee will issue a written notice to the TC, Complainant, and Respondent that the matter has been referred to the AHA for review.
g. Respondent will be invited to provide a response to the complaint in writing to the Review Committee within 30 days by registered or certified mail receipt of notice.
h. Once the response is received in writing the AHA Review Committee will review and provide in writing their decision and recommendation to the TC within 60 days as described in PAM on page 66.

B. **REFERENCES ~~LIST~~:**
1. AHA PAM 2012 Chapter 9

~~C. **APPROVAL PROCESS**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE:	**09/09**	**SUBJECT:**	**Conflict of Interest Policy for Medical Staff**
REVISION DATE(S): 09/09		**POLICY NUMBER:**	**8710-555**

Department Approval Dates(s):	**03/17**
Medical Staff Department Approval Date(s):	**09/09**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~09/09~~03/17**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**09/09**

A. **PURPOSE:**

1. To safeguard the integrity and reputation of ~~Tri-City Medical Center~~**Tri-City Healthcare District (TCHD)** and their medical staffs by fostering the proper and unbiased conduct of all medical staff activities.
2. To encourage unbiased, responsible management and decision-making.

B. **DEFINITIONS**

1. Conflict of Interest: a divergence between an individual's private interests and his/her professional obligations to the medical staff, hospital, patients, and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise.
2. Immediate family: Spouse, children, parents, siblings, or equivalents by marriage, or others residing in the physician's household.
3. This policy serves to:
   a. Describe situations that are prohibited.
   b. Educate medical staff members about situations that generate conflicts of interest.
   c. Provide means for the medical staff and the Hospital to disclose and manage conflicts of interest.
   d. Promote the best interests of patients, their families, employees, and other practitioners.

C. **POLICY:**

1. Medical Staff members shall conduct their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts of interest arise. The following are representative, but not inclusive, of conflict of interest situations:
   a. Influence on purchases of equipment, instruments, materials, or services for ~~TCMC~~ **TCHD** from the private firms in which the medical staff member, or an immediate family member, has a financial interest.
   b. Unauthorized disclosures of patient or Hospital's information for personal gain.
   c. Provide, offer, or promise anything of value, as a representative of ~~TCMC~~ **TCHD** to any government official to enhance relations with that official or the government.
   d. Transmit to a private firm or other use for personal gain of ~~TCMC~~ **TCHD** supported work, products, results, materials, record, or information that are not generally made available.
   e. Influence upon the negotiation of contracts between ~~TCMC~~ **TCHD** and private organizations with which the medical staff member, or immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.
   f. Improper use of institutional resources for personal financial gain.

g. Accept compensation or free services from a vendor, service provider, or contractor of ~~TCMC~~**TCHD**, when the medical staff is in a position to determine or influence ~~TCMC's~~ **TCHD's** purchases from those persons.

2. All members of the Medical Staff shall complete a general disclosure statement upon appointment and reappointment.
3. Candidates for Medical Staff elected offices must submit a Conflict of Interest statement.
4. Whenever a medical staff member is in a situation where he/she may have a potential conflict of interest, he/she shall make a full disclosure in writing to the Chief of Staff with details of the situation to request an exception.
   a. For any conflict of interest disclosed, the Chief of Staff shall evaluate and determine how the conflict of interest may be managed or avoided.
   b. Confirmed conflict of interest may be disclosed to the Medical Executive Committee by the Chief of Staff.
5. Suspected violations of this policy shall be reported to and evaluated by the Chief of Staff. Reports are confidential and shall remain anonymous.
6. Disciplinary action, if indicated, shall be taken in accordance with the Medical Staff Bylaws.
7. A confirmed conflict of interest shall result in one or more of the following:
   a. Disclosure of the conflict of interest to the Medical Executive Committee;
   b. Abstention from voting on the matter to which the conflict relates;
   c. Recusal from the decision-making process and participation in, including the receipt of information related to the matter to which the conflict relates.

D. **REFERENCES:**

1. Joint Commission Standards~~, Leadership 02.02.01 and Leadership 04.02.01~~ **2017**
2. Conflict of Interest Guidelines for Organized Medical Staffs. American Medical Association.

~~**Approvals:**~~
~~**Medical Department Approval: 09/09**~~
~~**Medical Executive Committee Approval: 09/09**~~
~~**Board of Directors Approval: 09/09**~~

Tri-City Medical Center

Conflict of Interest Form

Practitioner Name:_____ **Date:**_____
Print

Do you have any relationships that may be considered as potential conflict of interest which may include, but may not be limited to, other care providers, educational institutions, manufacturers, and payers? (See Medical Staff Policy, *Conflict of Interest Policy for Medical Staff, 8710-555*)

Yes _____ **No**_____

If you answered "YES," please disclose them in the space provided below.

_____

_____

Practitioner Signature

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 11/10	**SUBJECT:** Conflict Resolution Medical Staff
REVISION DATE(S): 11/10	**POLICY NUMBER:** 8710 – 562
Department Approval Dates(s):	03/17
Medical Staff Committee Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~09/10~~03/17
Professional Affairs Committee Approval Date(s):	~~10/10~~04/17
Board of Directors Approval Date(s):	11/10

A. **PURPOSE:**

1. The Medical Staff, ~~Tri-City Medical Center~~**Healthcare District (TCHD) hospital management**, and the District Board, will each use their best efforts to address and resolve all conflicts between the Board, Medical Center, and the Medical Staff in the best interests of patients, the Medical Staff, ~~Tri-City Medical Center~~**TCHD**, and the District Board.

B. **POLICY:**

1. Prior to the District Board taking any action contrary to a recommendation made by the Medical Executive Committee ("MEC") relating to patient safety or quality, the Chair of District Board, or a designee and management shall meet with representatives of the MEC, including the Chief of the Medical Staff, and seek to resolve the conflict through informal discussions.
2. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the District Board may request ~~a formal conflict resolution process.~~**the issue be addressed by the Joint Conference Committee. If a resolution is agreed upon in the Joint Conference Committee, the resolution will be forwarded to the MEC for approval.**

~~2.~~**3. If after consideration at the Joint Conference Committee the conflict is still unresolvable, then the Chief of Staff and the Chairman of the District Board or the Chief Executive Officer may request a formal conflict resolution process.**

C. **PROCEDURE:**

1. The formal conflict resolution process will begin with a meeting of an Ad Hoc Committee within 30 days of the initiation of the formal conflict resolution process. The Ad Hoc Committee will be composed of:
   a. The Chief of Staff, past Chief of Staff, and at the discretion of the Chief of Staff either the Medical Staff Professional Behavioral Chair or the Chair for Quality Assurance/Performance improvement/Patient Safety
   b. The Chair, Secretary, and Vice Chair of the District Board
   c. The Chief Executive Officer or his/her designee
2. If the Committee cannot produce a resolution to the conflict that is acceptable to the MEC and the Board within 30 days of the initial meeting, the MEC and the District Board shall enter into Mediation as that term is defined by California Evidence Code Section 1115. The MEC and the District Board shall together select the third-party mediator. The MEC and the District Board shall use their best efforts to collaborate with the third-party mediator to resolve the conflict. The District Board Chair and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such a meeting shall be subject to the approval of the MEC and the District Board. The Mediation proceedings shall be confidential pursuant to Evidence Code Section 1119.
   a. If, after 90 days from the date of the initial request for Mediation the MEC and the District

Board cannot resolve the conflict in a manner agreeable to all parties, the District board shall have the authority to act on the issue that gave rise to the conflict in a manner consistent with the Medical Staff Bylaws and California law.

b. With respect to membership, privileges and peer review matters governed by Articles IV, V, VI and VII of the Medical Staff By-laws, this Conflict Resolution Policy shall not be utilized until the procedures set out in the By-laws have been exhausted. This Policy shall also be used for the meet and confer requirements of California Business & Professions Code Section 2282.5.

c. If the Board determines, in its reasonable discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of ~~Tri-City Medical Center~~**TCHD**, the District Board may take action subject to subsequent review, and any necessary revision, through the conflict resolution process described above.

~~d. In addition to the formal conflict resolution process herein described, the Chair of the District Board or the Chief of Staff may call for a meeting of the Professional Affairs Committee at any time and for any reason to seek direct input from the Professional Affairs Committee, clarify any issue, or relay information directly to the MEC, the District Board, or management.~~

D. **REFERENCES:**

1. Joint Commission Standards ~~2010 MS.01.10.01~~**2017**
2. ~~Joint Commission Standards 2010 LD.02.04.01~~

~~**Approvals:**~~

~~**Medical Executive Committee: 09/10**~~
~~**Professional Affairs Committee Approval: 10/10**~~
~~**Board of Directors Approval: 11/10**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07

SUBJECT: Credentialing Criteria, Chronic Non Healing Wound Care

REVISION DATE(S): 03/07; 03/10; 07/11; 07/12

POLICY NUMBER: 8710 – 523

Department Approval Dates(s):	03/17
Credentials Committee Approval Date(s):	~~07/12~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~07/12~~03/17
Professional Affairs Committee Approval Date(s):	04/17
Board of Directors Approval Date(s):	07/12

A. **PURPOSE:**

1. The following sites have been designated as locations with adequate resources to allow the performance of the designated privileges:
   a. 161 Thunder Drive, Suite 112, Vista, California
   b. 6260 El Camino Real, Carlsbad California
   c. 4002 Vista Way, Oceanside, California

B. **POLICY:**

1. Physicians/~~physician assistants~~**Allied Health Professionals**/podiatrists who request wound care privileges **must work within their scope of practice (*Podiatrists scope of practice means foot and ankle only) and** shall demonstrate the ability to care for chronic non-healing wounds, including but not limited to: pressure, diabetic, venous, arterial, collagen vascular, autoimmune, and oncologic, and provide assessment and evaluations for patients with chronic non-healing wounds inclusive of:
   a. Routine review of patient record and recent labs
   b. Physical examination of all patient's bony prominences for evidence of excessive pressure or skin breakdown
   c. Determination of the number of observed chronic non-healing wounds and definition of their acuity
   d. Evaluation and management of any medical problems that would prevent wound healing
   e. Development of a treatment plan that facilitates wound healing
2. Physicians/~~physician assistants~~**Allied health Professionals**/podiatrists shall be knowledgeable and capable of managing:
   a. Wound colonization and infection
   b. Appropriate antibiotics usage
   c. Prescription of needed support surfaces
   d. Advisement on off-loading techniques
   e. Enzymatic, mechanical and sharp debridement
   f. Wound biopsy techniques
   g. Pain management
   h. Indications for the use of adjunctive chronic wound care therapy such as, but not limited to: Vacuum Assisted Closure Devices, Collagen Matrix Implants, Platelet Derived Growth Factor, Oxidized Regenerated Cellulose, Living Dressings, Selective Impedance Electrical Stimulation and other adjunctive therapy which may, from time to time, become available.
   i. Referrals - demonstrate proficiency in knowing when and to whom to refer a patient requiring specialized care outside of his/her area of expertise.

C. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following: Orthopedic Surgery, General Surgery, Vascular Surgery, Plastic Surgery or possess Board Certification in Podiatric Medicine.
   b. Non-Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Interventional Cardiology, Interventional Radiology, a fellowship in a field that includes the care of wounds, or completion of applicable course work within specified time frame.
   c. ~~Physician Assistant~~**Allied Health Professionals**: The applicant must be licensed by the Physician Assistant **Board of California** ~~Committee of the Medical Board of California~~ and have completed hands-on training that includes the care of wounds or completion of applicable course work within specified time frame.
2. Proctoring Criteria:
   a. Non-Surgeon: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at ~~TCMC~~ **Tri-City Healthcare District (TCHD)** or at another Joint Commission-approved facility.
   b. **Allied Health Professionals**~~Physician Assistant~~: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at ~~TCMC~~ **TCHD** or at another Joint Commission-approved facility.
   c. Surgeon: Does not require proctoring.
3. Reappointment Criteria:
   a. Twenty (20) documented procedures of chronic wound care per two-year reappointment cycle.
   b. Physician/**Allied Health Professionals**~~Physician assistant -~~ specific quality data outcomes for reappointment time frame as defined by the Chronic Wound Care Program. If a physician's wound healing outcomes, healing rates and debridement rates fall below the 65th percentile success rating, his/her reappointment shall then be based on a thorough review of his or her performance by physician(s) who hold unsupervised wound care privileges and compliance with any and all recommendations arising from that review.

~~**Approvals:**~~
~~**Credentials Committee Approval: 07/12**~~
~~**Medical Executive Committee Approval: 07/12**~~
~~**Board of Directors Approval: 03/07; 03/10; 07/11; 07/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/07

SUBJECT: Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy

REVISION DATE(S): 03/07, 03/11, 01/12, 07/12, 12/13

POLICY NUMBER: 8710 – 523A

Department Approval Dates(s):	03/17
Credentials Committee Approval Date(s):	~~11/13~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~11/13~~03/17
Professional Affairs Committee Approval Date(s):	04/17
Board of Directors Approval Date(s):	12/13

A. **PURPOSE:**

1. The following sites have been designated as outpatient chronic non-healing wound care centers ("WCCs") with adequate resources to allow the performance of the designated privileges:
   a. 161 Thunder Drive, Suite 112, Vista, California
   b. 6260 El Camino Real, Carlsbad, California
2. The following criteria shall be used in credentialing physicians who request privileges for Hyperbaric Medicine Oxygen Therapy in the WCCs.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. M.D., D.O., or DPM
   b. The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Orthopedic Surgery, Interventional Cardiology, Interventional Radiology, General Surgery, Vascular Surgery, Plastic Surgery, or hold a license to practice Podiatric Medicine.
   c. The applicant must have malpractice insurance that includes coverage for hyperbaric medicine.
   d. In addition to the above, the applicant must have one of the following:
      i. Completion of a Residency or Fellowship Training in hyperbaric medicine.
      ii. Completion of a hyperbaric medicine Training course approved by the American College of Hyperbaric Medicine (ACHM) or the Undersea and Hyperbaric Medical Society (UHMS)
      iii. Certified by the American Board of Preventive Medicine or the American Board of Emergency Medicine, in the subspecialty of Undersea and Hyperbaric Medicine.
   e. If more than two years has elapsed since completion of training, documentation of a minimum of sixteen (16) hours of CME related to hyperbaric medicine must be submitted.
2. Proctoring Criteria:
   a. A TCMC physician with unsupervised privileges in hyperbaric medicine, or a physician who holds hyperbaric medicine privileges at another Joint Commission-approved facility will proctor the first five (5) hyperbaric medicine therapy consults for practitioners with newly approved hyperbaric medicine privileges.
3. Reappointment Requirements:
   a. A minimum of sixteen (16) hours of CME related to hyperbaric medicine must be documented per two-year reappointment cycle. Half of this requirement can be met by reading hyperbaric literature, with the rest being fulfilled through attending meetings and

making presentations on hyperbarics.

b. Hyperbaric Medicine Oxygen Therapy: twelve (12) documented cases per two-year reappointment cycle.

c. Physician specific quality outcome data will be evaluated on an on-going basis as defined in Medical Staff Policy #8710-509.

~~**Approvals:**~~
~~**Credentials Committee Approval: 11/13**~~
~~**Medical Executive Committee Approval: 11/13**~~
~~**Board of Directors Approval: 03/07; 03/11; 01/12; 07/12; 12/13**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 06/08	**SUBJECT:** Credentialing Policy, Expedited Credentialing and Privileging Process
REVISION DATE(S): 06/08; 03/14	**POLICY NUMBER:** 8710 – 550

Department Approval Dates(s):	03/17
Credentials Committee Approval Date(s):	~~03/14~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~03/14~~03/17
Professional Affairs Committee Approval Date(s):	04/17
Board of Directors Approval Date(s):	03/14

A. **PURPOSE**:
1. An expedited Board of Directors approval process may be used for initial appointments, reappointments, and granting privileges when the Board of Directors is unable to meet and established criteria is met.
2. The ~~Professional Affairs Committee of the Board~~ **Chief Executive Officer (CEO) or Chief Board of Directors or Designee** shall be responsible for granting membership and privileges when the Chief of Staff or designee, Department Chair/Division Chief, Credentials Committee, and the Medical Executive Committee have recommended the applications for the expedited approval process.

B. **EXPEDITED PROCESS:**
1. Schedule for Initial Applications:
   a. All expedited initial applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Applications #8710-543.
2. Schedule for Reappointment Applications:
   a. All expedited reappointment applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Reappointments #8710-548.

C. **POLICY:**
1. The Medical Executive Committee will determine which applications meet the expedited criteria.
   a. An applicant for privileges is ineligible for the expedited process if any of the following has occurred:
      i. The applicant submitted an incomplete application.
      ii. The applicant reports an unacceptable health status.
      iii. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
      iv. There is a current challenge or previously successful challenge to licensure or registration.
      v. The applicant has received an involuntary termination of medical staff membership at another hospital.
      vi. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
      vii. The Medical Staff determines there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

2. Each credentialing application will be considered on a case-by-case basis.
3. The expedited application/reappointment reports will be forwarded the following month as an informational agenda item to the Board of Directors.

~~**Approvals:**~~
~~**Credentials Committee Approval: 03/14**~~
~~**Medical Executive Committee Approval: 03/14**~~
~~**Board of Directors Approval: 06/08; 03/14**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**02/07**	**SUBJECT:**	**Credentialing Policy, Processing Medical Staff Applications**
REVISION DATE(S):	**01/09; 04/09; 09/09; 06/10; 01/12; 01/13; 03/13**	**POLICY NUMBER:**	**8710-543**

Department Approval Dates(s):	**03/17**
Credentials Committee Approval Date(s):	**~~03/13~~03/17**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~03/13~~03/17**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**03/13**

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaw requirements.
   a. If the Medical Staff determines during the review process that more information is required to complete an applicant's application, the applicant shall be notified immediately to provide additional documentation and the application shall be deemed incomplete until such information is received and the Medical Staff considers the application complete.

B. **POLICY:**

1. Applications shall be processed in accordance with the timeframes set by the Medical Staff Bylaws to the extent possible.
2. Each individual medical staff member or applicant shall have a separate credentials file.
3. Telemedicine applicants shall be fully privileged and credentialed according to ~~TCMC~~ **Tri-City Healthcare District (TCHD)** Medical Staff policies, rules and regulations, and bylaws.
4. The applicant's ability to perform privileges requested shall be evaluated and documented in the applicant's credentials file.
   a. If there is a concern about the applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required to ascertain that the applicant can perform the requested privilege(s).
5. Requests for peer recommendations should address the following competencies:
   a. Medical/Clinical knowledge
   b. Technical and clinical skills
   c. Clinical judgment
   d. Interpersonal skills
   e. Communication skills
   f. Professionalism
   g. Ability to perform the requested privilege (e.g., physical and mental health status)
6. Requests for verification of internship, residency, fellowship, hospital affiliations and employment verification should address the following competencies:
   a. Patient care
   b. Medical/Clinical knowledge
   c. Practice-Based learning and improvement
   d. Interpersonal and communication skills

e. Professionalism
f. Systems-based practice

7. The following Joint Commission/CMS approved primary source verification sources shall be utilized:

Item Requiring Primary Source Verification	The Joint Commission/CMS Approved Verification Source
i. Medical education	AMA or AOA Physician Masterfile, ECFMG certificate for foreign medical schools, or directly from source.
ii. Postgraduate Training (Internship, residencies, fellowships)	AMA or AOA Physician Masterfile, or directly from source.
iii. Board Certification	ABMS or services designed by ABMS as an official display agent.
iv. Current Licensure	Directly from state licensing board. LVS system or the Osteopathic Medical Board of California for any 805 reports.
v. Sanctions against licensure	Directly from the state Medical Boards and/or National Practitioner Data Bank (NPDB).
vi. Peer Recommendation/Current Competence	Peer Reference forms that include the six areas of "General Competencies." Directly from the peer reference provided by the applicant.
vii. Medicare/Medicaid Sanctions	NPDB, AMA/OIG, and SAM (System for Award Management)
viii DEA Certificate	National Technical Information Service (NTIS) website query or the Drug Enforcement Agency verification website

8. The following additional queries shall be performed:
   a. Criminal background check via contracted agency
   b. NPDB (Claims history, OIG)
   c. Hospital Affiliations/Medical Staff Membership (past and present)
      i. Telemedicine applicants – If more than 10 affiliations/medical staff memberships, randomly select ten (10) entities to query. If necessary, more entities may be queried.
   d. Work History (within the past five (5) years)
9. The applicant shall explain all time gaps greater than thirty (30) days in writing.
   a. If clinical privileges are being requested and a time gap away from medicine is identified, the Credentialing Specialist shall collect as much information as possible to assist the Medical Staff in making a determination of competence.
   b. If the applicant identifies an entity that can be queried to verify the gap, the Credentialing Specialist shall attempt to contact that source.
   c. If a gap of a year or longer away from the applicant's practice is identified, the applicant must provide documentation of medical practice activity and/or CME within two (2) years of the application date to determine the applicant's competency.
10. The applicant shall explain in writing any convictions or guilty pleas to a criminal offense (felony or misdemeanor other than minor traffic violations).
    a. The applicant shall be referred to the Physician Well-Being Committee for evaluation in cases when the applicant's conduct or substance use is in question. His/her application will not be considered complete until an initial evaluation is completed and reported to the Credentialing Specialist.
11. The applicant's identity shall be verified using the "Positive ID" form in accordance with The Joint Commission Standard MS.06.01.03 (EP 5). Appropriate identification includes a valid state-issued identification card, driver's license, or a valid military ID. (This element shall be completed onsite by an authorized individual prior to final approval. Verification of the identity of telemedicine practitioners who will not be entering the facility may be performed by a Joint

Commission accredited organization, with verification provided by the organization.)

~~**Approvals:**~~
~~**Credentials Committee Approval: 03/13**~~
~~**Medical Executive Committee Approval: 03/13**~~
~~**Board of Directors Approval: 01/09; 04/09; 09/09; 06/10; 01/12; 01/13; 03/13**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/01	**SUBJECT:** Credentialing Standards for Catheter-Based Peripheral Vascular* Interventional Procedures
REVISION DATE(S): 09/07; 10/09	**POLICY NUMBER:** 8710-504

Department Approval Dates(s):	03/17
Medical Staff Division Approval Date(s):	~~10/09~~03/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~10/09~~03/17
Professional Affairs Committee Approval Date(s):	04/17
Board of Directors Approval Date(s):	10/09

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in catheter-based peripheral vascular interventional procedures.
   a. Catheter-based peripheral vascular interventional procedures include diagnostic angiography, balloon angioplasty, atherectomy, stent placement, and/or thrombolysis of the non-coronary native vasculature or grafts, either arterial or venous. (Refer to Appendix 1)
   b. Criteria for privileging and maintenance of privileges encompass four general areas:
      i. Didactic education in the diagnosis and treatment of patients with peripheral vascular disease;
      ii. Training in the technical aspects of the performance of peripheral vascular interventional procedures;
      iii. Proctoring;
      iv. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Body of Knowledge:
   a. The applicant must have completed an accredited residency program and possess board certification or board eligibility in general internal medicine, diagnostic radiology or general surgery.

   *Non-Cardiac

   b. The applicant must have additional fellowship training, board/CAQ eligibility or certification in interventional radiology, neuroradiology, peripheral vascular surgery or interventional cardiology. Individuals who completed their training prior to the establishment of fellowship programs in the above mentioned disciplines but who are engaged in the active practice of peripheral vascular interventions may be granted privileges established on the basis of guidelines described below with acceptable documentation of success and complication rates as defined in Appendix II and Appendix III.
   c. The applicant must be trained and licensed in fluoroscopy.
2. Basic Training
   a. Applicants for this privilege should have extensive training in the diagnosis and treatment of patients with peripheral vascular diseases to include anatomy, natural history, clinical manifestations, non-invasive assessment, indications and contraindications to catheter-based intervention, risks and benefits of catheter-based

intervention, alternative therapies and recognition and management of complications including catheter directed thrombolysis.

i. For individuals who have completed fellowship training in interventional radiology neuroradiology, or peripheral vascular surgery, ACGME accreditation of their fellowship and documentation of satisfactory completion of the fellowship will provide adequate documentation of this training.

ii. For individuals completing fellowship training in interventional cardiology, there must be both ACGME accreditation of the fellowship training, documentation of satisfactory completion of the fellowship and evidence that the fellowship includes formal didactic education in all aspects of peripheral vascular disease.

iii. For individuals who are practicing peripheral vascular surgery, interventional radiology or interventional cardiology but completed their training prior to the establishment of fellowship training program or inclusion of material on peripheral vascular in those fellowship training programs, documentation of 100 hours of CME approved credit directly pertaining to peripheral vascular disease or the equivalent of 20 days of such course instruction must be provided.

3. Specific Procedural Training and Experience:
   a. Applicants must be knowledgeable regarding appropriate use and options of x-ray imaging techniques for peripheral vascular applications.
   b. Individuals applying for this privilege must be able to document the performance and interpretation of the following:
      i. 100 Diagnostic peripheral arteriograms
      ii. 50 Peripheral arterial angioplasties
      iii. 10 Cases of peripheral stent placement
      iv. 10 Cases of catheter-directed peripheral thrombolysis
   c. The individual must be able to document that he/she was the primary operator (defined as the physician who physically performed the procedure and dictated the operative report) in the above listed procedures. For an individual trained in an approved fellowship, a standard procedural log indicating procedure, the individual's role in the procedure, outcome and complications, will be adequate documentation. For individuals whose training occurred outside of a fellowship setting, the above procedural log must be provided as well as copies of the dictated procedural reports.
4. Proctoring Criteria:
   a. Ten cases performed during the first six months after granting of the privilege(s) will be proctored. These cases should include two cases of peripheral arterial stent placement and two cases of catheter-directed peripheral thrombolysis. The proctor must be privileged for the specific procedure that he/she is proctoring.
5. Reappointment Criteria:
   a. Maintenance of peripheral vascular credentialing requires ongoing experience in performing these procedures with acceptable success and complication rates. In order to qualify for reappointment, the minimum number of cases to be performed in a two-year period for each procedure is:
      1) Peripheral transluminal angioplasty 25 cases
      2) Intravascular stent placement 10 cases
      3) Catheter-Directed Peripheral thrombolysis 10 cases
   b. Reappointment of privileges is also dependent on the active participation in the hospital's Quality Improvement program. The QI program will monitor indications, success rates and complications. The acceptable complication rates are outlined in Appendix II and Appendix III. Each physician QI data will be reviewed using the same criteria. If a physician's indications, success, and complication rates deviate from Appendix II or Appendix III, then these privileges may be revoked or not reappointed. It is recommended that any practitioner with this privilege maintain a database to record accurate information regarding numbers of procedures, indications and outcomes for quality assessment purposes.

C. **REFERENCES:**

1. White R.A. Training and Credentialing Requirements for Endovascular Procedures. Stanford Vascular Symposium: Frontiers in Vascular Disease 1999. (Abstract)
2. Levin DC, Becker GJ, Dorros G, et al. Training Standards for Physicians Performing Peripheral Angioplasty and other Percutaneous Peripheral Vascular Interventions – American Heart Association Medical/Scientific Statement Position Statement. Circulation. 1992;86(4):1348-1350.

~~**Approvals:**~~
~~**Medical Division Approval: 10/09**~~
~~**Medical Executive Committee Approval: 10/09**~~
~~**Board of Directors Approval: 09/07, 10/09**~~

[1] The criteria above are minimum criteria. Departments or Divisions performing these procedures may elect to require more stringent criteria.

APPENDIX I

For the purposes of these standards, a diagnostic angiogram is defined as the percutaneous passage of a catheter into an artery under fluoroscopic guidance with subsequent injection of contrast material and imaging of the entire vascular distribution in question using conventional serial film changers or large field digital imaging systems. For example, peripheral angiography of lower-extremity vessels must image the vessels of both lower extremities from the distal aorta to at least the ankles. Conventional cineradiography or video fluoroscopy alone is not sufficient for the routine recording of peripheral angiographic studies. Measurements of intra-arterial pressure gradients are a useful adjunct and may be necessary to fully assess the significance of vascular occlusive disease as well as the outcome of an interventional procedure.

Angioplasty is defined here as a percutaneous transluminal balloon dilation procedure or similar procedure using an atherectomy, stent or other interventional device. Such a procedure would generally involve percutaneous vascular access, transluminal passage of a balloon catheter or other interventional device and treatment at the appropriate sites. The angioplasty process includes angiographic and hemodynamic documentation of the result and appropriate clinical follow-up during the patient's hospitalization.

APPENDIX II

The following complications are the indicators of the safety of catheter-based diagnostic peripheral vascular procedures. If these threshold levels are exceeded, a QI review may be possible.

Puncture site complications:	
Hematoma (requiring transfusion, surgery or delayed discharge)	<3.0%
Occlusions	<0.5%
Psuedoaneurysm	<0.5%
Asteriovenous fistula	<0.1%
Contrast extravasation	<1.0%
Non-puncture site complications	
Distal emboli	<0.5%
Unintended dissection/occlusion of selected vessels	<2.0%
Neurologic complications (during carotid or cerebral angiography)	
All neurologic deficits	<4.0%
Permanent neurologic deficits	<1.0%
Contrast Reactions	
All idiosyncratic reactions	<3.0%
Major reactions (respiratory symptoms)	<0.5%
Contrast-related death	<0.01%
Non-idiosyncratic reactions (hypertension, nausea, vomiting, bradycardia)	<10.0%
Contrast-induced renal failure (increase in serum creatmine by 50% or by 1 mg/dl within 48 hours of the procedure resulting in an abnormal serum creatimine level)	
Transient	<10.0%
Permanent	<2.0%

REFERENCES:

1. Hessel SH, Adams DF, Abrams HL. Complications of angiography, Radiology 1981;138:273-281.
2. Abrams HL. The opague media: Psychologic effects and systematic reactions. In Abrams's Angiography: Vascular and interventional Radiology 3rd ed, Boston, Little & Brown 1983,15-39.
3. Sigstedt B, Lunderquist A. Complications of angiographic examinations. AJR 1978;130;455-460.
4. Shehadi WH, Tamolo G. Adverse reactions to contrast media. Radiology 1980;137:299-302.
5. Shehadi WH. Contrast media adverse reactions: occurrence, recurrence and distribution patterns. Radiology 1982;143:11-17.
6. Byrd L, Sherman RL. Radiocontrast-induced acute renal failure: a clinical and pathophysiologic review. Medicine 1979;58:270-279.
7. Earnest F. Forges G, Sandek BA, et al. Complications of cerebral angiography: Prospective assessment of risk. AJNR 1983;4:247-253.
8. Gomes AS, Baker JD, Martin-Paredero VWM, et al. Acute renal dysfunction after major anteriography AJR 1985;45:1249-1256.

APPENDIX III

The following complications are the indicators of the safety of percutaneous transluminal angioplasty procedures. If these threshold levels are exceeded, a QI review may be possible.

	Threshold
Emergency surgery	<3.0%
Severe bleeding or hematoma (requiring transfusion, surgery, or delayed discharge)	<4.0%
Puncture site occlusion	<0.5%
Angioplasty site occlusion	<3.0%
Distal Embolization causing tissue damage	<0.5%
Vessel perforation requiring surgery	<0.5%
Vessels perforation, no surgery required (Laser angioplasty)	<15.0%

For contrast reactions and contrast-induced nephropathy, refer to Appendix II

REFERENCES:

1. Johnson KW, Rae M, Hogg-Johnston S.A, et al. 5 year result of a prospective study of percutaneous study of percutaneous transluminal angioplasty. *Ann Surg* 1987; 206:403-413.
2. Spence RR< Freiman DB, Gatenby R. Long-term results of transluminal angioplasty of the iliac and femoral arteries. *Arch of Surg* 1980; 116:1377-1386.
3. Sos TA, Peckering TG, Sneiderman K, et al. Percutaneous transluminal angioplasty in renovascular hypertension due to atheroma and fibromuscular dysplasia. *NEJM* 1983; 309:274-279.
4. Rooke TW, Stanson AW, Johnson CM, Sheedy PF, Miller WE, Hollier LH, Osmundson PJ. Percutaneous transluminal angioplasty in the lower extremities: a 5-year experience. *Mayo Clinic Proc* 1987; 5:85-915.
5. Welbull H, Bergovist D, Jonsson K, Karlsson S, Takolander Complications after percutanious transluminal angioplasty in the iliac, femoral, and popliteal arteries. *J of Vasc Surg* 1987; 5:681-686.
6. Schwarter DE, Yune HY, Klatte EC, Grim CE, Weinberger MH. Clinical experience with percutanious transluminal angioplasty of stenotic renal arteries. *Radiology* 1980; 135:601-604.
7. Cumberland DC, Sanborn TA, Taylor DI, et al. Percutaneous laser thermal angioplasty: initial clinical results with a laser probe in total peripheral occlusions. *Lancet* 1986; 1:1457-1459.
8. McCowan TC, Ferris EJ Barnes RW, Baker ML. Laser thermal angioplasty for the treatment of obstruction of the distal superficial femoral or popliteal arteries. *AJR* 1988; 150:1169-1173.
9. Sanborn TA, Cumberland DC, Greenfield AJ, Welsh CI, Guben JK. Percutanious laser angioplasty: initial results and 1 year follow up in 129 femoropopliteal lesions. *Radiology* 1988; 168:121-125.
10. Gardiner GA, Meyerovitz MF, Stokes KR, Clouse ME, Harrington DP, Bettman MA. Complications of transluminal angioplasty. *Radiology* 1986; 158:201-208.
11. Bergquist D, Jonsson K, Weibull H. Complications after percutaneous transluminal angioplasty of peripheral and renal arteries. *Acta Radiological* 1987; 28:3-12.
12. Schwarter DE, Cutcliff WB. Arterial occlusive disease below the knee: treatment with percutanious transluminal angioplasty performed with low profile catheters and steerable guide wires. *Radiology* 1988; 169:71-74.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/05

SUBJECT: Documentation Requirements for Emergency Department Residents

REVISION DATE(S): 03/07

POLICY NUMBER: 8710 – 532

Department Approval Dates(s):	**03/17**
Emergency Medicine Approval Date(s):	**03/17**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~03/07~~03/17**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	**03/07**

A. **PURPOSE:**

1. To establish documentation requirements for Emergency Department Residents.

B. **POLICY:**

1. The Emergency Medicine residents evaluating patients in Tri-City Healthcare District's Emergency Department and responding to codes in the Medical Center are to do so under the supervision of the Emergency Medicine staff.
2. The resident will document the patient encounter in the same manner that ~~the~~ **a** staff emergency physician would document the patient encounter when seeing a patient without the resident. A dictation, or ~~PowerNote~~**electronic note**, meeting ~~department guidelines~~**Emergency Medicine standards** ~~or completed in some other appropriate manner,~~ is to be completed by the resident for each patient evaluated.
3. All patients evaluated in the Emergency Department by a resident will also be personally evaluated by a staff physician. The staff physician in turn will document his/her shared encounter with the patient and ~~may utilize a similar guideline as the resident or will elect to dictate~~ **create** a summary dictation, or **create an electronic summary note, that meets Emergency Medicine standards.** ~~document the encounter in some other appropriate manner.~~
4. The staff physician is responsible for authenticating all resident dictations and orders.
5. The Medical Records Department will review all Emergency Department records for the documentation requirements outlined above to ensure timely completion of all records.

C. **ATTACHMENT(S):**

1. Dictation Format (example)
2. Attending Summary Dictation (example)

~~**Approvals:**~~
~~**Graduate Medical Education:**~~
~~**Department of Emergency Medicine Approval:**~~
~~**Medical Executive Committee Approval: 3/07**~~
~~**Board of Directors Approval: 3/07**~~

~~DICTATION~~ DOCUMENTATION FORMAT

DEMOGRAPHICS:
~~Physician~~ **Resident** name, **Attending Physician name,** patient name ~~(Spell),~~ Medical Record Number, and admit date. ~~Statement "I am a resident physician seeing this patient along with Dr ?"~~

MODE OF ARRIVAL:
Triage or Ambulance, police, helicopter, etc.

~~**TIME OF REGISTRATION:**~~

CHIEF COMPLAINT:

PRE-HOSPITAL CARE:
Summarize EMS run information if any

HISTORY OF PRESENT ILLNESS:
Detailed history of present illness with duration and course of illness including pertinent negatives.

PAST MEDICAL HISTORY:

Pertinent diseases important to HPI. Also other important diseases like diabetes, TB, hypertension.

FAMILY HISTORY:
Relevant to present illness. Also, include heart, lung, and kidney disease, etc.

SOCIAL HISTORY:
Pertinent work status, marital status, smoking history, use or abuse of alcohol or drugs, foreign travel, etc.

MEDICATIONS:
~~If possible, list strength and doses.~~

ALLERGIES:
Type of reactions, if possible.

REVIEW OF SYSTEMS:

VITAL SIGNS:

DICTATION FORMAT (cont)

PHYSICAL EXAM:
- General Appearance
- Pertinent aspects of the exam including pertinent negatives

RESULTS:
- Lab and X-ray results and their significance
- EKG results, ABG results, ultrasound results, etc.

ED COURSE:
- Summary of evaluation and treatment done in the Emergency Department, Including conversations with consultants or other facilities

~~(DISCUSSION OR ASSESSMENT:)~~MEDICAL DECISION MAKING:
- ~~Sometimes optional depends on the uncertainty of the case~~
- ~~Reasons for this patient's diagnosis or~~ differential diagnosis
- Medical necessity for each exam ordered
- Reasons for this patient's particular treatment and disposition

CLINICAL IMPRESSION:
- List the primary or most acute diagnosis first

PLAN:
- Admission
- Treatment as an outpatient
- Referral

CONDITION ON DISCHARGE OR TRANSFER

- ~~**COPY TO DR. (_____)**~~
- ~~**Sign Off: This is Dr. _____ ending dictation on Name of Patient. Thank you!**~~

ATTENDING SUMMARY DICTATION (WHEN RESIDENT DICTATES)

~~I. Patient Demographics~~**Summary is generally included at the end of the Resident's documentation and ~~should~~may include:**

I.

~~II. This patient was seen in conjunction with:~~
~~Name of Resident~~

~~III.~~**A.** Pertinent History
~~A. HPI~~
~~B. Pertinent ROS, PH, FH, SH~~

~~IV.~~**B.** Pertinent Physical Exam
~~A. Summary Positive findings~~**Pertinent**
~~B. Pertinent negatives~~

~~V.~~**C.** ~~Lab~~**lab**/X-ray **findings**
~~A. Important Positive or negative findings~~
~~B. Interpretation of ABG's oximetry, peak flows, EKG~~

~~VI. ED course~~
~~A. Clinical~~
~~B. Procedures:~~
~~"Procedure was performed by _____ under my supervision~~
~~Name of Resident~~

~~VII. Clinical Impression~~

~~VIII.~~ Assessment
D.
~~IX.~~**E.** Plan

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/04	**SUBJECT:** Election Process of Member(s) at Large for the Medical Executive Committee
REVISION DATE(S): 04/08; 08/12	**POLICY NUMBER:** 8710 – 531

Department Approval Dates(s):	03/17
Medical Staff Committee Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~08/12~~03/17
Professional Affairs Committee Approval Date(s):	04/17
Board of Directors Approval Date(s):	08/12

A. **PURPOSE:**

1. To provide direction for the nomination and election process for the Member(s) at Large position on the Medical Executive Committee.

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

1. All Active Medical Staff members of may submit their names to the Medical Staff Office two months prior to the June General Staff Meeting.
2. Interested Active Medical Staff members are required to complete a Conflict of Interest form before being added to the ballot.
3. Candidates will be provided the opportunity to speak at the General Staff Meeting.
4. Voting will be by ballot.
5. A quorum of voting members is required to elect Members-at-Large.
6. Each voting member will be allotted two votes. A member may vote twice for any one candidate or vote once for any two candidates or withhold one or both votes.
7. For a Member-at-Large to be elected, the candidate must be the candidate receiving the most votes. If there are two vacancies being elected, then the candidates receiving the highest and second highest number of votes cast will win.
   a. If one or both of the available Member-at-Large Medical Executive seats are not filled, the seat(s) will remain vacant.
8. Vacant seat(s) after original appointment on the Medical Executive Committee shall remain vacant until the next June General Medical Staff Meeting.
9. Members-at-Large will serve a one year term and no member shall serve more than two successive terms.

~~**Approvals:**~~
~~**Medical Executive Committee Approval:** 08/12~~
~~**Board of Directors Approval:** 04/08; 08/12~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/02	**SUBJECT:** Emergency ~~Room~~ Department Call: Duties of the On-Call Physician
REVISION DATE(S): 07/10; 11/10; 05/14	**POLICY NUMBER:** 8710 – 520

Department Approval Dates(s):	03/17
Medical Staff Committee Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~05/14~~03/17
Professional Affairs Committee Approval Date(s):	04/17
Board of Directors Approval Date(s):	05/14

A. **PURPOSE:**

1. To define timely attention to patients in the Emergency Department (ED), including the timely response and duties of the on-call physician.

B. **DEFINITION(S):**

1. Emergency Department:
   a. The Emergency Department is a specially equipped and staffed department, designed to provide monitoring, close observation, skilled emergency medical/nursing care, and/or respiratory therapy to the acutely injured or critically ill surgical, medical, or cardiac patient.
2. On-call Physician:
   ~~b.~~**a.** The on-call physician is the individual physician available for his/her specialty who responds to the Emergency Department when his/her specialty is needed. The on-call physician is a resource to the hospital to assist in the screening evaluation and stabilization of a patient with emergency medical conditions. The on-call physician's duties mirror the hospital's three main duties under the law: medical screening, stabilization, and acceptance of appropriate transfers.
3. Emergency Medical Condition (EMC):
   ~~c.~~**a.** A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain, psychiatric disturbances, and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:
      i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy;
      ii. Serious impairment to any bodily function;
      iii. Serious dysfunction of any bodily organ or part or;
      iv. With respect to a pregnant woman who is having contractions, inadequate time to affect 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.
4. Medical Screening Examination (MSE):
   ~~d.~~**a.** The screening, examination, and evaluation by an emergency physician or other practitioner qualified to determine whether the patient is in active labor or has an emergency medical condition. It also includes the care, treatment, and surgery by a physician necessary to stabilize that emergency medical condition, within the capability of this facility (TCMC). A triage nurse exam is not a medical screening exam.
   ~~e.~~**b.** An MSE is required on all patients who present to the ED/hospital campus with a medical complaint.

~~f.~~**c.** A request for an MSE will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, the individual needs an examination or treatment for a medical condition.

~~g.~~**d.** The MSE is an ongoing process, not an isolated event.

5. Capacity:

~~h.~~**a.** The ability of the hospital to accommodate the individual requesting examination or treatment. In certain circumstances (e.g., redirecting an individual to an alternate location for a MSE pursuant to an emergency preparedness plan or a transfer as necessitated in the instance of a declared emergency), the hospital may be eligible to request a waiver.

~~i.~~**b.** Includes the hospital's past practices of accommodating patients in excess of occupancy limits.

~~2.~~**6.** Stable:

a. Stable for Transfer:

i. With respect to an emergency medical condition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during the transfer of the individual from a facility, or that the woman has delivered the child or placenta. A patient will be deemed stabilized if the treating physician attending the patient in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

b. For transfer between facilities:

~~ii.~~**i.** a patient is stable for transfer if the patient is transferred from one facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.

i. If the patient is determined by the treating physician to require a higher level of care than can be provided at TCMC, the transfer can be accomplished by mutual agreement between the sending and receiving physicians. This may be accomplished even if the patient is "unstable," if the physicians determine that the benefits of the transfer outweigh the risks.

ii. Transfers should only be made in the following circumstances:

1) For care that exceeds the capabilities of the transferring hospital
2) Upon patient request

c. Stable for Discharge:

~~iii.~~**i.** **M~~m~~eans the treating physician has determined within reasonable clinical confidence that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, may be reasonably performed on an outpatient basis or a later inpatient basis and the patient has been given a plan for appropriate follow-up care with the discharge instructions.

~~iv.~~**ii.** The emergency medical condition that caused the individual to seek care in the Emergency Department must be resolved (although the underlying medical condition may persist).

d. Psychiatric Patients Stable for Transfer:

~~v.~~**i.** A psychiatric patient is considered stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered stable when he/she is no longer considered an imminent threat to himself/herself or to others.

~~vi.~~**ii.** Psychiatric patients who are being transferred on a psychiatric hold will be placed in restraints, solely for the duration of the transfer, in order to minimize the risk of elopement.

~~b.~~**e.** Stable for transfer or Stable for Discharge: does not require the final resolution of the emergency medical condition.

7. Inpatient:

~~c.~~**a.** A person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

8. Outpatient:

~~d.~~**a.** A person who has come to a hospital outpatient department for the purposes of keeping a previously scheduled appointment. This shall include any patient presenting to the ED with a medical complaint.

C. **GUIDELINES:**

1. The goal is every ED patient will be seen by a physician or physician assistant within 30 minutes after the patient is placed in a bed and assessed by a nurse; this should occur in the majority of cases.
2. The appropriate on-call physician will be called when the Emergency Medicine physician:
   a. Does not have the expertise or capability to treat the EMC; or,
   b. Needs the on-call physician to stabilize the patient in the ED; or,
   c. Needs the on-call physician to admit the patient for further stabilizing treatment; or,
   d. Needs the on-call physician to help stabilize the patient in the ED prior to transfer to a tertiary facility or another acute care facility.
   e. Requires assistance of the on-call physician to determine if an EMC exists.
3. The on-call physician is expected to respond telephonically to the Emergency Department within 30 minutes for STAT calls, and within 60 minutes for routine calls. The on call physician will come to the Emergency Department to see the patient if the Emergency Medicine physician determines it is necessary, and within the timeframe reasonably determined by the Emergency Department physician. In any event, the on-call physician must be able to respond in person to the Emergency Department within 30 minutes of the request to respond in person.
4. If the personal physician is treating his/her patient in the ED, that physician is expected to see the patient in the ED or consult by telephone with the Emergency Medicine physician within 30 minutes of being notified the patient is in the ED, and see the patient in the ED less than 60 minutes after notification the patient is in the ED.
   a. If the on-call physician or a personal physician meets the patient in the ED, that physician's evaluation of the patient constitutes the MSE. The examination, the treatment, and the documentation of the encounter must comply with EMTALA exactly as if the Emergency Medicine physician were caring for the patient. The on-call or personal physician shall inform the Emergency Medicine Physician of the MSE.
   b. If a personal physician wishes to see their patient in the ED, but is unable to respond within 60 minutes, or if the Emergency physician or ~~Emergency Room~~**ED** nurse feels the patient is potentially unstable, the MSE will be performed by the Emergency Medicine physician.
5. A patient will not be sent to the on-call (or personal) physician's office for an examination or treatment, unless deemed stable and appropriate by the Emergency Medicine physician. Notwithstanding the above, if specialized equipment exists in the practitioner's office, which would be necessary for care, the on-call physician may confer with the Emergency Medicine physician to determine if further treatment in the office would be safe for the patient and beneficial for care.
6. With regard to ED patients and inpatients, the physician on the ED call panel at the time consultant/specialist/surgical services are needed is the physician responsible for ensuring the related needs of the patient are met during that service encounter/admission.
   a. If a patient presents to the ED with an Emergency Medical Condition and the on-call specialist is unavailable, the Emergency Medicine Physician will proceed as defined in section C.12 below.

7. Duties Of The On-Call Physician:
   a. Respond to the ED to medically screen and/or stabilize emergency patients.
   b. Respond to inpatient unit of the hospital to stabilize patients as requested. The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. See required timeframes under "duties of the on-call physician to inpatients" below.
   c. Accept transferred patients, from other hospitals, with an emergency medical condition on behalf of the hospital .If the hospital can provide the requested care for an emergency medical condition, and the transferring facility cannot provide this care, the hospital/on-call physician is obliged to accept the transfer.
   d. Report suspected EMTALA violations by other hospitals to the hospital's legal counsel and provide the necessary documentation.
8. Duties of the On-Call Physician to Inpatients
   a. Any member of the Medical Staff may request the services of the on-call physician to help stabilize and manage an inpatient in accordance with acceptable standards. All such requests shall indicate it is an urgent/emergent request (requiring a 30 minute telephone response) or non-emergent/urgent (requiring a 2-hour telephone response). The in-person consultation must be completed by the on-call physician or designated alternate within a clinically appropriate time frame and not to exceed 48 hours of request. Insurance Status:
   b. The hospital's normal registration process may be followed so long as a screening or stabilizing treatment is not delayed. The process may include discussion of insurance or payment obligations.
   c. The hospital will not require authorization from an individual's insurance company before providing a screening or initiating any necessary stabilizing treatment.
9. Mechanisms for maintaining the call roster:
   a. The rules and regulations of each applicable Department/Division will address credentials and qualifications regarding on-call services.
   b. The Emergency Department Roster for each specialty will:
      i. Be submitted to the Medical Staff Office at least two weeks in advance of the first day of the month.
      ii. Include the full month of coverage
      iii. List a specific physician's name for each day on call
         1. Every physician listed must be a member of the Medical Staff at TCMC and a member of the Department/Division responsible for the specialty's emergency coverage.
   c. Each on-call physician is solely responsible for arranging trades or temporary coverage of on-call duties. The on-call physician must notify the ED and the Medical Staff Office of any changes in advance.
   d. The Medical Staff Office will provide the ED on-call schedule to each physician who is taking call during the month.
   e. The Medical Staff Office will provide the ED on-call schedule to the ED and the TCMC Operators prior to the schedule starting.
10. Dispute Resolution:
   a. If an on-call physician disagrees with the Emergency Medicine physician about the need to come to the ED, he/she must still come to the ED to examine and treat the patient.
   b. The appropriateness of the Emergency Medicine physician's request for assistance can be reviewed through the regular Medical Staff processes after the patient has been treated (see Sections C.13 and 14).
11. Lack of Timely Response or refusal of the on-call to respond or unexpected lapses in on-call coverage:
   a. If the Emergency Medicine physician or any member of the Medical Staff pursuant to item #8 above determines the patient requires the services of a physician listed by the hospital on its roster of on-call physicians, and if after being notified, the on-call physician fails or refuses to respond as described above, the Division Chief or

Department Chair for the requested specialty shall be contacted to enforce the on-call obligation, or designate an alternative. A Quality Review Report (QRR) shall be completed regarding the failure/lack of timely response by the on-call physician, and submitted to Risk, Legal and Regulatory Services and the Medical Staff Office for follow-up.

b. If the failure/lack of timely response results in the Emergency Medicine physician ordering the transfer of the individual because without the services of the on-call physician the benefits of the transfer outweigh the risks of transfer; the Emergency Medicine physician responsible for transfer shall provide the name and address of the on-call physician to the receiving medical facility at the time of transfer. A QRR shall be completed for this event as well and submitted to Risk, Legal and Regulatory Services and the Medical Staff Office for follow-up.

c. In the event the on-call physician is unavailable as he/she is otherwise detained providing medical care, the on-call physician or his/her designee should inform the Emergency Medicine physician of the status of his/her availability. The Division Chief or Department Chair (for the requested specialty) shall be contacted to designate an alternative specialist to respond. If an alternative specialist is not available, the hospital's transfer policy will be invoked.

12. Disciplinary proceedings for failure to comply:
    a. Any QRR received due to failure to comply, will be referred to the respective Department Chair/Division Chief or designee for review and consideration. Investigation and subsequent actions may be instituted as described in the Medical Staff Bylaws, Article VI. At a minimum, a letter of inquiry should be sent to the non-compliant on-call physician requesting an explanation of his/her failure/lack of timely response to the request of the Emergency Medicine physician.
13. Quality Assurance Monitoring:
    a. Physician delay(s) as defined in this policy will be reviewed.
    b. Patient transfer(s) due to lack of response of on-call physician(s) or refusal to respond to Emergency Medicine physician when notified
14. CME:
    a. Provide a copy of current policy to each physician executing an agreement to provide on-call services.

D. **REFERENCES:**

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

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 05/14**~~
~~**Board of Directors Approval: 07/10; 11/10; 05/14**~~

Tri-City Health Care District
Oceanside, California

Medical Staff Policy Manual

ISSUE DATE: 12/19	**SUBJECT: Liability Insurance Requirements**
REVISION DATE(S): 12/09, 03/11	**POLICY NUMBER: 8710 – 558**

Department Approval Date:	**03/17**
Credentials Committee Approval Date:	**~~03/11~~03/17**
Pharmacy and Therapeutics Approval Date:	**n/a**
Medical Executive Committee Approval Date:	**~~03/11~~03/17**
Professional Affairs Committee Approval Date:	**04/17**
Board of Directors Approval Date:	**03/11**

A. **PURPOSE:**

1. To require professional liability insurance or approved form of financial security.

B. **POLICY:**

1. Consistent with Article VIII of the Tri-City Healthcare District Bylaws and Sections 2.2-1(c) and 4.5-1(g) of the Tri-City Medical Center Medical Staff Bylaws, every Practitioner on the medical staff or with privileges to attend patients at Tri-City Medical Center must, as a condition of holding staff membership or privileges, either carry professional liability insurance with an insurance company admitted to transact business in California in limits of not less than one million dollars ($1,000,000.00) per occurrence or claim/three million dollars ($3,000,000.00) annual aggregate, or furnish an approved form of equivalent financial security as described below in subsection 3.
   a. The Medical Executive Committee may, without the need to obtain the approval of the staff, modify the foregoing limits from time to time as may be appropriate to meet the needs of the Hospital and the Medical Staff and to reflect developments in the insurance industry, with the approval of the Board of Directors.
2. Each insured Practitioner must cause a current certificate of insurance or other acceptable evidence of liability coverage to be furnished to the Hospital. The certificate or other evidence of liability coverage must specify the expiration date of the policy, the amount of insurance, and reflect coverage for the privileges sought/granted.
   a. If the insurance policy or other coverage is restricted in any manner, the Practitioner must furnish a copy of such restrictions to the Hospital.
   b. The Practitioner shall not perform at the Hospital any procedure excluded from the insurance policy or other coverage. The Practitioner shall immediately notify the Hospital if the Practitioner's insurance or equivalent coverage expires, is reduced below the limits then in effect at the Hospital, or is canceled or terminated.
3. For purposes of this policy, an "approved form of equivalent financial security" means either:
   a. Insurance coverage that is written by or issued in connection with the Practitioner's membership in a cooperative, as defined in Section 1280.7 of the California Insurance Code; or successor legislation with minimum coverage conforming to the then applicable requirements; or
   b. Insurance coverage from an irrevocable trust established by an incorporated professional group to insure its members against damages and defense costs arising out of malpractice claims or litigation, and which has been actuarially determined to meet minimum coverage requirements then applicable.
   c. Self insurance coverage established by an incorporated professional group or other entity to insure the Practitioner against damages and defense costs arising out of

malpractice claims or litigation and which has been actuarially determined to meet minimum coverage requirements then applicable.

4. The "approved" forms of equivalent security shall be subject to review and approval by the Medical Executive Committee and Board of Directors.

~~**Approvals:**~~
~~**Credentials Committee Approval: 03/11**~~
~~**Medical Executive Committee Approval: 11/09; 03/11**~~
~~**Board of Directors Approval: 12/09; 03/11**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/12

SUBJECT: Management of Conflict between Medical Staff and the Medical Executive Committee (MEC)

REVISION DATE(S):

POLICY NUMBER: 8710 – 567

Department Approval Date:	03/17
Credentials Committee Approval Date:	03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~05/12~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	05/12

A. **PURPOSE:**

1. To define the process for resolution of conflicts that may arise between the organized Medical Staff and the Medical Executive Committee.
2. Nothing in this policy is intended to prevent Medical Staff members from communicating with the Board of Directors on a rule, regulation, or policy adopted by the organized Medical Staff or the Medical Executive Committee. The Board of Directors shall determine the method of communication, and shall provide timely notification to the Medical Executive Committee, through the Chief of Staff, of any such communications.

B. **POLICY:**

1. In the event that a member of the Medical Staff has an issue or concern regarding a proposed Medical Staff Bylaws addition/amendment, the provisions of Article XIV of the Medical Staff Bylaws shall apply.
2. In the event that a member of the Medical Staff has an issue or concern regarding a proposed Medical Staff Rules and Regulations addition/amendment, the provisions of Section 13.1 of the Medical Staff Bylaws shall apply.
3. In the event that a member of the Medical Staff has an issue or concern regarding a proposed or adopted Medical Staff Policy or other issues not encompassed within items 1 and 2 above, the following process shall apply:
   a. The Medical Staff member shall provide a written description of the specific issue/concern to the Chief of Staff. The Chief of Staff may request further information, and may attempt to resolve the issue/concern through informal discussion.
   b. If the Chief of Staff' is unable to resolve the issue/concern pursuant to informal discussion described above, the specific issue/concern will be placed on the Medical Executive Committee agenda for discussion at the next scheduled meeting.
   c. The Chief of Staff will discuss the outcome of the MEC meeting discussion with the referring Medical Staff member.
   d. If the referring Medical Staff member feels the issue/concern is not resolved, the member may have the issue/concern addressed at a meeting of the MEC at which up to three (3) representatives may attend, upon submission of a petition signed by at least ten percent (10%) of the Medical Staff members eligible to vote.
   e. If after such MEC meeting the issue/concern still has not been resolved to the members' satisfaction, the matter shall be referred to the Joint Conference Committee.

C. **REFERENCES:**

1. The Joint Commission, Hospital Accreditation Standards~~, MS.01.01.01. EP 10~~ **2017**

~~**Approvals:**~~
~~**Credentials Committee: 05/12**~~
~~**Medical Executive Committee Approval: 05/12**~~
~~**Board of Directors Approval: 05/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**7/01**	**SUBJECT:**	**Medical Record Documentation Requirements**
REVISION DATE:	**7/07, 3/08, 9/08, 6/09, 9/09 11/09; 7/11; 05/12; 08/12, 2/15, 12/15**	**POLICY NUMBER:**	**8710-518**

Department Approval Date:	**03/17**
Medical Staff Committee Approval Date:	**n/a**
Pharmacy and Therapeutics Committee Approval Date:	**n/a**
Medical Executive Committee Approval Date:	**~~10/15~~03/17**
Governance Committee Approval Date:	**~~12/15~~04/17**
Board of Directors Approval Date:	**12/15**

A. **PURPOSE:**
1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. **POLICY:**
1. It is the policy of Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)** that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. **RESPONSIBILITIES:**
1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration, with medical staff approval, will determine the criteria for current, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor records to aid the physicians and other medical services in the Medical Center in trying to ensure that medical records meet the requirements for completeness as set in this policy.

D. **PROCEDURE:**
1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports will be transcribed into the Medical Records Chartscript transcription system. Upon completion of transcription the report will be saved and sent electronically to the Cerner system (Clinical Notes folder).
   d. Paper-based documents will be scanned to the Clinical Notes section in Powerchart (Cerner) and will be signed electronically, if not already signed
   e. The Report Status in Cerner will be reflected as "Transcribed"
      i. Transcribed status reflects that the dictating physician has not yet authenticated the document.
   f. Physicians will utilize the Cerner Message Center function to authenticate transcribed documents in a timely manner.
   g. The Message Center feature supports the following actions to be taken by the physician:
      i. Sign/Review

1) Physician reviews the transcribed/scanned document and selects the OK button that updates the status of the report from "Transcribed" to "Auth (Verified)."
2) Only the responsible physician is eligible to sign a transcribed report.
   a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
   b) Resident reports will be signed by the supervising physician.
   c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician.

ii. Modify/Sign
1) Physician may modify the transcribed document PRIOR to signature to correct/clarify any elements of the report.
2) Modifications are to follow the structure of new information being Bolded and deleted information noted as a Strike-through
3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse
1) Physician identifies that he/she is not responsible for the report as well as a reason for refusal and redirects the report to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician.
2) Electronic signature of the transcribed and scanned reports by the physician will update the Medical Records/Health Information Profile system to eliminate the signature deficiency assigned by the department.

2. Written Signatures:
   a. It is expected that all members of the medical staff will utilize acceptable written signatures, including credentials (e.g., MD, PA, NP, CNM) for all paper documents being authenticated.
      i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, day surgery, and inpatient documentation.
   b. Acceptable written signatures are as follows:
      i. Legible full signature
      ii. Legible first initial and last name
      iii. Illegible signature over a typed or printed name
      iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
         1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
      v. Initials over a typed or printed name
      vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
   c. Unacceptable written signatures are as follows:
      i. Signature stamps alone
         1) These are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
      ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
      iii. Unsigned typed note with provider's typed name
      iv. Unsigned typed note without provider's typed/printed name
      v. Unsigned handwritten note, the only entry on the page
3. The following criteria must be met before a chart is considered complete:

a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
   i. Identification data
   ii. Legal status if mental health patient;
   iii. Emergency care given prior to arrival if any;
   iv. Findings of assessment;
   v. Conclusions or impressions from history and physical;
   vi. Diagnosis or diagnostic impression;
   vii. Reasons for admission or treatment;
   viii. Goals of treatment and treatment plan;
   ix. Known advance directives;
   x. Informed consent for procedures and treatment;
   xi. Diagnostic and therapeutic procedures and tests and their results;
   xii. Operative and other invasive procedures performed;
   xiii. Progress notes;
   xiv. Reassessments if needed;
   xv. Clinical observations;
   xvi. Response to care;
   xvii. Consultation reports;
   xviii. Every medication ordered; every dose administered and any adverse reaction;
   xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
   xx. All relevant diagnoses established during care;
   xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
   a. All handwritten documentation is to be without the use of Do Not Use Abbreviations.
      i. A reference of Do Not Use Abbreviations is available in multiple locations.
         1) Physician Order Forms
         2) Progress Notes
         3) ~~TCMC~~**TCHD** Intranet – Administrative Policy 367

5. A complete history and physical examination shall be recorded by the attending physician within twenty-four (24) hours of admission and/or prior to any surgical or invasive procedure.
   a. When the report is dictated it must be completed within twenty (20) hours of admission to allow for transcription and charting of the document.
   b. Legible, handwritten history and physicals are acceptable provided they meet the documentation requirements.
   c. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.

6. The history and physical shall include the following elements:
   a. Chief complaint;
   b. Personal, past medical and surgical history;
   c. Allergy history;
   d. Current medications;
   e. Family history;
   f. History of present illness;
   g. All important findings resulting from a review of systems;
   h. Physical examination;
   i. Diagnosis or diagnostic impression;
   j. Plan of treatment.

7. A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

a. An updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration. This is to occur prior to surgery or for a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration.
b. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.
c. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
    i. H&P was completed
    ii. H&P was reviewed
    iii. The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.
d. The Physician Pre-Procedure Documentation form must be recorded on the patient's medical record prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.
e. A history and physical document completed outside ~~Tri-City Medical Center~~**TCHD** is required to reflect date and time of the examination.
    i. Dictated documents are to reflect the date and time of both the dictation and transcription.

8. A history and physical dictated over 30 days prior to admission is not valid and must be re-dictated
9. When the required history and physical examination is not recorded on the chart before the time stated for the operation, the operation shall be canceled until the surgeon has documented a history and physical in writing or documented that such a delay would constitute a hazard to the patient.
10. History and Physical for Hospital Outpatient Procedures:
    a. Ambulatory surgery patients undergoing anesthesia shall have a complete H&P as defined above prior to surgery.
    b. Hospital outpatients undergoing invasive procedures with a significant level of risk shall have at least a limited History and Physical.
11. A limited History and Physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.
12. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.
    a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
    b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.
        i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.
13. Medication reconciliation:
    a. Admission
        i. The admitting physician is required to review, complete and reconcile Admission Medication Reconciliation information in Cerner collected upon admission of the patient within 24 hours.

ii. If new information is later obtained, the physician or nurse may update the Medication by History List in Cerner.

b. Transfer:
   i. All medications will be reviewed and revised as appropriate when patient is being transferred to the next level of care.
      1) Electronic Orders
         a) The physician will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.

c. Discharge:
   i. All medications will be reviewed against HOME medications in Cerner.
      1) Electronic Orders
         a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
         b) Prescriptions to be completed
            i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
            ii) Printed on the unit and handed to the patient
            iii) Handwritten on personal (physician's) prescription pad
      2) Written Orders
         a) Physician handwrites prescriptions on personal (physician's) prescription pad.
         b) Physician updates physician medication changes on the electronic Medication List through the Medication Reconciliation tool.

14. Daily progress notes must be documented by the attending member on all acute patients in the hospital.
   a. Progress notes for Behavioral Health unit patients, will be written six days per week by the attending member.
   b. All members of the medical staff will document progress notes in any of the following methods:
      i. Written on the progress notes form placed in the patient's active record;
      ii. Electronic note may be a Progress Note typed by the physician or a Progress Note generated using a voice recognition software application (e.g. Dragon)
   c. All Progress Note entries shall be timed, dated, and electronically signed by the physician recording the note. Electronic notes shall be signed electronically.
      i. The electronic Progress Note shall not be printed, signed and placed in the hard copy chart (this is duplicate documentation that may require both documents to be maintained in the legal record (i.e. scan document as well as maintain electronic version).
   d. Progress Notes recorded by Residents and/or Physician Assistants are required to be co-signed by the attending physician member.
   e. Interdisciplinary Notes recorded by the other care providers are available in the Cerner system for review by the physician.
      i. These notes are recorded by non-physicians within the Power Note application in the Cerner system.
   f. Physician evaluation of Occupational Health patients (Work Partners) and Wound Care Center patients may result in an electronic note captured directly into the Cerner system.
      i. Voice Recognition/Dragon application may be utilized by practitioners in these areas to generate a note summarizing the patient's history, assessments, and treatments.
      ii. These notes will be authenticated by the examining physician and will be displayed as part of Clinical Notes.

15. Consent for Photography will be obtained from the patient when a patient will be photographed while receiving treatment at the Medical Center. The term "Photograph" includes video or still

photography, in digital or any other format, and any other means of recording or reproducing images.

16. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
    a. The informed consent documented will include the following:
        i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
        ii. The likelihood of the patient achieving his or her goals
        iii. Any potential problems that might occur during recuperation
17. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.
18. A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.
19. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient.
20. Operative or other high risk procedure reports shall be dictated immediately after surgery and shall include:
    a. Pre-operative diagnosis
    b. Date of procedure
        i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
    c. Anesthesia type
    d. A detailed account of the findings;
    e. Technical procedure performed
    f. Estimated blood loss
    g. Specimen removed;
    h. Post-operative diagnosis;
    i. Name of the primary surgeon and any assistants.
    j. Complications
    k. Patient status
21. An Operative Note shall be documented immediately following surgery or other high-risk procedures. Use of the pre-printed Operative Note is necessary to document all required elements.
    a. Procedure performed
    b. Pre-Operative diagnosis
    c. Post-Operative diagnosis
    d. Patient status
    e. Estimated blood loss
    f. Name of primary surgeon and any assistants
    g. Anesthesia type
    h. Specimen collected
    i. Complications
    j. Findings
22. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
    a. Name and hospital ID number of the patient
    b. Name of anesthesiologist who administered the anesthesia
    c. Vital signs reflecting patient status just prior to induction
    d. Name, dosage, route, and time of administration of drugs and anesthesia agents

e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
f. Names and amounts of IV fluids, including blood or blood products
g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

23. The Operative Note shall be completed and signed by the surgeon prior to the patient being discharged or transferred from PACU.
24. All orders, including verbal orders, must be dated, timed, and authenticated.
    a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
25. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.
26. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
    a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders into Cerner or in writing.
    b. All orders for treatment shall be entered. An order for treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
    c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
        i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
        ii. Vaccines
        iii. Intravenous fluids
        iv. Medication doses that if weight based would equal or exceed normal adult doses.
27. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
    a. Electronic Orders
        i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
        ii. Complete the Transfer Medication Reconciliation function
    b. Written Orders
        i. Rewrite all orders OR document the following, "I have reviewed all orders, and they are appropriate for this patient at this level of care."
        ii. The physician is not required to rewrite orders when a patient is undergoing one of the following minor procedures and returns to the same level of care
            1) Heart Catheterization
            2) Interventional procedures including PICC line placement
            3) Endoscopy including bronchoscopies
            4) Inpatient dialysis
            5) Pain management
28. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.
29. Current obstetrical records shall include complete prenatal records, including a copy of the actual lab reports. The prenatal record may be a legible permanent copy of the attending practitioner's

office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

30. All patients evaluated by an Emergency Department physician are to have a documented report outlining the history of present illness, assessment, and treatment rendered.
    a. Records for patients evaluated by both a resident and an ED physician will include documentation by each of the evaluators. The attending ED physician is responsible for authenticating ED reports dictated by a resident.
    b. Records for patients evaluated by an ED Physician Assistant (PA) will include only documentation by the PA which will be authenticated/signed by both the PA and ED supervising physician.
31. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
32. Discharge/Depart Process
    a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
    b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
        i. Nursing will enter into the Depart Process application
        ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)
33. A Discharge Summary shall be dictated at all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
    a. Discharge Diagnosis
    b. Reason for hospitalization
    c. Significant findings
    d. Procedures performed and treatment given
    e. Condition on discharge
    f. Instructions given to the patient or patient representative
        i. Follow-up instructions
        ii. Diet instructions
    g. Discharge medications
    h. A written or dictated discharge note is acceptable for patient with a length-of-stay less than forty-eight (48) hours, normal obstetrical deliveries, and normal newborn infants.
        i. Requirements of the Note include:
            1) Discharge Diagnosis
            2) Follow-up instructions
            3) Diet Instructions
            4) Discharge Medications
    i. Physicians having a Discharge Summary that requires dictation will be notified via the Message Center in Cerner. All physicians will be required to complete all pending dictations and/or signature within 14 days of discharge.
34. Physicians will be notified of outstanding charts requiring signature via their Message Center as well as via letter and call to their office.
    a. Physicians will be suspended per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).
35. Late Entry:
    a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry will be made with the following required elements documented:
        i. The date and time of the observation
        ii. A note clearly identifying the documentation as "Late Entry"
    b. It is not permitted to have entries "backdated" or "predated".
    c. The chart shall be completed within fourteen (14) days of discharge; it is expected no Late Entries will appear after this time period.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 06/04	**SUBJECT:** Medical Staff Governance Documents Development and Review and Approval Mechanism
REVISION DATE(S):	**POLICY NUMBER:** 8710 – 500

Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~09/11~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	09/11

A. **PURPOSE:**

1. To provide guidelines for development, review, revision and approval of Medical Staff self-governance documents.

B. **DEFINITION(S):**

1. For purposes of this policy, Medical Staff governance documents are the Medical Staff Bylaws and documents that supplement them, including but not limited to, rules and regulations, policies, protocols, and standardized procedures.
2. Standardized Procedures are as defined by Title 22 and Title 16 for the performance of medical procedures outside the normal scope of practice for a Registered Nurse.
3. Protocols are developed when the supervising physician adopts standards to govern the performance of a physician assistant for some or all tasks.
4. Process is a series of steps taken to accomplish a goal.
5. Policy describes a deliberate plan of action to guide decisions and achieve rational outcome(s).
6. Procedure describes how each step in the process is to be carried out.
7. Rules and Regulations refer to the rules and regulations that describe the privileges, competency, and other requirements of each Medical Staff Department and/or Division. The General Medical Staff Rules and Regulations apply to all Medical Staff Members regardless of Medical Staff status.
8. Medical Staff Bylaws define the Medical Staff as a self-governing body.
   a. Issues that must be addressed in the Medical Staff Bylaws are as required by:
      i. The Medicare Conditions of Participation
      ii. The Joint Commission Standards pertaining to the Medical Staff.
      iii. California Code of Regulations, Title 22 pertaining to the Medical Staff
   b. The Criteria used to identify the issues that must be addressed in the Medical Staff Bylaws are as required by the:
      i. Medicare Conditions of Participation
      ii. Joint Commission Standards pertaining to the Medical Staff
      iii. California Code of Regulations, Title 22, pertaining to the Medical Staff
      iv. Specific issues reviewed and determined to be appropriate by the Medical Staff Bylaws Committee
      v. Specific issues as presented by Medical Staff members.

C. **GUIDELINES:**

1. Medical Staff governance documents are developed as needs are identified. They may relate to regular operations or functions of the Medical Staff and are used to assure consistency for

Medical Staff processes. Medical Staff governance documents are approved by the Medical Executive Committee and the Board of Directors. Medical Staff governance documents that are related to specific departments, divisions or committees will also be reviewed and approved by that respective group.

2. Standardized Procedures are developed when the physician is authorizing nurses to assist in certain patient care activities under the general supervision of physicians. Standardized Procedures are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Standardized Procedures are reviewed as provided in the standardized procedure, and updated as necessary.
3. Department and Division Rules and Regulations are subject to the approval process outlined in the Medical Staff Bylaws (Section 9.4(I) and 9.5).
4. The General Medical Staff Rules and Regulations are subject to the approval process outlined in Section 13.1 of the Medical Staff Bylaws.
5. Medical Staff Bylaws are reviewed and approved per Medical Staff Bylaws (Article 14).
6. The minimum content of protocols shall be as provided in California Business & Professions Code Section 3502. Protocols must be authenticated and dated by the supervising physician and the physician assistant, with a copy provided to the Medical Staff. The supervising physician shall review, counter-authenticate, and date a minimum of 10% sample of medical records of patients treated pursuant to protocols within thirty (30) days of the date of treatment. Protocols are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Protocols are reviewed and updated as necessary.

D. **REFERENCES:**

1. The Joint Commission ~~2011~~ **2017** Medical Staff Standards

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 09/11**~~
~~**Board of Directors Approval: 09/11**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/01

SUBJECT: Name Tags for Health Care Practitioners

REVISION DATE(S): 09/11, 11/14

POLICY NUMBER: 8710 – 521

Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~10/14~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	11/14

A. **PURPOSE:**

1. To outline the requirements for name badges for Medical Staff members and Allied Health Professionals (AHP) in accordance with the provisions of California Business & Professions Code Section 680.

B. **REQUIREMENTS:**

1. All health care practitioners who have been granted membership and/or clinical privileges must wear name badges.
2. The name badge must disclose his/her name per license/credential, licensure status as granted by the State, and photo.
3. This name badge must be in at least 18-point type font.
4. The name badge must be worn and visible while providing care in the hospital.

~~**Approvals:**~~

~~Medical Executive Committee Approval: 10/14~~
~~Governance Committee Approval: 11/14~~
~~Board of Directors Approval: 09/11; 11/14~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**1/07**	**SUBJECT:**	**Peer Review Process: OPPE and FPPE**
REVISION DATE:	**3/08, 5/08, 06/08, 07/~~20~~15**	**POLICY NUMBER:**	**8710 – 509**

Department Approval:	**03/17**
Medical Staff Committee Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/27/2015~~03/17**
Professional Affairs Committee Approval Date:	**04/17**
~~Governance Committee Approval:~~	**~~09/17/2015~~**
Board of Directors Approval:	**09/~~24/20~~15**

A. **POLICY:**

1. Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.

B. **ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):**

1. Ongoing Evaluation: At eight (8) month intervals, every Practitioner will undergo ongoing evaluations defined by each Department/Division. Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the Practitioner is performing: 1) well/within desired expectations and that no further action is warranted; or 2) that an issue exists that requires a focused evaluation; or 3) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege; or 4) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege; or 5) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be included in the Practitioner's credential file as part of the reappointment process. This process will evaluate a Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:
    i. Patient Care
    ii. Medical / Clinical Knowledge
    iii. Practice-based learning and Improvement
    iv. Interpersonal and communication skills
    v. Professionalism
    vi. Systems / Based Practice
2. Routine Individual Case Review is initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events,

levels of performance, or patterns or trends varying significantly from expected; (ii) performance varying significantly from other organizations; (iii) performance varying significantly from recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from regulatory bodies, accreditation agencies or third party payors involving quality of care, or if an appropriate, (vi) medical staff officer determines a need.

a. Initial Review: will be performed by the applicable department, division or committee (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical QA/PI Committee.

b. Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

c. Reporting Findings: The findings of peer review activities are reported through the department/division/quality review committee to the QA/PI/PS Committee and on to the Medical Executive Committee within forty-five (45) days of completion.

d. Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

C. **FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):**

1. FPPE includes monitoring, proctoring and focused review activities. These activities are intended to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.
2. Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.
3. Proctoring:
   a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.
   b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.
   c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.
4. Focused Review: In case where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions

arise regarding a Practitioner's ability to provide quality care, focused review may be initiated. Circumstances which may give rise to focused professional practice evaluation include, but are not limited to, provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or standards; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the FPPE may include but is not limited to periodic chart review, concurrent chart review, direct observation, monitoring diagnostic and treatment techniques, interviews with staff.
b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring
c. Monitoring Plan: If the MEC initiates the request for an FPPE, the Practitioner will be notified in writing within five business days. The initial written notice shall include a statement of facts demonstrating the request for FPPE was reasonable and warranted. This communication must also include what is wrong with the performance and what improvements are expected.

D. GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:

1. Participants in the Peer Review Process:
   a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.
   b. Reviewer(s): The Department/Division/Committee Chair/Chief shall appoint Practitioners to perform case screening. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.
   c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.
   d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.
   e. Data Sources/Collection: The cases for peer review are derived from quality review form, patient satisfaction surveys, department specific criteria and reports generated from coded medical records.
   f. Criteria shall be reviewed by each department/committee/ annually. The criteria can be changed before the annual review with request from Department Chair.
   g. Cases involving more than one discipline are referred to other areas for additional input or action. These are tracked in the original committee until completed.
   h. Incomplete case reviews are referred to the next scheduled meeting.
   i. Cases referred for review shall be reviewed by the Practitioner screener of each committee (or designee), who shall determine whether to refer the case to the full committee for discussion, and make the preliminary assignment of category.
   j. Cases referred for discussion shall be summarized in sufficient detail to ascertain the

salient facts of the case, the issue under discussion, and the reasoning underlying the committee(s) decision.

k. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.

l. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of Quality Assurance/Performance Improvement/Patient Safety Committee and may require direct intervention.

m. For cases of Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

E. **CATEGORY OF ASSIGNMENTS:**

1. Not Physician Related
   a. These events are casually related to the patient, to support care provided within the hospital, or care provided outside the hospital. Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may demonstrate trends useful for departmental or hospital wide management.
2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. In each occurrence below, the physician will be notified:
      i. Minimal Variance
         a. These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, and which might be to the detriment of the patient. There could be review, response or further study by the committee.
      ii. Moderate Variance
         a. These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department to the detriment of the patient. There must be review, response, trending, or further study by the committee.
      iii. Significant Variance
         a. These events represent gross departures from expected standards, raise immediate questions about judgment or technique and require an immediate response from the committee or department. In each occurrence, the physician will be notified.
      iv. Violation of Hospital Policy Includes poor communication or inadequate documentation.
      v. Violation of Physician Code of Conduct These behavioral events will initiate an immediate response. The physician will be notified.

F. **APPEAL PROCESS:**

1. Practitioner(s) asked for information by a reviewing committee with regard to quality events of a particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.
2. If the Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the Practitioner, the Medical Executive Committee shall serve as the final appeal body.
3. The Medical Staff member may review his/her file on request.
4. Quality Assurance/Performance Improvement/Patient Safety Committee oversees and

supervises all medical staff peer review activity. When a subsidiary peer review body is not performing appropriately, the Quality Assurance/Performance Improvement/Patient Safety Committee is responsible for resolving issues.

5. When the Quality Assurance/Performance Improvement/Patient Safety Committee disagrees with an assigned significance category, the case will be referred back to the Department Quality Peer Review Committee for reconsideration. If no agreement is reached, referral will be made to the Medical Executive Committee for final arbitration.
6. Any evaluation of a quality event that is not completed within six (6) months of initial review will be assessed by the Chairman of the Quality Assurance/Performance Improvement/Patient Safety Committee.

G. **REFRENCES:**

1. Medical Staff Standards, Joint Commission ~~2008~~**2017**
~~2. The compliance Guide to JCAHO Medical Staff Standards.~~
~~3.~~**2.** Effective Peer Review A Practical Guide to Contemporary Design, 2nd Edition, Robert Marder, May 2008

~~**Addendum A**~~

~~**CRITERIA FOR PRACTITIONER PEER REVIEW**~~
~~**ALL RECORDS FOR ALL DIVISION/DEPARTMENTS ARE REVIEWED FOR:**~~

~~**GENERIC SCREENING**~~

- ~~Re-admission with 30 days (usually 7 days or less unless significant related event)~~
- ~~Death with code, unexpected, coroner's case~~
- ~~Patient complaints (Incident reports, patient surveys)~~
- ~~Complications CVA, MI~~
- ~~Delay in service, physician not being available~~
- ~~Transfusion reactions, major blood loss requiring unplanned transfusion~~
- ~~Drug reaction~~
- ~~Unplanned transfer to ICU~~
- ~~CPR~~
- ~~Nosocomial infection~~
- ~~Random review~~
- ~~Quality Review Reports~~

~~**SURGICAL CASES**~~
~~**(GVS, UROLOGY, OB/GYN, ORTHOPEDICS, NEUROSURGERY, SUB SPECIALITY)**~~

- ~~Unexpected return to OR~~
- ~~Unexpected peri-operative injury~~
- ~~Excessive blood loss~~
- ~~Death in OR~~
- ~~Wound dehiscence~~
- ~~Intra-operative complication~~

~~**CARDIOTHORACIC**~~

- ~~Mortality~~
- ~~New renal failure requiring Dialysis~~
- ~~Stroke~~
- ~~Deep Sternal Wound Infection~~
- ~~Peri op MI~~

~~**Neurosurgery**~~

- ~~CNS Leak following surgery~~
- ~~Worsening neurological symptoms following surgery~~
- ~~All generic surgical criteria~~

~~**ANESTHESIA**~~

- ~~PACU stay over 4 hours~~
- ~~Anesthesia related event: Pneumothorax, aspiration, esophageal intubation, cardiac arrest, MI, seizure, malignant hyperthermia, transfusion reaction, neurological deficit~~
- ~~Death in OR or within 48 hours of surgery~~
- ~~Injury~~

~~**EMERGENCY ROOM**~~

- ~~Re-admission to ER within 72 hours~~
- ~~Patient complaints~~
- ~~Deaths (coded within the ED)~~
- ~~EMTALA concerns~~

~~OBSTETRICS~~

- ~~Apgar less than 4 at 5 minutes~~
- ~~Eclampsia~~
- ~~LOS over 3 days Vaginal Delivery~~
- ~~LOS over 5 days Cesarean Section~~
- ~~Injury to infant~~
- ~~Transfer to ICU~~
- ~~Stillborn or neonatal deaths greater than 2500 grams~~

~~PEDIATRICS~~

- ~~LOS over 5 days~~
- ~~Apgar less than 5 at 5 minutes~~
- ~~Injury~~
- ~~Seizures within first 24 hours~~
- ~~Meconium aspiration resulting in NICU stay~~
- ~~Neonatal deaths over 2500 grams~~
- ~~Neurological deficits~~
- ~~Readmissions within 72 hours~~

~~UTILIZATION REVIEW~~

- ~~PRO denial~~
- ~~Discharge planning~~
- ~~Referral by UR physician advisor~~
- ~~Admission denial~~
- ~~Continued stay denial~~

~~TISSUE REVIEW~~

~~There are three broad categories into which all surgical pathology and cytophology cases will be reviewed, A, B, or C. The pathologists will assign all cases to one of these classes at the time of microscopic sign-out. The case definitions are as follows:~~

~~Group A:~~

- ~~Gross exam only~~
- ~~A diagnostic procedure for clinical workup only, (e.g. no specimen)~~
- ~~The tissue pathology substantiates the clinical impression and / or the operative diagnosis~~
- ~~The tissue pathology does not confirm or support the clinical diagnosis, but significant pathology is present to justify the surgical procedure.~~

~~Group B:~~

- ~~All cases with normal tissue removed as identified by the pathologist, excluding appropriate~~
- ~~incidental organ removal.~~

~~Group C:~~

- ~~All cases where the pathologic findings do not appear to justify removal of tissue~~
- ~~All cases where the pathologic diagnosis differs from pre- or post-op diagnosis, and does not fit under A-4~~
- ~~All cases where the pre-op clinical diagnosis differs greatly from the post-op diagnosis.~~
- ~~The pathology findings suggest either too little or too much tissue was removed by the surgical procedure.~~
- ~~The tissue pathology does not support the clinical diagnosis.~~
- ~~The pathology and / or operative procedure warrants review for reasons other than those stated above.~~

~~All cases falling into group B, and C will be referred to the Tissue Committee. Bases on its review of~~

~~the cases, the Tissue Committee will have the option of disposing of cases at its level, or referring them back to the appropriate Divisions or departments, with a report of their findings to Tissue Committee.~~

~~SUMMARY~~

~~Most Practitioners will have sufficient cases reviewed through the above generic screen fall out to meet credentialing requirements. Random reviews are also done to supplement those physicians who have not had enough case review generated to adequately demonstrate their management of patient care. Random reviews are also generated to intensify review of Practitioners who have demonstrated some area of concern to their department or division quality review committees.~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 11/03	**SUBJECT: Physician Orders/Family Members**
REVISION DATE(S): 09/11. 12/14	**POLICY NUMBER: 8710 – 529**

Department Approval Date:	**03/17**
Medical Staff Committee Approval Date:	**n/a**
Pharmacy and Therapeutics Approval Date:	**n/a**
Medical Executive Committee Approval Date:	**~~11/14~~03/17**
Professional Affairs Committee Approval Date:	**04/17**
Board of Directors Approval Date:	**12/14**

A. **PURPOSE:**

1. To outline the ethical and compliance issues for a physician who wants to order tests or therapies on themselves or their family members.

B. **POLICY:**

1. It is the policy of the Medical Staff of ~~TCMC~~ **Tri-City Healthcare District (TCHD)** that it is inappropriate for physicians to evaluate and treat themselves or immediate family members except in emergency settings, isolated settings where there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. The AMA issued a statement, E-8.19 regarding physicians treating themselves or members of their immediate families and the Medical Staff supports that statement. (See attached AMA Statement)
3. The Code of Federal Regulations states that Medicare will not cover charges for services provided to a patient who is an immediate family member of the physician or a member of the physician's household.
4. ~~TCMC~~ **TCHD** follows Medicare rules with regard to compliance issues.

C. **DEFINITIONS OF TERMS:**

1. Immediate family members are defined as follows:
   a. Husband or wife
   b. Natural or adoptive parent, child or sibling
   c. Stepparent, stepchild, stepbrother, stepsister,
   d. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
   e. Grandparent or grandchild
   f. Spouse of grandparent or grandchild.
2. Member of the household means:
   a. Any person sharing a common abode as part of a single-family unit.
   b. Domestic employees and others who live together as part of a family unit, not a roomer or boarder.
3. Physician:
   a. Immediate family member
   b. Member of household
   c. MD, DO, DDS with membership to **TCHD**~~TCMC~~ Medical Staff
4. Patient means whoever of the following is receiving the tests or therapies:
   a. Physician
   b. Immediate family member
   c. Member of household

D. **PROCESS:**

1. Medical Staff members can only order tests and prescribe treatment for themselves, their immediate family members, and members of their household in an emergency, if there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. Per Code of Federal Regulations and other ~~TCMC~~ **TCHD** contractual agreements, the patient may be responsible for charges incurred.

E. **GUIDELINES:**
1. AMA Ethical Opinion E-8.19.
2. 42 C.F.R. § 411.12

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 11/14**~~
~~**Board of Directors Approval: 09/11; 12/14**~~

AMA STATEMENT

E-8.19 Self-Treatment or Treatment of Immediate Family Members.

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/05	**SUBJECT:** Physician/Podiatrist Surgical Assistant
REVISION DATE(S): 03/08, 11/14	**POLICY NUMBER:** 8710 – 536

Department Approval Date:	03/17
Credentials Committee Approval Date:	03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~10/14~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	11/14

A. **PURPOSE:**
1. To provide credentialing criteria for non surgeon physicians and podiatrists in non-podiatric cases to act as surgical first assistants.

B. **SCOPE OF PRIVILEGES:**
1. Provides aid in exposure, hemostasis, use of surgical instruments on tissues, and other technical functions to help the surgeon carry out a safe operation.

C. **CREDENTIALING CRITERIA:**
1. Letter(s) of reference from individual responsible for formal training and/or a surgeon who is familiar with the physician's experience as a surgical first assistant; **and**
   a. Completion of a surgical residency from a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); **or**
   b. Completion of a surgical rotation during internship training of at least (six weeks) in duration; **or**
   c. A licensed Doctor of Podiatric Medicine, licensed after 1984.

D. **PROCTORING:**
1. A minimum of three (3) cases in which the physician acts as the surgical first assistant shall be proctored by the primary surgeon. There should be at least two (2) different primary surgeons.

E. **REAPPOINTMENT:**
1. A minimum of three (3) cases as a surgical first assistant shall be performed per two-year reappointment cycle. Quality assurance mechanisms will be applied and considered in the reappointment process.

~~**Approvals:**~~
~~Credentials Committee Approval: 10/14~~
~~Medical Executive Committee Approval: 10/14~~
~~Governance Committee Approval: 11/14~~
~~Board of Directors Approval: 03/08; 11/14~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 06/04	**SUBJECT:** Physicians' Well-Being Committee Policy
REVISION DATE(S): 09/07, 03/12	**POLICY NUMBER:** 8710 – 511

Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~03/12~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	03/12

A. **POLICY:**

1. It is the policy of Tri-City ~~Medical Center~~**Healthcare District** (~~TCMC~~**TCHD**) Medical Staff to offer assistance to those physicians who are physically or emotionally impaired or under the influence of alcohol or drugs and who may benefit from rehabilitation or hospitalization. Furthermore, ~~TCMC's~~ **TCHD's** policy is to enhance the safety and security of patients, physicians, and employees and to prevent impaired physicians who may harm patients from practicing medicine.
2. In this regard, this process provides education about physician health; addresses prevention of physical, psychiatric, or emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.

B. **PURPOSE:**

1. The Physicians' Well-Being Committee is established to provide a process for assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients, staff and physicians. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a physician is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

C. **PROCESS:**

1. The process design includes but is not limited to the mechanisms for the following:
   a. Evaluate the credibility of a complaint, allegation, or concern; communicate with the referred physician.
   b. Provide annual education to the medical staff and other ~~TCMC~~ **TCHD** staff about illnesses and impairment recognition issues specific to physicians, (at-risk criteria), and to take steps to promote wellness.
   c. Establish a self-referral process by a physician or other ~~TCMC~~ **TCHD** staff.
      i. Self-referrals shall be made directly to the Chairman of the Physicians' Well-Being Committee when possible.
      ii. Issues identified through the hospital's Quality Review Reporting process should be routed directly to the Medical Staff Office and forwarded to the Chairman of the Physicians' Well-Being Committee.
   d. Referral of the affected physician to the appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

e. Assure and maintain the confidentiality of the physician who is seeking referral or being referred for assistance, and/or the informant if applicable, except as limited by applicable law, ethical obligation, or when the health and safety of a patient, staff, or other physician is threatened.
   i. Any retaliation against the informant will not be tolerated and will be referred to the Professional Behavior Committee for appropriate action.

f. Monitor the affected physician and the safety of patients until rehabilitation is complete and if applicable periodically thereafter.

g. Report to the Medical Staff leadership instances in which a physician is providing unsafe treatment or engaging in behavior that undermines the culture of safety.

D. **SPECIAL CONSIDERATION:**

1. It is the physician's responsibility to comply with the Physicians' Well-Being Committee's assistance and recommendations.
2. Noncompliance with completion of the required rehabilitation program will be reported to the Medical Executive Committee for appropriate action.
3. Unsafe treatment provided by an impaired physician will be reported to the Medical Executive Committee for appropriate action or referral.

E. **REPORTING:**

1. A report will be provided to the Medical Executive Committee and to the Board on a quarterly basis.

F. **DOCUMENTATION:**

1. While the Physicians' Well-Being Committee records are ultimately the property of ~~TCMC~~ **TCHD** Medical Staff, active records will be retained by the Chair of the Physician Well Being Committee.
2. Information, as applicable, will be maintained in a locked file in the Medical Staff Office with access only to the Chief of Staff and the Chair of the Physicians' Well-Being Committee.

G. **REFERENCES:**

1. The Joint Commission Medical Staff Standards **2017**
2. Medical Staff Bylaws~~, Section 10.20~~

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 03/12**~~
~~**Board of Directors Approval: 09/07, 03/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 02/01	**SUBJECT:** Professional Behavior Policy & Committee
REVISION DATE(S): 08/17, 01/13	**POLICY NUMBER:** 8710 – 570

Department Approval Date:	03/17
Medical Staff Committee Approval Date:	n/a
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~01/13~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	01/13

A. **POLICY:**

1. It is the policy of Tri-City ~~Medical Center~~**Healthcare District** (~~TCMC~~**TCHD**) Medical Staff to support and encourage appropriate professional behavior and a safe working environment at all times, and to evaluate allegations of behavior that undermines the culture of safety by physicians and to intervene when appropriate. The Medical Staff of ~~TCMC~~ **TCHD** recognizes the right of all individuals within the ~~TCMC~~ **TCHD** organization to be treated with dignity, courtesy and respect. Behavior that undermines the culture of safety compromises the ability of the healthcare team to perform effectively and may create a hostile work environment inhibiting optimal communication and performance.

B. **PURPOSE:**

1. To promote a professional atmosphere and a safe work environment where all Medical Staff members and Allied Health Professionals (AHP) shall conduct themselves in a professional manner when interacting with colleagues, hospital staff, patients, and guests. The Medical Staff, via the Medical Executive Committee (MEC) and in accordance with the Medical Staff Bylaws, shall be responsible for implementing and maintaining standards of behavior to promote and maintain a professional atmosphere.

C. **DEFINITION(S):**

1. Complainant: Any individual who witnesses a behavior and perceives it to be significant and worthy of intervention based on the Guidelines below.
2. Attributed Individual: Any Medical Staff member or AHP about whom a behavior concern has been reported.
3. Direct Supervisor: Hospital staff member (Director or Service Line Leader) who is responsible for initially investigating the alleged unprofessional behavior and initiating the process as defined below.

D. **POLICY:**

1. Acceptable behavior may include, but is not limited to the following attributes and behavior patterns:
   a. Consistent adherence to hospital and/or Medical Staff policies and procedures.
   b. Treatment of all persons with courtesy, respect, and dignity
   c. Appropriate response to inquiries
   d. Timely response to pages and staff requests
   e. Civil communication – i.e. well-mannered responses, appropriate language and tone, and a team-centered approach
   f. Utilization of chain of command to express concerns or to report issues

2. Unacceptable behavior may include, but is not limited to, the following attributes and behavior patterns:
   a. Disregard of hospital and/or Medical Staff policies and procedures
   b. Verbal or physical threats against anyone
   c. The use of demeaning or insulting remarks
   d. Aggressive or violent actions
   e. The use of profanity or excessive sarcasm
   f. Sexual or ethnic innuendos or harassment
   g. Inappropriate critiquing of hospital and/or Medical Staff members in public
   h. Inappropriate delay in responding to concerns and issues from hospital staff members
   i. Retaliation
3. The Professional Behavior Form provides a suggested sequence of procedural steps that creates a framework to document and resolve issues.

E. SPECIAL CONSIDERATIONS:

1. Communication:
   a. All parties involved, except when mandatory reporting is required by State or Federal regulations, will maintain confidentiality.
   b. Involved parties will limit discussion of the alleged issue to appropriate and/or formal venues.
   c. When there is suspicion the behavior is related to chemical dependency, or physical, psychological, or emotional impairment refer to Physician Well-Being policy, 8710-511.
   d. Education of Medical Staff and ~~TCMC~~ **TCHD** organization members will be provided to promote awareness of the policy.
   e. All new Medical Staff applicants will be informed about the policy
2. Flexibility:
   a. The Medical Staff leadership retains the prerogative to respond in an alternative manner other than by the Procedural Guidelines set forth below. In its discretion, leadership may direct a more immediate approach to an instance or a pattern of unacceptable behavior. Such a response may not utilize some or all of the elements of the Procedural Guidelines, or may use them in a different order. A situation may also necessitate a non-programmed response. Within the framework of the Medical Staff Bylaws and the operation of law, this policy is not intended to limit the responses of the Medical Staff to any prescribed formula or sequence of action.

F. PROCEDURE GUIDELINES:

1. This guideline is a suggested course of action, subject to deviation, based upon unique circumstances.
   a. Alleged unacceptable behavior occurs and is identified by the Complainant. (Box 1 of Professional Behavior Form)
   b. Complainant and Attributed Individual will attempt to resolve the issue in an amicable and timely manner. Direct communication between the Attributed Individual and the Complainant may be encouraged. If the issue is resolved then no further action will be needed.
   c. If Complainant is unable or unwilling to resolve the incident directly with the Attributed Individual, then the Direct Supervisor will become involved.
   d. The Direct Supervisor will investigate the perceived unacceptable behavior and document the findings on the Professional Behavior (PB) Form and assesses whether further intervention is required. (Box 2 of Professional Behavior Form)
   e. If the Direct Supervisor determines further intervention is not required, the completed Professional Behavior form will be forwarded to the Medical Staff Office for review by the Chief of Staff and for filing. Professional Behavior form will be labeled "No Intervention Required" and process will end.
   f. If the Direct Supervisor determines that further intervention is warranted, the Direct Supervisor and the Attributed Individual will meet to discuss the incident (Complainant

may be present).

g. If the issue is resolved, then an action plan, with identified goals for all involved parties, will be documented on the Professional Behavior Form and forwarded to the Medical Staff Office for review by the Chief of Staff and placement in the Professional Behavior Chair file.

h. If the issue is not resolved, the Director of the Direct Supervisor will contact the Director of the Medical Staff Office and relevant Hospital Administration (CEO, COO/CNE, and VP of Human Resources) if appropriate. The Chief of Staff will be notified.

i. The Chief of Staff will notify and confer with the Chair of the Professional Behavior Committee. An action plan will be developed that is tailored to the circumstances of the situation. The Authority of the Professional Behavior Committee Chair will be the following:
   i. Attempt further mediation and resolution by counseling the Attributed Individual.
   ii. Arrange meetings of relevant parties, at which he may attend or preside.
   iii. If voluntary measures fail to resolve the situation satisfactorily, the Chair, after consulting with the Professional Behavior Committee, may make any recommendations to the MEC, including:
      1) Mandatory psychological/medical evaluation and treatment,
      2) Restriction of privileges by the MEC and the Board of Directors,
      3) Suspension and/or termination of membership by the MEC and the Board of Directors.

j. All Professional Behavior Forms will be maintained in the Attributed Individual's Professional Behavior Committee file for confidential review by the Chief of Staff, Professional Behavior Committee Chair, and the Director of Medical Staff Services. The information contained therein will be considered at the time of reappointment of Attributed Individual, and may be shared on a strict-need-know basis with the Credentials Committee, the MEC, or ad-hoc committees, all meeting in executive session. The pertinent Department Chair or Division Chief may be invited to those sessions.

k. Non-confidential feedback may be provided to the Complainant regarding resolution of the issue, but only from the Chief of Staff, the Professional Behavior Committee Chair, or their designees.

l. This statement is included in #10

G. **DOCUMENTATION:**
1. Documentation will be prepared as objectively as possible, utilizing factual information.
2. Completion of the Professional Behavior Form (PB form).

H. **REFERENCES:**
1. The Joint Commission Standards, ~~2012~~**2017**

I. **ATTACHMENT(S):**
1. Professional Behavior (PB) Form (see attached)

~~**Approvals:**~~
~~**Medical Executive Committee Approval: 01/13**~~
~~**Board of Directors Approval: 08/07; 01/13**~~

Tri-City Medical Center

Professional Behavioral Form
(PB Form)
Confidential Report

Abbreviations Used:

PBC:	Professional Behavior Committee
MSO:	Medical Staff Office
COS:	Chief of Staff
AI:	Attributed Individual
MEC:	Medical Executive Committee

Box 1 (refers to step 1 of Procedural Guidelines)

I. Complainant will describe issues of concern:

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Complainant Printed Name: _____

Box 2 (refers to step 4 of Procedural Guidelines)

II. Direct Supervisor Investigation and Documentation:

_____

_____

_____

_____

_____

_____

_____

_____

A. Is intervention with the AI necessary? ☐ Yes ☐ No

If **NO**, forward this completed form to the MSO for review by the COS and the PBC Chair, and filing.

If **YES**, proceed with meeting the AI.

B. Did the meeting with the AI resolve the issue(s)? ☐ Yes ☐ No

If **Yes**, forward this completed form with an action plan and goals for all involved parties to the MSO for review and filing.

If **No**, COS and PBC Chair shall be informed immediately. Refer to step 8 of the Procedural Guidelines.

Documentation and narrative of meeting between AI and Direct Supervisor. Include Action Plan/Goals/and Resolution if they were achieved.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signatures

Direct Supervisor:_____ Date:_____

Direct Supervisor Printed Name:_____

AI:_____ Date:_____

AI Printed Name:_____

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/03

SUBJECT: Requests for New Privileges/Technologies New to TCHD~~TCMC~~

REVISION DATE(S): 03/08, 08/12

POLICY NUMBER: 8710 – 526

Department Approval Date:	02/17
Credentials Committee Approval Date:	03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~08/12~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	08/12

A. **POLICY:**

1. The Tri-City **Healthcare District**~~Medical Center~~ (**TCHD**~~TCMC~~) Medical Staff shall review requests for new procedures/technologies.

B. **PURPOSE:**

1. To provide a mechanism to evaluate requests for new procedures/technologies, to determine if criteria must be developed, and whether the resources necessary to support the request are available.

C. **PROCEDURE:**

1. Practitioners requesting new procedures/technologies must submit a request in writing along with supporting documentation and proposed criteria to the Medical Staff Office.
2. Upon receipt of a new procedure/technology request, the Medical Staff Office shall evaluate to determine the following:
   a. Is the procedure/technology new to ~~TCMC~~**TCHD: https://www.nlm.nih.gov/services/ctconsent.html**~~?~~
      i. If no, refer to appropriate department/division rules and regulations for criteria.
      ii. If yes, submit request and supporting documentation to the appropriate Department/Division to determine if it is similar to an existing procedure.– If there is a similar procedure/technology, are there additional qualifications?
         1) If no, add to the appropriate Rules and Regulations and process for approval.– Upon Board approval, add the procedures to the appropriate privilege list.
         2) If yes, assess resource availability.
            a) Submit request to the appropriate department director to determine; if there is sufficient space, equipment, staffing, and financial resources either in place or available within the specified time frame to support each requested privilege.
            b) If resources are available, the Medical Staff Office shall contact the appropriate Division and/or Department to review the request and develop criteria in collaboration.
               i) If the request involves more than one Division and/or Department, the criteria should be outlined in policy format.
               ii) If the request involves a single Division and/or Department, the criteria shall be outlined in the appropriate rules and

regulations.

c) Develop criteria based on current standards.– Resources to consider include, but are not limited to:
   i) Clinical White Papers
   ii) Clinical resources
   iii) Community standards.

d) Criteria shall address as applicable:
   i) Board certification or equivalent training
   ii) Procedure-specific certification/training
   iii) Documentation of Current Competency – i.e. case logs
   iv) Initial Criteria
   v) Proctoring Criteria
   vi) Reappointment Criteria.

e) If resources are not available, request shall be denied.
   i) Such denial is not considered practice specific and is not subject to procedural rights of the Medical Staff Bylaws.

3. Upon finalization of proposed criteria, the Medical Staff Office shall submit the proposed criteria to the appropriate Division and/or Department, and the clinical director (as applicable) for review.
4. Upon Division and/or Department approval, the request shall be forwarded to:
   a. Credentials Committee along with the appropriate Division/Department's recommendation, if the criteria involve one or more Divisions and/or Departments, then to the Medical Executive Committee (MEC).
   b. Medical Executive Committee (MEC) along with the appropriate Division/Department's recommendation, if the criteria involve a single Division and/or Department..
5. Favorable recommendations from the MEC shall be submitted to the Board of Directors for approval.
6. Upon approval, the criteria shall be incorporated into the appropriate privilege forms and made available to Medical Staff members.

D. **ONGOING EVALUATION**:
1. The Medical Staff works in collaboration with administration to consistently review the resources needed to perform the requested privileges.

E. **REFERENCES:**
1. Joint Commission Medical Staff Standards ~~(MS.06.01.01)~~**2017**
2. The Compliance Guide to the Joint Commission Medical Staff Standards

~~**Approvals:**~~
~~**Credentials Committee Approval: 08/12**~~
~~**Medical Executive Committee Approval: 08/12**~~
~~**Board of Directors Approval: 03/08; 08/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

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

Department Approval Date:	03/17
Division of GVS Approval Date:	03/17
Medical Executive Committee Approval Date:	~~09/07~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	09/07

A. **STANDARDS:**

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

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

~~**Approvals:**~~
~~**Division of Imaging Approval:** _____~~
~~**Division of General Vascular Surgery Approval:** _____~~
~~**Division of Cardiothoracic Surgery Approval:** _____~~

~~**Medical Executive Committee Approval: 9/07**~~
~~**Board of Directors Approval: 9/07**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**1/01**	**SUBJECT:**	**Supervision of Residents/ Fellows/Medical Students**
REVISION DATE:	**8/02, 8/04, 6/06, 3/08; 10/11; 9/13 1/15**	**POLICY NUMBER:**	**8710 – 513**

Department Approval:	**12/16**
Graduate Medical Education Approval:	**~~01/15~~12/16**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/15~~03/17**
Professional Affairs Committee Approval Date:	**04/17**
~~**Governance Committee Approval:**~~	~~**04/15**~~
Board of Directors Approval:	**04/15**

A. **POLICY:**

1. All Emergency Medicine, Family Medicine, and/or Internal Medicine residents and Sports Medicine Fellows and activities of Residents, Fellows and Students are under the supervision of the Director of the Residency Program(s) and a designated Medical Staff member(s) who are member(s) of Tri-City ~~Medical Center~~**Healthcare District** (~~TCMC~~**TCHD**) Medical Staff. Each person is expected to follow the ~~Tri-City Healthcare District~~**TCHD** standards of service excellence and applicable policies.

B. **JOB DESCRIPTION BY PROGRAM**

1. Internal Medicine Family Medicine Rotation:
   a. Attitudes: The resident should develop attitudes that encompass:
      i. Awareness that Internal Medicine is a major portion of the fund of knowledge of a family physician.
      ii. Assessment of the patient's and family's understanding of the medical disorder. This should also include the value of non-intervention and when to use it.
      iii. Assessment of the impact of the medical disorder, its evaluation, and its treatment on the patient and the family.
      iv. Enlistment of the family support systems in patient treatment and compliance.
      v. Recognition of limitations and when to seek appropriate consultation and referral.
   b. Knowledge: The resident should develop knowledge of the pathophysiology, recognition, and management of the following common problems in adult medicine, **of the following but not limited to:**
      i. Hypertension
      ii. Type 1 Diabetes Mellitus
      iii. Type 2 Diabetes Mellitus
      iv. Myocardial Infarction
      v. Coronary Artery Disease
      vi. Stable and unstable angina
      vii. Congestive heart failure
      viii. Lipid disorders
      ix. Obesity
      x. Common Arrhythmias
      xi. Asthma
      xii. COPD
      xiii. GI Bleeding
      xiv. Gastroesophageal reflex / Peptic ulcer disease

xv. Irritable bowel syndrome
xvi. Anemia
xvii. Drug ingestions and overdoes
xviii. Thrombophlebitis
xix. Alcoholism and detoxification
xx. Hepatitis
xxi. Mononucleosis
xxii. Pneumonia
xxiii. Sepsis
xxiv. Meningitis
xxv. Tuberculosis
xxvi. Chronic bronchitis
xxvii. Arthritis (Osteoarthritis and Osteoporosis)
xxviii. Pulmonary embolism
xxix. Renal disease
xxx. Fever of unknown origin
xxxi. Stroke
xxxii. Fluid and electrolyte abnormalities
xxxiii. Envenomation
xxxiv. Abnormal liver function tests
xxxv. Syncope
xxxvi. Smoking cessation
xxxvii. Pre-operative evaluation

c. Skills: The resident should demonstrate the ability to:
   i. Evaluate the patient with a medical illness, including performance of adequate history and physical examination.
   ii. Learn more complex diagnostic and therapeutic skills.
   iii. Demonstrate proficiency in performing arterial puncture and arterial line placement, lumbar puncture, bone marrow biopsy, paracentesis, thoracentesis, arthrocentesis.
   iv. Perform and interpret exercise tolerance testing.
   v. Perform central vein catheterization including Swan – Ganz catheter insertion, (w/supervision)
   vi. Manage patients requiring ventilatory assistance.
   vii. Interpret EKGs.
   viii. Interpret X-rays.
   ix. Order and properly utilize laboratory and radiological studies.
   x. Appropriately use anticoagulants.
   xi. Know personal limitations.
   xii. Request appropriate consultation.

d. Implementation: Training in Adult Medicine is accomplished as follows –

PGY I (4 wk block)	**Med Ward**	**Med Ward**	**ICU**	**FP Inpatient Service**
PGY II	**Med Ward / ICU**	**Med Clinic**	**Cardiology**	**Hosp / Geri**
PGY III	**Med Ward (Tri-City)**	**HIV/Endocrine**	**Neurology**	**FP Inpatient Service**

   i. Residents are advised to use their elective time wisely in selecting other areas of subspecialty medicine for which they have an interest. Longitudinal experience is maintained through the resident's family practice continuity patients as well as through attendance at morning and noon conferences.

2. Emergency Department Rotation: (refer to Medical Staff Policy & Procedure #8710-513E)
3. Sports Medicine Fellow Rotation:
   a. San Diego Sports Medicine (SDSM) also hosts a nationally respected Orthopaedic Fellowship program that provides advanced training for new Orthopaedic Surgeons, while

conducting high-level research.

4. Medical Student Rotation:
   a. Medical Students are unlicensed persons prohibited from making a diagnosis, treatment or operating upon a patient except when prescribed as part of their course of study in an approved medical school.
   b. ~~Tri-City Medical Center~~**TCHD** has become part of an approved teaching program by means of an affiliation agreement with various medical schools. Preceptor rotations within the scope of this policy are periods of observation and do not constitute part of the course of study.
   c. Each Medical Student must have an identified preceptor who is a member of the Medical Staff. The preceptor(s) shall direct and supervise the Medical Student at all times.

C. **ROTATION DESCRIPTION:**

1. Family Medicine and Internal Medicine Rotation:
   a. Third year residents shall spend 4 weeks on the Internal Medicine service at ~~Tri-City Medical Center~~**TCHD**.
   b. The residents shall be supervised either directly or indirectly by the attending physicians responsible for the Internal Medicine service. The level of supervision shall be determined by the responsible attending physician.
   c. The resident shall be present Monday to Friday during the assigned 4-week block. Work hours should be arranged by the attending staff, but should generally involve daytime shifts without over night call.
   d. The resident duties should include performing history and physicals, daily rounds and routine ward care including discharge planning of patients admitted to the Internal Medicine service. Residents should be given opportunities to perform typical inpatient procedures under the supervision of the attending staff. These procedures would include, but are not limited to, arterial line placement, paracentesis, thoracentesis, exercise stress testing, endotracheal intubation, and cardioversion.
   e. Resident evaluation should be an ongoing process throughout the four weeks. For residents performing below standards, written notification to the resident and the Director for Residency Training should be done at the two week point. A written evaluation shall be completed in a timely manner using the standard form provided on all residents.
2. Emergency Department Rotation (Refer to Medical Staff Policy & Procedure #8710-571)
3. Sports Medicine Rotation:
   a. All orders, history and physical, discharge summaries and progress notes written by Sports Medicine Fellows shall be reviewed by the Medical Staff member(s).
   b. The medical care provided by the Sports Medicine Fellow shall be discussed with the designated Medical Staff member(s) on a frequent basis. The Fellow must document this in the medical record.
   c. The scope of activities shall be the same as that of the supervising physicians. Sports Medicine Fellows may be the first assist at surgery, consistent with appropriate departmental rules and regulations.
4. Medical Student Rotation ($3^{rd}/4^{th}$ year):
   a. Prior to a surgical rotation, the Medical Student shall complete an orientation to include a Sterile Technique and Surgical Safety Module (including Fire Prevention). Prior to an Emergency Medicine Rotation, the Medical Student shall complete an orientation to include introduction to the ER environment, overview of EHR, introduction of HIPAA, role in the department, and general policies of the ED. Prior to an Ob/Gyn rotation, the medical students shall complete the OR orientation as well as a Labor and Delivery orientation.
   b. Medical Students may perform and document written histories, physical examinations, and progress notes with the patient's permission and under the direct supervision of the attending physician. These must be countersigned by the attending physician.
   c. Medical Students cannot write orders, enter electronic orders, or give any verbal orders to RNs.

d. Medical Students may make rounds with the preceptor and participate in the examination of that medical staff member's patients. Protocols for examining female patients with a chaperone present must be followed.

e. Students on a surgical rotation may scrub and participate in surgery under the direct supervision of a preceptor surgeon to aid in learning surgical disease and principles. This includes placing and holding retractors, suctioning, suturing (above the fascia), and dissecting. Students on an emergency medicine rotation may participate in ED procedures under the direct supervision of a preceptor to aid in learning. This includes simple suturing, assisting with reductions and splinting, simple incision and drainage, lumbar puncture, ultrasound techniques, assist with central lines, assist with para/thora/arthrocentesis.

f. Medical students on an Ob/Gyn rotation may evaluate obstetric and gynecologic patients. They may perform breast and pelvic exams; obstetrical exams and cervical exams in labor; and write notes in the medical record. The students may be present in the operating room and are able to assist in major or minor gynecological surgical procedures under the direct supervision of a preceptor surgeon to aid in learning Ob/Gyn disease and principles. This includes placing and holding retractors, suctioning, suturing (above the fascia), and dissecting. The students may also participate in vaginal and cesarean deliveries.

g. Patients shall be informed and sign consent of their knowledge of presence of Medical Students in the hospital caring for them under attending physician.

h. Medical Students are not authorized to dictate or access the EMR.

D. **SUPERVISION DESCRIPTION:**

1. First Year Residents:

a. First year residents are unlicensed physicians, and the mechanism for their supervision is more direct than for second and third year residents.

i. Orders:

1) First year residents may write orders, however they must be countersigned by a supervising licensed independent practitioner prior to implementation.

2) Staff member(s) shall review all orders written by first year residents. If a nurse or other hospital employee has any question about an order written by a first year resident, the supervising higher level resident or Medical Staff member(s) may be contacted directly.

ii. Other Care:

1) History and physical, discharge summary, and progress notes may be written or dictated by first year residents and shall be countersigned by a supervising licensed independent practitioner.

2) All medical care provided by a first year resident shall be discussed with the designated Medical Staff member(s).

3) The resident must document in the progress notes that the patient was seen and/or discussed with the attending Medical Staff member(s).

4) The scope of activities shall be the same as that of the supervising physicians. Residents may be the first assistant at surgery, consistent with departmental rules and regulations.

2. Second and Third and Fourth Year Residents:

a. All orders, history and physical, discharge summaries and progress notes written by second, third and fourth year residents shall be reviewed and countersigned by the Medical Staff member(s).

b. If a nurse or other hospital employee has any question about an order written by a second, third and fourth year resident, the supervising higher level resident, or Medical Staff member(s) may be contacted directly.

c. The medical care provided by residents shall be discussed with the designated Medical Staff member(s) on a frequent basis. The resident must document this in the medical record.

d. Second, third and fourth year residents shall supervise such care depending upon the judgment of the Medical Staff member(s). The scope of activities shall be the same as that of the supervising physicians. Residents may be the first assist at surgery, consistent with appropriate departmental rules and regulations.

3. Sports Medicine Fellows:
   a. All orders, history and physical, discharge summaries and progress notes written by Sports Medicine Fellows shall be reviewed by the Medical Staff member(s).
   b. If a nurse or other hospital employee has any question about an order written by a sports medicine fellow the supervising Medical Staff member(s) may be contacted directly.
   c. The medical care provided by the Sports Medicine Fellow shall be discussed with the designated Medical Staff member(s) on a frequent basis. The Fellow must document this in the medical record.
   d. The scope of activities shall be the same as that of the supervising physicians. Sports Medicine Fellow may be the first assist at surgery, consistent with appropriate departmental rules and regulations.
4. Emergency Department Residents: (Refer to Medical Staff Policy & Procedure #8710-571)
5. Medical Students:
   a. All activities of 3rd and 4th year Medical Students including documentation of histories, physicals, and progress notes shall be under the direct supervision of an identified preceptor who is a member of the Hospital Medical Staff and shall be co-signed.
6. Medical Staff Attending:
   a. The designated Medical Staff member(s) shall be ultimately responsible for all care provided by Medical Students, Residents, and Sports Medicine Fellows and making decisions regarding each resident's progressive involvement and independence with specific patient care activities in accordance with this Policy and Procedure.
   b. Medical Staff member(s) shall write a daily progress note on each patient for which they are responsible. The note should reflect physical examination of the patient and include the physical assessment of current status, diagnostic and therapeutic plan.
   c. Documentation requirement(s) for Emergency Department Residents refer to Administration policy and procedure #351.
   d. Documentation requirement(s) for the Sports Medicine Fellow, the Medical Staff member(s) shall supervise the dictation of the Operative Report within the required time frame and Medical Staff member(s) shall co-sign Operative Report and all other Medical Record documentation including History and Physicals, Discharge Summaries and physician orders.

E. **GENERAL OVERSIGHT:**

1. Information regarding the safety and quality of patient care, treatment, and services provided to patients by a resident shall be discussed at the Graduate Medical Education (GME) Committee.
2. Reports shall be presented to the Medical Executive Committee and the Board at least annually.
3. The Medical Staff Director/Supervisor of each resident/student/fellowship program shall be responsible for communicating directly with the affiliated training institution regarding medical student/resident/fellow activities (as well as for reporting to GME committee) regarding quality of care, treatment, services and education needs of the participants. **(See notes below stating mechanism used to gather this information.)**

F. **REFERENCES:**

1. The Joint Commission Hospital Accreditation Standards **2017**

Note: Mechanism used to gather information noted in E-3 of this policy includes: Hospital's Risk Assessment program (RL) and the Spotlight for Success "Applause Card" program both of which allow for submission of comments from the community as well as internal staff.

Tri-City Medical Center
Medical Staff Office
4002 Vista Way
Oceanside, CA 92056
(760) 940-3071 (phone) * (760) 940-3486 (fax) plantsm@tcmc.com (e-mail) *

ANNUAL ASSESSMENT "EFFECTIVENESS OF GENERAL MEDICAL EDUCATION PROGRAM"

The Medical Executive Committee is interested in your comments regarding the GME program held at TCMC. Your feedback is vital to the continued success of the program.

ANNUAL ASSESSMENT "Effectiveness of GME Program"	Yes	No
1. Do you feel that the GME Program meets your needs? Comments:_____		
2. Have the medical students/residents/fellows been well received by the patients and staff? Comments:_____		
3. Are the medical students/resident's/fellows rotations sufficient to enable them to experience all acuity levels of the patients? Comments: _____		
4. Has the supervision of the medical students/residents/fellows been consistent with the standards? Comments: _____		
5. Was this program successful in meeting the needs of the hospital, patients and participants, and should the program be continued? Comments: _____		
6. During peer review, have there been any identified outliers that have not been consistent with the standard of care within the department? Comments:_____		
7. Has the clinical decision making process been appropriate and dependable? Comments: _____		
8. Were all safety precautions/protocols identified/followed? Comments: _____		
9. Any additional comments/suggestions or educational needs suggestions:_____		
10. Future Goals and Actions for following year: _____		

Thank-you for participating in the evaluation of TCMC's GME Program.

_____ _____ _____ _____ _____ _____ _____

Signature *Date*

Please return completed form to the Medical Staff Office: Attn: Sarah Plant

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 03/07 **SUBJECT:** Surgical Assistance

REVISION DATE(S): 11/11, 07/12 **POLICY NUMBER:** 8710 – 545

Department Approval Date:	03/17
Division of GVS Approval Date:	03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~07/12~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	07/12

A. **PURPOSE:**

1. To identify Amount and Level of Assistance required in Surgical Cases.

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
GENERAL					
Abdominal Perineal	X			X	
Bowel Resections (Major, as determined by surgeon)	X			X	
Gastric Procedures (Major, as determined by surgeon)	X			X	
Bariatric Procedures (Major, as determined by the surgeon)	**X**			**X**	
Biliary Procedures (Major, as determined by surgeon)	X			X	
Robotic Procedures (Major, as determined by the surgeon)	**X**			**X**	
Hepatic/Pancreatic Procedures	X			X	
Mastectomy Radical	X			X	
~~Omentectomy~~	~~X~~			~~X~~	
Pelvic Exenteration	X			X	
Thyroid Procedures	X			X	
VASCULAR					

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
Aortic Procedures	X			X	
Carotid Procedures	X			X	
Peripheral Vascular Bypass	X			X	
THORACIC					
Open Esophageal Procedures	X			X	
Thoracoscopy Procedures	X			X	
Thoracotomy Procedures	X			X	
UROLOGIC					
Open Prostatectomy Procedures	X			X	
Open Renal Procedures	X			X	
Open Ureteral Procedures	X			X	
Cystectomies	X			X	
ORTHOPEDIC					
Total Large Joint Procedures	X			X	
Spinal fusion/rodding procedures	X			X	
OB/GYN					
Hysterectomy Procedures	X			X	
Cesarean Sections	X			X CNM	X Emergency
NEUROSURGERY					
Craniotomies (except burr holes)	X			X	
Spinal fusion/rodding procedures	X			X	
ENT					
Radical Neck Procedures	X			X	
Thyroid Procedures	X			X	
Parotidectomy	X			X	
ORAL/MAXILLOFACIAL					
Cranial/Facial Procedures	X			X	X DDS

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

2. Amount and level of assistance for all other procedures are at the discretion of the operating surgeon.
3. For emergent surgical cases, the amount and level of assistance for procedure may be waived at the discretion of the ~~Department Chair or Chief of Staff~~**surgeon.**

B. **Open Heart Procedures**:
1. 1st Assistant must be another cardiac/thoracic surgeon or surgeon
2. 2nd Assistant may be MD or PA/RNFA

~~**Approvals:**~~
~~**General & Vascular Surgery Division Approval: 07/11**~~
~~**Cardiothoracic Surgery Division Approval: 10/11**~~
~~**Orthopedic Division Approval: 02/12**~~
~~**Neurosurgery Division Approval: 03/12**~~
~~**Subspecialty Surgery Division Approval: 02/12**~~
~~**Urology Division Approval: 05/12**~~
~~**Surgery Department Approval: 04/12**~~
~~**Ob/Gyn Department Approval: 10/11**~~
~~**Medical Executive Committee Approval: 07/12**~~
~~**Board of Directors Approval: 11/11; 07/12**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**7/01**	**SUBJECT:**	**Suspension for Delinquent Medical Records & Fine Process**
REVISION DATE:	**3/05, 4/06, 3/07, 7/07, 3/08, 9/09, 10/14; 3/15; 2/16**	**POLICY NUMBER:**	**8710 – 519**

Department Approval Date:	**03/17**
Medical Staff Committee Approval Date:	**n/a**
Pharmacy and Therapeutics Approval Date:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~03/17**
Professional Affairs Committee Approval:	**~~04/16~~04/17**
Board of Directors Approval:	**04/16**

A. **POLICY:**

1. It is the policy of Tri-City ~~Medical Center~~**Healthcare District (TCHD)** and its Medical Staff that all medical records are completed in a timely manner, in accordance with Medical Staff Policy 8710-518, Medical Record Documentation Requirements, applicable laws, and accreditation standards.

B. **PROCEDURE:**

1. Applicable ~~TCMC~~ **TCHD** departments shall enforce pre-procedure requirements for History and Physical exam, as outlined in Medical Staff Policy 8710-518, Medical Record Documentation Requirements.
2. In order to facilitate timely medical record completion and appropriate practitioner notification, the ~~TCMC~~ **TCHD** IT Department shall develop and implement such automated notification mechanisms as requested by the Medical Records/HIM Department.
3. The Medical Records/HIM Department is responsible for reviewing medical records and identifying deficiencies of dictations and signatures, as outlined in Medical Record Documentation Requirements.
4. The practitioner is responsible for identifying any error(s) in assigned dictations/signatures by "refusing" the item within the Cerner Message Center, and indicating the appropriate practitioner if possible.
5. The Medical Records/HIM Department will run a weekly report to identify dictations and signatures that are not complete following patient discharge.
   a. A letter under the Chief of Staff's signature will be initiated to each practitioner weekly when the practitioner has any deficiencies aged 7 days from discharge. A second communication will be sent at 10 days post discharge.
6. Each week the Medical Records/HIM Department will submit to the Chief of Staff (via the Medical Staff Office) a list of verified deficiencies.
7. The Medical Staff Office shall:
   a. Call the physician to give verbal notice of the impending suspension.
   b. Prepare and send a written Notice of Automatic Limited Suspension to the physician.
8. Limited suspension shall apply to the practitioner's right to admit, treat or to provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the practitioner has already admitted or has scheduled to treat or to perform any invasive procedure. Obligations to fulfill ED On-Call duties as per existing schedule shall remain in effect.

9. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available.
10. In the case of a patient care emergency, the suspension may be lifted by the Chief of Staff or his/her designee, otherwise the suspension shall continue until the medical records are complete.
11. If the physician is on vacation or has an illness when his or her records become delinquent, with Chief of Staff approval, such physician shall have five (5) days of returning to practice from vacation or illness to complete the records.

C. **MEDICAL STAFF FINES FOR DELINQUENT MEDICAL RECORD DICTATION:**

1. Purpose:
   a. To provide a Policy and Procedure for implementation and ongoing enforcement of fines for Medical Staff members with delinquent medical record dictation.
2. Definition Of Terms For Fine Process:
   a. Delinquent Dictation: A medical record is considered "delinquent" 14 calendar days after discharge, however, for this purpose fines will only be imposed for "dictations only", i.e. H&P, Op Reports, and Discharge Summary.
   b. Limited Suspension: A Limited Suspension permits the practitioner to continue to care for a patient he/she is already treating in the hospital or has scheduled to treat prior to the date of the imposed suspension.
   c. Fines: A fine of $10.00 will be imposed and billed to any practitioner who appears on the suspension list for each delinquent dictation. The $10.00 fine will be compounded weekly if not completed.
3. Policy And Procedure:
   a. Each Monday, prior to suspension, Medical Records sends Medical Staff office a list of physicians with delinquent dictation(s). Medical Staff office notifies the practitioner of the delinquent dictations indicating that the delinquent dictation(s) must be completed by the following Wednesday or a $10 per each delinquent dictation will be assessed.
   b. Medical Staff suspends each Wednesday. Physicians with delinquent dictation(s) will be billed $10 per delinquent report via the Medical Staff Department.
   c. Fines are due and payable when the practitioner receives a bill. (Physicians must notify Medical Records prior to leaving on vacation in order to be considered "exempt" from the fining process during their absence from the facility.)
   d. Loss of privileges/membership will result in the following circumstances:
      i. If, at the time of reappointment, the practitioner is found to owe outstanding fines, the application for reappointment will be considered "incomplete";
      ii. If the physician is found owing a fine for delinquent medical records for a period of 6 months or more;
         1) The practitioner will be sent a certified letter, including a copy of this Policy/ Procedure, which states that "failure to pay the outstanding fine, within twenty-one days of the date of the final notice, will result in the automatic relinquishment of his/her membership".
         2) The letter will give the practitioner an opportunity to forward a written response, within seven days of the date of the final notice, to be considered at the Medical Executive Committee meeting.
         3) The outcome of the deliberations/decision determined at the Medical Executive Committee meeting will be forwarded to the practitioner in question via certified mail. Should the practitioner fail to submit a letter for consideration at the Medical Executive Committee meeting or after consideration of such a letter, if it is determined at the Medical Executive Committee meeting that the practitioner does owe the fine, the payment of such fine is due and payable on the date identified in the first notice. A practitioner who has failed to pay the outstanding fine(s) within the

timelines as defined in this policy will be considered to have automatically relinquished his/her medical staff privileges and membership at ~~Tri-City Medical Center~~**TCHD** and therefore will not be entitled to a hearing as set forth in Article VII of the Medical Staff Bylaws. If the practitioner wishes to reapply to the staff he/she will be required to pay the full application fee plus the total of any outstanding fines owed for delinquent medical record dictation.

e. The monies collected from this process will be added to the Medical Staff Checking account and used as determined by the Medical Executive Committee on behalf and in support of the Medical Staff.

D. **MEDICAL STAFF SUSPENSION MONITORING:**

1. The Medical Staff Office shall notify Medical Records/HIM, IT, Surgery, Administration, Admitting, Cardiology and Radiology of the automatic suspension.
   a. Each of these departments is responsible for enforcing the suspension.
   b. Any questions shall be directed to the Chief of Staff via the Medical Staff Office.
2. The Medical Records/HIM Department shall notify the Medical Staff Office when a suspended practitioner has completed all deficiencies.
3. The Medical Staff Office shall notify the practitioner and applicable departments that the suspension has been lifted.
4. Days on suspension shall be tracked in the Medical Staff's credentialing database and considered at the time of OPPE and reappointment.
5. The Medical Executive Committee will serve as the intermediary in resolving suspension/delinquency status questions from physicians and will assist the Medical Records Department in communications with practitioners who have disputes regarding the actions of this policy.
6. Practitioners indicating an intent to resign will be advised to complete all outstanding dictations and signatures before departure, as failure to do so will make them ineligible for "good standing" affiliation verifications.

E. **REFERENCES:**

1. Medical Staff P&P 8710-518: Medical Record Documentation Requirements
2. Medical Staff Bylaws: Article VI, § 6.4-4

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 05/01	**SUBJECT:** Temporary Privileges for ~~/Temporary~~ Medical Staff ~~Membership~~
REVISION DATE(S): 03/08, 04/09, 09/13	**POLICY NUMBER:** 8710-515

Department Approval Date:	~~09/13~~02/17
Credentials Committee Approval Date:	~~09/13~~03/17
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~09/13~~03/17
Professional Affairs Committee Approval Date:	04/17
Board of Directors Approval Date:	09/13

A. **POLICY:**

1. Temporary privileges may be granted for circumstances and in accordance with procedures as outlined in the Tri-City ~~Medical Center~~**Healthcare District (TCHD)** Medical Staff Bylaws~~, Section 5.5~~.
2. ~~Temporary Medical Staff membership may be granted to physicians to act as proctors consistent with Section 3.9 of the Medical Staff Bylaws.~~

B. **DEFINITION(S):**

1. Temporary Privileges: May be granted to a physician who has a particular skill that is needed or desired in the organization for a period of time but not related to a disaster or emergency procedure.

C. **PROCEDURE:**

1. Temporary Privileges for Medical Staff Applicants:
   a. Refer to Medical Staff Policy #8710-543, Credentialing Policy, Processing Medical Staff Applications, for medical staff applicant credentialing criteria.
   b. In accordance with the Medical Staff Bylaws~~, Section 5.5-2~~.
2. Temporary Privileges –Important Care Need and Locum Tenens
   a. The Medical Staff Office shall verify, at a minimum, the following information when temporary privileges are requested for an important patient care need and/or locum tenens:
      i. Current California license to practice
      ii. Drug Enforcement Administration registration
      iii. Current malpractice insurance and claims history
      iv. Current Competence
      v. NPDB
      vi. Peer References (at least one)
      vii. Letter(s) of Hospital Affiliation (at least one)
   b. Other verification may include:
      i. Positive identification
      ii. AMA or AOA Profile (Medicare/Medicaid exclusions)
      iii. Board Certification (Certifacts)
3. ~~Temporary Medical Staff Membership for Proctors:~~
   a. ~~The temporary Medical Staff member shall submit an application on the approved application form.~~
   b. ~~The Medical Staff Office shall verify, at a minimum when temporary membership is~~

~~requested:~~

~~i. Licensure~~

~~ii. Current competence (generally will consists of current affiliation where he/she currently holds/exercises the privilege being proctored)~~

~~c. Other verification may include:~~

~~i. Positive identification~~

~~ii. Such other information as may be available as directed by the Credentials Committee~~

~~d. The verifications remain valid for six (6) months; renewals of temporary membership beyond that time require submission of an application update and attestation.~~

~~**Approvals:**~~

~~**Credentials Committee Approval: 09/13**~~

~~**Medical Executive Committee Approval: 09/13**~~

~~**Board of Directors Approval: 03/08; 04/09; 09/13**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 9/07

SUBJECT: Unintended Intraoperative Awareness during General Anesthesia

REVISION DATE(S):

POLICY NUMBER: 8710 – 546

Department Approval Date:	**02/17**
Department of Anesthesiology Approval Date:	**~~09/09~~03/17**
Pharmacy and Therapeutics Approval Date:	**n/a**
Medical Executive Committee Approval Date:	**~~09/07~~03/17**
Professional Affairs Committee Approval Date:	**04/17**
Board of Directors Approval Date:	**09/07**

A. **PURPOSE:**

1. To establish a process for preventing and dealing with unintended intraoperative awareness during general anesthesia.

B. **DEFINITION(S):**

1. Anesthesia Awareness: Unintended intraoperative awareness occurs when a patient receiving general anesthesia as the primary anesthetic becomes cognizant of some or all events during surgery, or other procedure. Anesthesia awareness does not include the time before the complete induction of anesthesia, or during intended emergence.
2. Background:
   - i. The incidence of awareness during general anesthesia is reported to be greater in patients, for whom a smaller-than-usual dose of general anesthetic is necessary to decrease dangerous side effects (e.g., hemodynamic instability). Procedures identified as typically failing into this category are some cardiac, obstetric, and major trauma cases. Because unintended intraoperative awareness during general anesthesia is not always preventable, health care practitioners should be prepared to anticipate, acknowledge, and manage this occurrence with compassion and diligence.
   - ii. Monitoring patients during general anesthesia to prevent intraoperative awareness can be challenging. Despite a variety of available monitoring methods, awareness is difficult to recognize while it is occurring. Typical indicators of physiologic and motor response, such as hypertension, tachycardia, or movement are often masked by the use of neuromuscular blocking agents to achieve necessary muscle relaxation during the procedure, as well as the concurrent administration of other drugs necessary to the patient's management, such as beta-blockers or calcium channel blockers.

C. **GUIDELINES:**

1. Prevention:
   - a. Equipment Maintenance:
     - i. Periodic maintenance of the anesthesia machines and its vaporizers will be performed and documented.
2. Preoperative Identification:
   - a. Certain procedures may entail a higher risk of unintended intraoperative awareness and some patients with certain characteristics may be at an increased risk for the occurrence of intraoperative awareness. These include:
     - i. Cardiac surgery patients
     - ii. Acute trauma patients with hypovolemia
     - iii. Cesarean section patients under general anesthesia

iv. Patients undergoing emergency surgery
v. ASA Physical Status 4 and 5 patients
vi. Patients with impaired cardiovascular status
vii. Patients with anticipated difficult intubation
viii. Patients with a history of awareness
ix. Patients with a history of heavy alcohol intake
x. Patients with a history of chronic use of benzodiazepines, opioids or both.
1) Patients considered by the anesthesiologist to present significantly higher risk for an awareness experience should be informed of the potential for awareness in preoperative discussions with their anesthesiologists.

3. Reducing the risk of intraoperative awareness during general anesthesia:
a. The appropriate anesthesia techniques and medications are determined by clinical judgment based on each patient's unique circumstances.
b. The anesthesia provider should consider pre-medication with an agent that may reduce the incidence of awareness (e.g. a benzodiazepine or scopolamine) when deemed appropriate.
c. If intubation of the trachea is difficult, consideration should be given to the administration of additional dosages of the induction or amnesic agent.
d. Anesthesia practitioners should realize that certain medications (e.g. beta-blockers, calcium channel blockers, alpha-2 agonists) and neuromuscular blocking agents may mask the homodynamic and physiologic responses to inadequate anesthesia.

4. Managing an Episode of Unintended Intraoperative Awareness During General Anesthesia:
a. When an anesthesiologist learns that a patient may have had unintended intraoperative awareness of surgical or procedural events during general anesthesia, the anesthesiologist should explore, document, and report the experience and provide for any necessary follow-up care. When other personnel learn that a patient may have experienced unintended intraoperative awareness during general anesthesia, the personnel should inform the anesthesiologist of record about the suspected occurrence.
b. If an episode of unintended intraoperative awareness during general anesthesia occurs or is suspected, the anesthesiologist who was responsible for the patient's care, or a qualified designee, should interview the patient and document the details of the patient's experience. If the anesthesiologist determines that unintended intraoperative awareness during general anesthesia has occurred the following steps may serve mitigate serious patient sequelae:
i. Assure the patient of the credibility of his or account and sympathize with the patient's experience;
ii. Explain what happened and why, if a reason can be given (e.g., the necessity to administer light anesthesia in the presence of significant cardiovascular instability);
iii. Offer the patient support, including referral of the patient to a psychiatrist, psychologist, or the Hospital Counseling Services if appropriate;
iv. Document any referrals or treatment provided to the patient;
v. Notify the patient's surgeon and nurse;
vi. Complete an occurrence report concerning the event for the purpose of quality management.

D. **REFERENCES:**

1. ASA. (2004, Dec. 17). Sample of a policy on unintended anesthesia awareness. Retrieved May 10, 2005 from http://www.asawebapps.org/docs/SampleAwarenessPolicy.pdf
2. JCAHO (2004, Oct. 6). Preventing and managing the impact of anesthesia awareness. Joint Commission on Accreditation of Health Care Organizations Sentinel Alert, Issue 32. Retrieved May 10, 2005 from http://www.jcaho.org/about+us/news+letters/sentinel+event+alert/sea32.htm.

~~**Approvals:**~~
~~**Department of Anesthesia Approval: 09/09**~~
~~**Medical Executive Committee Approval: 09/07**~~

~~**Board of Directors Approval:** 09/07~~

Tri-City Medical Center	Women's and **Newborn**~~Children's~~ Services Manual - NICU
PROCEDURE:	**PERIPHERALLY INSERTED CENTRAL CATHETERS AND MIDLINE CATHETERS, INSERTION OF**
Purpose:	To outline the procedure for the placement of peripherally inserted central catheters (PICC) in the neonate by a qualified PICC Registered Nurse.
Equipment:	1. PICC kit 2. Appropriately sized catheter 3. 26-gauge autoguard introducer 4. Mask, cap, sterile gown, and sterile gloves 5. 1:1 heparinized normal saline 6. Transfer set
Issue date: 9/07	Revision date(s): 6/09, 11/09, 6/11, 8/12, 4/14

A. **POLICY:**

1. RN Requirements/Experience

~~1.~~**a.** **There is an application and interview process for new PICC team members.**

~~a.~~**b.** Must have a minimum of 2 years experience as a NICU RN at Tri City Medical Center.

~~b.~~**c.** Must be a benefitted TCMC employee~~, preferably full time FTE~~.

~~c.~~**d.** Must demonstrate proficiency in peripheral IV skills.

e. Must successfully complete a PICC Insertion didactic and laboratory practical course every 2 years.

~~d.~~**f.** **Must schedule at least one 4-hour PICC on-call shift per pay period**

~~e.~~**g.** RNC-NIC preferred.

2. Initial and Ongoing Competency Evaluation
   a. Initial Competency Evaluation includes completion of three successful PICC placements under the direct supervision of PICC team coordinator or designee, within 6 months of didactic training completion.
   b. Annual Competency Evaluation includes the completion of 4 successful PICC insertions per year (1 per quarter), one of which will be proctored. If the PICC RN is unable to achieve 4 successful PICC insertions per year (1 per quarter), then demonstration of a PICC insertion will either be performed in a lab setting or through the completion of one successful PICC placement under the direct supervision of the PICC team coordinator or designee.
3. The medical team in collaboration with the PICC qualified RN**s** ~~and Assistant Nurse Manager (ANM) or designee~~ will determine the need for a PICC and discuss any special considerations/ contraindications including septicemia, thrombocytopenia or coagulopathy, **decreased venous return, cardiac malformations** or the presence of fractures **or other musculoskeletal abnormalities** prior to insertion.
   a. Indications for PICC placement include **but are not limited to**:
      i. Infants requiring venous access for long term (≥7 days) intravenous fluid/hyperalimentation or medications.
      ii. Infants with poor vascular access.
      iii. Caustic drug therapy,
      iv. **Infants less than 32weeks gestation or less than 1500 grams birth weight**~~Very low birth weight~~**.**
4. **An informational handout will be provided to the parent or legal guardian. Questions will be answered or forwarded to the infant's physician or allied health professional (AHP).**
5. The PICC qualified RN will notify the physician if complications occur during insertion including excessive bleeding from the site, bradycardia or cardiac arrhythmia, catheter embolism, or a failed PICC attempt.

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/16	10/16	02/17	03/17	04/14, 04/17	04/14

6. Maximal Barrier Precautions and sterile technique will be used at all times. Staff within 3 feet of the sterile field will wear a hat and mask.
7. ~~The physician will verify placement of the c~~**C**atheter **placement will be verified** by chest and/or abdominal x-ray immediately after the procedure. The PICC RN will make any necessary adjustments in catheter placement. Line placement will be verified on all subsequent x-rays.
8. PICC placement will~~th~~ be verified a minimum of every 2 weeks by X-ray.
9. ~~An informational handout will be provided to the parent or legal guardian. Questions will be answered or forwarded to the infant's physician.~~

B. **PICC PLACEMENT:**

1. Procedure:
   a. Verify ~~order from physician to place PICC and that~~ informed consent has been obtained from parent or legal guardian **and review PICC placement orders in EMR**.
   b. Ensure that comfort is provided for the infant during the procedure. Refer to NICU "Pain Management" policy.
   c. Perform hand hygiene.
   d. Perform "time out" to verify patient and procedure. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" policy.
   e. Select vein to be **cannulated**~~used~~ for procedure.
   f. Measure the desired length of the catheter.
      i. For arm placement, measure from the insertion site up to the shoulder, across the chest to the top of the sternum and then down to the midpoint of the sternum (the third intercostal space).
      ii. For leg placement, measure from insertion site following vein track up to the xyphoid process.
   g. Position patient using developmentally supportive methods and immobilize the infant securely.
      i. Position patient with desired insertion site accessible.
      ii. For arm insertion, position the patient's head facing toward the insertion side with chin down, to prevent catheter insertion into the jugular vein.
   h. Restrict traffic near the sterile field.
   i. Don a mask, cap, and sterile gown. If assistant will enter the sterile field or reach over it, they will perform hand hygiene and also wear maximal barrier precautions (sterile gown, mask, **cap**~~hair covering~~, and sterile gloves).
   j. Open the PICC kit. Put on sterile gloves, set up, and drape a sterile work area. Cover the infant with a full-body sterile drape with only the involved skin area exposed.
   k. Prepare the involved skin area with three 2% chlorhexidine gluconate swabs per manufacturer's guidelines.
   l. Do not touch the part of the catheter to be inserted; use forceps to manipulate it. Check the catheter and insertion needle for defects.
   m. Fill two 10 mL syringes with 1:1 heparinized flush solution.
   n. Attach syringe and flush catheter with heparinized saline solution.
   o. Insert the introducer bevel up at a 15 ° -30 ° angle into the skin a few millimeters before anticipated entry into the vein. Observe for blood return. **Advance slightly then retract needle.**
   p. Advance the catheter through the introducer with small forceps to thread it into the vessel to the pre-measured length. Apply pressure well above the tip of the introducer to stabilize the catheter during the removal of the introducer. Remove the introducer and pull the wings apart to break and remove them.
   q. Aspirate to verify blood return and flush with heparinized normal saline.
   r. Secure catheter at insertion site with sterile adhesive skin closure strip.
   s. Obtain an order for x-rays. Catheter placement is to be confirmed by x-ray and read by a physician **or AHP** prior to infusing fluids. It is optimal to have the infant's arms in a neutral**, flexed** position for the x-ray, (not raised above shoulder level).

t. If catheter tip is not in the desired location, adjust catheter placement to desired location **and confirm with follow-up x-ray**.

u. **Cleanse extremity of residual chlorhexidine gluconate with sterile water or normal saline.**

v. Apply dressing by removing the skin prep with sterile water or normal saline and allowing to dry.
   i. Secure catheter at insertion site with sterile adhesive skin closure strip (if not already done).
   ii. Coil the external catheter in small concentric circles (avoid kinks) and secure with a second steri-strip.
   iii. ~~Use foam tape to fit and place under hub to avoid skin irritation/breakdown.~~ Secure hub with sterile adhesive skin closure strip.
   iv. Place transparent dressing**(s)** over the insertion site, length of catheter and hub

w. Secure the exit site:
   i. Apply sterile adhesive skin closure strip using chevron technique (v-shaped pattern) and secure to skin above transparent dressing.

x. Begin infusion of IV fluids after proper placement is confirmed.

y. ~~Cleanse extremity of residual chlorhexidine gluconate with sterile water or normal saline.~~

z. Document the procedure in the patient's medical record, including the Central Line Insertion Procedure (CLIP) form.

C. **REFERENCES:**

1. **Gorski, L. et al. (2016). *Journal of Infusion Nursing: Infusion Therapy Standards of Practice*. Norwood, MA: Infusion Nurses Society**
2. **Verklan, T., Walden, M. (2015). Core curriculum for neonatal intensive care nursing (5th ed.,pp. 290-299). St Louis, MO: Saunders**
3. **Wyckoff, M., Sharpe, E. (2015). Peripherally inserted central catheters: guidelines for practice (3rd ed.). Chicago, IL: National Association of Neonatal Nurses.**
1. ~~Chathas, M.K., & Paton, J. (1997). Meeting the special nutritional needs of sick infants with a percutaneous central venous catheter quality assurance program. *Journal of Perinatal and Neonatal Nursing*, 10, (4), 72-87.~~
2. ~~Heiss-Harris, G.M., Bailey, T. (2010). Common Invasive Procedures. In T. Verklan and M. Walden, Core curriculum for neonatal intensive care nursing (4th ed., pp. 299-332). St. Louis: Saunders.~~
3. ~~Lesser, E., Chhabra, R. Bryon, L.P., & Suresh, B.R. (1996). Use of midline catheters in low birth weight infants. *Journal of Perinatology*, 16(3), 205-207.~~
4. ~~Marino, C., Aslam, M. Kamath, V., Rosenberg, H.K., Rajegowda, B.K. (2006). Life threatening complication of peripherally inserted catheter (PICC) in a newborn. *Neonatal Intensive Care*, 19(2), 63-65.~~
5. ~~Marx, M. (1995). The management of the difficult peripherally inserted central venous catheter line removal. *Journal of Intravenous Nursing*, 18(5), 246-249.~~
6. ~~Masoorli, S. (1997). What to do about PICC line problems. *Nursing* 27(2), 32aaa-32ddd, 32fff, 32hhh.~~
7. ~~Nobuhara, K.K., Gilbert, J.C., & MacDonald, M.G. (2002). General principles of central venous (*3rd Ed.*, pp 195-213). Philadelphia: Lippincott, Williams & Wilkins.~~
8. ~~Pettit, J. (2002). Assessment of infants with peripherally inserted catheters: Part I. Detecting the most frequently occurring complications. *Advances in Neonatal Care*, 2, 304-315.~~
9. ~~Pettit, J. (2003). Assessment of infants with peripherally inserted catheters: Part II. Detecting less frequently occurring complications. *Advances in Neonatal Care*, 3, 14-26.~~
10. ~~Petit, J. (2003). Assessment of the infant with a peripherally inserted device. *Advances in Neonatal Care*, 3, 230-240.~~
11. ~~Pettit, J. & Wyckoff, M. (2001). *Peripherally inserted central catheters: Guidelines for practice*. Glenview, IL: National Association of Neonatal Nurses.~~

~~12. Trotter, C. (2004). Why are we trimming peripherally inserted central venous catheters? *Neonatal Network*, 23, 82-83.~~

~~13.~~**4.** ~~Wall, J., & Kierstead, V. (1995). Peripherally inserted central catheters: Resistance to removal: A rare complication. *Journal of Intravenous Nursing*, 18(5), 251-254.~~

~~14.~~**5.** CPQCC quality improvement toolkit, hospital-acquired infection prevention.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: ANESTHESIA: TYPE, LOCATION AND MONITORING OF

ISSUE DATE: 6/09
REVISION DATE(S): 5/15; 11/15

Department Approval Date(s):	**10/16**
Department of Anesthesiology Approval Date(s):	**10/16**
Operating Room Committee Approval Date(s):	**10/16**
Pharmacy and Therapeutics Approval Date(s):	**02/17**
Medical Executive Committee Approval Date(s):	**03/17**
Professional Affairs Committee Approval Date(s):	**04/17**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To provide guidelines for type, location and monitoring of Anesthesia Services throughout Tri-City Medical Center under various forms of anesthesia.

B. **DEFINITION(S):**
1. **General Anesthesia:** ~~Loss of consciousness induced by anesthetic administration. Drug induced d~~**Depression of consciousness caused by the administration of anesthetic agents during which the patient is not arousable.**
~~1.~~**2.** **Spinal Anesthesia:** Injection of anesthetic substances in the spinal fluid.
~~2.~~**3.** **Epidural Anesthesia:** Injection of anesthesia substances in the epidural space.
~~3.~~**4.** **Regional Anesthesia:** A region of the body anesthetized with local anesthesia.
~~2.~~**5.** **MAC:** Monitored Anesthesia Care- ~~Patient sedated but awakea~~**Anesthesia provider present during a procedure and includes varying levels of sedation, analgesia and anxiolysis as necessary**.
~~3.~~**6.** **IV Sedation:** ~~Conscious Sedation-~~**Depressed level of consciousness induced by the administration fof** sedatives **in which** patients retain **the ability to maintain an open airway and respond to physical stimulation or verbal commands**.
~~4.~~**7.** **PACU:** Post Anesthesia Care Unit.

C. **POLICY:**
1. General Guidelines:
   a. A pre-anesthesia assessment is performed for each patient before anesthesia induction.
   b. Each patient's anesthesia care is planned.
   c. Anesthesia options and risks are discussed with the patient and family, if appropriate, prior to administration.
   d. Each patient's physiological status is monitored during anesthesia administration.
   e. The patient's post-procedure status is assessed on admission to and before discharge from the PACU.
   f. Patients are discharged by a qualified licensed independent practitioner or according to criteria approved by the medical staff.
2. Type and Location:
   a. General, spinal and epidural procedures are conducted in the Operating Rooms (OR), Radiology **Suite**, **Cardiac** Cath**eterization** Lab **(Cath Lab),** Labor & Delivery, and **in other designated monitored units** (e.g., **PACU**).

b. MAC may be performed in Endoscopy, ~~**Cardiac Catheterization Lab**~~**Cath Lab**, ~~Operating Rooms~~**OR**, Radiology **Suite**, **Intensive Care Unit (ICU),** and in **other** designated monitored units.

c. IV sedation procedures may be performed in **the** Emergency Department **(by non-anesthesia providers)**, Endoscopy, ~~**Operating Room**~~**OR,** PACU, Radiology **Suite**, ~~Intensive Care Unit (~~ICU~~)~~, and in **other** designated monitored units.

D. **REFERENCES:**

1. Title XXII §70233 & 70235.
2. ~~JCAHO TX.2.2.~~**The Joint Commission 2017**

Tri-City Medical Center	Surgical Services
PROCEDURE:	**ANTICOAGULATION MANAGEMENT DURING CARDIOPULMONARY BYPASS**
Purpose:	To outline perfusionist's responsibilities related to • Monitoring anticoagulation status for cardiopu • Heparinization for CPB • Reversal of anticoagulation • ACT controls • Quality Assurance/Preventive Maintenance
Supportive Data:	The standard of practice for heparinization of patients requiring CPB at Tri-City Medical Center is 350 USP/kg administered either by surgeon (directly into the right atrium), or anesthesiologist (via a central IV line). Activated clotting times (ACTs **and Heparin Dose Response (HDR)** are used to monitor the patient's overall coagulation status prior to heparinization (baseline ACT), two to three minutes after the initial heparin dose (post-heparin ACT / **Heparin Protamine Titration (HPT)**, and a minimum of every 30 minutes while on CPB. A post-protamine ACT/**HPT will** may or may not be checked approximately 10 minutes after protamine administration (depending on clinical situation/physician preference). Controls are performed for each ACT/**HMS** machine in use on a given day as well as for each lot number of ACT cartridges to verify the performance of same.
Equipment:	• **Medtronic Hepcon HMS Plus** • High range ACT cartridges (located oin shelves**cart** in heart room) • Heparin Assay Cartridges • Non-heparinized syringes with large bore needles (3mL) (located on perfusion cart or anesthesia workroom)Heparin (1000U/ml)
Issue Date: 06/94	Revision Date(s): 04/00; 03/03; 07/04; 02/08; 10/09; 08/10

DELETE

Keep as Perfusion Practice Guidelines for reference – maintained in Surgery department files

A.MEASURING ACTs

1. Verify the **HMS** machine isis plugged in and warmed up to a temperature of 37 +/- 0.5º C. ☐
   a. Machine should be left on 24 hours/day to assure readiness for emergencies.
2. **Refer to Medtronic HMS Plus Operator's Manual for step-by-step instructions** on performing **ACT and Heparin Assay (HPT) measurement.**
4. Verify that baseline is within normal limits (WNL) (90-120 seconds), and notify anesthesiologist of abnormal results. Repeat if indicated.
   a. Baseline ACT **and Heparin Dose Response (HDR) tests** should be drawn prior to sternal incision whenever possible.
5. Ensure that post-heparinization ACT is >400 seconds prior to commencing CPB.
   a. Before commencing CPB, it is imperative that circuit be carefully observed for evidence of fibrin formation (i.e. by visualization of suction/vent lines and cardiotomy reservoir with institution of cardiotomy suction).
6. Maintain ACTs ≥ >400 seconds at all times during CPB.
   a. Frequency of sampling may need to be increased with warming or if ACT/**HPT** results are consistently low or erratic.
7. Anesthesiologist may or may not **R**request a post-protamine ACT/**HPT from the Anesthesiologist.**

a. Sample should be checked as clinical situation dictates (e.g., excessive oozing/ chest tube output.

B.HEPARINIZATION

1. Calculate the loading dose of Heparin based on patient weight and inform circulating and scrub RN's.
2. Verify that loading dose has been given before turning cardiotomy suction on.

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
DELETE 11/16	n/a	12/16	n/a	03/17	04/17	

a. Verbalize correct dose of Heparin and time as it is given.

3.In addition to loading dose, add 10,000USP of Heparin to prime during recirculation.

a.Heparin (1000U/ml) should be utilized.

4.If post-heparinization ACT is <>480 seconds, have anesthesiologist administer additional Heparin according to the following protocol and/or HMS calculation:

a. Reassess ACTs as time allows and clinical situation dictates.

ACT (SECONDS)	ADDITIONAL HEPARIN (USP)
400-479	50/kg
350-399	100/kg
300-349	150/kg
250-299	200/kg
200-249	250/kg
<199	300/kg

5. If ACTs/**HPT** do not increase with administration of additional Heparin, suspect:

a.Bad lot of Heparin

i.Change lot numbers.

b.Antithrombin III deficiency (especially in patients who have been on Heparin pre-operatively or have a history of thromboembolic events).

i.Administer 1-3 Units of fresh frozen plasma (FFP) (as ordered by physician).

C.HEPARIN REVERSAL

1. Protamine dose will be determined **calculated** by anesthesiologist **the HMS Plus** based on the total amount of Heparin given during the case. **Notify the Anesthesiologist** of **the protamine dose.**

a.All coronary suction should be turned off as soon as protamine administration commences.

2.Should emergent resumption of CPB become necessary, loading dose of Heparin must be repeated, and 20,000 USP should be added to prime.

D.ACT CONTROLS

1. Obtain necessary equipment:

a. CLOTrac controls (one normal and one abnormal) with deionized water vials

b. HR ACT cartridges

c. **Medtronic HMS Plus machine**

d. Non-Heparinized 3cc syringe with large bore needle

2. Refer to ACT Plus**Medtronic's** Operator Manual**s** and CLOTrac control package inserts for manufacturer's instructions for performing controls.

a.Electronic QC is done prior to each case.

E.QUALITY ASSURANCE/PREVENTIVE MAINTENANCE

3. Obtain necessary equipment:

a. Medtronic ACT Plus **Hepcon HMS Plus** Cleaning Kit (located in bottom drawer of Digital perfusion cart)

b. Thermometer

c. ACT Cartridge

d. Deionized water

4. Wipe up blood spills on outside of machine with hospital-approved solution as they occur.

2.Clean actuator according to manufacturer's instructions utilizing the Medtronic ACT cleaning kit (Liquinox solution and applicators).

a. Cleaning should be performed monthly and as needed.

3.Perform temperature verification by following the steps listed below (monthly and as needed):

a.Turn machine on and allow to warm up for at least ten minutes.

b.Verify heat block temperature with electric thermometer.

i.Heat block must be at 37 +/- 0.5º C to ensure accurate test results.

c. Follow manufacturer's instructions for correction if heat block temperature is out of range or a discrepancy exists between the measured temperature and that displayed on the machine.

7. Perform Volume Verification (monthly and PRN).

a. Select QC menu.

b. Select "Verify and dispenser volume delivery" and follow instructions per machine.

F.DOCUMENTATION:

8. Record Heparin loading dose amount and time of administration; amount of Heparin in prime; any additional doses of Heparin/times; all ACT/**HPT** results; and total amounts of Heparin and protamine administered on perfusion record as indicated in "Guidelines For Filling Out Perfusion Record."

2.Record ACT control results, temperature verification (displayed/measured), and documentation of cleaning on log sheet entitled "Automated Coagulation Timer Maintenance and Quality Control Record" (kept in third drawer of perfusion cart).

G.REFERENCES:

10. Hensley F.A. and Martin D.E., et.al. *Bulletin:* "The Practice of Cardiac Anesthesia," p.552, Brown and Co.

2.CLOTrac HR Control package insert, Medtronic Hemotec, Inc.

3.Operator's Manual ACT Medtronic, Inc.

13.1. **Operator's Manual HMS Plus Medtronic, Inc.**

Tri-City Medical Center	Surgical Services
PROCEDURE:	**DISINFECTION OF STOCKERT® HEATER-COOLER SYSTEM 3T TANKS**
Purpose:	To outline the necessary steps for disinfecting the Stockert® Heater-Cooler System 3T tanks and describe the safety measures to process.
Supportive Data:	To prevent germ growth, the Stockert® Heate disinfected at routine intervals. Disinfection of the tanks requires using Clorox®, a bleach containing 6.15% sodium hypochlorite. The Clorox® solution is corrosive and may cause severe irritation or damage to eyes, skin and respiratory tract. Proper personal protective equipment (PPE) must be worn while handling the Clorox® solution.

Equipment:	• Stockert® Heater-Cooler System 3T Unit
	• Clorox Commercial Solutions® Ultra Clorox® Germicidal Bleach, 200mL
	• Graduated beaker
	• Personal Protective Equipment (PPE):
	  • Gloves
	  • Face splash shield

Issue Date: 06/10	Revision Date(s):

DELETE
Refer to manufacturer's IFU's

A. POLICY

1. The water tanks must be disinfected prior to operating the heater-cooler for the first time.
2. The water tanks shall be disinfected every 14 days, independent of the device's frequency of use.
3. Proper PPE, including gloves and face splash shields, shall be worn by all personnel while handling the Clorox® solution.
4. The Clorox® solution shall be stored in an anti-corrosive container in the laboratory.
5. The Clorox® solution must only be used pre- and postoperatively, never intraoperatively.

B. PROCEDURE

1. Bring the heater-cooler to the OR dirty utility room, where the disinfection process shall be performed.
2. Obtain the Clorox® solution in the anti-corrosive container from the laboratory.
3. Don PPE:
   a. Gloves
   b. Face splash shield
4. Plug in the heater-cooler and press the main power switch to power up the unit.
5. Unscrew the cover of the filler neck.
6. Fill the water tanks with sterile or tap water.
   a. Maximum filling is ensured as soon as both green LED's of the bar graph display for the patient circuit light up or water flows into the overflow bottle.
7. Utilize the included graduated beaker to pour 200mL of Clorox® solution into the tanks.
   a. To ensure a homogeneous solution in the tanks:
      i. Replace the cover of the filler neck.
      ii. Close the three venting valves at the rear of the heater-cooler.
      iii. Establish a connection between the inlet of the cardioplegia circuit and the inlet of one of the patient circuits.
      iv. Note: A temperature alarm can be triggered if the temperature deviates in the individual tanks. To avoid this alarm, adjust the set temperature values of both cardioplegia circuits and the patient circuit to approximately 20°C.
8. Start the cardioplegia circuit.

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a. Press the "Circuit Start/Stop" key on the heater-cooler to start the cooling circuit (cooling tank=blue dot).
b. The green LED's on the heater-cooler flash alternatively.

9. The water flow changes the fill level in the tanks.
   a. One or both green LED's of the bar graph display for the patient circuit go out (no effects).
   b. As soon as the orange LED flashes, fill 0.2 to 0.5L of water as quickly as possible.
      i. The alarm is triggered if the level drops any further.
10. Stop the cardioplegia circuit.
   a. After 10 minutes, press the "Circuit Start/Stop" again to stop the circuit.
   b. The water flow is stopped.
   c. The green key LED's go out.
11. Empty the water tanks.
   a. Open the drain valves.
   b. Empty the water containing the Clorox® solution and pour into hopper.
   c. Thoroughly rinse once by filling the tanks with water and emptying.
12. Disinfection is complete. Close the drain valves and re-fill the tanks with water.
13. Remove PPE and discard in trash.
14. Return the heater-cooler to its proper location and return the Clorox® solution to the lab for storage.

C. REFERENCES

1. Manufacturer's Operating Instructions: Stockert® Heater-Cooler System 3T (2009).
2.1. Material Safety Data Sheet: Clorox Professional Products Company- Clorox Commercial Solutions® Ultra Clorox® Germicidal Bleach (2004).

Tri-City Medical Center	Surgical Services
PROCEDURE:	**DONOR CORNEAS, TRANSPLANT PREPARATION**
Purpose:	To outline the nursing responsibilities in handling and preparation of donor corneas for implantation.
Supportive Data:	To ensure proper transplantation of donor cor
Equipment:	• Donor cornea • Sterile trephines, sizes 7.0 to 9.0 inches, in increments of 0.25 inches • Sterile balanced salt solution 15mL • Sterile basin • Sterile Teflon block • Sterile specimen container • Microbiology lab slips • Corneal transplant instrument tray
Issue Date: 04/94	Revision Date(s): 01/97; 04/00; 03/03; 11/07; 7/09; 09/12

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Keep as Practice Guideline

A. DONOR CORNEAS, TRANSPLANT PREPARATION

1. Complete Tissue Request Form and send with courier to Lab to retrieve cornea.
   a. Donor cornea is requested by the surgeon from San Diego Eye bank, delivered in the morning of Surgery and stored in the tissue bank until requested.
   b. Donor cornea must be stored in a monitored temperature refrigerator at 2-8ºC.
2. Remove the vial containing the cornea from the refrigerator and allow it to warm to room temperature (at least 30 minutes).
3. Verify donor information with label on vial.
   a. Donor cornea must be verified by physician prior to scrubbing in.
4. Circulator:
   a. Remove seal from tissue container.
   b. Rotate or shake the container to dislodge the tissue from the bottom or side.
   c. Open the tissue container close to the sterile field and pour the tissue into a dish/basin under sterile conditions.
   d. Save the solution for cultures.
5. Scrub person:
   a. Receive donor cornea soaked in media solution in a basin, until ready to implant.
   b. Media button is punched out on Teflon block. Cover block with specimen, with media covering button.
      i. Trephine is used to cut appropriate size button from donor cornea
      ii. Protect implant from light after cutting.
6. Send donor rim and media in a sterile container to lab for routine cultures, anaerobic and fungus.
   a. Note on Microbiology Request Form to culture specimen and discard.

B. DOCUMENTATION

1. The Eye Bank is to be notified immediately if surgery is cancelled, to facilitate redistribution of the cornea.
2. Donor cornea is to be noted on the Implant Record with all pertinent information.
   a. Listed under "cornea" in implant list.
3. Culture is to be noted in the Specimen section of the OR Record and accompanied to the Lab by a Microbiology Request Form.
4. Send patients cornea to pathology as permanent specimen.
5. Record all information needed on form from the Eye Bank
   a. Return necessary forms to the Eye Bank

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~~6. Adverse reaction form goes with surgeon for post-op if needed.~~

~~C. **REFERENCE**~~

~~1. Eye Bank, Cornea Manufacturer's Recommendations~~

Tri-City Medical Center	Surgical Services
PROCEDURE:	**EYE LASER PATIENT MANAGEMENT**
Purpose:	To outline the nursing management of adult patients undergoing eye laser procedures.
Supportive Data:	Laser is an accepted form of treatment in nu... retinal vascular disease, capsular fibrosis po... iridotomies for narrow angle glaucoma.
Equipment:	**Argon/Yag Lasers** • Laser safety goggles for all personnel • Eye medications • Eye room keys • Tissues • Site marking pen **Diode Laser** • Flame retardant drapes • Laser sign outside room • Laser safety goggles for all personnel • G-probe • Alcohol swabs • Goniosol or BSS • Eye pad and eye shield
Issue Date: 06/07	Revision Date(s): 12/09; 09/12

DELETE
No longer have eye laser clinic

A. ARGON/YAG LASERS

1. Indication
   a. For all patients scheduled for Argon or Yag laser procedures.
2. Pre-Laser Management
   a. Prepare the following and send to Eye Laser Room with the patient
      i. Chart with completed and signed patient consent form
      ii. Keys for laser room (located in SPRA and OR)
      iii. Eye medications as ordered
3. Special Considerations
   a. Assess and document blood pressure, heart rate and temperature prior to installation of eye drops.
   b. Notify physician of patient admission and hypertension, if applicable.
   c. Administer eye drops as ordered by physician.
   d. When done on emergency basis or on PM shift or night shift, PACU staff are designated to attend to the patient.
      i. If PACU staff are not available and OR staff are available, they shall follow the above protocol.
   e. Portable blood pressure equipment is available in the anesthesia workroom and PACU.
4. Management during procedure
   a. All personnel must wear specified laser safety goggles during the procedure.
   b. Door of procedural area must remain closed during the laser procedure.
   c. After the procedure, turn off the Yag laser and cover it.
   d. Clean and re-stock room.
   e. Return laser room keys to SPRA/OR.
5. Transportation
   a. An RN is to accompany the patient to the eye room.

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6. Documentation
   a. Include patient teaching to reinforce the physician's instructions to patient and sign orders.
7. Discharge
   a. Discharge the patient per physician's orders when discharge criteria are met.

B. DIODE LASER

1. Indication
   a. For all patients scheduled for Diode laser procedures.
2. Pre-Laser Management
   a. Patient will be admitted in SPRA/POH and ordered eye drops will be instilled.
   b. No IV is required
   c. Patient is to undress from waist up and don hospital gown
   d. Prepare the chart with completed and signed patient consent form
   e. Document blood pressure, pulse, temperature and oxygen saturation on nursing record
   f. Notify physician of patient admission
3. Management During Procedure
   a. Procedure to be done in PACU cubicle
   b. OR staff shall obtain necessary equipment
   c. For patients admitted in SPRA, notify SPRA personnel when ready for the patient in the PACU cubicle
   d. RN remains with the patient during the procedure to monitor vital signs every 5 minutes during the procedure
   e. Room should be isolated with flame retardant drapes
   f. Hang laser signs outside room
   g. Laser safety goggles must be worn by all personnel during the procedure
   h. The laser must remain in standby when not in use
   i. Open the G-probe to the MD and offer to clean the tip with alcohol swabs at intervals to prevent scleral burn.
   j. Keep operative site moist with Goniosol or BSS.
   k. Dispose of G-probe after procedure.
   l. Apply eye pad and eye shield after treatment
4. Special Considerations
   a. Emergency basis or on PM or night shift, PACU staff are designated to be with patient. If they are not available and OR staff is available, they should follow above procedure. Diode laser is in portable black case in OR Storage Room 2. Laser keys are kept in Eye Cabinet in OR 7.
5. Transportation
   a. After registration, accompany patient to procedure room.
6. Documentation
   a. OR Nursing Record, reinforce and review physicians instructions and sign orders.
7. Discharge
   a. Discharge patient per physician's orders, documenting vital sings and patient status comparable to pre-procedure.

C. REFERENCES

1. Coherent 7901 Yag Laser Operator's Manual
2. Coherent Argon Dye Laser Operator's Manual

Tri-City Medical Center	Surgical Services
PROCEDURE:	**HEART LUNG MACHINE**
Purpose:	To outline the perfusionist's responsibilitie • Setting up the heart lung machine • Priming the heart lung machine –
Supportive Data:	Must be performed by a perfusionist. NO times. Set up should be completed as soon as a case is finished.

Equipment:	**Nondisposables:**
	• Heart lung machine with 2 pressure manometers and the following holders:
	  • Oxygenator/Venous Reservoir (VR)
	  • Arterial line filter (ALF)
	  • Hemofilter
	• Sterile and Non-sterile scissors
	• Tie straps/gun
	
	Disposables:
	• On case cart outside of heart room or from Materials Distribution (MDC)
	• Tubing pack
	• Oxygenator with integrated venous reservoir
	• Cell Saver aspiration line
	• Sterile 60mL bulb syringe
	• Sterile suction line
	*Primary equipment is in heart room or in/on perfusion cart or shelves in heart room.

Issue Date: 04/94	Revision Date(s): 06/96; 01/00; 03/03; 10/09; 08/10; 09/12

DELETE

Keep as Perfusion Practice Guidelines for reference – maintained in Surgery department files

A. SETTING UP HEART LUNG MACHINE (STERILE DRY SETUP)

1. Ensure power supply to pump and heater cooler are intact and that all lights/switches are functional.
   a. Pump and heater cooler should each have their own isolated power supply.
2. Gather equipment from case cart and bring to room where cardiopulmonary bypass (CPB) is to be performed.
   a. Masked personnel should open sterile disposables in a sterile environment.
3. Verify package integrity, assemble remaining circuit components as follows: (Oxygenator and AV loop should be set up first to enable emergent establishment of CPB if needed)
   a. Oxygenator/Venous Reservoir:
      i. Remove caps from gas ports and place in holder.
      ii. Attach gas line from blender to gas filter and then to oxygenator.
   b. AV Loop:
      i. Attach tapered ½" tubing to VR outlet and through arterial pumphead raceway.
      ii. Attach distal end of tapered tubing to inlet at bottom of oxygenator.
      iii. Place ALF in holder.
      iv. With AV loop hanging on pump mast, attach ½" venous tubing to VR inlet.
      v. Attach ⅜" arterial line to oxygenator.
         1) Arterial pumphead should be unoccluded at this point.
         2) Ensure there are no kinks between oxygenator and ALF.
         3) Ensure all connections are secure and tight.
         4) Circuit could now be easily prepared for emergency CPB.
   c. Cardioplegia system:

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i. Secure heat exchanger in holder.
ii. Attach pressure veil line to manometer only at this point.
iii. Attach ¼" tubing to ¼" Y at oxygenator outlet and then through plegia pump raceway along with tubing from cardioplegia bag.
1) ¼" portion of Y connector should be oriented downward.
2) Plegia tubing should be out of raceway at this point.

d. Suction/vent lines:
i. Place aortic root, PA vent and coronary suction lines through color coded pumpheads
ii. Attach to VR.
1) Ensure one-way valves are properly oriented.
2) If second case is not pending, leave tubing out of raceway.

e. Cooling jacket:
i. Place coil in bucket near fifth pump head.
ii. Ask surgeon before opening sterile jacket.

f. Hemofilter (HF):
i. Located in cabinet.

g. Other:
i. Attach bulb syringe to piece of sterile ¼" tubing and attach this to VR at extra suction inlet port.
ii. Attach short gas filter to arterial filter for $C0_2$ flush.
iii. Attach distal end of ALF purge line to VR.
iv. Pass wrapped table lines, cardioplegia line, and cooling jacket to circulator or scrub nurse.
v. Attach venous and arterial temperature probes to port on VR.
1) Ensure one-way valve is correctly oriented.
2) If no case is pending keep these on top of the perfusion cart.
3) Keep connector from cell saver line package for bottom of cell saver cardiotomy.

4. Documentation:
a. Document lot numbers of oxygenator, tubing pack, and cardioplegia unit on pump record (if second case is not pending, save insert from tubing pack displaying lot number and place in perfusion cart).

B. PRIMING THE HEART LUNG MACHINE

1. Equipment:
a. Heart lung machine
b. Terumo heater cooler with water
c. Extracorporeal circuit (as described in Procedure, Setting up Heart Lung Machine)
d. Wall suction sources (x2)
e. IV fluids to include:
i. PLA or Isolyte 2L
ii. 0.9% NaCl 1L and 0.5L
iii. Cardioplegia 2L
f. 100% CO_2 tank
g. 100% O_2 tank (as back-up)
h. Tubing clamps (x7)
i. Flashlight and hand cranks
j. O_2 air supply

2. Drugs:
a. 25% Albumin, 100mL
b. 25% Mannitol, 100mL
c. Amicar, 5grams
d. NaHCO3, 50mEq

e. Heparin, 10,000USP for circuit, and 40,000USP for Cell Saver
f. Neo-Synephrine

3. Procedure
a. Preparation for CO_2 flush:
i. Apply tubing clamps (2) to the following:
1) ALF inlet and distal to ALF, leaving ALF bypass open
2) May be eliminated in an emergency.
ii. Attach 100% CO_2 source to filtered, sterile gas tubing on arterial filter to allow gas through ALF to oxygenator.
1) All other stopcocks/caps should be closed.
iii. With tubing in unoccluded raceways of arterial and plegia pumpheads, flush circuit with 100% CO_2 at 3-5LPM for approximately 5 minutes, venting through oxygenator.
1) Continue to flush the remainder of circuit with CO_2.
iv. At the completion of the CO_2 flush, turn the CO_2 tank off, close all stopcocks to air, and remove the gas filter from the arterial filter.
1) Now is a good time to attach purge line to ALF.
v. Place tubing in the raceway.
b. Testing for water leaks:
i. During CO_2 flush, test oxygenator heat exchanger for water leaks by connecting H_2O inlet and outlet lines to each, and running H_2O through them for 5-10 minutes. Repeat procedure for cardioplegia unit PRN.
1) H_2O inlet and outlet ports are labeled on oxygenator and cardioplegia heat exchangers.
2) And H_2O leak would be indicated by the presence of moisture in the blood pathway, and would necessitate changing out the component that leaked, as well as any parts of the circuit potentially contaminated with tap H_2O.
3) Ensure proper cardioplegia H_2O temperature at this time, add H_2O to heater/cooler minimum level PRN.
c. Priming the circuit:
i. Drop 1.4L of Isolyte into VR. The circuit should be primed and recirculating prior to the induction of the patient.
ii. Allow circuit to fill by gravity, venting air out through stopcock on top of VR.
iii. Clamp ALF out of system and prime remainder of circuit through filter bypass line by running pump at approximately 2LPM. Delete pre-bypass filter and replace with HCT/SaO2 cuvette. Continue priming rest of circuit at 4LPM.
1) NOTE: THE ARTERIAL PUMPHEAD WILL NOT RUN UNLESS THE AIR BUBBLE DETECTION (ABD) MODULE IS TURNED ON.
iv. To prime ALF, open purge line partially, unclamp filter outlet, and allow to fill slowly retrograde. Once fluid level has cleared level of ALF inlet, unclamp it as well, and place clamp on filter bypass line.
v. Fill pressure veil line by connecting 60mL syringe to distal stopcock and aspirating prime through line. Fill veil with this fluid keeping diaphragm compressed.
vi. De-air ALF by inverting and tapping gently.
d. Priming the cardioplegia delivery system:
i. With the IV tubing clamped, spike a 1L bag of premixed cardioplegia with additives (added by perfusionist and expiration date checked just before use). Set occlusion on cardioplegia pump, and fill unit.
ii. De-air the heat exchanger by tapping with the heater cooler still running in cardioplegia mode and large tank mode.
1) Can be done after initiation of bypass in emergency

iii. Connect blood outlet line to table line (passed off of field when patient is draped).
1) Ensure aortic root line is connected and on before starting cardioplegia pump.
iv. Prime remainder of table line by unclamping blood outlet and slowly running plegia pump forward, checking for leaks at connections site (with arterial pump running).
v. **Arterial pumphead must be rotating at a rate faster than the cardioplegia pump to avoid pulling air across membrane.**

e. Aerating the circuit:
i. Flush CO_2 out of the system by running room air sweep at 2LPM for approximately 5 minutes.
ii. Be sure to turn sweep off before stopping fluid circulation to prevent pressure build-up on gas side of membrane and bubble formation.

f. Addition of drugs to circuit:
i. Once debubbling and aeration of circuit are complete, turn off gas, then blood flow, and clamp venous line.
ii. Lower prime line with attached IV bags to clean towel on floor; clamp end of prime line distal to Y connector and unclamp recirc line. Remove excess prime as desired via recirc line up to IV bag.
1) Do not allow VR to empty completely.
iii. Add the following additives to the isolated VR through the bulb syringe: 25% Albumin 100mL; Mannitol 25grams; $NaHCO_3$ 50mEq; and *Amicar 5grams; Heparin 10,000Units.
iv. Once completed, clamp prime line to IV solution and recirc line and unclamp distal prime line beyond Y connector.

g. Set arterial pumphead occlusion:
i. Zero press transducers and check alerts and alarms.
ii. With sampling manifold stopcock and ALF purge line still closed, set occlusion of arterial pumphead by clamping distal to the ALF and slowly turning the pumphead so that both rollers are perpendicular to the side of the pump.
iii. While observing the manometer, tighten or loosen the occlusion until the manometer drops 10mmHg in a minute.
iv. Repeat this procedure for the other roller.
v. Ensure press alerts and alarms are functioning properly.

h. Recirculate prime (warm if needed, check with surgeon for re-do operation prime temperature):
i. After occlusion is set, open both stopcocks listed above, and recirculate prime with heater cooler set at 27°C, and gas flow on at about 1LPM at 21%.
1) Continue to recirculate until just prior to the administration of Heparin.
ii. Check circuit integrity and all connectors for leaks.
1) At low blood flow rates (less than 2LPM), gas flow should not exceed 1LPM (per manufacturer's instructions).
iii. Ensure that circuit is bubble free and bubble detector/level sensors are functioning properly.

i. Other:
i. Check cardiotomy suckers, PA and Aortic vents for correct occlusion and direction of one-way valves.
ii. Attach CDI 500 sensor to appropriate cuvettes (if not previously done).
1) Check for battery life and proper functioning.
2) Place in standby until initiating bypass.

iii. Ensure that venous and arterial temperature probe is connected to oxygenator and module is functional with correct channel selected.
iv. Attach ¼" tubing from hemofilter to suction canister and clamp (PRN).

j. Prepare Cell Saver:
i. Add 30,000USP of Heparin to 1L bag of 0.9% NaCl.
ii. Ensure suction source is functional and accessible.
iii. Attach aspiration and anticoagulation line to CR (passed off from field after patient is draped).
iv. Adjust suction before priming line with the Heparin drip.

k. Prepare the cooling jacket:
i. Place tubing in pumphead (if surgeon requests one).
ii. Tighten occlusion (if needed). Occlusion is usually preset from previous case.
iii. Spike 500mL bag of 0.9% NaCl at uncovered spike port.
iv. Slowly pump saline through coil and out vented end-cap. Ensure all caps are tight.
v. Fill bucket containing coil with ice.
vi. Attach coil to jacket via tubing passed off from field (once surgeons/ assistants are in place at table). Spike remaining end into covered port of NaCl, and hang bag on pump.
vii. Circulate at approximately 20RPMs.

l. Prepare paperwork, lab supplies, drugs:
i. Paperwork may be completed after the initiation of CPB.
ii. Paperwork to be completed by perfusionist will come in a packet from the front desk and includes:
1) CVS STAT Lab Requests
2) Bypass Drugs charge document
3) Surgeon's dictation green sheet.
4) National Cardiac Surgery Database. Perfusionist to complete section entitled "Cardioplumonary Bypass and Support Data"
5) Pre-bypass Check List
iii. Label purple top tubes (perfusion cart) and 12mL luer lock syringes (with needles) with patient labels.
iv. Draw up and/or prepare the following drugs:
1) Lidocaine 100mg
2) Neosynephrine 10mg (prepared as 1mg/mL concentration)
3) Calcium Chloride 1gram
4) Magnesium Sulfate 2grams
v. Ensure that appropriate, type specific blood products are available.
vi. Check availability of extra solutions, drugs, syringes, lab tubes, needles, and other supplies.
vii. NOTE: Circuit is now ready in the event it is needed emergently. The following steps should be completed just prior to initiating CPB.

m. Prepare Heater/Cooler
i. Ensure adequate ice and H_2O level.
1) Heater/cooler should be kept "ON" with ice maker on at all times.
ii. Turn plegia mode to large tank at 3RPMs and turn "OFF" until use.
iii. Set heater/cooler temperature to 27°C.

n. Prepare to pass lines to table
i. Turn off sweep gas and clamp arterial and venous lines as surgeon administers heparin.
ii. Turn off purge and manifold stopcocks.

iii. Connect suction and vent lines. Pay particular attention to AV connection (tap gently while observing for bubbles). Set blender to proper FiO_2 for bypass.

iv. Turn suckers on once Heparin is in and circulated (please see Surgical Services Procedure, Anticoagulation Management During Cardiopulmonary Bypass).

1) Surgeon will heparinize just prior to cannulation.

2) Monitor ACT results prior to start of CPB.

v. Detach tape from each end of blue sterile wrap, over AV loop and remove outer wrap only. On surgeon's direction, hand AV loop to table by peeling back sterile wrap, and holding loop horizontally.

vi. Surgeon will grab sterile portion, and perfusionist removes wrap.

vii. On surgeon's request, advance roller pump slowly by hand to allow prime to aid in a bubble-free connection to arterial cannula.

1) Unclamp arterial line before advancing pump.

viii. Verify arterial fluctuation on manometer and correlate mean with mean arterial pressure on monitor and CPC.

1) Reclamp arterial line at ALF inlet.

ix. With ALF stopcock turned off to purge line, place hemofilter inlet line to stopcock/purge line, and attach hemofilter outlet line to filtered port on CR (PRN).

x. Don gloves and goggles (if not previously done), and prepare to initiate bypass.

4. Documentation

a. Record lot numbers of disposables, priming fluids, drugs and blood products (when available) on Perfusion Record.

C. REFERENCES

1. The Affinity Membrane Oxygenation Module Instructions for Use; Medtronic Corporation, Sorin.

2.1. Blood Cardioplegia Delivery System Instructions for Use; Sorin Vanguard BCD package insert.

Tri-City Medical Center	Surgical Services
PROCEDURE:	**HEART VALVES THAWING (CRYOPRESERVED)**
Purpose:	To outline the nursing responsibilities in thawing and diluting of Cryopreserved allograft heart valves.
Supportive Data:	Homograft valves are used to replace valve.
Equipment:	**Sterile:** • 1 Large Basin • 1 Liter 5% Dextrose and Lactated Ringers at room temperature (D5/LR) • 1 pair of scissors • 1 Kelly clamp or Sponge forceps **Non-sterile:** • 1 Large Basin • 3 Liters or more of Normal Saline or Water at 37°-42°C (98°-108°F) • 1 pair of scissors • 1 Kelly clamp or Sponge forceps
Issue Date: 08/95	Revision Date(s): 09/96; 12/99; 03/03; 09/08; 09/12

DELETE
Keep as Practice Guidelines for reference – maintained in Surgery department files

A. UNPACKING INSTRUCTIONS

1. Read these instructions in their entirety before opening the CryoPak.
   a. The CryoPak shipper contains a Cryoguard thermal indicator to monitor the shipping environment.
   b. The donor valve must be stored and shipped at Nitrogen vapor temperatures (-196°C).
      i. The donor valve must be maintained in this environment until surgery.
      ii. If excessive thermal exposure occurs and the inside of the shipping container becomes warmer than -70°C, the thermal indicator turns an irreversible red color.
2. Open the pouch in the following manner to avoid false readings:
   a. Remove the envelope containing the package insert and Certificate of Assurance from the top of the shipping box.
      i. Ensure there is sufficient space in the freezer for the allograft to be immediately placed in the freezer after removal from the box.
   b. Don a pair of insulated gloves.
   c. Remove the foam plugs which seal the inner chamber.
   d. Open the box labeled "Allograft Contained Within This Protective Sleeve".
   e. With gloved hands, remove the inner box containing the allograft.
      i. The Cryoguard indicator will be in the inner box.
      ii. In the case of a multiple shipment, the indicator will be found in the box furthest to the rear.
   f. Hold the indicator with the label facing you, and observe the color in the clear area below the seal.
      i. If the vial has **any visible green color** the allograft may be safely placed into a liquid nitrogen freezer or thawed and implanted.
      ii. If the vial is **completely red**, the allograft must be maintained between -70°C and -80°C and implanted within 72 hours (NOTE: Dry ice temperature is -77°C).

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
09/96; 12/99; 03/03; 09/08; 09/12; 06/15;	n/a	12/16	n/a	03/17	04/17	

iii. If the vial has **some visible pink, or a combination of red and green color,** the allograft has been maintained at a suitable temperature and can be placed in a liquid nitrogen freezer or thawed and implanted.

iv. If the vial has turned **any color other than green, pink, or red,** call CryoLife, Inc.

B. THAWING INSTRUCTIONS

1. On a separate non-sterile table, remove the Cryo-Safe pouch containing the allograft from the cardboard sleeve and carefully place on the table next to the thawing basin.
2. Allow the allograft to air thaw at room temperature for 3 minutes before immersing in the basin of solution.
3. After the 3 minutes air thaw, completely immerse the Cryo-Safe pouch containing the allograft in at least 3 liters of saline or water at 37-42°C (98°-108°F).
   a. Ensure that the pouch remains completely submerged until all ice crystals are dissolved as determined by visual inspection of the pouch.
   b. DO NOT allow the pouch to remain in the water after the ice has dissolved.
   c. Thawing time averages 15-22 minutes.
   d. Continuous agitation will shorten thawing time.
   e. Do not squeeze or otherwise manipulate the allograft until thawing is complete.
   f. **CAUTION: The Cryoprotectant becomes cytotoxic as the solution approaches room temperature.**
4. Remove the Cryo-Safe pouch from the saline or water solution after complete dissolution of ice.
5. Carefully dry the Cryo-Safe pouch and take the pouch to the table containing the large sterile basin.
   a. Pour one liter of D5/LR into the large sterile basin.
6. Using scissors, cut the outer pouch, taking care to avoid the peel pouch.
   a. The Cryo-Safe packaging system allows direct visualization of the two inner pouches.
7. Carefully remove the peel pouch from the outer pouch.
8. Open the peel pouch aseptically and pass the innermost pouch to the scrub nurse or surgical technologist.

C. RINSING INSTRUCTIONS

1. On the sterile field, open the inner pouch using sterile scissors and gently remove the allograft.
2. Place the allograft into the larger sterile basin containing D5/LR.
3. Allow the allograft to passively dilute in this solution for a minimum of 5 minutes.
   a. At the end of 5 minutes, the allograft is ready for transplantation.
   b. If more than 30 minutes is expected to elapse before the allograft is used, place the basin containing the allograft on sterile ice and cover with a sterile drape.
   c. DO NOT leave the allograft at room temperature or allow it to dry out.

D. DOCUMENTATION

1. Document the information and numbers from the valve company on the implant section of the OR Record.
2. Document the valve information and numbers in the Open Heart Valve Log Book.
3. Document on OR Record under "Operative Procedure" with "Homograft Valve".
4. Complete the Implant Summary card and place in the designated box at the Surgery desk.

E. REFERENCE

1. CryoLife Corporation Manufacturer's Instructions

Tri-City Medical Center	Surgical Services
PROCEDURE:	**LASER SAFETY MANAGEMENT**
Purpose:	To outline the nursing management o
Supportive Data:	Safety is the most important compone related to laser powers high enough t eyes and skin of patient or staff.
Equipment:	See below.
Issue Date: 11/04	Revision Date(s): 12/96; 04/99; 09/01; 1/06; 09/08; 10/09; 09/12

DELETE
Info from this procedure added to the Surgical Services "Laser Safety" Policy

A. MANAGEMENT/STAFFING

1. Provide a laser-trained nurse or technician to operate the laser.
   a. The nurse or technician will not leave the operating room while laser is in use.
   b. If an RN is operating the laser, a second RN will assume the circulating role.
2. Obtain all accessories prior to case and ensure that they are ready for use.

B. SAFETY/ALL LASERS

1. Place American National Standards Institute (ANSI) approved laser warning signs at all entrances to laser treatment area.
2. Doors in the laser treatment area should remain closed during the laser procedure, and windows (including door windows) should be covered with a barrier that blocks transmission of the laser beam being used, with the exception of CO2 lasers (windows do not need covering).
3. Provide adequate eye protection for patient, staff, physician and all personnel in the laser treatment area throughout procedure
   a. Eye protection of appropriate optical density for the wavelength of the laser and having peripheral protection, shall be worn by all personnel in the room when the laser is in use.
   b. In case of accident or injury during surgery, a post-incident eye exam shall be performed.
   c. **Do not put any kind of tape under or over the laser eyeshields.**
   d. Protect the patient's eyes with the equivalent material required for laser wavelength:
      i. CO_2: **laser AID eyeshields**, wet eye pads.
      ii. Appropriate eye wear for Argon, Holmium & ND:Yag
4. Provide laser specified masks for all personnel in the laser treatment area.
5. Set-up and test laser before patient is brought into room. Test on wet tongue blade placed on wet blue towel. Use hand piece with lens inside or connect to microscope with micromanipulator to test. Test according to how it will be used during procedure. Be careful not to drop the lens, which is a separate piece inside the hand piece. Test on continuous mode at 10 watts.
6. Keep a basin of water close to the operative field during the procedure in case of laser induced fire
7. Use only non-flammable or non-explosive gases in the presence of laser
8. Return laser to "standby" mode when not actively being used.
9. Turn off laser in case of accident or fire. Red button on laser is emergency shut-off.
10. Remove key from laser after use and return to Main Pyxis by the OR desk.
11. Remove laser warning signs from entrances to laser treatment area after case.

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/96; 04/99; 09/01; 1/06; 09/08; 10/09; 09/12; 11/16 DELETE	n/a	12/16	n/a	03/17	04/17	

C. SAFETY SPECIFIC FOR CO2 LASERS

1. Dampen all combustible materials that will be used close to the CO2 laser field. This includes drapes, towels, raytec, laps, and Q-tips. Check frequently to ensure that they remain damp throughout the procedure.
2. Use instrumentation appropriate for the CO2 laser such as blackened or dulled equipment to avoid reflection of laser beam on shiny surfaces. Do not use glass, quartz, or plastic near laser beam.
3. Use smoke evacuators on all laser procedures:
   a. In-line filter for procedures involving only a small amount of plume or laparoscopic procedures.
   b. External evacuators for larger amount of plume
4. Provide laser safe endotracheal tubes for all laser procedures of the mouth and throat.
5. Use anesthesia machines with compressed air for procedures of the mouth, throat, and airway.

D. PRE-OPERATIVE ASSESSMENT

1. Assess patient's skin integrity

E. POST-OPERATIVE ASSESSMENT

1. Assess patient skin integrity.
   a. Patient should be free of reddened areas and burns in immediate surgical area.

F. DOCUMENTATION

1. Record use of laser in the OR Record.
2. Record patient skin and eye pre-operative assessment and post-operative evaluation in the OR Record.

G. REFERENCES

1. TCMC Laser Program Manual
2. K. Ball. Laser, The Perioperative Challenge, AORN, Denver, CO (2004).
3. AORN Perioperative Standards and Recommended Practices, 2010 edition, "Recommended Practices for Laser Safety in Practice Settings", AORN, Denver, CO.
4. American National Standards Institute, Z136.3-2007

Tri-City Medical Center	Surgical Services
PROCEDURE:	**MIRA CRYO UNIT SET-UP**
Purpose:	To provide a basic understanding and seque… Unit.
Supportive Data:	The Mira Cryo unit is a machine designed to meet the cryosurgical needs of the ophthalmologist. It is non-electric and can be used with medical grade CO_2 or N_2O. The cryo probe provides instantaneous freezing at the tip only while the shaft and handle of the probe remain warm.
Equipment:	• Mira Cryo Unit (Storage Room 2) • N_2O tank (at the side of Accurus Machine Cart) • Cryo probe (Eye Cart)
Issue Date: 11/94	Revision Date(s): 06/00; 12/05; 5/08; 10/09; 09/12

DELETE
Follow manufacturer's IFU's

A. CIRCULATING NURSE

1. Attach the cylinder connector (at the end of the high-pressure hose from the back of the machine) to the N_2O gas tank, make sure tank is at the green level.
2. Connect a scavenger hose (suction tubing) to the rear panel exit port. Make sure scavenger hose is not kinked.
3. Do not connect to suction, leave tubing free (connecting to suction creates negative pressure on suction canister)
   a. This will help to make operation extremely quiet and prevent nitrous leak into room air.
4. Ensure the ON/OFF valve on the front panel is in the OFF position.
5. Open the valve on the top of the gas tank by turning the valve counterclockwise.
6. Listen for leaks at either end of the high-pressure hose.
   a. An audible hiss or any amount of frost visible on a fitting will identify a leak.
   b. If a leak is noted tighten connectors until leak disappears.
7. Select Cryo probe and open to the sterile field.
8. Take connector end from scrub nurse and remove protective cap from probe jack.
9. Insert jack all the way into the receptacle on the front panel.
10. Turn ON/OFF valve on front panel to ON position.
    a. The pressure gauge should read 680PSI or higher. If under 680PSI Cryo will not freeze.

B. PRE-COOL PROBE

1. Select the -25°C temperature setting.
2. Depress the foot pedal for 10 seconds, then release.
   a. The air must be flushed from the probe prior to use.
   b. Care should be taken as this procedure ensures proper operation of the probe.
3. Wait 60 seconds.

C. ICEBALL TEST

1. Select the -85°C temperature setting.
2. Submerge probe tip in sterile water or saline.
3. Depress the foot pedal for 10 seconds, keeping the probe tip in the liquid.
4. Remove probe tip from liquid while the foot pedal is still depressed.
   a. An iceball of 4-7mm should have formed.
5. Release the foot pedal.
   a. Within 2 seconds the iceball should be free to move.
   b. If proper function is not seen:
      i. Turn off machine and unplug probe.

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/00; 12/05; 5/08; 10/09; 09/12; 06/15; 11/16 DELETE	n/a	12/16	n/a	03/17	04/17	

ii. Plug probe in again, turn on machine.
iii. Repeat iceball test.

c. If proper function is still not seen:
i. Obtain a second probe and repeat pre-cool and iceball tests.
ii. Send first probe for repair.
iii. The system is now ready.

6. Remove probe by turning ON/OFF valve to OFF while depressing the foot pedal.
a. This action depressurizes the system instantly.
b. Ensure the N_2O gas tank is turned OFF.

D. PROBE CARE

1. Clean probe with mild soap and water.
a. Do not immerse in solution.
2. Store probe in natural coil of not less than 6 inches in diameter, in two peel packs.
a. Tighter coil will break internal fibers.

1.

3. Attach probe jack protective cap when not in use.
a. Prevents moisture and foreign particles from entering probe lines.
b. The cover must be in place during sterilization cycles.
c. Moisture from steam media will freeze and clog Cryo probe during set-up and operation.

E. DOCUMENTATION

1. Document Equipment and Procedure on OR Record.

F. REFERENCE

1. Mira Cryo Unit Equipment Manual

Tri-City Medical Center	Surgical Services
PROCEDURE:	**PATIENT TRANSPORTATION IN THE PERIOPERATIVE ENVIRONMENT**
Purpose:	To outline responsibilities in transfe… …al suite: • OR Assistant Nurse Manager/de… • Perioperative Aide/Transporter …
Supportive Data:	None
Equipment:	• SBAR Report worksheet • Clean gurney with IV pole • Oxygen tank with holder
Issue Date: 11/04	Revised Date(s): 12/96; 04/99; 09/01; 1/06; 09/08; 10/09; 08/10; 09/12

DELETE
Combine with Surgical Services Policy "Patient Transport in the Perioperative Environment"

A. INPATIENT SURGICAL PROCEDURES (NON-ICU PATIENTS)

1. OR Assistant Nurse Manager (ANM)/designee duties:
   a. Call nursing unit at least 30 minutes prior to transfer and obtain SBAR hand-off report from the nurse caring for the patient.
   b. Complete the SBAR report worksheet and Transporter patient information ticket; provide to the transporter.
   c. Send Perioperative Aide/Transporter to pick up the patient 45 minutes-1 hour before the surgical procedure.
   d. NOTE: For ICU patients, the perioperative nurse assigned to the case is to go to the ICU and obtain bedside SBAR hand-off report in-person from the ICU RN prior to transporting the patient to surgery.

B. PERIOPERATIVE AIDE/TRANSPORTER

1. Obtain SBAR report worksheet and Transporter patient information ticket from ANM/designee.
2. Obtain clean gurney (if required) from PACU, with a sheet, blanket and pillow.
   a. Patients unable to move to the gurney, due to traction, fracture or general condition, will be transported in their bed.
   b. Patients on a cardiac monitor must be transported with a transport monitor and RN, unless the physician writes and order that the patient may be transported without monitoring.
   c. Pediatric patients under 4 years of age will be transported to Surgery in a crib. If the patient's condition permits, a parent may hold the child while sitting in a wheelchair.
   d. NICU patients will be transported in an incubator and will be accompanied by a NICU RN.
   e. Intubated patients from ICU will be accompanied by the Perioperative RN and Anesthesiologist or Respiratory Technician.
   f. High acuity, non-intubated patients will be accompanied by an RN.
3. Obtain oxygen tank in safety holder, if necessary per report worksheet.
4. Proceed to appropriate nursing unit.
5. Obtain patient's chart on the nursing unit.
6. Follow appropriate isolation precautions if applicable (See Infection Control Manual).
7. Proceed to patient's room; introduce self.
8. Verify patient's identification, using two patient identifiers (name and medical record number).
   a. Cross check patient's identification band with the chart, confirming with the patient.
9. Draw curtain and place blanket over patient prior to removing bed linen.
   a. Always ensure patient privacy.

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/96; 04/99; 09/01; 1/06; 09/08; 10/09; 08/10; 09/12; 11/16 DELETE	n/a	12/16	n/a	03/17	04/17	

10. Position gurney next to bed.
11. Lock wheels on gurney and bed.
12. Assist patient to gurney.
    a. Assistance from the patient's nurse may be required.
    b. Ensure IV and drainage bags are moved with the patient.
        i. Hang the IV bag from the IV pole.
13. Raise and secure the gurney side rails, ensuring the patient's arms and legs are well inside the side rails.
14. Remain at the head of the gurney.
15. Transport feet first, at an appropriate speed. Enter elevators head first.
16. Upon arrival to PreOperative Holding area, give the patient a warm blanket and surgical hat.
17. Place a blood pressure cuff on the patient's bed or gurney.
18. If dropping patient off in a cubicle or in PACU:
    a. Place a pulse oximeter on the patient's finger.
        i. Use a disposable pulse oximeter for patients in isolation.
    b. Give the patient the call bell and instruct on use.
19. Lock the bed or gurney and place in the lowest position with side rails up.
20. Notify PreOp Hold (RN or Secretary) and OR ANM/designee of arrival to PreOp Hold area.
21. Remain with patient until nurse arrives to assume care of patient.

C. POST SURGERY

1. Position gurney/bed next to the OR table, at the appropriate level.
    a. Ensure OR table is locked.
    b. Lock wheels on gurney/bed.
2. Cover roller with a draw sheet/chux.
    a. A minimum of 4 people is required to transfer the patient:
        i. Anesthesiologist at the patient's head
        ii. 1 person at the patient's feet
        iii. 1 person on each side of the patient
3. Turn patient slightly away from gurney/bed, to place the roller with draw sheet under the patient.
    a. Ensure Anesthesiologist is ready- wait for Anesthesia to signal ready to move.
    b. Ensure IV, monitoring lines, drainage bags, etc. are free and able to move with the patient.
4. Pull draw sheet with roller toward the gurney/bed, causing the roller to transfer the patient to the gurney/bed.
    a. Ensure all personnel are ready for the transfer; check with Anesthesiologist before moving.
5. Check all lines and drainage bags.
6. Raise and secure the side rails.
    a. Ensure patient's legs and arms are within the side rails.
7. Transfer the patient to the appropriate post-surgical area.
    a. Anesthesiologist at the patient's head and Perioperative RN at the foot.

D. DOCUMENTATION

1. Document on the OR Record:
    a. Area patient discharged to after surgery
    b. Level of alertness
    c. Mode of transfer
    d. Any equipment utilized during transport
    e. Condition of the patient

E. REFERENCE

1. AORN Perioperative Standards and Recommended Practices, 2011.

Tri-City Medical Center	Distribution: ~~Women and Newborn Services~~ **DELETE – no longer required**
PROCEDURE:	~~**AMNIOINFUSION**~~
Purpose:	~~Amnioinfusion is a procedure used during the intrapartum period for pregnancies complicated by oligohydramnios to eliminate repetitive variable decelerations by augmenting the amniotic fluid volume to prevent or relieve umbilical cord compression during labor.~~
Supportive Data:	~~Amnioinfusion has been shown to decrease the occurrence and severity of variable and prolonged decelerations by providing "cushioning" for the umbilical cord when utilized in labor. Note: Prophylactic amnioinfusion for oligohydramnious (≤ 50 mm) does not appear to confer any advantage over therapeutic amnioinfusion after the development of an abnormal FHR pattern (Spong, 2009). Amnioinfusion does not significantly reduce the risk of meconium aspiration syndrome and is not indicated for prophylactic use for meconium-stained amniotic fluid in the absence of repetitive decelerations (AAP & ACOG, 2007; Spong, et Ross, 2009~~
Equipment:	~~1. Infusion pump and tubing~~ ~~2. Normal Saline 500ml bag – room temperature~~ ~~3. Intrauterine pressure catheter (IUPC), double lumen~~ ~~4. Electronic Fetal Monitor~~

Procedure exists in Mosby nursing procedure and is equivocal. Remove as a unit specific procedure.

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

~~1. Indications for the use of amnioinfusion in labor include:~~

~~a. Less than 32 weeks gestation:~~

~~i. Intermittent or recurrent variable decelerations with a documented amniotic fluid index of ≤ 7.0cm.~~

~~b. Greater than or equal to 32 weeks gestation:~~

~~i. Intermittent or recurrent variable decelerations~~

~~c. Oligohydramnios~~

~~2. Contraindications:~~

~~a. Vaginal bleeding~~

~~b. Thick meconium and/or meconium stained amniotic fluid without variable decelerations~~

~~c. Uterine anomalies~~

~~d. Active infection such as human immunodeficiency virus (HIV) or herpes~~

~~e. Impending delivery~~

~~f. Anomalous fetus~~

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

~~1. Recurrent decelerations – decelerations that occur with > 50% of uterine contractions in any 20 minute window.~~

~~2. Intermittent decelerations – decelerations that occur with < 50% of uterine contractions in any 30 minute window.~~

~~C. **PROCEDURE:**~~

~~1. Requires ruptured membranes to proceed.~~

~~2. Verify provider order.~~

~~3. Explain procedure to patient and obtain verbal consent.~~

~~4. Position patient for insertion and assist provider in placement of an Intra Uterine Pressure Catheter (IUPC). Double lumen allows for continuous measurement of intrauterine pressure during infusion.~~

Department Review/Revision Date	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
4/97; 6/99; 5/03; 5/09, 02/15, **11/16**	06/09, 06/15, **12/16**	12/15, **02/17**	02/16, **03/17**	03/16, **04/17**	6/03, 03/16

5. An external tocodynamometer or manual palpation may also be used during infusion to assess for increased intrauterine pressure.
6. An infusion pump is recommended to prevent a rapid rate of infusion, and to limit the volume of fluids infused. Set up Alaris infusion pump, and attach in the following order:
a. Prime tubing with normal saline or lactated ringers.
b. Insert tubing into Alaris infusion pump.
c. Attach to IUPC.
7. Administer 250 - 500 mL of normal saline or lactated ringers via infusion pump over 30 minutes per provider's orders.
8. After initial infusion, if recurrent variable decelerations persist continue infusion of 150 mL per hour up to a maximum infusion of 1000 mL can be given.
a. Notify provider if recurrent variable decelerations remain unresolved.
9. DO NOT heat fluid in the microwave or blanket warmer. Infuse at room temperature.
a. Warming of the fluids may be appropriate for preterm or growth restricted fetuses via blood warmer or IV fluid warmer if temperatures are regulated, acceptable temperatures are 93-96° F (34-37°C).
10. Monitor fetus continuously for improvement of FHR pattern or aberrant changes.
11. Monitor uterine contractions for hypertonus and tachysystole and uterine baseline for unrest or increased tone secondary to over-distension.
12. Assess for:
a. Fluid return by weighing underpads (1mL of fluid equals= 1g of weight)
i. As a general consideration, if 250mL has infused with no return, the infusion should be discontinued until fluid return is noted.
b. Over distention, notify provider.

D. **REFERENCES:**

1. AWHONN. (2006). Fetal Heart Monitoring Principles & Practices, 4th Edition.
2. Simpson, K. R. and Creehan, P. A. (2014). Perinatal Nursing (4th Ed). Philadelphia: Lippincott Williams and Wilkins
3. Spong, C.Y., & Ross, M.G., (2009). Amnioinfusion: Indications and outcome. ©2009 *UpToDate®*. Retrieved February 5, 2009 from http://www.uptodate.com

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**CORD GAS COLLECTON**
Purpose:	To outline the **process for** ~~nursing responsibilities in~~ assisting the physician/ **Allied Health Professional (AHP)** with cord gas collection at delivery.
Supportive Data:	Obtaining a cord gas specimen provides useful information regarding blood pH levels of the neonate at delivery. The intrapartum acid-base status of the fetus is an important component in establishing the link between intrapartum events and neonatal condition. The analysis of cord blood gases from the umbilical artery is believed to be the best representation of the fetal acid-base status immediately before birth.
Equipment:	1. Personal protective equipment 2. Disposable umbilical cord clamps, 2 3. Plastic specimen bags, 2 **(One must be a Biohazard labeled bag for transport)** 4. **Newborn's**~~Mother's~~ Identification label ~~5. Ice~~

A. **PROCEDURE:**

1. Don personal protective equipment.
2. **Obtain** ~~Receive~~ a section of the umbilical cord from the physician/ **AHP**.
3. If the physician/**AHP** -has not placed a disposable cord clamp at each end of the umbilical cord specimen, then do so at this time.
   ~~4.~~**a.** Remove the surgical clamps from each end of the umbilical cord specimen **and replace with the disposable clamps,** .
~~5.~~**4.** Place **the** umbilical cord specimen in first plastic bag **with ice, close the bag, and label the outside of the bag with the newborn's identification label**.
~~6. Cover umbilical cord specimen with ice and close bag.~~
~~7. Label specimen bag with maternal identification label .~~
   a. Write delivery date and time of birth on the label.
      i. Date and time of birth is essential to processing the test within the defined **30-60** ~~60~~-minute window.
~~8.~~**5.** **Next, put** ~~Place~~ **the** specimen bag in -**the** second **biohazardous labeled** plastic bag, **in preparation for transport.** ~~.~~
~~9.~~**6.** **Call the Neonatal Intensive Care Unit (NICU) Respiratory Care Provider and indicate there is cord gas specimen sample that needs to be retrieved and processed.** ~~Specimen is to be sent to pulmonary section of the Neonatal Intensive Care Unit (NICU).~~

~~B. INTERPRETATION:~~

~~Table B-1~~

~~Single-Digit Value Guideline for Initial Assessment of Normal and Abnormal Umbilical Cord Blood Acid-Base Values*~~

	~~Normal Values~~	~~Metabolic Acidemia~~	~~Respiratory Acidemia~~
~~pH~~	~~> 7.10~~	~~< 7.10~~	~~< 7.10~~
~~pO_2 (mm Hg)~~	~~>20~~	~~< 20~~	~~Variable~~
~~pCO_2 (mm Hg)~~	~~< 60~~	~~< 60~~	~~> 60~~
~~Bicarbonate (mEq/L)~~	~~> 22~~	~~< 22~~	~~>22~~
~~Base deficit (mEq/L)~~	~~< 12~~	~~> 12~~	~~< 12~~
~~Base excess (mEq/L)~~	~~> -12~~	~~< -12~~	~~> -12~~

~~*Values above are suggested as a guide for evaluating acid-base status; arterial cord blood gases are more reflective of fetal status (Lyndon et al, 2008)~~

Review Revision Date	Division of Neonatology	Department of Pediatrics	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
3/97, 5/03, 7/09 01/16	08/16	11/16	01/13, 02/17	n/a	05/13, 03/17	06/13, 04/17	06/13

~~Table B-2~~

~~Significance of Deviation from Normal Values for Acidosis (Freeman et al., 2003; King & Parer, 2000)~~

~~Types of Acidosis~~	~~*PH~~	~~PO_2~~	~~*PCO_2~~	~~HCO_3~~	~~*Base Deficit~~
~~Respiratory~~	~~Decreased~~	~~Variable~~	~~Increased~~	~~Normal~~	~~Normal~~
~~Metabolic~~	~~Decreased~~	~~Decreased~~	~~Normal~~	~~Decreased~~	~~Increased~~
~~Mixed~~	~~Decreased~~	~~Decreased~~	~~Increased~~	~~Decreased~~	~~Increased~~

~~C.~~ ~~**DOCUMENTATION:**~~

~~1. Document in the infant cord blood results, including the sample source (arterial or venous) information of the labor and delivery summary and on obstetrics surgical record, if applicable.~~

~~D.~~**B. REFERENCES:**

1. Lyndon, A., Usher-Ali, L. (201~~509~~). *Fetal heart rate monitoring principles and Practice (* **5th** 4th Ed.). Dubuque, IA: Kendall Hunt.
2. Blickstein, Isaac, MD., Clinics in Perinatology, vol 34, Issue 3, 09/2007, *Umbilical Cord Gases*, W.B. Saunders and Company.

Tri-City Medical Center
Oceanside, California

Women and Newborn Services (WNS)

SUBJECT: ELECTIVE DELIVERY UNDER 39 WEEKS

ISSUE DATE:
REVISION DATE(S): 06/14

Department Approval Date(s):	**12/16**
Department of OB/GYN Approval Date(s):	**~~04/14~~02/17**
Department of Pediatrics Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~05/14~~03/17**
Professional Affairs Committee Approval Date(s):	**~~06/14~~04/17**
Board of Directors Approval Date(s):	**06/14**

A. **PURPOSE:**

1. The purpose of this policy is to eliminate non-medically indicated (ELECTIVE) deliveries prior to 39 weeks Estimated Gestational Age (EGA).

B. **POLICY:**

1. Non-medically elective Cesarean Section (C-Section) or induction of labor prior to 39 weeks EGA requires approval of the Obstetrics and Gynecology Department Chairperson or Designee.
2. Amniocentesis and documentation of fetal lung maturity is NOT an indication to deliver a less than 39 week EGA pregnancy.
3. Medical and/or obstetric indications that may require delivery before 39 weeks, via C-Section or induction which DO NOT require approval from the OB/GYN Department Chair or designee include:

Medical and Obstetric Indications	
☐ Abruption	☐ Chronic Hypertension
☐ Coagulation Defects (Antiphospholipid Syndrome)	☐ Cardiovascular Disorders/Diseases
☐ Fetal Demise (Current)	☐ Diabetes (Type I or II)
☐ Fetal Distress/Abnormal FHR	☐ Fetal Demise (Prior)
☐ Fetal CNS Malformation or Chromosomal Abnormality, Suspected Damage to Fetus from Viral or other Diseases in Mother,, Drugs, Radiation	☐ Gestational Diabetes (GDM with Insulin)
☐ Gestational Hypertension	☐ Heart Disease
☐ HIV Infection	☐ IUGR
☐ Isoimmunization/Fetal-Maternal Hemorrhage	☐ Liver Disease (Cholestasis of Pregnancy)
☐ Multiple Gestation	☐ Oligohydramnios
☐ Placenta Previa	☐ Polyhydramnios
☐ Post Dates	☐ Preeclampsia
☐ Unstable Lie	☐ PROM
	☐ Renal Disease
	☐ Other _____ (Perinatology Consult Obtained/Agrees with Plan. Name: _____)

C. **PROCEDURE:**

1. Confirmation of Gestational Age: Gestational age needs to be confirmed using one of the American College of Obstetrics & Gynecology (ACOG) criteria:

a. An ultrasound measurement at less than 20 weeks of gestation that supports an EGA of 39 weeks or greater.
b. Fetal heart tones that have been documented as present for 30 weeks by Doppler ultrasonography.
c. It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.
d. NOTE: If the patient does not meet ACOG's criteria for confirmation of EGA, an amniocentesis to confirm lung maturity should be discussed.

2. Scheduling an Induction: When a provider or designee contacts the L&D charge nurse, these items will be provided:
   a. Woman's name and other patient identifiers, as necessary.
   b. Woman's due date and her EGA at the time of the scheduled procedure and indication for the procedure (induction or C-Section reason).
   c. If the patient's EGA is greater than >39 weeks, the procedure is scheduled.
   d. If the patient's EGA is less than <39 weeks, the pre-screening form for induction and C-Section shall be completed.
      i. The L&D charge nurse compares the indications to the pre-determined/approved list of medical and obstetric reasons for C-Section and induction. If the indication is on the list, the procedure is "medically indicated" and scheduled.
      ii. If the indication provided DOES NOT appear on the approved list, the L&D charge nurse will inform the provider/designee and offer an alternate date selection.
      iii. If the provider continues to request that the non-medically indicated procedure be scheduled prior to 39 weeks, the L&D charge nurse will inform the provider that documented approval from the OB/GYN department chair or designee is required.
3. Scheduling a C-Section: When a provider or designee contacts the surgery scheduler, information is obtained based on the pre-operative questionnaire.
   a. If the patient's EGA is greater than >39 weeks, the C-Section is scheduled.
   b. If a patient's EGA is less than <39 weeks at the time of the desired surgery date, the surgery scheduler will contact the L&D charge nurse to complete and review the pre-screening request form for induction/C-Section BEFORE the surgery is scheduled.
      i. The L&D charge nurse compares the indications to the pre-determined/approved list and if medically indicated, will notify the OR scheduler to schedule the C-Section.
      ii. If the indication provided DOES NOT appear on the approved list, the L&D charge nurse will inform the OR scheduler the procedure CANNOT be scheduled and physician notification required.
      iii. If the physician continues to request that the non-medically indicated procedure be scheduled, the OR scheduler will inform the provider that documented approval from the OB/GYN department chair or designee is required.
4. **Informed Consent:** Any woman with a scheduled non-medically indicated (elective) procedure (either by C-Section or induction) prior to 39 weeks EGA, will have an informed consent discussion documented in the medical record.
   a. The informed consent will include the usual discussion of risks and benefits of induction of labor/C-Section AND also include a discussion of the risks to the baby being born electively,prior to 39 weeks.

D. **FORM(S):**
1. Pre-Screening Form for Induction and (C-Section) Requests.

E. **REFERENCES:**

1. ACOG, (2009). Induction of Labor. American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin No. 107. Obstetrics and Gynecology, 114(2), pp. 386-97.
2. Elimination of Non-Medically Indicated (Elective) Deliveries before 39 Weeks Gestational Age. www.marchofdimes.com, CMQCC.org.

Tri-City Medical Center ADVANCE

PRE-SCREENING FORM FOR INDUCTION AND CESAREAN SECTION (C-Section) REQUESTS
Call TCMC Labor & Delivery to Schedule (Induction/ C-Section): 760-940-7453
Call TCMC Surgery Scheduler to Schedule (C-Section): 760-940-3888

PATIENT/PROVIDER INFORMATION
Name: _____ Date of Birth: _____ Phone Number: _____
G/P_____ OB Provider: _____
Type of Procedure Planned: ☐ Induction ☐ C-Section Desired Date/ Time: _____

EDC: _____ Gestational Age at Date of Induction/ C-Section:_____

DATING CONFIRMED BY:
EDC Based on: ☐ US @10-20 weeks ☐ Doppler w/ Fetal Heart Tones for 30 weeks
☐ (+) hCG result for 36 weeks ☐ Other dating criteria: _____

Fetal Lung Maturity Test Results, as indicated: _____ Date: _____

INDICATIONS: Obstetric and Medical Conditions (If marked, OK to schedule if < 39 weeks EGA)

- ☐ Abruption
- ☐ Coagulation Defects (Antiphospholipid Syndrome)
- ☐ Fetal Demise (Current)
- ☐ Fetal Distress/Abnormal FHR
- ☐ Fetal CNS Malformation or Chromosomal abnormality, suspected damage to fetus from viral or other diseases in mother, drugs, radiation
- ☐ Gestational Hypertension
- ☐ HIV Infection
- ☐ Isoimmunization/Fetal-Maternal Hemorrhage
- ☐ Multiple Gestation
- ☐ Placenta Previa
- ☐ Post Dates
- ☐ Unstable Lie
- ☐ Chronic Hypertension
- ☐ Cardiovascular Disorders/Diseases
- ☐ Diabetes (Type I or II)
- ☐ Fetal Demise (Prior)
- ☐ Gestational Diabetes (GDM with Insulin)
- ☐ Heart Disease
- ☐ IUGR
- ☐ Liver Disease (Cholestasis of pregnancy)
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Preeclampsia/Eclampsia
- ☐ PROM
- ☐ Renal Disease
- ☐ Other_____ (Perinatology consult obtained/ agrees with plan. Name:_____)

RESULTS:

- ☐ Procedure is Medically Indicated or EGA is > 39 weeks. Scheduled by_____ Confirmed Date/ Time:_____
- ☐ Procedure is NOT Scheduled Reason: _____
- ☐ Case referred to OB/GYN Department Chair: Date/ Time_____ Result:_____

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**HUMAN IMMONUDEFIECIENCY VIRUS (HIV) INTRAPARTUM, POSTPARTUM AND NEWBORN MANAGEMENT**
Purpose:	To provide nursing guidelines for the administration of antiretroviral medications to reduce the risk of mother to child transmission of HIV.
Supportive Data:	HIV~~uman immunodeficiency virus~~ may be transmitted from mother to infant during the perinatal period. The risk of infection for a neonate born **from**~~to~~ ~~an~~ HIV-positive mother has been reduced from 25% to less than 2% by the use of currently recommended prenatal antiretroviral therapy and obstetric interventions for women who are aware of HIV infection early in pregnancy. It has been found that HIV prophylaxis, even when begun during labor ~~and delivery~~ can reduce mother to child HIV transmission by 50%.
Equipment:	1. Alaris pump, (2) tubing sets, and **(2) Intravenous (IV) Lines**~~3 lead extension set~~ 2. **Normal Saline (NS)** 500 mL for dedicated infusion line **for antiretroviral medication.** 3. Premixed antiretroviral medication **per** ~~in 250 mL D5W or as ordered my~~ physician/**Allied Health Professional (AHP) order**

A. POLICY:

1. **Every pregnant woman shall be tested for HIV during pregnancy unless she refuses testing.**
   a. **If she declines a HIV test, this decision should be documented in her medical record.**
2. **Women admitted to the hospital without receiving prenatal care will be screened with a rapid HIV test(ordered as HIV 1/ 2 Screen) and will be counseled about reducing the risk of mother to infant HIV transmission if indicated.**
3. **Women who do not have a documented prenatal HIV result available on admission to Labor and Delivery (L&D) shall be offered a rapid HIV test (ordered as HIV 1/ 2 Screen).**
4. **Women who are identified as being HIV positive during prenatal screening will be referred to the University of California San Diego (UCSD) Mother, Child and Adlolescent HIV program as soon as possible for prenatal management.**
5. **Patient's receiving antiretroviral prophylaxis, will need to have two IV lines. (One dedicated for antiretroviral medication and a second line for any labor management needs.**
6. **Infants born to HIV positive mothers at Tri City Medical Center shall receive treatment and screening for mother to infant transmission within 6- 12 hours post delivery.**
   a. ~~Provider~~**Physicians/Allied Healthcare Professionals (AHP) caring for infants can consult a Neonatologist as needed.**
7. **Any patient with HIV findings shall be referred to social services for needs assessment, resource referral,and discharge planning anticipations.**

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

1. Intrapartum treatment **for positive HIV findings in labor and not receiving HIV treatment**:
   a. **Discuss the use of antiretroviral prophylaxis to reduce HIV transmission during labor and prepare to administer the antiretroviral therapy a minimum of four hours prior to delivery.**
   b. **Method of delivery considerations include:**
      i. **If the amniotic fluid membranes have not ruptured, the patient shall be offered a Cesarean-Section (C-Section) as a method to reduce HIV transmission.**

Review/Revision Date	~~Clinical Policies & Procedures~~	~~Nurse Executive Committee~~	Department of OB/GYN	Department of Pediatrics	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
1/10, 03/16	~~02/13~~	~~02/13~~	1/13, 08/16	11/16	02/17	05/13, 03/17	06/13, 04/17	06/13

ii. **If the amniotic fluid membranes have ruptured less than four hours, start antiretroviral medications and ~~ready~~prepare the patient for C-Section per ~~provider~~physician/AHP orders.**

iii. **If the amniotic fluid membranes have ruptured more than four hours, give antiretroviral treatment and avoid performing any procedure that may increase the risk of fetal contact with maternal blood or vaginal secretions such as:**

1) **Fetal scalp electrode placement**
2) **Intrauterine pressure catheter placement**
3) **Episiotomy, if possible**
~~a.~~4) **Forceps or vacuum assisted birth** ~~If the results are positive and the woman is in labor, prepare to administer the antiretroviral therapy within a timely manner~~

~~i. 4 hours prior to delivery is preferred length of time~~

~~b.~~**c.** Obtain and verify ~~physician~~ order for antiretroviral treatment **from ~~provider~~physician/AHP STAT**

~~i. Refer to PPO: "WCS HIV Intrapartum Treatment Order Set"~~

~~c.~~**d. Weigh the patient and** ~~Obtain actual body weight (to~~ convert lbs to kg 2.2lbs = 1kg)

e. Begin administration of intravenous antiviral infusion of Zidovudine (Retrovir/ ZIDOVUDINE) in a dedicated line and via an infusion pump per ~~provider~~physician/AHP order.

~~d.~~**i. An initial loading dose of 2mg/kg over one hour followed by a continuous infusion of 1 mg/kg until delivery may be initiated by ~~provider~~physician/AHP.** ~~Administer the mainline infusion solution (NS) and rate as specified and ordered by the physician.~~

~~i. Maintain this line as a dedicated line for the administration of the antiretroviral treatment~~

ii. Zidovudine does not mix well with **Lactated Ringers** and other medications

~~e. Begin administration of IV antiviral infusion via continuous infusion pump during labor~~

~~i. Attach pre-mixed antiretroviral solution via IV pump tubing into nearest IV port (using the 3-lead extension set) to the patient and label tubing~~

~~ii. Continuous IV infusion until delivery~~

iii. ~~Refer to PPO: "HIV Intrapartum Treatment Order Set"~~**Zidovudine infusion should be administered for 3 hours pre-delivery.**

~~iii.~~**iv. Discontinue Zidovudine after delivery**

~~2. Method of delivery for women with positive HIV results:~~

~~a. Refer to physician order (PPO)~~

~~i. If the woman presents in active labor and she is progressing rapidly, provide intrapartum treatment and delivery vaginally.~~

~~ii. If admitted in labor with intact membranes, may labor.~~

~~iii. If membranes intact, may be offered a c-section as a potential strategy to reduce HIV transmission.~~

~~b. Women who have had a rupture of membranes for >4 hours, may be offered a c-section (rupture of membranes ≥ four hours increases the risk of perinatal transmission and should be avoided)~~

~~i. Page physician ASAP if ROM ≥ 4 hours.~~

~~c. Notify neonatologist to allow the NICU team to prepare for attendance at delivery and to initiate admission and treatment plans for the exposed neonate~~

~~i. Refer to Refer to WCS/NICU Procedure: "HIV Exposed Infant, Management of"; and PPO: "NICU Order Set: Treatment for HIV Exposed Infant"~~

~~3. Precautions:~~

~~a. If labor progresses and membranes are intact, avoid performing any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions such as:~~

~~i. Artificial rupture of membranes~~

~~ii. Fetal scalp electrode~~
~~iii. Intrauterine pressure catheter~~
~~iv. Fetal scalp pH sampling~~
~~v. Episiotomy (if possible)~~
~~vi. Forceps or vacuum extraction~~

f. No breastfeeding. Prepare and educate mother about the risk of mother to child transmission that occurs with breastfeeding.

2. Intrapartum treatment for positive HIV findings in labor who are taking antiretroviral therapy

a. Method of delivery considerations include:

i. The delivery plan may be individualized according to HIV plasma viral load (RNA PCR) obtained in the third trimester or the most recent RNA PCR results. If the patient has a RNA PCR <1000 copies, a C-Section provides no additional reduction in HIV transmission.

ii. Patients who have a HIV (RNA PCR) >1000 copies should be scheduled for an elective C-Section at 38 weeks gestation.

1) This patient should have IV Zidovudine administered 3 hours before surgery

2) If the patient presents in active labor and is progressing rapidly, provide intrapartum treatment and deliver vaginally.

3) If cervical dilation is minimal and a long labor anticipated, the ~~provider~~physician/AHP may begin a loading dose of ZIDOVUDINE and proceed with C-Section to minimize duration of ROM and avoid vaginal delivery.

iii. Patients who are admitted in labor with intact membranes, may labor

b. ROM considerations:

i. ROM > 4 hours increased the risk of perinatal HIV transmission, avoid artificial rupture of membranes (AROM).

ii. ROM .> 4 hours when patient has a viral load (HIV RNA PCR) <1000 copies is unlikely to increase the risk of mother to child HIV transmission

iii. ROM is not an indication for a C-Section when the HIV RNA PCR is <1000 copies.

c. If a preterm patient presents with SROM, request immediate Perinatology consult.

d. If labor progresses and membranes are intact, avoid performing any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions such as:

i. AROM
ii. Fetal scalp electrode placement
iii. Intrauterine pressure catheter placement
iv. Episiotomy
v. Forceps or vacuum assisted birth

e. Medication considerations should include administration of ZIDOVUDINE via a dedicated line.

i. Once order received by ~~provider~~physician/AHP, stat loading dose of ZIDOVUDINE, 2mg/kg IV over one hour, followed by a continuous infusion of 1mg/kg/ hour untill delivery.

ii. Ideally, ZIDOVUDINE infusion should be given for 3 hours pre-delivery

iii. Discontinue ZIDOVUDINE after delivery

iv. Continue other HIV medications as prescribed through the patients intrapartum and postpartum periods.

~~b.~~1) Medications containing ZIDOVUDINE like (Combivir/ Trizivir) can be held until ZIDOVUDINE infusion is discontinued.

~~4.~~**3.** Care of the HIV exposed newborn:

a. The newborn will **have**~~be cleaned off of~~ blood and body fluids immediately **cleaned off** after **delivery and be bathed as soon as possible after birth.**
b. **The newborn can be placed skin to skin with the mother. The mother shall wear her bra to prevent the infant from latching and should NOT breastfeed.**
c. **Place bottle feeding only identification on newborn crib so medical team is aware of infant feeding method.**
d. **Evaluate the newborn for maternal co-infections. Review maternal history for syphilis, toxoplasmosis, Hepatitis B and C, Herpes, cytomegalis virus and tuberculosis and pursue newborn testing per** ~~**provider**~~**physician/AHP order.**
e. **Obtain the following labs before the infant is discharged per** ~~**provider**~~**physician/AHP order.(These do not have to be drawn prior to the start of Zidovudine) Labs can be drawn with the routine California Newborn Screen and include:**
   i. **CBC with differential and platelets**
   ii. **HIV DNA PCR**
f. **Complete a social worker consult to assist newborn with California Children Services (CCS) qualifying process for the CCS HIV screening program at UCSD**
   i. **This program should cover costs of HIV testing, medications, and follow-up.**

4. **Treatment considerations for the newborn:**
   a. **All newborns born to HIV infected mothers should receive Zidovudine at gestational age appropriate doses for six weeks. This should be initiated as close to the time of birth as possible, preferably within 6-12 hours of delivery.**
   b. **For newborns born to the HIV infected mother who has received standard combination antiretroviral therapy during pregnancy with consistent viral suppression and there are no concerns to maternal adherence, a 4 week dose of Zidovudine may be considered.**
   c. **Dosing considerations are per** ~~**provider**~~**physician/AHP order and if infant is unable to tolerate oral agents, the newborn will need NICU admission for IV administration.**
5. **Treatment considerations to reduce the risk of HIV infections in newborns at greatest risk, can include a combination antiretroviral prophylaxis.**
   a. **Newborns at greatest risk include:**
      i. **When there is no maternal antiretroviral antepartum or intrapartum treatment**
      ii. **The mother only received intrapartum treatment**
      iii. **The mother's last HIV RNA PCR is > 10,000 copies**
      iv. **Suboptimal maternal viral suppression and known maternal ARV drug resistant virus**
      v. **When the newborn rapid HIV test is positive**
   b. **Newborn** ~~**provider**~~**physician/AHP should consult with a USCD Pediatric HIV Specialist to discuss medication options.**
      ~~i. Delivery~~
~~b. The neonatologist/NICU team working in the NICU will be called to attend the delivery and will initiate orders and assume care for treatment of the exposed infant~~
      ~~i. Refer to the WCS/NICU procedure: "HIV Exposed Infant, Management of"~~
      ~~ii. Refer to WCS/NICU PPO: "NICU Order Set: Treatment for HIV Exposed Infant"~~

~~5.~~6. Postpartum Treatment:
~~a. Obtain and verify physician order set~~
   ~~i. Refer to PPO: "Postpartum HIV Treatment Order Set"~~
   a. Administer antiretroviral medication as ordered by the ~~**provider**~~**physician/AHP**.~~hysician~~
      i. **In women who are receiving a cytochrome P(CYP) 3A4 "enzyme inhibitor" such as protease inhibitor, methergine should be used only if no**

alternative treatments for postpartum hemorrhage (PPH) are available and the need for medication treatment outweighs the risks.

1) If methergine is used it should be at the lowest effective dose for the shortest possible duration.

~~b.~~**ii. In women who are receiving a CYP 3A4 "enzyme inducer" such as nevirapine, efavirenz or etravirine, additional uterotonics agents may be needed because of the potential for decreased methergine levels and inadequate treatment effect.**

~~c. If HIV test confirmation is negative~~

~~i. Notify physician and discontinue treatment per order~~

~~ii. Patient may initiate breastfeeding~~

~~d.~~**b.** ~~If HIV test is confirmed positive,~~**~~Provider~~Physician/AHP** ~~MD~~ may review treatment **plan** with UCSD Mother-Child**, and Adolescent** HIV team

~~e. Refer patient to the UCSD Mother, Child & Adolescent HIV Program as soon as possible to review therapy for follow up. (Andrew Hull, M.D. (619) 290-3807, or Mary Caffery, RN, MSN, pager (619) 290-3118 or (619) 543-8089.)~~

~~i. Mother's name, medical record number and telephone number~~

~~ii. Fax any lab tests information to pediatric nurse practitioner, Pediatric Infectious Diseases~~

~~B.~~C. DOCUMENTATION:

1. In addition to usual unit standard documentation:
   a. Document antiretroviral treatment administered, including dose and time per unit
   b. Document any side effects to medication
   c. Document instruction and education given to patient in medical record

~~C.~~D. DISCHARGE:

1. ~~Check with physician to~~ Ensure prescription for home medication is written early in hospitalization to allow time for patient to fill prescription prior to discharge. Most outside pharmacies need >48 hours to obtain zidovudine and fill the prescription.

~~2. Provide patient with ongoing treatment plan as ordered by physician~~

2. Review and verify that the family has the medication and knows how to administer it to the infant prior to discharge home.

3. Ensure that mother and her infant ha**ves** ~~been~~ referred to and ha**ves** ~~an~~ appointment**s** with UCSD Mother, Child & Adolescent HIV Program **in** ~~for~~ 4-6 weeks **for follow-up** ~~postpartum or~~ as directed by the UCSD HIV program staff. **Call 619-543-8089 for an appointment.**

~~3.~~**4. Families shall be referred to a primary care ~~provider~~physician/AHP for well infant care and should have a copy of the discharge summary prepared to give to the infant's ~~provider~~physician/AHP.**

~~D.~~E. REFERENCES:

1. American Academy of Pediatrics **(AAP)** and American College of Obstetricians and Gynecologists **(ACOG)**. 2012~~07~~. *Guidelines for Perinatal Care* ***Seventh~~Sixth~~*** *Edition.* Washington, DC

~~1.~~**2. National Institutes of Health (Aug 6, 2015) Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. Available online at http//aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf**

3. AAP Policy Statement:~~,~~ **Evaluation and Management of the Infant exposed to HIV-1 in the United States Pediatrics 2012; 130-64: http//pediatrics.aappublications.org/content/130/6/64.full.pdf+html**

4. AAP Policy Statement: Infant Feeding and Transmission of HIV in the United States. Committee on Pediatric AIDS **Pediatrics 2013: 131:391. http//pediatrics.aappublications.org/content/131/2391.full.pdf+html**

~~2. 120(6) e1547. *Diagnosis of HIV-1 Infection in children younger than 18 months in the United States.* Washington, DC~~
~~3. AB 682 Assembly Bill - CHAPTERED~~
~~4.~~**5.** ACOG Committee Opinion: ~~# 418 (9/08),~~ Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations **includes College recommendations for prenatal testing, rapid testing in labor and delivery and repeat testing in the third trimester. # 418 (9/08, Reaffirmed 2011),**. ~~November, 2004~~
~~5. ACOG Committee Opinion #389, Human Immunodeficiency Virus*, December, 2007~~
~~6. California Law: Assembly Bill No. 1676~~
~~7. California Perinatal Quality Care Collaborative, 2008 Standards of Care for the Prevention of Perinatal Transmission (HIV Toolkit)~~
~~8. Pickering LK, ed. *2009 Red Book: Report of the Committee on Infectious Diseases.* 28th ed. Elk Grove Village, IL: American Academy of Pediatrics.~~
~~9. Public Health Service Task Force. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States, April 29, 2009, http://aidsinfo.nih.gov/guidelines/perinatal\perinatal Updated yearly.~~
~~10. Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings. MMWR Recommendations and Reports, September 22, 2006/55 (RR14); 1-17.~~
~~11. Revised CDPH Perinatal Policy (2008)~~
~~12.~~**6.** National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1-888-448-8765
~~13. UCSD Medical Center, Woman's and Infant's Department Policy/Procedure: "HUMAN IMMUNODEFICIENCY VIRUS PREVENTION OF PERINATAL TRANSMISSION" (8/15/09).~~

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**HIV NEWBORN MANAGEMENT**
Purpose:	~~To outline the steps necessary to screen and~~
Supportive Data:	~~Human immunodeficiency virus may be transr perinatal period. The risk of infection for a nec been reduced from 25% to less than 2% by th antiretroviral therapy and obstetric interventior infection early in pregnancy. It has been found during labor and delivery can reduce mother to child HIV transmission by 50%.~~

DELETE - replace HIV Newborn Management with HIV Intrapartum, Postpartum and Newborn Management. Procedures were combined because information was similar.

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

1. ~~Infants born to HIV positive mothers at Tri-City Medical Center shall receive treatment and screening for mother-to-child transmission as soon after birth as possible, within 6 hours post delivery.~~
2. ~~Transmission of HIV to the fetus can be significantly reduced if the mother is treated during her pregnancy and intrapartum period, with antiretroviral drugs. Postpartum treatment of the newborn with antiretroviral drugs further reduces transmission risk and infection.~~
2. ~~A variety of tests are available for determining the HIV infection. Both the ELISA (enzyme-linked immunosorbant assay) and the western blot tests detect HIV antibodies, not the HIV virus. In the neonate, the presence of these antibodies may result from passive placental transfer from mother and not necessarily indicative of active neonatal disease. Specific tests, such as the HIV DNA PCR (polymerase chain reaction) detect the presence of the HIV virus.~~

B. ~~**PRIOR TO DELIVERY:**~~

1. ~~See "TCMC PCS Standardized Procedure: "HIV SCREENING & IDENTIFICATION FOR THE PREVENTION OF PERINATAL TRANSMISSION" for care of the mother.~~
2. ~~Standard infection precautions are used during delivery.~~
3. ~~Carry out care practices in the normal manner, regardless of HIV status of infant.~~
4. ~~Refer to the WCS/NICU PPO/HIV Order Set: Treatment for HIV Exposed Infant.~~
   a. ~~Scan completed neonatologist's PPO order set to the pharmacy ASAP.~~

C. ~~**ONCE INFANT DELIVERED:**~~

1. ~~Verify mother's HIV status and document status of mother's HIV serology on neonatal chart.~~
2. ~~Verify physician's order for treatment as soon after birth as possible.~~
3. ~~Administer antiretroviral meds per physician order.~~
   a. ~~Refer to PPO: HIV Treatment Plan for HIV Exposed Infant.~~
4. ~~No special care practices or standards are required for the HIV exposed newborn.~~
5. ~~Verify feeding order set.~~
   a. ~~Infant will be formula fed only. DO NOT breastfeed. Discuss and reinforce this with infant's mother.~~
6. ~~Obtain labs per order set.~~
   a. ~~Call lab prior to drawing the test: verify proper drawing and processing technique.~~
7. ~~Place social worker consult order in Cerner to implement/or assist with CCS qualifying process for the CCS HIV screening program at UCSD.~~
   a. ~~Social worker shall ensure mother receives information regarding CCS HIV Screening Program. This program will cover costs of HIV testing, medications and follow up. Parents may call CCS at (619) 528-4000, to start the process.~~

Review/Revision Date	~~Clinical Policies & Procedures~~	~~Nurse Executive Committee~~	Department of OB/GYN	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
1/10, 03/16	~~02/13~~	~~02/13~~	08/16	11/16	02/17	05/13, 03/17	06/13, 04/17	06/13

D. **DOCUMENTATION:**

1. In addition to usual unit standard documentation:
   a. Document zidovudine (Retrovir) dose and time per unit standards.
   b. Document any side effects to medication.
   c. Document instruction and education given to mother or primary caregiver in medical record.

E. **DISCHARGE:**

1. *Check with physician to ensure prescription for home medication is written early in hospitalization to allow time for parents to fill prescription prior to discharge. Most outside pharmacies need >48 hours to obtain zidovudine and fill the prescription.
2. Provide maternal or primary care giver information as follows:
   a. Instruct mother or primary caregiver on the following medication issues:
      i. Review procedure for accurately drawing up and administering zidovudine
      ii. Zidovudine may be kept at room temperature.
      iii. Importance of the drug is given every 6 hours or as ordered by physician to maintain adequate drug levels.
      iv. Zidovudine must be given for 6 weeks.
      v. Fill prescription for zidovudine as soon as it is received.
      vi. Pharmacies may take 48 - 72 hours to fill a prescription for zidovudine if they do not have it in stock.
3. Ensure infant has an appointment with UCSD Mother, Child & Adolescent HIV Program for 4-6 weeks of age, call (619) 543-8089; leave a message for pediatric nurse practioner with the following information:
   a. Mother's name, medical record number and telephone number.
   b. Infant's name, medical record number and date of birth, and primary pediatrician, if available.
   c. Fax any lab tests information to pediatric nurse practitioner, Pediatric Infectious Diseases.

F. **REFERENCES:**

1. California Perinatal Quality Care Collaborative, 2008 Standards of Care for the Prevention of Perinatal Transmission (HIV Toolkit).
2. Public Health Service Task Force Recommendation for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States, April 29, 2009 Web site (http://AIDSinfo.nih.gov).
3. TCMC PCS Standardized Procedure: "HIV SCREENING, IDENTIFICATION/TREATMENT OF HIV POSITIVE WOMEN IN LABOR TO PREVENT PERINATAL TRANSMISSION.
4. TCMC PCS Policy: "HIV PREVENTION OF PERINATAL TRANSMISSION".
5. Red Book Pickering LK, ed. *2009 Red Book: Report of the Committee on Infectious Diseases.* 28th ed. Elk Grove Village, IL: American Academy of Pediatrics.
6. Young, T.E., Mangum, B. Pharm D, NEOFAX® 2009 (22nd ED). © 2009 Thomas Reuters.

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**MISOPROSTOL (CYTOTEC)**
Purpose:	Misoprostol may be used for ripening of the cervix, induction of labor, and postpartum hemorrhage. Cervical ripening may be used when induction of labor is indicated and the cervix is unfavorable. Misoprostol can be used in the third stage of labor to treat severe postpartum hemorrhage secondary to uterine atony.
Supportive Data:	Cervical ripening is considered after evaluation of maternal-fetal status, cervical status, gestational age and other relevant factors. Misoprostol is a PGE_1 analog (synthetic) that has been shown to be safe and effective for cervical ripening. Misoprostol is indicated for ripening of the cervix and/or induction of labor in pregnant women at or near term with a live fetus. It is also indicated for cervical ripening and/or induction of labor for a non-viable fetal demise. Insertion of Misoprostol is appropriate with ruptured membranes.
Equipment:	1. Sterile examination glove 2. Ordered dose of misoprostol 3. Sterile lubricant

A. POLICY:

1. The initial dosage of misoprostol is administered by the ~~provider~~**physician/Allied Health Provider (AHP)** when placed vaginally.
2. Oral administration may be given initially by the Registered Nurse (RN), after a vaginal examination is done to confirm fetal position (presentation), station and cervical status (dilation, effacement, consistency and position).
3. If any examination of the cervical status is in question, it is the ~~provider~~**physician/AHP**'s responsibility to verify the assessment prior to the induction/augmentation.

B. INDICATIONS/ELIGIBILITY CRITERIA FOR USE (Includes but are not limited to the following):

1. Singleton pregnancy
2. Normal fetal lie and documented presentation
3. Unfavorable cervix with indications for induction
4. Obstetrical or medical indication for induction of labor
5. Nulliparous OR Multiparous with < 7 term pregnancies
6. Category I fetal monitoring tracing
7. Premature rupture of membranes
8. Fetal Demise

C. GENERAL PRECAUTIONS:

1. Non-vertex presentation
2. History of:
   a. Hypertonic uterus
   b. Glaucoma
   c. Childhood asthma, even though no adult episodes
   d. Cardiac Disease
   e. Pulmonary Disease
   f. Renal Disease
   g. Hepatic Disease
3. Oligohydramnios - ≤ 5.0 cm
4. Category II fetal heart rate tracing- requires ~~provider~~**physician/AHP** evaluation with documentation of the order to continue with the procedure
5. Preeclampsia

Review/Revision Date	Department of OB/GYN ~~Committee~~	~~Clinical Policies & Procedures~~	~~Nursing Executive Committee~~	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
3/03; 2/06; 3/09, 12/12, 05/16	01/13, 08/16	~~2/13~~	~~2/13~~	02/17	5/13, 03/17	6/13, 04/17	6/13

D. CONTRAINDICATIONS (include but are not limited to the following):

1. Previous Cesarean Section or Uterine Surgery
2. Patients with known hypersensitivity to prostaglandins
3. Category II Fetal Monitoring (FM) tracing, progressing to a Category III OR Category III FM strip tracing.
4. Breech presentation or transverse fetal lie
5. Placenta previa/ vasa previa
6. Simultaneous use of oxytocin
7. Maternal fever (≥ 101˚ F)
8. Active herpes
9. Multiparous, > 6 previous pregnancies at viability

E. PROCEDURE for CERVICAL RIPENING/ INDUCTION OF LABOR:

1. Admit patient to Labor and Delivery and review induction plan with the patient/ family.
2. Confirm informed consent was provided by the ~~provider~~**physician/AHP** and consent signed by the patient.
3. Obtain baseline assessment of maternal vital signs
4. Obtain a 20 minute Fetal Monitoring Strip, per department Fetal Heart Rate Surveillance Policy, to determine fetal well-being and uterine activity.
5. Establish IV access with a 16/18 g IV catheter or place a ~~Heplock~~**saline lock per physician/AHP order**.
6. Have the patient void
7. A cervical exam should be completed by the RN or ~~provider~~**physician/AHP** (Clinical Nurse Midwife (CNM) or Obstetrician) prior to administering Misoprostol to obtain a baseline BISHOPS Score.
   a. An exam should also be performed prior to giving subsequent doses.
   b. Misoprostol should be discontinued once a Bishop score of greater than 8 has been achieved or a cervical exam of 80% effacement and 3 cm dilation, the patient enters active labor or the FHR demonstrates a Category II progressing to a Category III tracing or Category III tracing.
8. Oral / **Buccal** Administration:
   a. Usual dosing schedule is 50 micrograms (mcg) by mouth every four hours, per ~~provider~~**physician/AHP** order. DO NOT exceed a total of 300 mcg of oral Misoprostol or six doses.
9. Vaginal Administration:
   a. Intra-vaginal misoprostol shall be inserted by a ~~provider~~**physician/AHP** initially; subsequent doses may be inserted by the RN.
   b. Usual dosing schedule is 25 mcg intra-vaginally initially; followed by 25- 50 mcg every four hours intra-vaginally, per ~~provider~~**physician/AHP** order.
   c. Avoid the use of lubricating gel (only a small amount or use water if necessary) and place Misoprostol tablet high into the posterior vaginal fornix.
   d. Maintain lateral supine tilt position for 60 minutes after insertion of Misoprostol.
10. Vital Signs: Blood Pressure, pulse, respiratory rate and temperature are taken every 30 minutes times two after each dose, then every FOUR hours if stable and not in active labor. Once active labor is established, follow vital sign guidelines for intrapartum management or if an epidural is placed per epidural procedure.
11. Assess and document FHR and uterine activity via continuous external electronic fetal monitoring after insertion of Misoprostol and per ~~provider~~**physician/AHP** order.
    a. Actions for uterine tachysystole:
       i. Tachysystole is defined as > 5 contractions in 10 minutes, averaged over 30 minutes.
       ii. If tachysystole occurs and FHR tracing indicates Category II, progressing to Category III or III finding, notify the ~~provider~~**physician/AHP** and institute

measures to remove the Misoprostol tablet and improve fetal oxygenation **per physician/AHP order(s)**:
1) Position laterally
2) Provide O_2 8-10 liters/minute via non-rebreather mask
3) Hydrate with 400-500 mL bolus of non-dextrose solution
4) Administer 0.25 mg terbutaline subcutaneously ~~per provider order~~

iii. Evaluate maternal/fetal responses to interventions and prepare for emergency **Cesarean Section**~~/s~~ if indicated

iv. Patient assessment must be performed by the ~~provider~~**physician/AHP** prior to resuming misoprostol induction.
1) Allow patient to rest at minimum 4 hours prior to resumption of misoprostol induction (normal dosing interval)

12. Reassessment of the clinical situation by the ~~provider~~**physician/AHP** is necessary after 12 hours or two RN administered doses. Further administration requires a note by the ~~provider~~**physician/AHP**.
13. Oxytocin (Pitocin) may be initiated no sooner than four (4) hours after the last Misoprostol dose **per physician/AHP order**.

F. MISOPROSTOL USE FOR (IUFD) INDUCTION/ PREGNANCY TERMINIATION:

1. For Estimated Gestational Ages (EGA) LESS THAN 22 weeks:
   a. Apply tocodynamometor (toco) to assess uterine activity, per ~~provider~~**physician/AHP** order.
   b. Perform vaginal examination for cervical assessment (effacement and dilatation) and fetal station evaluation prior to insertion of each dose of misoprostol.
   c. Administer 400 micrograms (mcg) vaginally every THREE to SIX hours for a maximum of FIVE doses or 600 mcg vaginally every 12 hours **per physician/AHP order**. (Either protocol may be repeated after 24 hours if induction is not complete)
   d. Women with a prior Cesarean Section who undergo labor induction for miscarriage/ fetal demise with prostaglandin (including misoprostol) have been shown to have outcomes that are similar to those women with an unscarred uterus so its use can be considered a reasonable option in this gestation.
2. For EGA BETWEEN 23-26 weeks:
   a. Apply toco to assess uterine activity, per ~~provider~~**physician/AHP** order
   b. Perform vaginal examination for cervical assessment (effacement and dilatation) and fetal station evaluation prior to insertion of each dose of misoprostol
   c. Since the potency of Misoprostol varies with gestational age the following dosage regime may be considered: 100 mcg vaginally ~~q~~**every** 6 hours **per physician/AHP order**.
   d. Women with a prior cesarean section who undergo labor induction for miscarriage/ fetal demise with prostaglandin (including misoprostol) have been shown to have outcomes that are similar to those women with an unscarred uterus so its use can be considered a reasonable option for use in this gestation.
3. For EGA GREATER THAN 27 weeks:
   a. Apply the toco to assess uterine activity, per ~~provider~~**physician/AHP** order
   b. Perform vaginal examination for cervical assessment (effacement and dilatation) and fetal station evaluation prior to insertion of each dose of misoprostol.
   c. Administer 50 mcg Misoprostol, vaginally every FOUR hours for a total of SIX doses **per physician/AHP order**.
   d. For patients with a prior cesarean scar who undergo labor induction for fetal demise greater than 27 weeks EGA, cervical ripening with a "transcervical Foley catheter" has been associated with uterine rupture rates comparable with spontaneous labor and should be considered a helpful adjunct in patients with an unfavorable cervical examination.

G. USE IN POSTPARTUM HEMORRHAGE (PPH):

1. Administer Misoprostol per ~~provider~~**physician/AHP**'s order. Usual range is 800- 1000 mcg X1 rectally (PR)
2. Monitor vital signs q 15 min x one hour or until stable per ~~provider~~**physician/AHP** order.
3. Reassessment of the clinical situation by the ~~provider~~**physician/AHP** is necessary after 12-24 hours or prn. Further administration requires a note by the ~~provider~~**physician/AHP**.

H. DOCUMENTATION:

1. Document patient assessment, misoprostol insertion, fetal monitoring, nursing actions and interventions, and maternal/fetal responses in the patient record as needed.

I. REFERENCES:

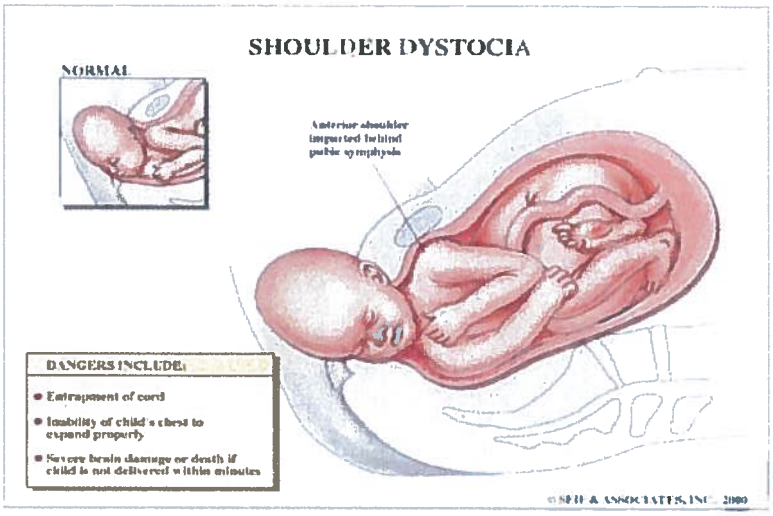
1. AAP & ACOG. (201~~0~~). Guidelines for Perinatal Care, **7~~6~~th** Edition
2. American College of Obstetrics & Gynecology (2009). Induction of Labor. ACOG Practice Bulletin, No. 107.
3. Wildschut, H., Both, M., Medema, S., et al. Medical methods for mid-trimester termination of pregnancy. Cochrane Data Base System Rev 2011; CD005216.
4. ~~Gilbert, E.S. (2007). Manual of High Risk Pregnancy & Delivery, (4th Edition), Mosby~~
5. **~~4.~~** Gomez Ponce de Leon, R., Wing, D. A., Fiala, ~~C.C.~~ Misoprostol for **termination of pregnancy with** Intrauterine Fetal **demise**~~Death~~ **in second and theird trimester of pregnancy – a systematic review**. ~~International Obstetrics & Gynecology~~ (200~~7~~) **Contraception 79, 259-271~~99, S190- S193~~.**
5. Simpson, K.R. & Creehan, P.A. (201~~4~~**~~08~~**). Perinatal Nursing, (**4~~3~~rd** Edition), Philadelphia, PA: Lippincott, Wilkins & Williams.
6. **Carlan, S.J., Blust, D., and O' Brien, W. F. (2002) Buccal verses instravaginal misoprostol administration for cervical ripening. American Journal of Obstetrics and Gynecology, 186: 229-233.**
7. ~~Wing, D.A. (2008) Induction of labor in women with prior cesarean delivery. Retrieved from www.uptodate.com 4/06/09.~~
8. ~~Wing, D.A. (2008) Induction of labor. Retrieved from www.uptodate.com 4/06/09.~~

Tri-City Medical Center	Distributi
PROCEDURE:	**SHOULDER DYSTOCIA**
Purpose:	Shoulder Dystocia is defined as the impaction maternal symphis pubis after the baby's head shoulders exceeds the diameter of the pelvic occur in the normal birth weight baby, making this an unpredictable obstetrical emergency. Nursing knowledge of prenatal risk factors, intrapartum warning signs, and specific interventions using the HELPERR pneumonic, is essential to ensure the best possible outcomes for the laboring woman and her baby.
Supportive Data:	There is no evidence that any one maneuver is superior in releasing an impacted shoulder; however, the McRoberts maneuver and suprapubic pressure are easily implemented without an associated risk of injury to the baby. Excess traction and fundal pressure should be avoided because of increased risk of injuries to the baby (ACOG, 2002b). Key interventions include calling for additional help, calm supportive actions, and working in sync with the provider who is directing maneuvers to deliver the impacted shoulder.
Equipment:	Foot stool

DELETE – Online Clinical Skills (Mosby's) Resource has a Shoulder Dystocia Procedure. Remove from Unit Specific Manual 12/2016

A. **RISK FACTORS**

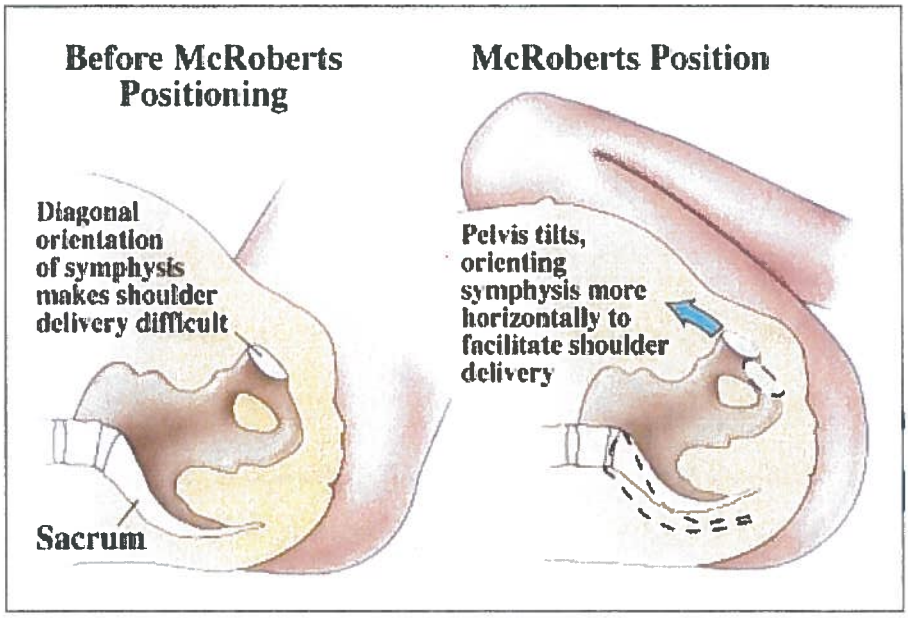
1. Maternal risk factors associated with shoulder dystocia include
   a. Abnormal pelvic anatomy
   b. Gestational diabetes
   c. Post-dates pregnancy
   d. Previous shoulder dystocia
   e. Short stature
2. Fetal risk factors associated with shoulder dystocia include:
   a. Suspected macrosomia
   b. Labor related
   c. Assisted vaginal delivery (forceps or vacuum)
   d. Protracted active phase of first-stage labor
   e. Protracted second-stage labor with "head-bobbing" or "turtling" (head emerges and then retracts up against perineum)



Revision Date	Department of OB/GYN	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
07/14, 12/16	06/13, 02/17	n/a	n/a	06/14, 03/17	06/14, 04/17	07/14

B. **PROCEDURE:**

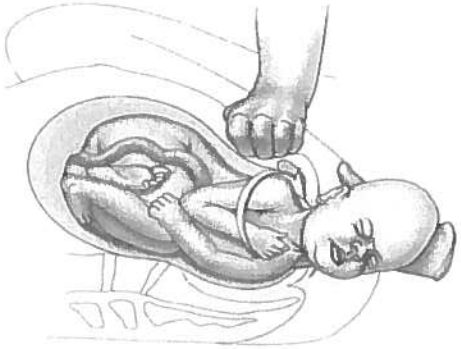
1. Nursing staff should be aware of Antepartum and Intrapartum risk factors/warning signs that could indicate a potential shoulder dystocia, so it can be anticipated and interventions provided quickly, if necessary.
2. Educate patient and family on the possibility of a potentially difficult delivery and show them what they may be asked to do in that event.
3. Review the role and responsibilities with all key personnel to ensure someone is assigned to record the events and others to provide the intervention
4. Ensure the delivery room is free of clutter and step stools are available at the patient's bedside.
5. Assure the patient's bladder is empty prior to delivery.
6. Anticipate that the provider may "deliver through" the anterior shoulder and not use bulb suction in a patient with a known risk factor.
7. If shoulder dystocia occurs, the delivering provider announces he/she has a "shoulder dystocia" and needs HELP!
8. Staff should immediately initiate **HELPERR**
   a. **H- CALL FOR HELP**
      i. Provider should notify delivery room personnel of shoulder dystocia and need for immediate assistance
      ii. **E- EVALUATE FOR EPISIOTOMY (Provider Intervention**
      iii. This may be considered by provider, but may also be performed after the next two steps since most shoulder dystocia's are resolved with McRoberts Maneuver and/or suprapubic pressure
   b. **LEGS (MCROBERTS MANUEVER)**
      i. Enlisting the help of a staff member, flex the maternal hips to position the maternal thighs up onto the maternal abdomen to stimulate a squatting position and increasing the pelvic inlet diameter.



   c. **P- EXTERNAL SUPRAPUBIC PRESSURE**
      i. Use step stool to reach height of mother in bed or kneel next to the patient in the bed. The hand should be placed over the fetus' anterior shoulder, or slightly above the maternal syphilis pubis, and apply pressure with palm of hand from the side of the mother that will allow the hand to move in a downward and lateral motion to adduct the fetal shoulder.
      ii. Initially the pressure may be continuous, but depending on effectiveness, a rocking motion may be recommended to dislodge the shoulder.

iii. The delivering provider should inform the assistant of the correct direction to apply the pressure base on baby's position.

d. **E- ENTER-INTERNAL MANUEVERS (Provider Interventions)**



i. These maneuvers are intended to manipulate the fetus to rotate the anterior shoulder into an oblique plane under the symphysis pubis

ii. **RUBIN II MANUEVER-** Insert the fingers of one hand vaginally behind the anterior shoulder and push the shoulder towards the baby's chest, while maintaining suprapubic pressure. If unsuccessful, the wood screw maneuver is the next step.

iii. **RUBIN II with WOOD SCREW MANUEVER-** This is used in combination with the Rubin II maneuver. The provider now uses the opposite hand to approach the posterior shoulder from the front of the baby, maintains two fingers behind anterior shoulder, and rotates the shoulder toward the syphilis pubis in the same direction as the Rubin maneuver

iv. **REVERSE WOOD SCREW MANUEVER-** If the above is unsuccessful; the provider may attempt to rotate the baby the opposite direction, with fingers on the posterior shoulder from behind.

e. **R- REMOVE POSTERIOR ARM (Provider Intervention)**

i. The posterior arm is removed by the provider in which he locates the arm, flexes the elbow in that the forearm sweeps across the chest, and is then removed from the birth canal creating room for the anterior shoulder to collapse.

f. **R- ROLL THE PATEINT (Provider Initiated)**

i. The "all fours" or "Gaskin" maneuver is a safe, rapid and effective technique for shoulder reduction. The baby's shoulder often dislodges during the act of turning. The precise mechanism by which this works is unknown, but is thought that the pelvic diameter increases with this movement.

9. If the above is unsuccessful, the methods of last resort are considered by the provider:
   a. Deliberate clavicle fracture.
   b. Zavanelli maneuver: (This is the cephalic replacement followed by an **EMERGENCY C-SECTION**. Continuous upward pressure on fetal head once replaced should be maintained and tocolysis anticipated) **A clamped and cut cord is contraindicated** for this maneuver.
   c. Muscle or uterine relaxation, induced with general anesthetic.
   d. Abdominal surgery and Hysterotomy.
   e. Symphysiotomy,performed within 5-6 minutes of delivery of the head when all other efforts have failed, and cesarean delivery is not available
   f. Post-delivery, complications for mother and baby are listed below and should be considered when performing ongoing assessments.

10. MATERNAL:
    a. Postpartum hemorrhage
    b. Third- or fourth-degree episiotomy or tear
    c. Uterine rupture
    d. Recto-vaginal fistula
    e. Symphyseal separation or diathesis, with or without transient femoral neuropathy

11. FETAL:
    a. Brachial plexus palsy
    b. Clavicle fracture
    c. Fetal hypoxia, with or without permanent neurological damage
    d. Fracture of the humerus

e. Fetal death

C. **DOCUMENTATION:**

1. Document events and maneuvers performed in a logical step-by-step sequence with clear and precise terms, noting the duration of the interventions, when performed and result/s of the interventions.
2. Document fetal heart rate assessment.
3. Document any instructions given to patient/family.
4. Avoid late entries, and document as soon as possible after delivery secondary to patient care.

D. **REFERENCES:**

1. Simpson, K. R. & Creehan, P.A. (2008). Perinatal Nursing. (3rd ed.). Philadelphia: Lippincott.
2. Gobbo, B. & Baxley, E. Advanced Life Support in Obstetrics: Shoulder Dystocia.
3. Tucker, S.M., Miller, D.A. (2009). Fetal Monitoring and Assessment (5th Ed), Mosby: Elsevier.
4.1. Sokol, R. & Blackwell, S. (2002) ACOG Practice Bulletin #40, Shoulder Dystocia.

Tri-City Medical Center
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WOMEN'S AND ~~CHILDREN'S~~ NEWBORN'S SERVICES

SUBJECT: STANDARDS OF CARE – ANTEPARTUM

ISSUE DATE: 06/14
REVISION DATE(S):

Department Approval Date(s):	**12/16**
Department of OB/GYN Approval Date(s):	**~~04/13~~02/17**
Department of Pediatrics Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~05/14~~03/17**
Professional Affairs Committee Approval Date(s):	**~~06/14~~04/17**
Board of Directors Approval Date(s):	**06/14**

A. **PREAMBLE:**

1. Nursing practice in the care of **w**~~W~~omen and **n**~~N~~ewborns is delivered in an environment that respects the goals, preferences, and patient rights of ~~the unique dyad of the maternal-fetal unit and/or mother-baby couplet and~~ the family from admission, through the episode of care, to discharge. The Women's and ~~Children's~~ **Newborn Services (WNS)** nursing staff shall use established T**ri** C**ity** M**edical** C**enter (TCMC)** and unit specific policies and procedures, and ~~shall~~ adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN). ~~Couplet care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant and is grounded on evidence-based practice~~.

B. **DEFINITION(S):**

1. ~~Standards of~~**Standards of** ~~Care~~ **Professional Nursing Practice**: "Authoritative statements ~~by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p.77)". "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p.78) and are examples of the nursing professional expected roles and responsibilities for providing patient care~~ **of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA) 2016~~~~10~~**, p.2)"**.
2. **Scope of Nursing Practice: "Describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2016~~10~~)".**
3. **Standards: "~~Authoriative~~Authoritative statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2016~~10~~, p. 67).**
   a. **"Standards of care are Standards of Professional Nursing Practice."**

~~2.~~**4.** Nursing Process: **"The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The practice as outlined by the ANA (2016) includes the following:** ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision-making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to the woman and for her fetus or newborn, caregivers, maintaining a patient safe environment,~~

~~and patient health care promotion and the planning for continuity of care. The nursing process includes the following.~~

a. Assessment: A systematic, dynamic **way to collect and analyze data about a ~~client~~patient i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data**

i. Subjective-what the patient says.

~~1.~~**ii. Objective-observation based on assessment findings**~~process by which the registered nurse, through interaction with the patient, significant others, and health care providers, collects comprehensive data with the priority of data collection determined by the immediate condition of the woman, the fetus or newborn and their needs for health promotion, maintenance and restoration~~.

~~i.~~**iii.** ~~Obstetrical Technicians (OB Techs) and OB Advanced Care Technicians (ACTs) collect patient data.~~**Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items need to be ~~ed~~ reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to: orientation assessment, level of consciousness, affect/behavior, respiratory symptoms, respirations, respiratory pattern, and skin color and skin temperature.**

~~a. Only RNs perform admission, transfer, and and/ or discharge assessments.~~

b. Diagnosis: A **nurse's** clinical judgment about the ~~client~~**patient**'s response to actual or potential health conditions or needs.

c. Outcomes/**Planning: "Based on the assessment and diagnosis. Outcomes ~~are :~~are: m**Measurable~~, expected, client-focused goals~~ **and achievable short and long-range goals".**

~~2.~~**i.** Planning: ~~(~~**Care Plan i.e.,** Plan of Care~~)~~: A comprehensive outline of care to be delivered to attain expected outcomes

d. Implementation: ~~Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~ **"Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".**

~~b. TCMC's, Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropriate.~~

e. Evaluation: The process of determining both the **"patient's status and the effectiveness of nursing care. It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care**~~client's progress toward the attainment of expected outcomes and the effectiveness of nursing care~~.

~~3.~~**5.** Patient: Recipient of nursing care.

~~4.~~**6.** Health Care Providers: Individuals with special expertise who provide health care services or assistance to ~~client~~**patient**s

~~5.~~**7.** Significant Others: Family members and/or those significant to the ~~client~~**patient**

~~6.~~**8.** Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.

~~7.~~**9.** Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with **the** patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 201~~6~~10)".

C. **~~WCS~~WNS-WNS STANDARDS OF PRACTICE:**

1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic data-base shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.
4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according **to** the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **NURSING PROCESS:**

1. Standards Of Care: Assessment
   a. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. Standards Of Care: Diagnosis
   a. RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.
3. Standards Of Care: Outcome Identification
   a. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. Standards Of Care: Planning
   a. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.
5. Standards Of Care: Implementation
   a. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task**s** appropriately.
6. Standards Of Care: Evaluation
   a. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCMC policy.
   b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
   c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds, or as soon as possible within the shift the changes were identified
7. Standards Of Care: Documentation
   a. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.

b. When it is not possible to document ~~shift assessments, reassessments, PRN assessments and/or care provided~~ due to unforeseen circumstances such as urgent or emergent situations, changes in assignment, or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.

c. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

E. **GENERAL OB NURSING ASSESSMENT:**

~~I.~~**1.** Standards Of Care: Vital Signs:

2. Maternal vital signs shall include:

~~A.~~**a.** -Temperature, documented in Celsius (preferred)

~~a.~~**b.** Blood Pressure (BP)

~~b.~~**c.** Heart Rate (HR)

~~c.~~**d.** Respiratory Rate (RR)

~~d.~~**e.** SpO2 **prn**

~~e.~~**f.** Pain Level

~~2.~~**3.** Vital~~s~~ signs shall be obtained on admission, transfer to a unit, at discharge per Patient Care Services (PCS) procedure: Discharge of Patients, per provider's orders, and as follows:

a. Antepartum:

i. **Approximately**~~At minimum~~ every 6 hours, ~~or~~ as ordered by provider, ~~or~~ as clinically indicated, or per procedure, i.e., PCS procedure: Magnesium Sulfate Administration for Obstetric Patient.

ii. ~~Notify~~ If **premature rupture of membranes (PROM)** or **prolonged** PROM, temperature every ~~2 hrs~~ **4 hrs.** if afebrile ~~every hour until resolved~~ **or per provider orders. Notify** provider if:

1) Temperature greater than or equal to 100.4° F or 38° C

2) BP~~lood pressure~~ greater than or equal to ~~systolic~~ 140 **Systolic** and/or d~~iastolic~~ **greater than or equal to** 90 **diastolic.**

~~i.~~**a)** **If patient has hypertension or preeclampsia history, a BP**; greater than or equal to **a** ~~systolic~~ 160 **systolic** and/or 110 diastolic **is known as a hypertensive emergency and may require IV anti-hypertensive medications per provider order.** ~~if known preeclamptic~~

~~2)~~**3)** Pulse greater than or equal to 120 bpm

~~3)~~**4)** Respirations greater than 28 or less than 12

b. Fetal Monitoring (per Fetal Heart Surveillance procedure):

i. The antepartum patient:

1) Document the fetal heart rate **(FHR)** tracing and uterine activity every hour or as ordered by provider.

2) Palpate the uterus (goal soft without a contraction and if felt during a contraction document if palpates mild, moderate or firm)

3) Assess uterine tenderness

4) Assess for fetal movement once a shift

~~B. Reference: Women's and Children's **Newborn's** Services Policy: "FHR Surveillance~~

~~I.~~**4.** Standards Of Care: Pain Assessment:

~~A.~~**a.** Assessment: Pain per Pain Management Policy

~~1.~~**i.** Acceptable level of intensity

~~2.~~**ii.** Pain scale

~~3.~~**iii.** Current pain intensity

~~4.~~**iv.** If patient complains of pain, assess the following:

~~a.~~**1)** Location, intensity, and duration/onset

~~b.~~**2)** Quality/type

~~c.~~**3)** Aggravating factors

~~d.~~**4)** Alleviating factors

~~B.~~**b.** Assess for presence of pain/discomfort with vital signs and PRN

~~C.~~**c.** Perform a pain assessment with each patient report of new or different pain.

~~D.~~**d.** Perform a pain reassessment as follows:

~~1.~~**i.** Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous intervention

~~2.~~**ii.** One (1) hour after **oral medication**~~PO~~ intervention

~~II.~~**5.** Standards Of Care: Intake And Output:

~~A.~~**a.** Intake and output shall be monitored as ordered and as follows:

~~1.~~**i.** Antepartum:

~~a.~~**1)** I&O totals every shift with 24 hour totals when patient has Intravenous (IV) Fluids ordered

~~b.~~**2)** Assess bladder every 4-6 hours ~~when sleeping~~, or as ordered by provider.

~~c.~~**3)** Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours.

~~d.~~**4)** Bleeding

~~i.~~**a)** Patients shall be screened for risk of obstetrical hemorrhage upon admission, and as part of the ongoing reassessment throughout antepartum and/or intrapartum admission.

~~ii.~~**b)** Patients will be screened who present to labor and delivery with placenta previa accreta and its variants, possible placental abruption with or without vaginal bleeding.

~~1)~~**i)** Assess and document quantity (# of pads/chux, degree of saturation and/or weigh as needed), color, associated symptoms and frequency of bleeding.

~~2)~~**ii)** Notify provider for active bleeding, and report above findings.

~~3)~~**iii)** Refer to ~~WCS~~**WNS** ~~-~~**WNS** procedure: Obstetrical Hemorrhage.

~~III.~~**6.** Standards Of Care: Height And Weight/Other Measurements:

~~A.~~**a.** Height and weight will be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation permits, it is preferred that the patient be weighed upon admission.

~~1.~~**i.** Weights shall be documented in kilograms (kg) and height in centimeters (cm)

~~B. Antepartum patients shall be weighed on admission if not contraindicated and every seven days thereafter until discharge or delivery~~.

~~C.~~**b.** Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.

~~IV.~~**7.** Standards Of Care: Aspiration Assessment:

~~A.~~**a.** Maintain aspiration precautions for maternal patients identified at risk.

~~1.~~**i.** Maintain head of bead (HOB) at 30 degrees at all times.

~~a.~~**1)** If eclamptic seizure, lower head of bed, open airway, roll patient to side and suction secretions as necessary.

~~b.~~**2)** Avoid attempts to insert suctioning device when patient's teeth are clenched.

~~2.~~**ii.** Maintain suction equipment at bedside at all times.

~~V.~~**8.** Standards Of Care: Patient Safety:

~~A.~~**a.** The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet. This includes the bed in the lowest position, wheels locked, and room free of clutter.

~~B.~~**b.** Patient safety shall be assessed per the following:

~~1.~~**i.** The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures, and as needed.

~~2.~~**ii.** Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.

~~3.~~**iii.** Allergies will be monitored and documented upon admission

~~a.~~**1)** Any known medication or food allergy shall be documented as follows:

~~i.~~**a)** The patient allergy band

~~ii.~~**b)** Allergy sticker placed on the front of the chart

~~iii.~~**c)** **In the patient's Electronic Medical Record (EMR)**~~Medication Administration Record~~

~~4.~~**iv.** Orders shall be obtained, reviewed, and implemented per PCS: Physician Orders Policy.

~~5.~~**v.** Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.

~~6.~~**vi.** Patient's specimens shall be handled per PCS: Specimen Handling Procedure, or by selecting the appropriate Mosby's Online Specimen Collection Procedure.

~~7.~~**vii.** Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.

~~8.~~**viii.** Patients shall be assessed for falls per PCS: Falls Risk Procedure.

~~9.~~**ix.** Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.

~~10.~~**x.** Medication shall be reconciled per PCS: Medication Reconciliation Policy.

~~11.~~**xi.** All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

F. **SYSTEM REVIEW:**

1. All maternal, fetal/or newborn patients will have a general system review **of**~~in~~ all systems completed and documented **at least once a shift. A focused**~~Detailed system~~ assessment,~~s~~ **or any** ~~shall~~**reassessment, shall** be completed and documented as indicated by the patient's condition.
2. Standard Of Care I: Assessment:
   a. All patients admitted to ~~WCS~~**WNS** nursing units shall be assessed by a Registered Nurse**(RN)** per the following:
   b. Admission and/or Transfer: Assessment
      i. All patients admitted or transferred to a higher level of care shall have a head to toe assessment initiated **as soon as possible**~~within 15 minutes~~**3 hours** upon arrival to unit, a detailed or disease specific assessment shall be documented as needed.
      ii. The assessment shall be completed in a timely manner.
   c. Admission Assessment- Patient History:
      i. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
         1) This assessment-patient history shall include an assessment for obstetric hemorrhage
   d. Medication Patient History Form
      i. All patients shall have a Medication Patient History completed ~~as soon as possible~~ upon arrival to the unit per the Medication Reconciliation Policy.
   e. Initial Shift Assessment
      i. RN shall initiate an ongoing head to toe assessment **at the beginning of each shift.** ~~as follows: within 2 hours of the start of the shift~~
   f. Reassessment/**Focused Assessment may be documented as no change since last assessment.**

i. After completion of an Admission or an ~~i~~**I**nitial shift assessment, patients shall have a focused reassessment performed and documented during the shift, **when clinically** ~~every 6 hrs or more frequently as clinically~~ indicated:
1) If the patient refuses a reassessment, document **her**~~their~~ refusal in the medical record.
ii. System Specific Assessment (Focus assessment) shall be completed as follows:
1) Change in patient's condition from the initial shift assessment or reassessment.
2) Response to treatment provided to a patient.

3. Standards Of Care I.1: Assessment Neurological System Review:
a. Neurological: System Review
~~i.~~ Assess the ~~following:~~
~~1.~~**i.** ~~Level~~**following: Level** of consciousness
ii. Orientation
iii. Presence of:
1) Headache
2) Visual disturbances, e.g. blurred vision or scotoma
iv. Deep Tendon Reflexes
1) Patellar or brachial
2) Clonus

4. Standards Of Care I.2: Assessment Cardiovascular System Review:
a. Cardiovascular System Review
i. Assess heart sounds ~~in all auscultatory areas~~; note regular or irregular
ii. ~~-~~Check capillary refill
iii. Check edema location and grade
~~iv. Palpate bilateral peripheral pulses: radial and dorsalis pedis~~
~~v.~~**iv.** Assess peripheral perfusion; skin warm and dry

~~A. Assess Homan's sign for presence of thrombophlebitis.~~

5. Standards Of Care I.3: Assessment Pulmonary System Review:
a. Pulmonary: System Review
i. Check oxygen delivery devices if applicable
ii. Check amount **of** oxygen flow if applicable
iii. Assess pulse oximetry prn ~~or per~~
~~a.~~**iv.** PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"
~~iv.~~**v.** Assess respiratory effort **(pattern, symptoms)**
~~v.~~**vi.** Auscultate breath sounds **in** all lobes
~~vi.~~**vii.** Assess sputum amount, color, and consistency if applicable
~~vii.~~**viii.** Assess for presence of cough
~~viii.~~**ix.** Assess for presence of artificial airway, tubes, and drains if applicable
~~ix.~~**x.** Assess chest expansion for symmetry

6. Standards Of Care1.4: Assessment Gastrointestinal (Gi) System Review:
a. GI: System Review
i. Assess abdomen
1) Round, gravid, distention
2) Soft, firm, distended, non-distended
~~2)~~**3) Pain in upper right quadrant**
ii. Assess for nausea and/or vomiting
iii. Auscultate for presence of bowel sounds in all four quadrants
iv. Assess bowel function including passing flatus or last stool

7. Standards Of Care 1.5: Assessment Genitoutinary System Review:
a. Genitourinary (GU) System Review
i. Assess urine color and clarity, frequency and dysuria.
ii. Assess for bladder distension.
iii. Assess external anatomy/perineum as applicable.

~~1.~~ ~~Assess risk for obstetric hemorrhage.~~
~~2.~~**iv.** Assess for leaking of amniotic fluid.~~ (if applicable).~~
1) Color, amount, and/or odor
~~iv.~~**v.** Assess vaginal discharge.~~ if applicable.~~
1) Color, amount, and/or odor~~.~~

8. Standards Of Care 1.6: Assessment Musculoskeletal System Review:
   a. Musculoskeletal System Review
      i. Presence of assistive devices~~.~~
      ii. Presence of joint or musculoskeletal abnormalities~~.~~
      iii. Full range of motion against gravity, some to full resistance of all extremities~~.~~
      iv. Mobility appropriate for age~~.~~
9. Standards Of Care 1.7: Assessment Integumentary System Review:
   a. Integumentary System Review
      i. Assess mucous membranes and skin color; consistent with person's ethnicity~~.~~
      ii. Palpate skin for temperature and moisture~~.~~
      iii. Assess skin turgor~~.~~
      iv. Assess skin integrity, temperature, and condition of any dressings
      v. Complete Braden Scale~~.~~
      vi. ~~Assess for presence of specialty mattress/bed or overlays~~Assess for the presence of skin abnormalities~~.~~
      vii. Assess for the presence of pressure ulcers
10. Standards Of Care 1.8: Assessment Psycho/Social:
   ~~B.~~**a.** Psychosocial assessment shall consist of the following:
      i. Coping
      ii. Affect/Behavior
      iii. Social Service (SS) Referral Reason
         1) Distress
      iv. Stressors
      v. Support/Coping Interventions
      vi. Psycho/Social: Nursing Interventions
      vii. In ordered to promote family centered care, the nurse shall:
         ~~1.~~**1)** Introduce bedside health care providers to the patient/family.
         ~~1)~~**2)** Review visitation and unit policies to patient/family on admission and as needed.
         ~~2)~~**3)** Assess and then verify with patient/family age appropriate needs.
         ~~3)~~**4)** Assess and then verify patient/family's ability to understand and participate in the plan of care.
         ~~4)~~**5)** Encourage the family to have periods of uninterrupted sleep when appropriate.
      viii. Promote patient/family centered care
         1) Discuss expectations and collaborate with patient/family
         2) Encourage patient/family to ask questions
         3) Promote patient independence in Activities of Daily Living (ADL)
      ix. Promote comfort measures (if ordered or request order) by:
         1) Music therapy
         2) Therapeutic recreation
         3) Spiritual comfort
            a) Guided imagery
         4) Reminiscence therapy
         5) Encourage family/friend to visit
         6) Arrange for a child's visitation
         7) Arrange for pet therapy
         8) Arrange for physical or occupational therapy

~~x. Patients shall be informed of their responsibilities upon admission and as necessary thereafter.~~
~~xi. These responsibilities include:~~
~~xii. Providing information~~
~~xiii. Asking questions~~
~~xiv. Following instructions~~
~~xv. Accepting consequences~~
~~xvi. Following rules and regulations~~
~~xvii. Showing respect and consideration~~
~~xviii. Meeting financial commitments.~~
~~xix. See TCMC Patient Handbook.~~
~~xx. Encourage patient and/or their family to participate in their plan of care.~~
~~xxi.~~**x.** Assess for history of domestic violence/safety in home.
~~xxii.~~**xi.** Request social services as appropriate.
1) Initiate social services referrals for the following (including, but not limited to):
a) Adoptions
b) Infants going to foster care
c) Patients with no prenatal care
d) Teen moms
e) Positive toxicology results
f) Mothers of infants in Neonatal Intensive Care or in another facility
g) All mothers and families experiencing Perinatal loss.
h) High risk mother and/or newborn, as defined by their provider.

11. Standards Of Care: Infusion Therapy:
a. Central venous (i.e. PICC) lines shall be assessed per PCS Central Venous Access Devices Procedure
~~A.~~**i. Note date and time of next central venous dressing change**
~~a.~~**b.** Peripheral IV site shall be assessed on admission, ongoing and transfer from other nursing unit.
i. The following shall be assessed:
a) IV insertion date
b) IV access type
c) IV site and condition
2) Patency
a) Dressing type and condition
~~a.~~**b)** Date infusion changed ~~Date central venous dressing changed~~
~~b.~~**c.** Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN **per provider order**.
~~c.~~**d.** Maintenance or continuous infusion shall be assessed **and documented** every **shift** ~~2 hours~~ and PRN**.**
~~d.~~**e.** Infusion Therapy: Nursing Interventions
i. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
ii. Document initials and date IV started directly on the dressing.
iii. Pre-hospital IV starts shall be discontinued and restarted within 48 hours of admission.
iv. IV site shall be discontinued and restarted with complaint of persistent discomfort not relieved by comfort measures, the presence of an infiltration, inflammation, pallor, phlebitis, bleeding at insertion site, or leaking of IV solution at insertion site.
v. IV solutions and tubing shall be changed as follows:
1) Change every 4 days
a) All IV tubing

b) Add-on devices (neutral displacement connector MicroClave~~),~~ antireflux, extension set, etc) and with tubing change.
c) Rotate IV insertion sites.
d) Commercially prepared solutions, if the bag is spiked once with initial start.
e) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback**).**

2) Change every 24 hours
a) All IV solutions mixed by pharmacy or nursing, unless manufacturer's expiration recommends less than 24 hours
b) Lipids or lipid containing products
c) Neutral displacement connector (MicroClave, anti-reflux, extension set, etc) and with tubing change

vi. Label IV tubing and/or neutral displacement connector (MicroClave) with *change date sticker* indicating date tubing is to be changed using numerical day and month.
vii. Label IV solutions with date and time IV solution hung.
viii. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site.
1) Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
ix. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy
x. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter related infection is suspected or documented.
xi. Swab Cap**s should be used:**
1) When a Central Venous line injection port is not in use, place ~~an orange~~ Swab Cap on the ~~unused port~~**unused port**(s)
2) When a peripheral line, if injection port is not in use, place a swab cap on the port closest to the IV insertion site.~~**patient**~~.
~~1)~~**3) When a saline lock is not in use**
~~2)~~**4)** Apply a new Swab Cap
a) Every time the cap is removed.
b) Every 8 hours with routine IV flushing.

12. ~~PRN IV flushin~~**On a saline lock.**Standards Of Care: Immunizations/Other:
a. Rhogam will be administered if indicated
b. During flu season: all patients will be screened for influenza and vaccination will be administered if indicated per the Standardized Procedure Pneumococcal and Influenza Vaccine Screening Administration
c. All patients will be screened for Tetanus, Diphtheria, Pertussis (Tdap) and vaccination will be administered if indicated per the Standardized Procedure Tetanus, Diphtheria, Pertussis (Tdap) Vaccine Administration for Postpartum Patients

G. **REFERENCES:**

1. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 201~~42~~. *Guidelines for Perinatal Care Seventh Edition.* Washington, DC
2. ~~American Academy of Pediatrics (2010*). Policy Statement – Hospital Stay for Healthy Term Newborns.* Retrieved on 01/12/2011: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;125/2/405.pdf~~ **American Nurses Association (ANA). (201610). *Nursing scope and standards of practice.* Silver Spring, MD: Nursesbooks.org.**
3. **American Nurses Association (ANA). (2016). The nursing process. Retrieved from http://www.nursingworld.org**

4. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns*, Sixth Edition.
5. **Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Perinatal Nursing. (2014). 4th edition.**
6. Besuner, P. AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition (2007). Washington, D.C.
~~7. California Board of Registered Nursing. (2010). Nursing practice act business and professions code. Chapter 6 Nursing: Section 2725. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~
~~8. California Board of Registered Nursing. (2010). Standards of competent performance, California code of regulations, title 16, section 1443.5. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~
~~9. California Board of Registered Nursing. (2010). California code of regulations, title 22, section 70125. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~
~~10.~~**7.** Mattson, S., & Smith, J.E. (Eds.) (2011) *Core Curriculum for Maternal-Newborn Nursing (4th Ed.)* Philadelphia, PA: Saunders

Tri-City Medical Center
Oceanside, California

Women and Newborn Services (WNS)

SUBJECT: UMBILICAL CORD BLOOD BANKING: PRIVATE COLLECTION

ISSUE DATE: 06/14
REVISION DATE(S):

Department Approval Date(s):	**01/16**
Department of OB/GYN Approval Date(s):	**~~06/13~~02/17**
Department of Pediatrics Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~05/14~~03/17**
Professional Affairs Committee Approval Date(s):	**~~07/14~~04/17**
Board of Directors Approval Date(s):	**07/14**

A. **PURPOSE:**

1. Once considered a waste product that was discarded with the placenta, umbilical cord blood is now known to contain potentially life-saving hematopoietic stem cells. When used in hematopoietic stem cell transplantation (HSCT), umbilical cord blood (UCB) offers several distinct advantages over bone marrow or peripheral stem cells, which may be the reason the use of UBC for HSCT has grown exponentially.
2. According to the American Society for Blood and Marrow Transplantation's Position Statement in 2008, expectant parents are encouraged to donate their newborn's UBC for public banking when that option is available. Donation makes the cord blood, which is rich in hematopoietic stem cells available for life-saving treatments for others in need when there is a suitable match.
3. According to the American College of Obstetricians and Gynecologists Committee Opinion in February 2008, if a patient request information on UCB banking, balanced and accurate information regarding the advantages and disadvantages of public versus private UCB banking should be provided.
4. In lieu of these considerations, patients who report to Labor and Delivery with the intent to have UCB collected for private banking (have brought a collection kit), shall be supported by the hospital staff, when possible. The collection process shall not impede routine practice for the timing of umbilical cord clamping and specimen may be uncollectable if unexpected medical conditions arise.

B. **PROCEDURE:**

1. Upon admission to the unit and before the birth of her baby, the patient is required to have a cord blood collection kit from a resource organization that is Food and Drug Administration (FDA) registered, which is given to a staff member to review.
2. Once received, the staff member shall notify the patient's provider and give the patient the hospital's checklist and consent form to sign (enclosure 1).
3. The nurse and/or provider shall open the cord blood collection kit before delivery to review the collection requirements and obtain the required sample collection, per collection kit instruction, when indicated.
   a. Since the collection of UBC for HSCT is an elective request, the hospital staff will do what it can to facilitate this collection process, but will NOT compromise the safety of the patient or newborn.
   b. There may also be instances where the unit census, acuity level, and staffing availability prohibits accommodating the request to obtain a specimen.
4. Once the samples are obtained and labeled, these will be returned to the patient who then becomes responsible for the specimens transport to an appropriate agency.

5. Staff members can assist the patient with these arrangements by allowing her to utilize the phone to make any necessary transport arrangements.

C. **FORM(S):**

1. Umbilical Cord Blood Sample Collection Consent - **Sample**

D. **REFERENCES:**

1. American Society for Blood and Marrow Transplantation (ASBMT) Board of Directors. Position Statement 2008. Collection and Preservation of Cord Blood for Personal Use, Biology of Blood and Marrow Transplantation 14:364.
2. American College of Obstetricians and Gynecologists (ACOG) Committee Opinion #399 (02/2008). Umbilical Cord Blood Banking.

Umbilical Cord Blood Sample Collection Consent – Sample

Women and Children's Services Department

1. I _____ request the assistance of Tri City Medical Center's
(Patient Name)
staff to obtain an umbilical cord blood (UCB) sample after the birth of my child for private storage with
_____.
(Name of Company)

2. I have discussed and researched the advantages and disadvantages of UCB banking during my prenatal period with my provider and have brought a Cord Blood Collection Kit, with a Company that is registered with the Food and Drug Administration (FDA), with me for the staff to utilize.

3. I understand that although I have brought the collection kit for use, the staff may not be able to obtain the sample due to other medical priorities. The hospital staff, as a courtesy, will do what it can to support this request, when possible.

4. I understand that blood samples should be handled as if potentially infectious and I will not tamper with the samples in the kit once the staff returns them to me.

5. I agree to send the collected samples directly to the private UCB banking company for proper processing and storage. These samples will not be sold or distributed to third parties.

6. To the extent allowed by law, I further agree to indemnify and hold harmless Tri City Medical Center from any claims, costs, damages or expenses resulting from any collection complications, damages or loss that may arise during the specimen collection or transport processes.

By my signature below, I agree to the statements set above:

_____
Signature Date / Time

CHECKLIST

- ☐ Unopened, FDA registered, Umbilical Cord Collection Kit brought by patient
- ☐ A signed UCB Sample Collection Consent Form (current form)
- ☐ Samples are obtained, labeled, and returned to the patient for inclusion in the Kit
- ☐ Pick up arrangements for the Kit is made by the patient/family. Plan includes:

_____
Expected Date / Time By what Company / Service

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

UMBILICAL CORD BLOOD
SAMPLE COLLECTION CONSENT

7400-1072
(Rev 12/13)

Affix Patient Label

White - Chart Yellow - Patient

Acetaminophen Maximum Daily Dose: Practice Change Recommendation

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: As an institution, TCMC currently limits the maximum daily exposure to acetaminophen at 3 grams.

Background: In 2011 following concerns regarding possible liver injury secondary to acetaminophen overdose, the FDA mandated drug manufacturers to incorporate no more than 325mg of acetaminophen in prescription combination products such as hydrocodone/acetaminophen. Secondary to this, the manufacturer for Tylenol® voluntarily modified their package insert to indicate a maximum over-the-counter daily dose of 3 grams on its labeling. Following this change, several healthcare institutions adopted this language and set their institutional limits for inpatients to the same standard of a daily maximum of 3 grams.

Assessment: The purpose of the changes implemented by drug manufacturers and the FDA was to mitigate the risk of outpatient acetaminophen overdose. The accepted daily limit of 4 grams has never been changed by the FDA. Additionally, the package insert for the OTC acetaminophen product does include guidance to patients that their dose may be increased to a maximum of 4 grams by their physician under appropriate monitoring conditions. The self-imposed 3 gram limit set at TCMC is based on outpatient standards and should not apply to admitted patients under direct physician care. This lower limit has been a large dissatisfier for nursing and physicians, particularly in the post-surgical setting when minimizing opiate exposure is a shared institutional objective.

Recommendation(s):

- The Pharmacy Service recommends that the TCMC accepted maximum dose of acetaminophen be raised from 3 grams, back to the FDA recognized maximum of 4 grams
    - Pharmacists will continue to recommend lower total daily doses (<3 grams) for any patient with identified hepatic impairment
- If this change in practice is approved by the P&T Committee, the Pharmacy Service would take the immediate following actions:
    - Modification of all Power Plans to revise order comments instructing providers not to exceed 3 grams of acetaminophen within 24 hours (raise limit to 4 grams)
    - Change default dosing interval for intravenous acetaminophen from Q8H to Q6H (standard adult dose is 1000 mg Q6H)

Artifical Saliva (Biotene ®)

Requesting Provider: Oska Lawrence, PharmD

Requesting provider conflicts of interest: None

Drug class[1]**:** GI agent, miscellaneous

FDA Approval: None (OTC product)

Indications[1]**:** Mucositis, xerostomia

Manufacturer: GSK

Formulations[1]**:** Oral gel, mouth spray

Background:

Patients with xerostomia are generally managed non-pharmacologically using a combination of dryness prevention (hydration, avoidance of oral irritants, avoidance of anticholinergic drugs, use of humidifiers) and topical stimulation (gums, lozenges). If response to these modalities is insufficient, the use of saliva substitutes is recommended. It is only after failure of saliva substitutes that sialogogues such as pilocarpine or cevimeline should be considered.

Mechanism of Action:
Protein or electrolyte mixture which restores/replaces saliva, lubricates, moistens, cleans, and/or provides a coating on oral mucosa.

Dosing:

Gel: Apply half inch of gel on tongue and spread as often as needed for dry mouth

Spray: 2 sprays orally 3-4 times daily as needed for dry mouth

CONTRAINDICATIONS:

- Hypersensitivity to any component

Cost Considerations:

Biotene® Gel 42 gram tube: $5.44 per tube (TCMC acquisition cost as of 3/6/17)

Summary:

- No artificial saliva products currently on the TCMC formulary (2nd line therapy after non-pharmacologic treatment options have failed)
- No sialogogues currently on the TCMC formulary

Recommendations:
The use of saliva substitutes can provide a low-cost treatment option for xerostomia and is recommended after basic non-pharmacologic options have failed. It should be trialed before more expensive, systemic agents such as pilocarpine or cevimelene are used. At this time, the TCMC Pharmacy Service recommends the addition of artificial saliva to the formulary.

References

1. Lexicomp Online®, Hudson, Ohio: Lexi-Comp, Inc.; March 6, 2017

Meperidine oral tablets: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: The use of meperidine as an analgesic has largely fallen out of favor due to safer alternatives and recommendations from several organizations including the American Pain Society and ISMP advocating against its use for this indication.

Background: Meperidine is a synthetic opioid that was originally marketed for its antispasmodic effects. It is available in both oral and intravenous formulations. Due to significant number of reports and studies concerning adverse events in patients given meperidine, opinion shifted regarding its appropriateness. The most concerning risk involves the accumulation of a neuro-excitatory metabolite which can trigger anxiety, hallucinations, tremors, and seizures. While patients with impaired renal function are at highest risk, no patient is absolved of these risks even when renal function is normal. In 2017, Tri-City Medical Center formally halted the practice of compounding meperidine for PCA analgesia.

Assessment: Nationwide, institutions have taken steps to limit the use of meperidine, restricting its availability to the procedural settings where it is mainly intravenously used to mitigate shivering. Meperidine tablets remain on the TCMC formulary at this time. A usage assessment was conducted which determined that meperidine tablets were not dispensed during the year 2016.

Recommendation(s):

- Given strong institutional guidance from ISMP/Pain Society and general lack of use, the Pharmacy Service recommends the removal of meperidine oral tablets from the TCMC
- The Pharmacy Service recommends keeping the intravenous formulation of meperidine available for use in all procedural areas

Tobramycin Nebulized Solution (Tobi®): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: The commercially available pre-mixed tobramycin nebulized solution (300mg/5mL) is expensive and rarely used at TCMC.

Background: Inhaled tobramycin is indicated for patients with cystic fibrosis (CF) or non-cystic fibrosis bronchiectasis. While mainly used in these patient groups for suppressive therapy, it has also been used in an off-label fashion in the setting of a gram-negative pulmonary infection where there is concern for kidney insult resulting from systemic aminoglycoside administration. Due to the high cost of Tobi®, several institutions have explored administering intravenous tobramycin via nebulizer. Several reports have demonstrated that this is a safe, tolerated, efficacious, and cost-effective alternative to dispensing the commercial product.

Assessment: At TCMC inhaled tobramycin has been administered to 4 patients between January 2016 and March 2017 for a total of 15 doses. Tobi® must be purchased in a box of 56 ampules which costs approximately $6900 ($120 per dose). Due to low use, the majority of ampules expire on a regular basis. By comparison, compounding all 56 doses using the intravenous solution would cost only $224 (~$6680 cost avoidance). This conversion has been discussed at length with Respiratory Therapy. They have indicated that while the conversion would result in an increase in the nebulized volume (from 5ml to 7.5mL) that this would not be an issue with the equipment they currently use.

Recommendation(s):

- The Pharmacy Service recommends the removal of the commercially available pre-mixed tobramycin 300mg/5mL formulation from the formulary
- With P&T approval, the Pharmacy Service will implement the following process to fulfill orders for Tobramycin 300mg per nebulizer
  - Compound patient specific doses in the Pharmacy using intravenous tobramycin solution (300mg/7.5 mL sterile water)
  - Mark these doses for nebulizer use only and deliver to the appropriate care area for administration by a Respiratory Care Practitioner

MARK EACH SERVICE THAT THE PATIENT WILL REQUIRE UPON DISCHARGE. THIS ORDER WILL INITIATE FOLLOW-UP WITH THE SPECIFIC CLINICAL SERVICE AREA.

Form approved for deletion and retirement. All DELETE- all orders exist in Cerner now. Approved by PPO committee 2/13/17. Approved by MEC 3/27/17. Approved by PAC 4/20/17.

INPATIENT SERVICES:

- ☐ Acute Rehabilitation Unit
  - ☐ Evaluate for Treatment
  - ☐ Transfer to Acute Rehab Unit if patient meets criteria

HOME HEALTH SERVICES:

- ☐ Tri-City Home Health 760-94
  2095 W. Vista Way, Suite 101, Vista, CA 92083
- ☐ Care South Home Health of San Diego 619-25[illegible]
  1870 Cordell Court, Ste. 106, El Cajon, CA 92020
- ☐ We Care 619-220-3800
  4636 Mission Gorge Place, Suite 200A, San Diego, Ca 92120

HOSPICE SERVICES:

- ☐ Tri-City Hospice 760-940-5801
  2095 W. Vista Way, Suite 220, Vista, CA 92083

OUTPATIENT REHABILITATION SERVICES:

- ☐ Cardiac Rehabilitation 760-940-3096
  - ☐ Evaluate
  - ☐ Evaluate and Treat
- ☐ Occupational Therapy 760-940-7278
  - ☐ Evaluate
  - ☐ Evaluate and Treat
- ☐ Physical Therapy 760-940-7278
  - ☐ Evaluate
  - ☐ Evaluate and Treat
- ☐ Pulmonary Rehabilitation 760-940-3055
  - ☐ Evaluate
  - ☐ Evaluate and Treat
- ☐ Speech Therapy 760-940-7272
  - ☐ Evaluate
  - ☐ Evaluate and Treat

WOUND CARE SERVICES:

- ☐ Tri-City Wound Care Center 760-940-5600

Diagnosis: 8711-4539

Special Instructions:

☐ Read Back all T.O./V.O.orders

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

Affix Patient Label

DISCHARGE REFERRAL SERVICES ORDERS

Governance & Legislative Committee
(No meeting held in
April, 2017)

Audit, Compliance & Ethics Committee
(No meeting held in April, 2017)

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

March 30, 2017 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on March 30, 2017.

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

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Chris Miechowski, Director, Facilities Management
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Chairperson Dagostino stated the Auxiliary Report has been pulled from the Open Session agenda.

   Chairperson Dagostino requested an item be added to the Closed Session Potential Litigation due to the fact that an issue arose after the agenda was published.

   It was moved by Director Kellett to approve the amended agenda. Director Grass seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the March 30, 2017 Regular Board of Directors Meeting Agenda.

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

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the March 30, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; eight (8) matters of Potential Litigation; two Reports Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding four (4) matters of Existing Litigation; Public Employee Evaluation: General Counsel and Chief Compliance Officer and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Nygaard to go into closed session at 1:35 p.m. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in open session.

10. Director Reno led the Pledge of Allegiance.

11. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12. Special Presentations

1) Recognition of hospital leadership during our recent kitchen closure caused by basement pipe break

Chairman Dagostino read a statement into the record explaining the internal disaster that the hospital experienced on February 28th in which pipes burst, placing the safety of our patients and staff at risk. He stated that under the leadership of Kelly Gecewicz, Food & Nutrition, Chris Miechowski, Plant Operations, Kevin McQueen, Disaster Planning, Hope Chaney, EVS and Jami Piearson, Regulatory Compliance, the team responded immediately by isolating the impacted area and establishing a mobile kitchen in a matter of hours. To see our team activate and mobilize during an actual disaster was awe inspiring. Their timely response ensured the safety of our patients. Chairman Dagostino expressed his utmost appreciation on behalf of the entire Board for staff's efforts during this internal disaster.

Director Mitchell commented that everyone came together so phenomenally however she wanted to give a big thank you to the dietary workers, who without missing a beat and having to work under less than optimal conditions with temporary cooking facilities and temporary washing facilities managed to continue to feed our patients day in and day out while the kitchen was out of service.

Director Reno urged the Board to issue a Proclamation to the Dietary Department for their service.

2) Recognition of Vista Unified School District for use of kitchen/dish machine during piping issue

Chairman Dagostino stated he has the privilege of presenting a plaque to Mr. Jason Philips, Director of Child Nutrition Services of Vista Unified School District who stood up and unselfishly extended assistance to Tri-City hospital in our time of need. Chairman Dagostino stated the Vista Unified School District, during this crisis appeared and allowed us to use their kitchen to clean and sterilize our equipment so that we could feed our patients.

Chairman Dagostino invited Mr. Philips to the podium to accept a plaque recognizing their extraordinary service. Chairman Dagostino stated Tri-City prides itself in being part of the community and working for the community however in this instance the community came to our aid.

13. Introductions

a) Himani Singh, M.D.

Mr. Knight introduced Dr. Himani Singh, an Oncologist who joined the North County Oncology team in January of this year.

Dr. Singh expressed her appreciation for the opportunity and for welcoming her to the community. She stated she is very excited to be here and the climate is a welcome change for her.

Dr. Paroly joined Dr. Singh at the podium. He stated Dr. Singh has been with North County Oncology for a couple of months now and comes to us with excellent credentials and a few years of experience in practice. Dr. Paroly stated Dr. Singh is an excellent addition to the group.

Dr. Paroly expressed his appreciation to the Board and Mr. Knight and all who worked to bring Dr. Singh on board.

b) Aaron Boonjindasup, M.D.

Mr. Knight introduced Dr. Aaron Boonjindasup who joined North Coast Urology along with Dr. Frasier, Dr. Guerena, Dr. Philips and Dr. Colangelo.

Dr. Boonjindasup expressed his appreciation to the Board for their support. He stated his family loves it here and he hopes to be here for a very long time.

Mr. Knight stated this Board has been very active and engaged in making sure that we recruit and retain and support physicians to help meet the medical needs of our community. He expressed his appreciation for their continued support in our recruitment efforts.

Chairman Dagostino expressed his appreciation to Dr. Singh and Dr. Boonjindasup on behalf of the Board of Directors for sharing their medical skills with our community.

14. Community Update –

1) Media – David Bennett, CMO –

Mr. David Bennett provided an update on programs that will replace the filming of our monthly Board meetings. He stated he firmly believes that we will be able to reach our community in a more efficient manner.

Mr. Bennett stated at last month's Board meeting there was some concern about whether the City of Vista was getting their distribution share of Coast News. Mr. Bennett explained the Coast News drops over 100 publications at over 100 distribution sites across Vista so we feel strongly that the City of Vista does get the news here. In fact we have received numerous positive comments from the citizens of Vista regarding the marketing ads that we have placed in the Coast News. Mr. Bennett stated in his opinion the Coast News is well distributed to the community. Thinks we get ample distribution and it is well distributed to the community through the Coast News.

Chairman Dagostino expressed his appreciation to Mr. Bennett for the courage to suggest change. He stated we will be reaching out to the community in a little better fashion and hope it is successful.

Director Grass stated previously we had discussed having someone videotape the Board meetings internally so that they could still be placed on a website for public view. Mr. Bennett clarified that he has not been asked to do that.

15. Report from TCHD Auxiliary, Pat Morocco, President

The TCHD Auxiliary Report was pulled from today's agenda.

No action was taken.

16. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO stated he wanted to revisit Vista Unified School District stepping up when we had a community need and express our appreciation to them once again. Additionally, he reached out to Dietary, Safety and Engineering for assessing, handling and professionally repairing the piping issues we had here over the last month. He stated as Director Mitchell previously commented the Dietary staff didn't miss a beat. The needs of the patients come first and not one meal was missed. In fact patients did not even notice there was a disruption in service.

Mr. Dietlin stated one of the things we have talked about over the past 10 months is the need for a long term financial partner. He stated he is pleased to report that we have a new long term financial partner with the US Housing & Urban Development (HUD) and Lancaster Pollard. Mr. Dietlin explained that we entered into a 25 year long term finance agreement at 4.32%, a favorable rate over a long term period. He acknowledged everyone who participated in that process including the entire Board, the Medical Staff, Community Leaders, the Chambers, etc. Mr. Dietlin emphasized that as we all know access to long term capital is critical to deliver our mission and this is a big step in that process and creates a platform for us to move forward.

Mr. Dietlin reported today is National Doctor's Day which we celebrated yesterday due to today's Board meeting. This is a day where we really do need to recognize our Medical Staff which is second to none. Mr. Dietlin commented on our outstanding clinical outcomes and the fact that Tri-City has the highest safety rating in North County and one of the highest in all of San Diego.

Mr. Dietlin explained each year on Doctor's Day the Tri-City Healthcare District's Foundation recognizes the excellent care provided by our physicians right here at Tri-City. This year 79 physicians were recognized by their patients for their compassion and care. Mr. Dietlin read a few of the comments that patients sent in recognizing their physician that are visible on the wall. Mr. Dietlin stated we need to remind ourselves of the great care our physicians provide and the fact that the care is very individualized.

Finally, Mr. Dietlin invited Dr. David Tweedy and Mr. Glen Newhart to present Dr. Gene Ma, Chief of Staff with recognition pin for a patient that he treated.

Chairman Dagostino stated he looks at the pinning of Dr. Ma as a symbolic pinning of all of our doctors.

No action was taken.

17. Report from Acting Chief Financial Officer

Mr. Rivas reported on the Fiscal Year to Date Financials as follows (Dollars in Thousands):

- Operating Revenue – $222,308
- Operating Expense – $223,708
- EBITDA- $13,163
- EROE - $3,050

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 182
- Adjusted Patient Days – 75,115
- Surgery Cases – 4,169
- Deliveries – 1,777
- ED Visits – 41,828

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $27,023
- Operating Expense – $27,350
- EBITDA - $1,428
- EROE – $181

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 178
- Adjusted Patient Days – 8,620
- Surgery Cases – 479
- Deliveries – 197
- ED Visits – 4,673

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.0
- Days in Net Accounts Receivable – 49.9

Mr. Rivas stressed the importance of increasing our volumes which will be addressed as to consider our Strategic Plan.

No action was taken.

18. New Business

a. Consideration to appoint Dr. Gene Ma, Interim Medical Director for Employee Health Services

It was moved by Director Reno to appoint Dr. Gene Ma, Interim Medical Director for Employee Health Services at no cost to the District. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration to approve a 60-day extension to the Employee Leasing Agreement with Venus Medical Group

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors approve a 60-day extension to the Employee Leasing Agreement with Venus Medical Group. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c. Consideration to match community donations for the Back Pack Program for North County Schools

Director Schallock stated he would like to amend the suggested motion.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve matching community donations for the Backpack Program for North County schools for a period of not more than four years and not to exceed $100,000 during that time frame subject to the review of any contracts by General Counsel and Compliance with applicable procurement rules. Director Nygaard seconded the motion.

Mr. David Bennett stated we supported the Backpack Program in Oceanside several years ago and it was very successful. He explained there is a need in the cities of Carlsbad, Vista and Oceanside to start a similar program on a district-wide basis. Mr. Bennett stated he has contacted the Chamber Presidents in Vista, Oceanside and Carlsbad and will draft a letter that outlines what we want to do on a matching basis. The Chambers have indicated that they will not go out and ask the communities for donations but will support Tri-City by asking their members (approximately 6,000) for matching funds.

Director Nygaard questioned what will happen if the matching funds don't materialize. Mr. Bennett stated we should know more in 60-90 days whether businesses are willing to participate and match. Mr. Bennett stated he also intends to talk to some people who we do sponsor events for and ask them to partner with us on a matching basis. He stated he believes strongly in his program and hopes our community will step up and match.

Director Schallock stated the San Diego Foodbank has a program which they are willing to offer $10,000 per school per year. He explained that the reason he modified the suggested motion from one year to four is they have five schools specifically that have been identified that need help right now and we need to have the matching part to make the program work. He believes the District's match

should be $25,000 per year for each of the four years. Director Schallock stated this is consistent with what we have done in the past but on a larger scale.

Director Reno questioned if anyone has thought about allowing this program to go through the Grants Committee and perhaps use some discretionary funds. Mr. Bennett stated the San Diego Food Bank has applied for a $50,000 grant through the CHAC committee. Director Reno emphasized she is wondering about using discretionary funds.

Chairman Dagostino stated he looks at this as a partnership between schools, the community businesses and this hospital. Ideally, Vista would support the Vista Schools, Carlsbad the Carlsbad schools, etc. Mr. Bennett stated he believes this program would provide great visibility to go forward and lead this program, however if there is no interest we may need to abandon the idea.

Director Kellett requested clarification on the motion. Director Schallock stated his intent was to cap the contribution at $25,000 for each of the four years.

The maker of the motion agreed to amend the motion to include $25,000 per year over a period of four years. Director Nygaard seconded the amendment.

Chairman Dagostino personally encouraged the community to step up and support this program,

Director Nygaard called for the question.

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard,**
Reno and		**Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Old Business

Consideration to direct staff to implement plans related to an internal Board Portal as described in the Report of the Ad Hoc Technology Committee dated March 30, 2017

Director Mitchell reported the Ad Hoc Committee recommends that we utilize an internal solution via our website. She reassured everyone that paper is still an option.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors direct staff to implement plans to facilitate an internal Board Portal and establish a standing Board Committee to oversee implementation composed of the Ad Hoc Committee members for a period of two years. Director Schallock seconded the motion.

Director Reno stated per Roberts Rules an Ad Hoc committee cannot meet more than six (6) times. Mr. Moser explained that is correct however the motion speaks to a standing Board Committee due to the intended duration. Mr. Moser further clarified

that a standing Board Committee meets the parliamentary standard and the Brown Act.

Chairman Dagostino questioned the plan as it relates to devices for the Board members. Mr. Moser stated his understanding of the motion is that the hardware is well within management's authority to spend money and since they are directed to look at the portal the purchase of devices would be part of it. He stated management has this discretion under the Signature Authority Matrix.

Director Reno expressed concern that the motion does not include a total or approximate cost. Director Mitchell explained the cost is limited to the devices.

Director Kellett called for the question.

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell Nygaard, and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Chief of Staff

a. Consideration of March 2017 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on March 27, 2017.

It was moved by Director Nygaard to approve the March 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on March 27, 2017. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Approval of Anesthesiology Privilege Card

It was moved by Director Reno to approve the Anesthesiology Privilege Card as recommended by the Medical Executive Committee on March 27, 2017. Director Kellett seconded the motion.

Director Kellett commented that the Board does not have the knowledge of the scope of the Privilege Cards and recommended the Medical Staff be free to approve Privilege Cards consistent with their specialty.

Director Mitchell questioned if there is a rationale for the Board to approve Privilege Cards. Dr. Ma thanked Dr. Ma for recognizing the independence of

the Medical Staff. He stated the Board does delegate to the Medical Staff to oversee the quality of care and ultimately delegates oversight of the Privilege Cards and determines what can be practiced at our institution.

General Counsel, Mr. Moser stated he will determine if there is a mandate by state licensing rules that the Governing Body approve the Privilege Cards.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Consent Calendar

It was moved by Director Kellett to approve the Consent Calendar. Director Nygaard seconded the motion.

It was moved by Director Nygaard to pull item 21 (1) F. 4. Recommend the Board discuss scheduling a potential Board Educational Workshop at the April 25, 2017 Strategic Planning Workshop. Director Schallock seconded the motion.

It was moved by Director Schallock to pull item 21 (1) F. Recommend presentation to the Board on Midwives. Director Kellett seconded the motion.

Mr. Moser requested that the Allied Health Rules & Regulations be removed from the Consent agenda and referred back to the committee. Director Kellett made the motion. Director Nygaard seconded the motion.

Ms. Sharon Schultz stated an amended version of Patient Care Policy Stroke Code; Emergency Department Procedure has been placed at the Dais for consideration.

It was moved by Director Reno to pull items 21 (1) E.1 b) Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure, 21 (1) F. i. Approval of an agreement with Masimo Americas, Inc. for pulse oximetry technology for a term of 60 months, beginning April 1, 2017 through March 31, 2022 for an annual cost of $384,713 and a total cost for the term of $1,923,565 and item 21 (1) G. 1) a. Policy 8610-292 – Internal Charge Audit. Director Kellett seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**

ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

22. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 21 (1) E.1 b) Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure requested clarification on the title and location of the Cardiac Wellness. Upon further discussion it was determined that the title should be amended to Cardiac Rehab rather than Cardiac Wellness.

It was moved by Director Mitchell to approve Cardiac Wellness Center (On Campus) Emergency Treatment Standardized Procedure as amended. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

It was moved by Director Kellett to approve Patient Care Policy Stroke Code, Emergency Department Procedure. Director Nygaard seconded the motion.

Ms. Schultz explained the Stroke Code Procedure was revised to reflect an estimated weight versus actual weight due to the fact that there are no scales in the Emergency Department.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

It was moved by Director Mitchell to approve the Allied Health Rules & Regulations and refer them back to the Governance Committee for further review per General Counsel's recommendation. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Nygaard who pulled item 21 (1) F. 4. Recommend the Board discuss scheduling a potential Board Educational Workshop at the April 25, 2017 Strategic Planning Workshop recommended that this item be discussed at a more appropriate venue. Director Schallock suggested this topic be discussed in the fall at the time the Board has their Self-Assessment retreat. Chairman Dagostino further commented that it is necessary to determine what type of workshop Board members are interested in having. Director Schallock suggested the Board Chair contact two-three facilitators and bring information back to a future meeting.

Director Schallock who pulled item 21 (1) F. Recommend presentation to the Board on Midwives stated the Board has previously discussed Midwives at both the Governance and Board level. Dr. Ma stated he can work along with Ms. Schultz on a presentation that will focus on CNM's and their selection criteria and in particular how they get into the program. He stated he will also work with NCHS to make sure that information is available.

Director Mitchell stated there are other categories of Allied Health Professionals in addition to Midwives and the Board may find it beneficial to learn the scope of their practice. Ms. Schultz stated there is a Multidisciplinary Practice Committee that meets during the year to review all of their credentials. Dr. Ma stated there are nine (9) categories of Allied Health Professionals.

Director Schallock concurred a presentation on the broader group of Allied Health Practitioner's would be helpful as opposed to only Midwives.

The Board directed staff to bring a presentation forward to next month's meeting that describes the various categories of Allied Health Professionals and their scope of practice.

Director Reno who pulled item 21 (1) G. 1) a. Policy 8610-292 – Internal Charge Audit requested clarification on what the internal charge audit consists of. Mr. Rivas explained Tri-City did have a chart auditor who left us and we have been trying to fill that position. In the meantime we brought in an RN that we contract with to assist us in meeting with insurance companies and payors who might challenge our bills. Mr. Rivas stated this individual also meets with patients who have billing issues. Mr. Rivas stated we are still attempting to fill the Internal Auditor position.

It was moved by Director Schallock to approve Policy 8610-292 – Internal Charge Audit. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled item 21 (1) F. i. Approval of an agreement with Masimo Americas, Inc. for pulse oximetry technology for a term of 60 months, beginning April 1, 2017 through March 31, 2022 for an annual cost of $384,713 and a total cost for the term of $1,923,565 questioned if this contract went out to bid. Mr. Rivas stated this is simply a renewal of an existing agreement.

It was moved by Director Nygaard to approve item 21 (1) F. i. Approval of an agreement with Masimo Americas, Inc. for pulse oximetry technology for a term of 60 months, beginning April 1, 2017 through March 31, 2022 for an annual cost of $384,713 and a total cost for the term of $1,923,565. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

23. Reports (Discussion by exception only)

Director Schallock stated his handout was inadvertently omitted from the Board packet however he would like to comment verbally. He noted Chairman Dagostino provided a very detailed report on the CHA Legislative meeting in Sacramento.

Director Schallock reported Governor Brown was the keynote speaker however he did not focus too much on healthcare. Director Schallock stated that Governor Brown commented that we need to work together to address the healthcare needs here in California and the process should not be partisan.

Director Schallock stated he had the opportunity to meet with Assembly Member Waldren. In his visit with Mrs. Waldren the opiate issue was raised and the fact that a number of states are trying to limit the number of opioids a physician can order in a single prescription. Director Schallock stated New Jersey now allows a five day supply. He stated that California has not yet implemented such a requirement however he noted the importance of educating the physicians to encourage a non-narcotic for a first ling drug.

Director Schallock stated CHA commented on several specific issues and one in particular relates to AB387 Minimum Wage, Allied Healthcare Trainees. He stated CHA is concerned that if this legislation were to pass you would need to pay trainees $15/hour as a minimum wage. Director Schallock further explained that facilities feel that is an unnecessary burden because these trainees cannot function independently and therefore you are paying two people to perform the same job. Furthermore, facilities may not accept trainees which would affect the future job market.

Director Schallock reported SB687 relates to closure of Emergency Department rooms. He stated the Legislature wants to add another level of surveillance as part of the process and the reviews would be an additional expense on the facilities who are already having difficulty staying open.

Director Schallock did note that the bills are not even out of the committee level at this point and need to be fine-tuned.

Director Schallock stated Senator Bates was very complimentary of her recent visit to Tri-City and commented how impressed she was with our innovative equipment, the procedures we perform and the quality of care we provide for our patients.

Director Reno stated she had a question on the Non-Clinical Contract Spreadsheet. Chairman Dagostino stated that item was listed on the Consent Agenda which has already been discussed.

Director Reno stated she is voting "no" on all minutes listed on the agenda. Director Nygaard stated she will be abstaining from the minutes of the February Regular meeting due to her absence at that meeting.

24. Legislative Update

1) Chairman Dagostino stated he and Director Schallock were selected to be leaders of the Legislative Team in Sacramento at the CHA Legislative Days. He stated be believes they represented the hospital quite well. Chairman Dagostino stated your Board is committed to be involved legislatively and Director Schallock will join him in Washington, D.C. at the AHA meeting where they will listen intently about what changes might be coming about in healthcare.

2) Chairman Dagostino stated there has been a request from Administration to consider writing a letter in opposition to AB387, the bill in which Director Schallock previously commented on related to minimum wage for interns. Chairman Dagostino stated CHA as well as other associations are opposed to this bill for fear of losing internships. Ms. Norma Braun, Chief Human Resource Officer strongly suggested the Board consider writing a letter in opposition as we do have affiliations with schools and this could limit the opportunities we have to work with students which is also a source of candidates. Director Mitchell stated she believes this bill is based on an erroneous assumption that these are employees rather than trainees. The Board concurred they would be in support of writing a letter of opposition. Chairman Dagostino directed Ms. Braun to draft a letter for the Chair's signature.

25. Comments by members of the Public

Chairman Dagostino recognized Ms. Chris Hart, Emergency Department RN who urged the Board to direct administration to work together with the union to formalize a contract. She commented on the number of Travelers and Registry staff that are needed due to staff who have left the organization for better pay.

Director Mitchell commented that CFO Ray Rivas is currently working on the costing as was requested by the union.

26. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

27. Board Communications

Director Schallock expressed his appreciation to the Physicians for all they do to take care of our patients throughout the year, and one day of recognition is certainly not enough. We very much appreciate everything that they do.

Director Schallock commented that while up in Sacramento at the CHA meeting, members were well aware that Tri-City has instituted the HUD transaction and were excited for us. He stated that very few hospitals west of the Mississippi have been able to achieve this and other facilities have indicated they may look into doing something similar.

Director Schallock reported Prescription Drug Take Back Day is April 29th. He encouraged everyone who has outdated drugs or drugs you are not using to drop them off in the hospital parking lot. Director Schallock stressed the importance of keeping narcotics from getting into the wrong hands.

Director Schallock commented on a unique experience that he witnessed coming into the hospital this afternoon in which a nurse took time out to assist a patient's family and took their dog for a stroll while a family member visited with their loved one in the ICU.

Director Reno reported three Board members attended the Doctor's Day recognition luncheon which was held yesterday due to today's Board meeting. She commented that our doctors are never thanked enough for all the good work that they do. Director Reno sincerely thanked all the doctors who cared for her and her loved ones this past year.

Director Reno recognized Mr. Glen Newhart for introducing the "thank a doctor" concept in which comments were made to specific physicians and those comments are still visible on the walls today. Physicians who were recognized by their patients were also given a pin.

Lastly, Director Reno stated the Board recognizes the nurses as well as all the ancillary staff who participate in patient care. She stated the nurses and staff are an asset to this hospital and well as an investment as they deliver excellent patient care across the continuum. Director Reno stated that sometimes the game works both ways. It is important for the parties to come together and meet as the Board cannot participate in the negotiation process.

Director Nygaard did not have any comments.

Director Grass, being an Emergency Department Trauma Nurse herself for many years expressed her appreciation to Ms. Hart for her passionate plea. She stated that she wants the nurses to know that they are being heard.

Director Mitchell stated she has been on the CNA side of the bargaining table in two negotiations, one with Tri-City Healthcare District and one with UCSD, however what is most concerning to her about these negotiations is the lack of meetings. She emphasized that you will not get anywhere if you are only meeting one day every 4-6 weeks. Director Mitchell stated if you truly want to get this contract settled the parties have to come together and meet every day until you have a contract.

Director Kellett did not have any comments.

28. Report from Chairperson

Chairman Dagostino expressed his appreciation to his colleagues for speaking their mind.

29. Chairman Dagostino reported the Board would be returning to Closed Session to complete unfinished business at 5:17 p.m.

31. The Board returned to open session with all Board members present.

32. Chairman Dagostino reported the Board agreed by a unanimous vote to engage defense counsel Foley & Lardner and Mintz Levin.

33. Hearing no further business, Chairman Dagostino adjourned the meeting at 7:58 p.m.

_____
James J Dagostino, DPT
Chairman

ATTEST:

_____
Laura E. Mitchell, Secretary

Stakeholder Experience

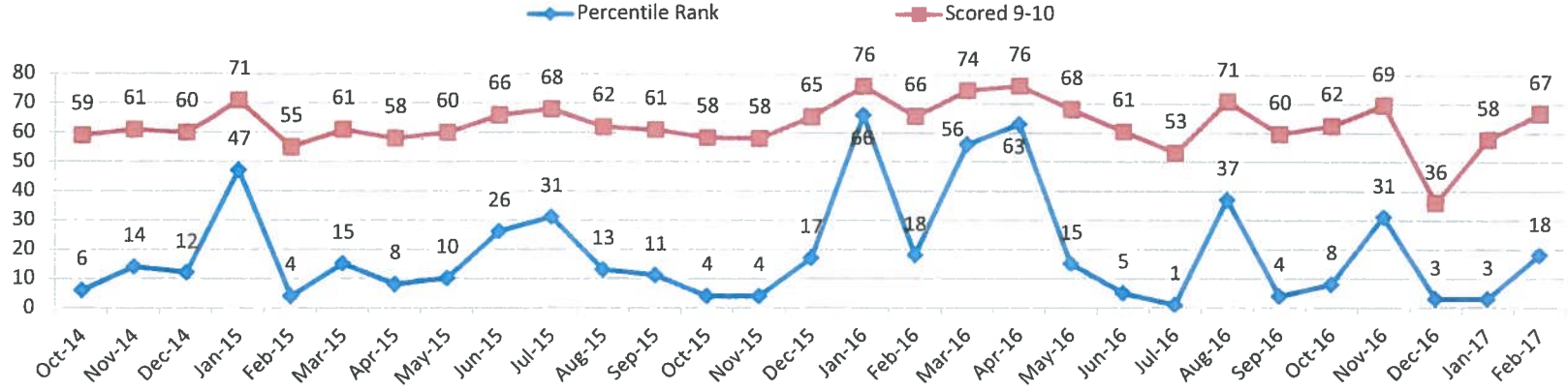
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

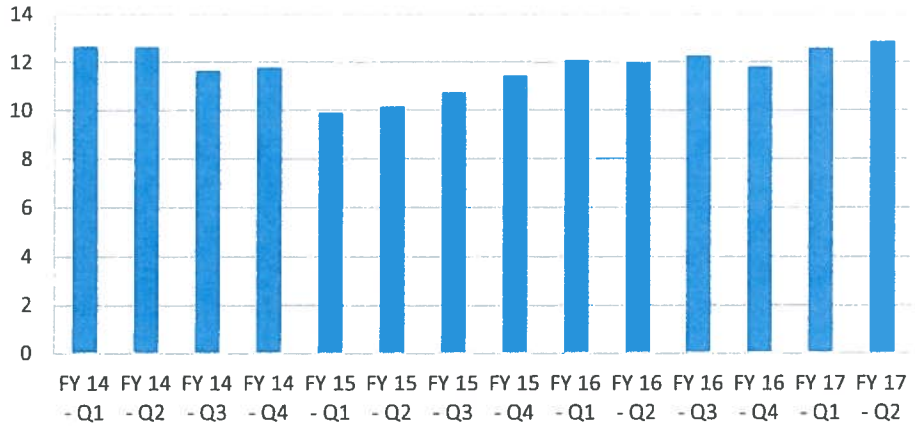
HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

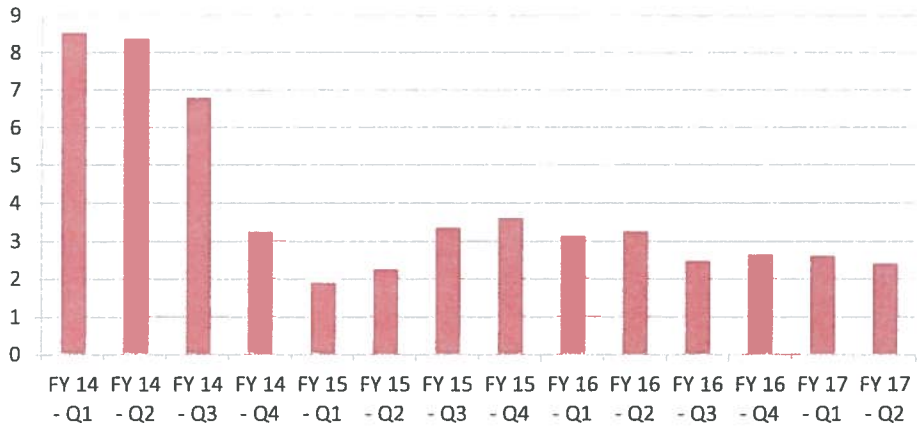
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

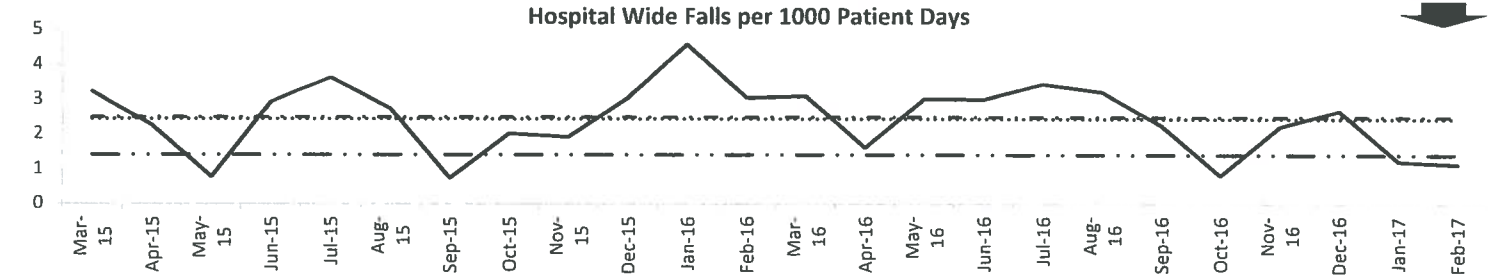


Fall & HAPU's

TCMC Rate Mean CA Mean TCMC Target

Better

Hospital Wide Falls per 1000 Patient Days



Action Plan

Goal to monitor & sustain improvements.

Toileting:

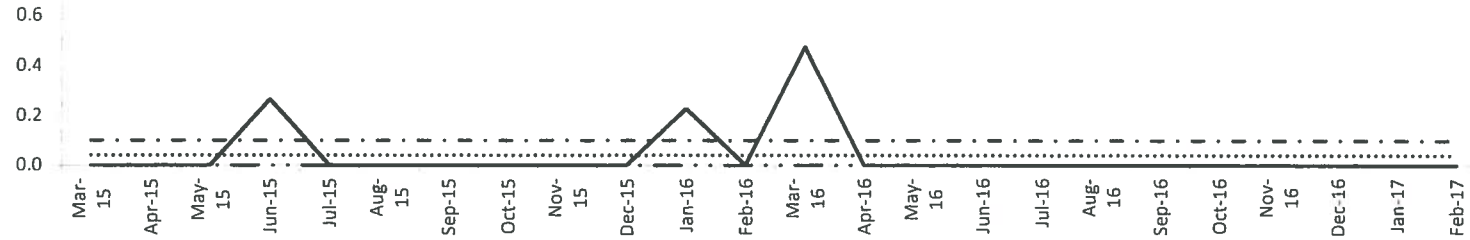
- Hourly rounding
- At risk assist to bathroom q. 4-6 hours.
- Remain in BR with high risk pts.
- Educate pt and family.

Redesign Fall Risk:

- **"Fresh visibility"**

Better

Hospital Wide Falls with Injury per 1000 Patient Days



Action Plan

Partnering for Fall Prevention:

- Plan reviewd & signed by pt & RN.

New Tele sitter program.

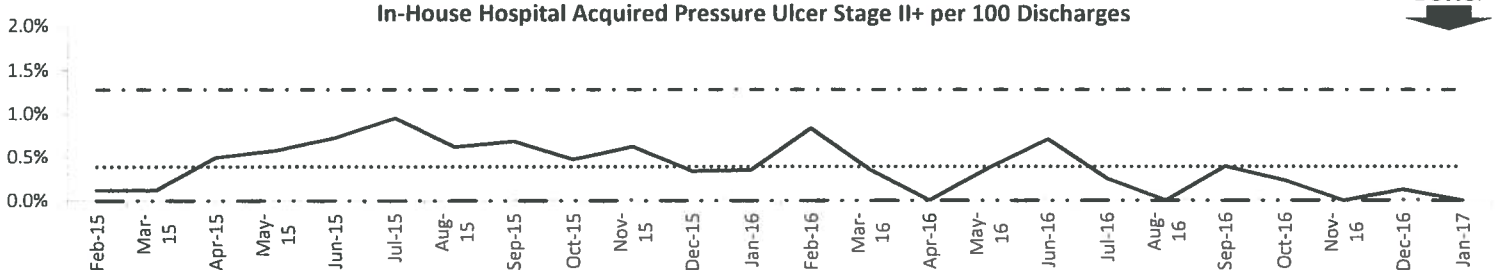
Education posters as staff reminder.

Safe Unit:

- 4P 8 beds (June 2016).

Better

In-House Hospital Acquired Pressure Ulcer Stage II+ per 100 Discharges

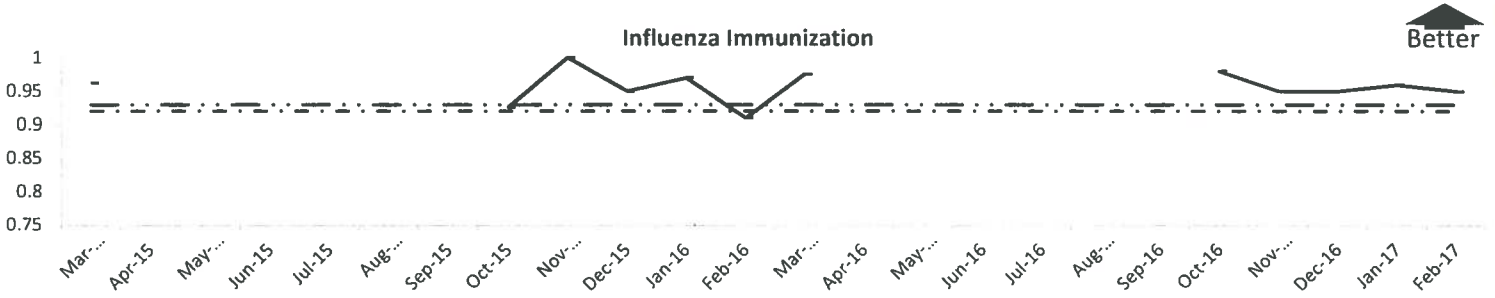


Action Plan

Units are working on unit based skin champions, rounding, and increasing the comfort level of skin integumentary changes. Staff is continuing to work on prevention of pressure injuries implementing interventions and general awareness of Skin assessment.

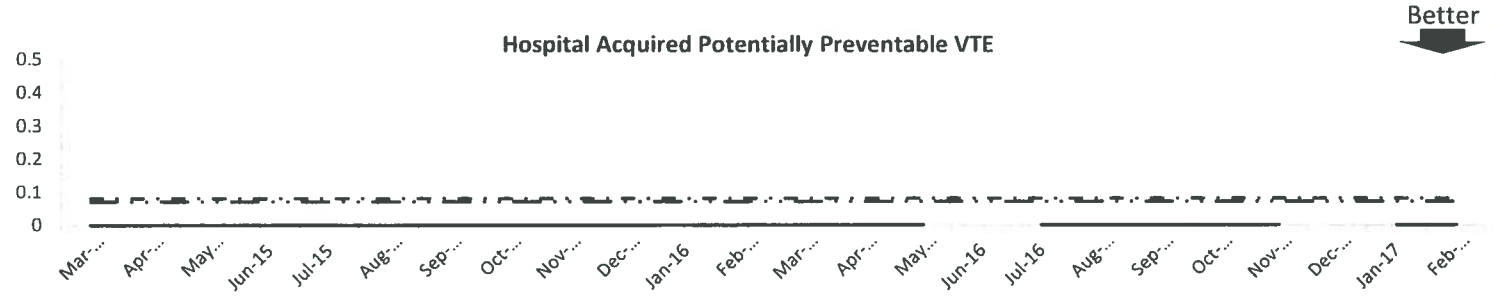
Core Measures

TCMC Rate ····· Mean — · — · — CA Mean — · — · · · TCMC Target



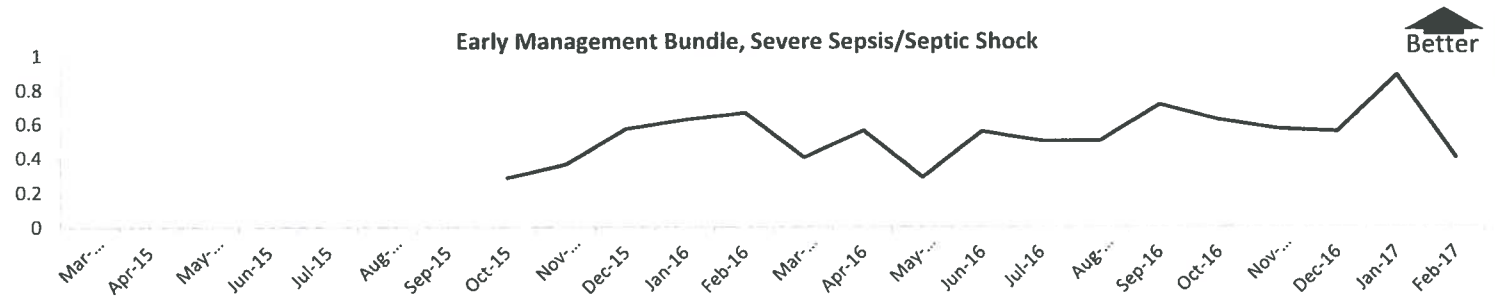
Action Plan

Consistently above our goal.



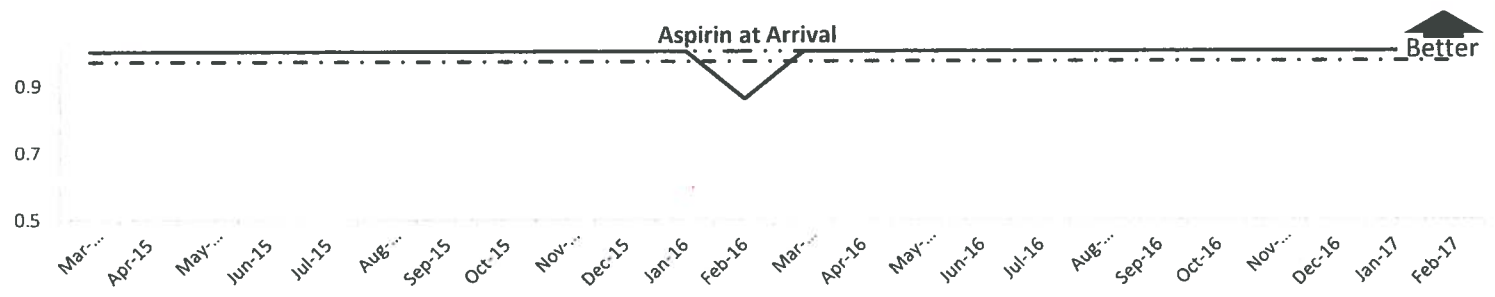
Action Plan

Consistently at 0%.



Action Plan

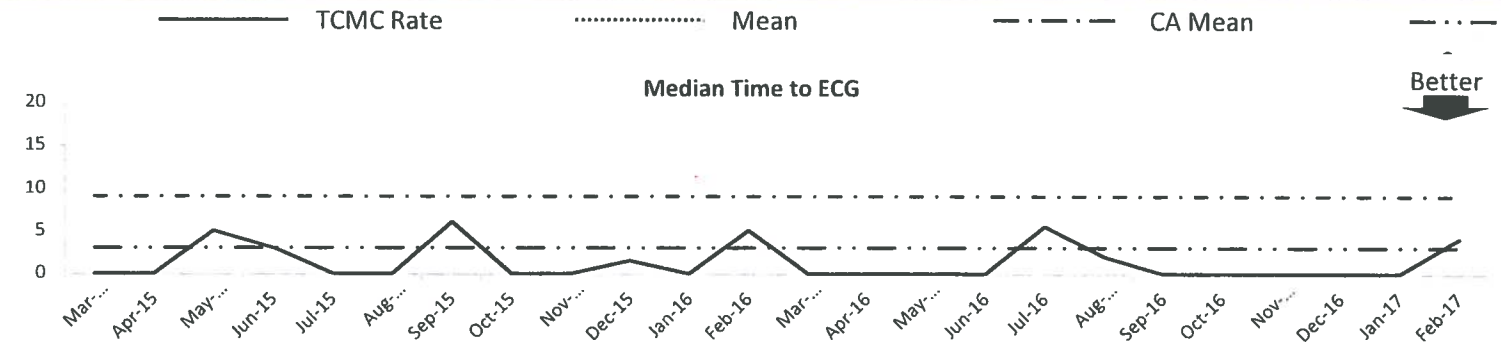
Took hit in February. Only 5 patients in sample this month. Still above 70% goal for quarter.



Action Plan

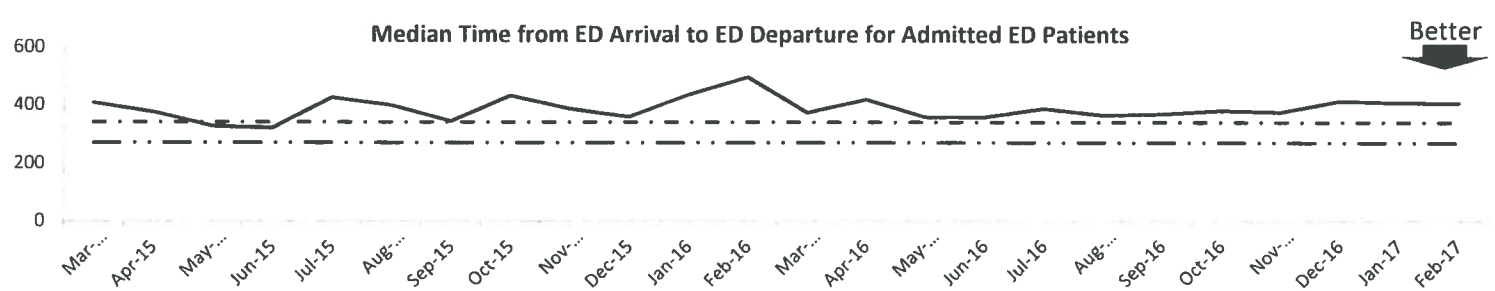
Consistently at 100%.

Core Measures



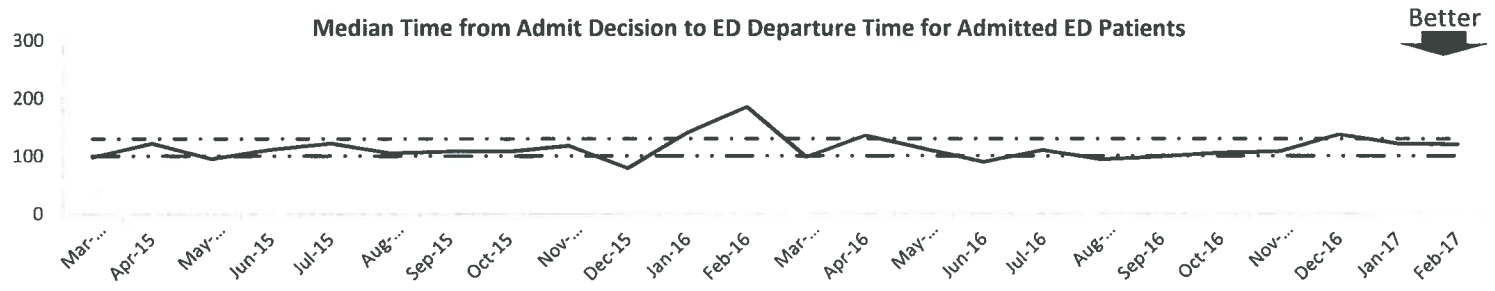
Action Plan

Consistently well below 10 minute CMS guidelines.



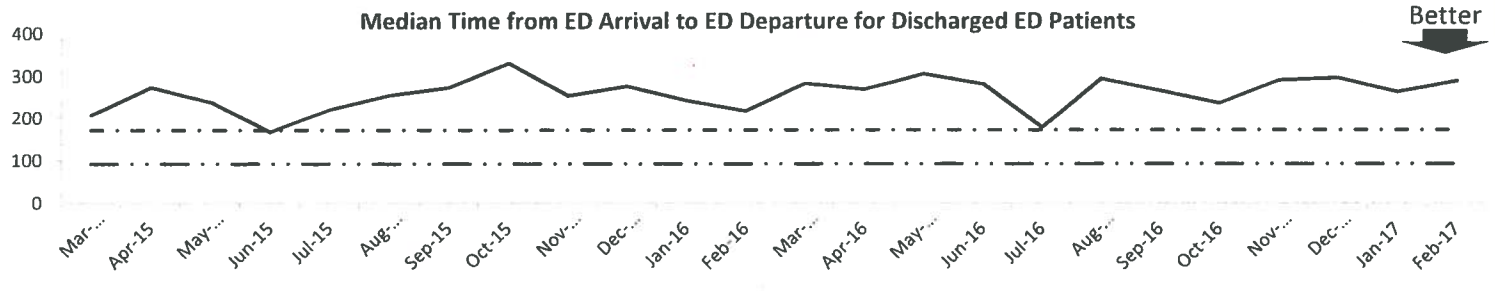
Action Plan

Triage remodel. Expect completion October 2017.
Admission RN started 3/1 daily from noon to MN. Start with Adm orders. Start Adm assessment, Skin check, SBAR report, transport patient.



Action Plan

This is expected to reduce delays & improve hand off process.
Discharge Hospitality suite started in mid-January. Expected to improve bed availability for discharged pts.
Crisis Stabilization Unit continuing work to smooth pt flow.



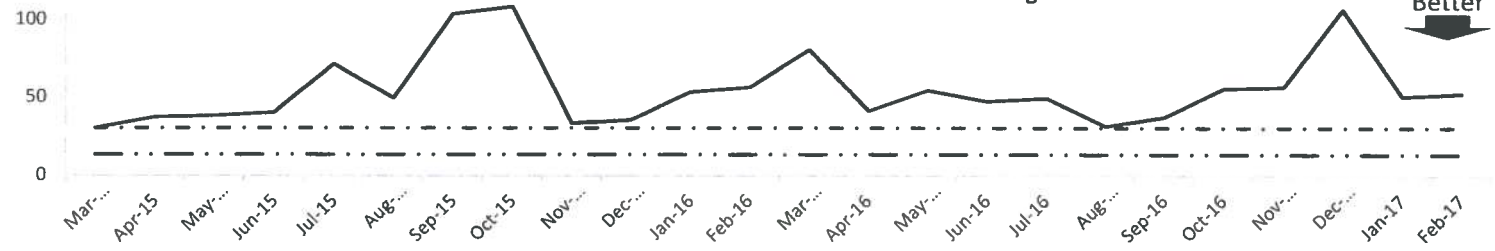
Action Plan

(Above)

Core Measures

TCMC Rate Mean CA Mean TCMC Target

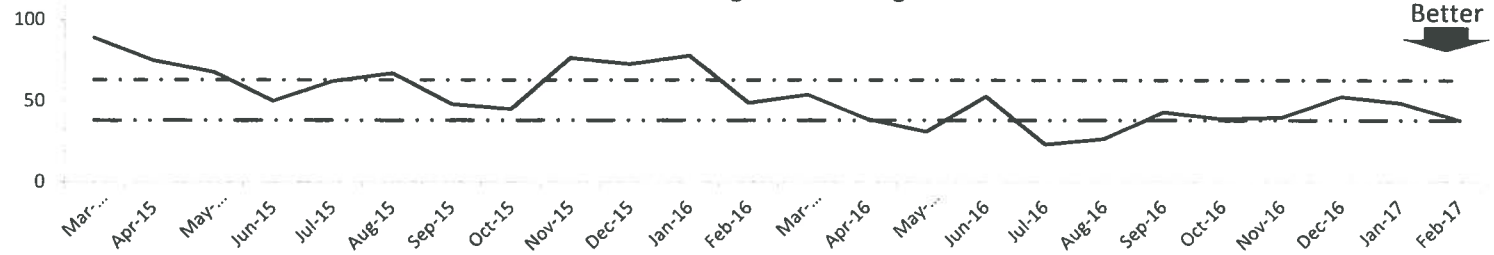
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

PA's providing MSE on all patients presenting to Triage from 8a to 2a. MD in Triage 3/1/2017.

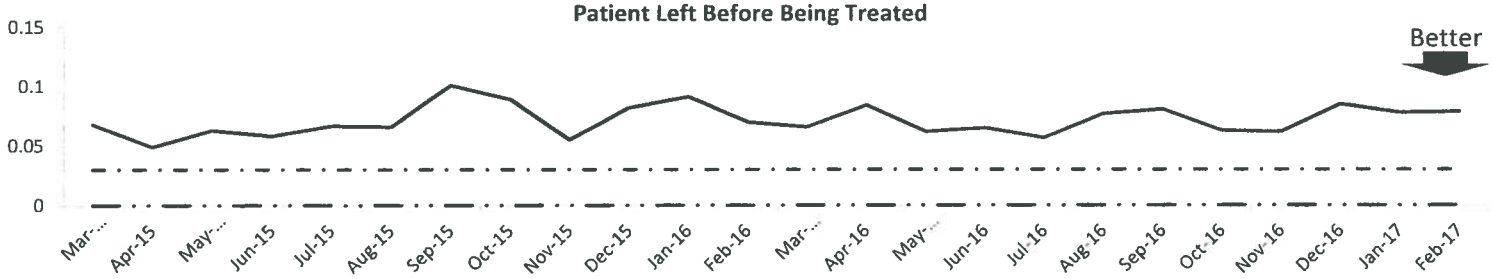
Median Time to Pain Management for Long Bone Fracture



Action Plan

Consistently below 60 minute CMS standard. Maintaining improvement due to improved Triage documentation.

Patient Left Before Being Treated



Action Plan

Extended hours for Provider in Triage.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	28	22	13	25	27	23	19	24	25			206
FY16	49	29	30	30	23	29	23	28	32	27	27	356

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	9	9	5	13	12	11	10	8	15			92
FY16	20	19	15	23	12	13	16	15	15	17	8	188

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	8	11	8	13	12	8	12	10	12			94
FY16	9	10	8	8	13	11	9	13	14	8	8	120

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	18	18	17	14	20	22	20	16	18			163
FY16	16	19	13	4	7	9	15	20	15	13	17	163

Performance compared to prior year: Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	31	35	29	42	34	29	31	30	31			292
FY16	40	36	37	44	34	33	45	39	38	39	38	473

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5			15.8
FY16	19.9	19.6	17.6	18.0	16.0	16.7	17.5	15.5	15.2	14.5	15.3	17.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9			6.2
FY16	7.1	4.9	5.6	6.9	7.1	6.7	6.5	6.6	5.0	6.5	5.5	6.2

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7			15.2
FY16	13.3	11.1	14.3	15.1	16.3	19.0	20.1	16.3	13.5	16.0	17.1	15.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4			181.1
FY16	183.9	183.4	199.7	187.7	182.4	200.6	202.9	203.0	186.7	200.7	183.9	191.9

Performance compared to prior year: Better Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	223	239	274	230	197	200	217	197	202			1979
FY16	215	214	252	227	232	220	216	183	209	189	208	2565

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	12	11	12	16	11	14	15	11				102
FY16	16	9	19	12	16	10	11	15	15	15	18	168

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	4	4	6	6	5	7	2	2				36
FY16	7	3	7	4	5	7	6	6	6	4	2	64

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	10	9	8	7	6	9	8	6	16			79
FY16	7	14	4	6	7	10	2	8	13	12	5	95

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73			1.70
FY16	1.65	1.63	1.60	1.62	1.63	1.56	1.54	1.63	1.65	1.60	1.66	1.62

Performance compared to prior year: Better Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8				49.7	48-52
FY16	46.7	45.7	45.7	45.3	47.0	49.1	51.7	48.9	49.5	50.4	47.4	46.7	47.7	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6	79.9	74.6				83.8	75-100
FY16	83.6	85.8	92.1	88.7	84.0	82.5	83.6	81.1	81.4	81.1	81.1	80.7	84.7	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)				$138	$3,508
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)	($220)	$331	$315	($1,842)	($496)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%				0.05%	1.35%
FY16	3.03%	2.20%	0.66%	-0.68%	-2.00%	3.40%	-6.31%	-1.53%	-0.77%	1.13%	1.09%	-6.82%	-0.20%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010	$1,428	($1,630)				$11,534	$15,253
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797	$1,019	$1,530	$1,598	($558)	$10,252	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%				4.58%	5.85%
FY16	7.20%	6.53%	4.90%	3.65%	2.50%	7.58%	-2.10%	2.97%	3.56%	5.22%	5.55%	-2.07%	4.11%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25				6.08	6.03
FY16	6.13	6.05	5.91	5.98	6.11	6.01	5.77	5.43	6.07	5.86	6.09	5.99	5.94	

TCHD Fixed Charge Coverage Covenant Calculation

	TTM Jul	TTM Aug	TTM Sep	TTM Oct	TTM Nov	TTM Dec	TTM Jan	TTM Feb	TTM Mar	TTM Apr	TTM May	TTM Jun	Covenant	
FY17	1.37	1.37	1.37	1.59	1.73	1.50	1.35	1.37	1.51				1.10	
FY16	1.88	1.96	2.15	2.05	1.85	1.92	1.87	1.73	1.70	1.82	1.63	1.47	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6				
FY16	$30.7	$33.4	$36.1	$35.7	$31.8	$28.0	$26.3	$27.5	$24.8	$28.0	$37.6	$31.7	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending March 31, 2017

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	1,558	$2.25	(a)	4,809.44	01/27/17	05/31/20	**Venus OBGYN Clinic** 2067 W. Vista Way, Ste 160 Vista, CA 92083
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.85	(a)	10,264.71	4/1/2016	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.63	(a)	20,106.00	2/1/2015	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,265.25	12/01/15	12/31/20	**PCP Clinic** 2375 Melrose Dr. Vista Vista, CA 92081
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.92	(a)	3,398.15	01/01/13	03/31/17	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.86	(a)	10,013.01	09/01/12	08/31/17	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.37	(a)	10,101.01	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.00	(a)	25,580.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$2.11	(a)	5,039.70	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	246,428.00	07/01/13	06/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009
Total				**$345,005.27**			

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

Education & Travel Expense
Month Ending 3/31/2017

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6150	GE PATIENT MONITORING TRAINING	31617	2,094.21	77850	PRISCILLA REYNOLDS
6171	CANCER BASICS	22217	765.00	49112	NURSING STAFF
6171	CHEMO BIO CERTIFICATE COURSE	22217	1,912.00	49112	NURSING STAFF
7010	MCIN COURSE	110216MATTKE	500.00	31263	TERA MATTKE
7790	STROKE REHAB COURSE	20717	199.00	78654	LANA CUSICK
7790	STROKE REHAB COURSE	20317	199.00	82928	EMILY SMITH
8390	340B COALITION CONFERENCE	113016	233.61	10894	LAURA BALL
8390	340B COALITION CONFERENCE	22817	256.18	81163	LAURA BALL
8480	ONSITE TRAINING	30617	1,472.60	82709	RODOLFO RAMOS
8610	DHLF BOARD MEETING - EXPENSES	31617	138.00	81508	STEVEN DIETLIN
8614	AMERICAN ACADEMY OF ORTHO SURGEONS MTG - REGISTRATION	32017EXP	250.00	77376	JEREMY RAIMO
8614	MAZOR ROBOTICS REVIEW - AIRFARE	32017EXP	627.40	77376	JEREMY RAIMO
8615	EMPLOYEE BEHAVIOR CONFERENCE	30117EXP	248.00	80986	JAMIE JOHNSON
8620	CHA HEALTH POLICY LEGISLATIVE DAY - FLIGHT	22817	259.90	81163	LARRY SHALLOCK
8620	BOARD AUDIT COMM COMPLIANCE CONFERENCE - EXPENSES	30917	840.88	81515	JAMES DAGOSTINO
8700	HEALTH RECORD CLASS	22817	230.00	81163	MELISSA SANCHEZ
8700	HEALTH RECORD CLASS	22817	230.00	81163	LEILANI SAGALE
8740	ONS-ONCC CHEMOBIOTHERAPHY COURSE	30917	103.00	82051	MARY JENNIFER CATACUTAN
8740	ACLS COURSE	32317	105.00	44920	LYNN MISNER
8740	NEONATOLOGY CONFERENCE	32317	125.00	80257	KIMBERLY MARQUARDT
8740	ACLS COURSE	21617	130.01	69729	JIANHUA WU
8740	ACLS COURSE	30917	150.00	82013	INJA KIM
8740	ACLS SOURSE	32317	155.00	77564	GAIL HART
8740	ACLS COURSE	30917	155.00	78966	FELICIA NEUMEYER
8740	FETAL ASSESSMENT	32317	200.00	77472	KRISTEN D'ELISEO
8740	AHA-ACLS COURSE	22317EXP	200.00	77478	KATE WILDERN
8740	TRAUMA TREATMENT CLASS	30117	200.00	81769	KRISTINA DITULLO
8740	RADIOGRAPHY TECHNICIAL COURSE	21617	2,000.00	82924	ROBERT MONTEFALCON
8740	RN TO BSN	32317	2,500.00	38544	ROSENDA MCDOWELL
8750	COMPLIANCE INSTITUE MEETING - HOTEL	30217	329.22	82462	CHERYLE BERNARD-SHAW
8750	2017 HEALTH CARE COMPLIANCE CONFERENCE	687586	1,099.00	78762	CHERYLE BERNARD-SHAW
8790	NATIONAL SOCIETY OF HISTOTECHNOLOGY ANNUAL SYMPOSIUM	33117	1,000.00	23245	CARRIE DOLAN
8790	BHU-INTL CRITICAL INCIDENT STRESS FOUNDATION	33117	601.00	81645	CAROLYN SIDHU
8790	BHU-ASSISTING INDICIDUALS IN CRISIS	33117	477.00	77345	CAROLA HAUER
8790	BHU-ASSISTING INDICIDUALS IN CRISIS	33117	583.00		ELIZABETH RAIMO

EVALUATION FORM

SEMINAR: CHA LEGISLATIVE DAY
LOCATION: SACRAMENTO, CA DATE: MARCH 14-15, 2017

REASON TO ATTEND: Legislative Advocacy

IMPORTANT TOPICS/SPEAKERS:

This meeting is held annually to introduce Board members, Government liaison and administrators to recently introduced bills and associated topics in the legislative session that may have an impact on hospitals.

Our keynote speaker for the meeting was Governor Jerry Brown. He did not focus a lot on healthcare at this point in time. He stated that we all have to work together to address the health needs of the people living in California and that this process should not be partisan. He recognized the work of Duane Dauner, President of CHA, who will be retiring in 2018. There was some overview of the ACA on the federal level and possible impacts on California depending on changes that might occur.

I met with Marie Waldron, Assembly member for East North County, and Senator Pat Bates for this region. The support and oppose bills in the handouts were reviewed with each legislator. One problem this year as the bills have just been submitted and are not at committee for review yet and the bills are not as clearly defined as one would desire. Two opposition bills with special emphasis were AB 387 to pay Allied Health Trainees at Minimum Wage and SB 687 related to closure of Emergency Rooms. In the case of AB 387, paying the minimum wage to a trainee would be extremely costly to hospitals as a current staff person is paid as well as the proposed trainee for the same work. It was felt many facilities will cease training programs if they have to pay and this will ultimately have a negative impact of availability of the workforce. For SB 687, it is felt that there are adequate requirements already in place to address the issue of an ER closure. This bill adds more and duplicative responsibilities as well as costs on a facility that is already in financial difficulties.

The proposed Budget has some red flags as funding is being reduced or transferred in some General Medical Education programs and it was requested the funding be restored to last years levels. Also funds from Proposition 56 were anticipated to be used for reimbursement to physicians and providers; however, it appears the monies will be for Medi-Cal spending. Finally, the 340B program for medication purchases at reduced rates for Medi-Cal patients has issues on new requirements for receiving this benefit.

In the visit with Ms. Waldron, one member of our team brought up the problems with opiate usage as a state and national problem. Currently no changes were discussed but I had the opportunity to mention that some states are limiting quantities to a 5-7 day supply on initial prescriptions—not for chronic pain or terminal cancer. In addition there is an effort to better educate physicians on use of non-opiates as the first drug of choice. There is also an extensive monitoring program through the State Department of Justice for physicians and pharmacies.

Senator Bates was highly complimentary of Tri-City, its staff and facility. She had a recent tour of the hospital and saw some of the new and innovative equipment as well as procedures available to the patients as well as future plans for renovation. Also, Senator Bates was selected the day before we met with her as the Senate Minority Leader—clearly a recognition by her colleagues of their trust in her leadership abilities in the Senate.

Larry Schallock

SEMINAR TITLE: ACHD LEG DAY

LOCATION: SACRAMENTO CA. DATES: APRIL 2-5TH

I attended Leg Day to have an opportunity to get caught up on the current legislation in Sacramento and to attend ACHD Board meetings.
There is a lot going on right now. There is new legislation coming out of the Special District committee. It is clear that they do not clearly understand how hospital districts work. Many of the healthcare districts in the state do not have hospitals anymore. They are primarily focused on community health. Those districts are clearly in the head lights. There is a bill moving through the legislature AB 1728 which ACHD is supporting that requires minimum reporting requirements for all districts. We already comply with all the requirement of the legislation.

Marie Waldron is carrying a Heroin and Opioid Public Education Bill. It requires the Health and Human Services to developer and implement a comprehensive multicultural public awareness campaign to combat the growing Herron and opioid medication epidemic. I had an opportunity to meet with Marie. She is very interested in our Crisis Stabilization Unit and would like a tour of our facility.

As you know we receive weekly briefing from ACHD lobbyist group Hurst Brooks Espinosa, LLC. They have been following testifying at the Little Hoover hearings. As it stands now the legislators feel that they need more information before making a recommendation.They will continue their hearings in September. They are trying to understand how special districts work.

Burt Margolin President of Margolin Group gave us an update on the Affordable Care Act and where he believes it is going. He explained why it failed to move forward and expects that many of the same divides that stopped the new health care legislation will continue to make it difficult to pass a replacement bill. The legislature is so polarized and don't show signs of much moving forward any time soon. What ever moves forward will have significant impact on our hospital. California stands to loose 24 billion dollars. There is talk about a work requirement for healthy people to receive Medical. Health care will be a major project for the congress for the next few years. There is talk in the California legislature about a single payer system. San Francisco already has a system in place. Hospitals need to plan to be very flexible. We are in rocky times.

I also had a chance to meet with Pat Bates our Senator and Senate Minority leader and Randy Vopel who is the chair of the committee studying special districts.

ACHD honored Ben Hueso for his work on Design Build legislation. They also honored Jim Wood who carried the legislation to allow critical access hospitals to hire their doctors. He is interested is seeing how this works out and than trying to spread it to all hospitals in California. CHA is very opposed to this so it will be battle. The legislature has located money to study the impact of allowing hospitals to hire their doctors directly. Something to watch
There are many new faces in the legislature. It is going to take some time for them to feel comfortable in their jobs. ACHD is doing a good job of working with them so that they clearly understand our challenges. It was a good conference.