TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
September 29, 2016 – 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: New Facilities; Conference with Real Property Negotiators (Authority: Health and Safety Code, Section 32106, Gov. Code Section 54956.8) Property: 4002 Vista Way, Oceanside, CA 92056 Agency Negotiator: Steve Dietlin Negotiating Parties: Tri-City Healthcare District and United States Under Negotiation: Development program Date of disclosure: September 29, 2016		
	d. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (3 Matters)		
	e. Approval of prior Closed Session Minutes		
	f. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4		

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.

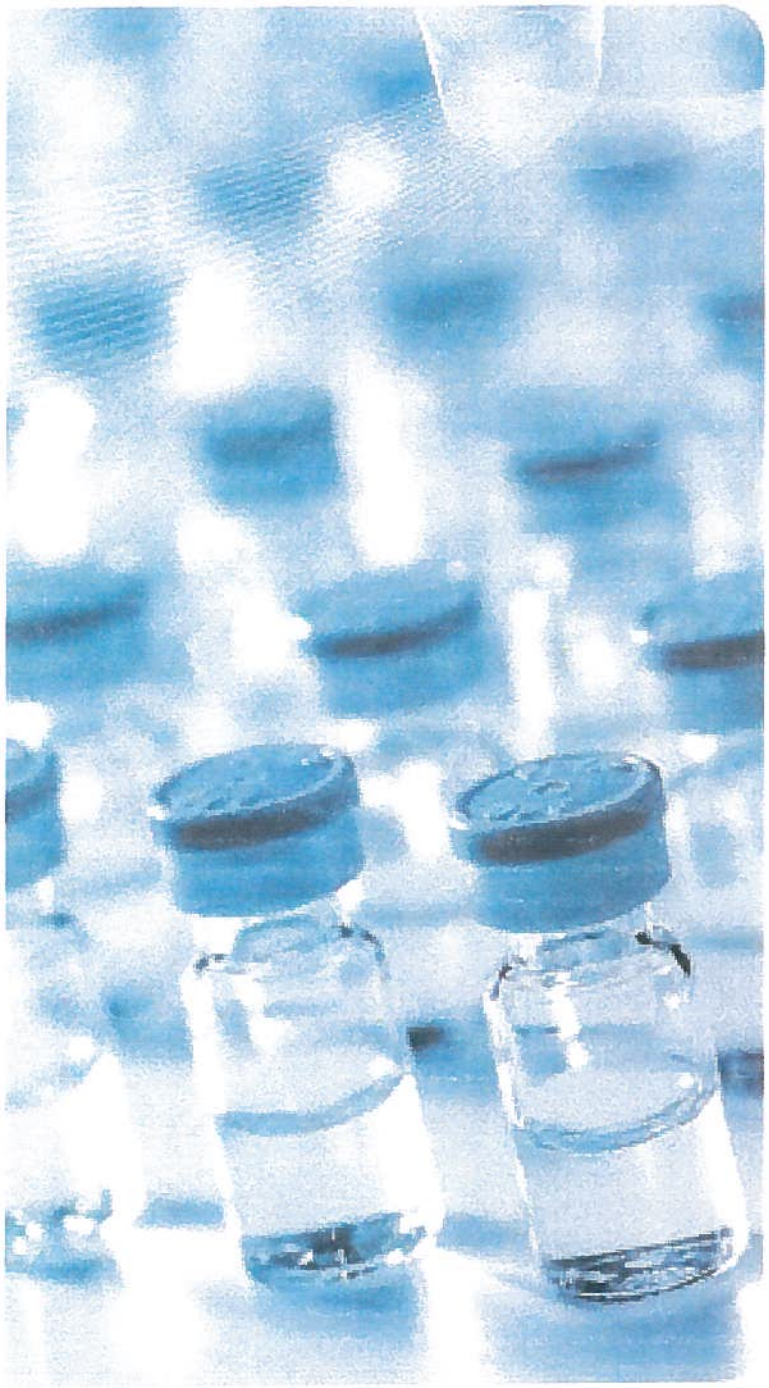
	Agenda Item	Time Allotted	Requestor
	(1) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (2) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities 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	Special Presentations – (1) Clinical Medical Equipment Update– Dr. Donald Ponec (2) Information Related to Quality – Sharon Schultz, CNE (3) Marketing Report – David Bennett, CMO a) NICU Reunion – Sharon Davies, Director of Women's & Children's Services and Nancy Myers, Manager, NICU	1 hour	Chair
13	Report from TCHD Foundation	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Acting Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Consideration to accept the FY2016 Financial Statement Audit	10 min.	Moss Adams
	b. Consideration of Resolution Authorizing the District to submit HUD Application	5 min.	Chair/CEO
	c. Consideration to approve the Physician Recruitment Agreement with Dr. Anton M. Kushnaryov, and North County Ear, Nose, Throat and Head & Neck Surgery	10 min.	J. Raimo/Sr. Director
17	Old Business a. Report from Ad Hoc Committee on electronic Board Portal	5 min.	Ad Hoc. Comm.

	Agenda Item	Time Allotted	Requestor
18	Chief of Staff a. Consideration of September 2016 Credentialing Actions and Reappointments Involving the Medical Staff b. Consideration of October 2016 Time Limited Reappointments	5 min.	Standard
19	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) **Administrative Policies & Procedures**: a. 8610-415 – Dress & Appearance Philosophy b. 8610-424 – Coaching & Counseling for Work Performance Improvement c. 8610-430 – Licensure-Monitoring Licenses, Registrations and Certificates – TCMC d. 8610-437 – Flex/Float to Activity e. 8610-474 – Compensation for Education f. 8610-478 – Authorization to Hire new Employees & Engage Consultants g. 8610-426 – Performance Evaluations h. 8610-485 – Hiring & Employment; Screening Current Employees i. 8610-486 – Hiring & Employment; Pending Charges against Current Employees j. 8610-487 – Hiring & Employment; Conviction /Exclusion/License Revocation of Current Employee k. 8610-488 – Hiring and Employment; Employee Requirements to Report Changes in Certification 2) Approval of 2017 Benefits Plan recommendations **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Sears – 0 *No meeting held in September, 2016* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 0 (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 Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) Approval of Drs. Daniel L. Gramins, Eugene Golts, Steven Howe, Michael Madani, Anthony Perricone, Travis Pollema, Gert Pretorius and Patricia Thistlewaite to the currently existing ED On Call Coverage Panel for Cardiothoracic Surgery for a term of 22 months, beginning September 1, 2016 through June 30, 2018. 2) Approval of Dr. Aaron Boonjindasup to the currently existing ED On-Call Coverage Panel for Urology Surgery for a term of 12 months, beginning October 1, 2016 through September 30, 2017. 3) Approval of Dr. Jan Penvose-Yi to the currently existing ED On-Call Coverage panel for OB/GYN for a term of 20 months, beginning November 1, 2016 through June 30, 2018. 4) Approval of an agreement with Siemens Healthcare Diagnostics, Inc. for Blood Gas Instruments and Consumables for a term of five (5) years, beginning October 1, 2016 through September 30, 2021 for a total expected cost for the term of $798,527. 5) Approval of the extension of the Clinical Coverage and Medical Director Agreement between TCHD and North County Oncology Medical Clinic, Inc. for a term of 36 months, beginning October 1, 2017 through September 30, 2020 as follows: Coverage Agreement, full time at $43,333.33 per month; Co-Medical Director Agreement at $6,666.67 per month (not to exceed 34 hours per month) for a total cost for the 36-month term of $1,800,000.00.		FO&P Comm.
	E. Professional Affairs Committee Director Mitchell, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1) **<u>Patient Care Services Policies</u>** a. Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents Procedure b. Chemotherapy Extravasation Procedure c. Chemotherapy Pre-Administration Reqts. and Transportation d. Documentation in the Medical Record Policy e. Influenza Nasopharyngeal Swab Testing Procedure 2) **<u>Administrative Policies & Procedures:</u>** a. Student Clinical Rotation Education 249		PAC

	Agenda Item	Time Allotted	Requestor
	3) **Unit Specific – Infection Control** a. Waste Management IC 101 4) **Neonatal Intensive Care** a. Peripheral Intravenous Infiltrations, Treatment For c. Skin to Skin Contact d. Umbilical Catheters, Insertion, Management, and Discontinuation of 5) **Oncology** a. Chemotherapy Administration Procedure Tracked Changes b. Chemotherapy Administration Procedure Clean Copy 6) **Outpatient Infusion Center** a. Ambulatory Infusion Pump (AIP) Policy b. Chemotherapy Administration Procedure Infusion Center c. Chemotherapy Exposure Spills and Handling of Linens Contaminated with Chemotherapeutic Agents d. Chemotherapy Extravasation e. Chemotherapy Writing and Preparation f. Disposal of Chemotherapy Waste 7) **Pharmacy** a. Chemotherapy Prescribing, Processing and Preparation 7) **Women's and Newborn Services** a. Dinoprostone (Cervidil) b. WNS Admission Registration Policy Tracked Changes		
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 2 (Committee minutes included in Board Agenda packets for informational purposes.) 1) Approval of Board Policy 14-020 – Business Expense Reimbursement; Ethics Training 2) Approval of Committee Charter: a. Professional Affairs Committee 3) Medical Staff Rules & Regulations: a. Department of Pediatrics 4) Medical Staff Privilege Cards: a. OBGYN		Gov. & Leg. Comm.

	Agenda Item	Time Allotted	Requestor
	G. Audit, Compliance & Ethics Committee Director Finnila, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Administrative Policies & Procedures**: a. 8760-573 – Business Courtesies to Physicians and Immediate Family Members b. 8760-576 – Controls and Monitoring of Payments to Physicians or Referral Sources (2) Minutes – Approval of: a) Regular Board of Directors Meeting – August 25, 2016 b) Special Board of Directors Meeting – September 6, 2016 c) Special Board of Directors Meeting – September 19, 2016 (3) Meetings and Conferences - None (4) Dues and Memberships – None		Audit, Comp. & Ethics Comm. Standard Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (August 2016) (d) Reimbursement Disclosure Report – (August, 2016) (e) Seminar/Conference Reports - None	0-5 min.	Standard
22	Legislative Update	5 min.	Standard
23	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
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	3 hours	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		



2016 Audit Results
COMMUNICATION WITH THOSE IN CHARGE OF GOVERNANCE

Tri-City Healthcare District

SEPTEMBER 15, 2016

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

Audit Committee

Tri-City Healthcare District

Dear Audit Committee Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the consolidated financial statements of Tri-City Healthcare District (the "District") for the year ended June 30, 2016.

The accompanying report, which is intended solely for the use of the Audit Committee and management, presents important information regarding the District's consolidated financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other that these specified parties.

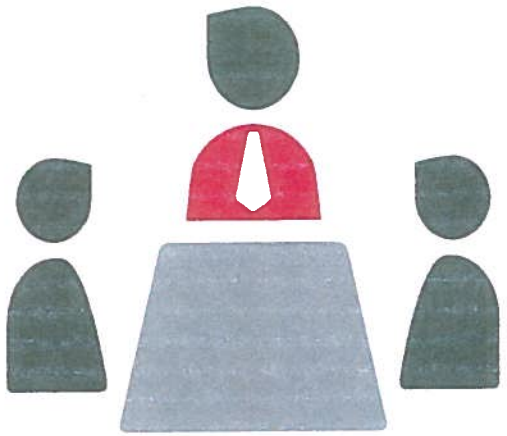
We conducted our audit with the objectivity and independence that you expect. We received the full support and assistance of the District's personnel. We are pleased to serve and be associated with the District as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

MOSS-ADAMS LLP

Agenda

- Auditor Opinion and Report
- Communication with *Those Charged with Governance*
- Other Information



MOSS-ADAMS LLP

Auditor Opinion and Report

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

Scope of Services

We have performed the following services for Tri-City Healthcare District:

- Annual consolidated financial statement audit for the year ended June 30, 2016.

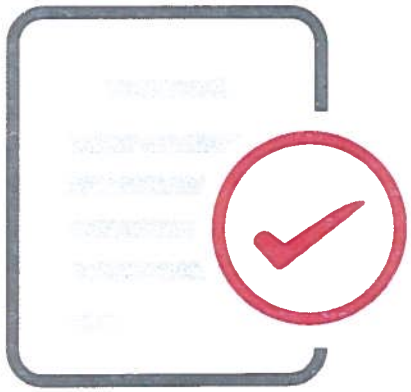
We have also performed the following non-attest services:

- Assisted in the drafting of the consolidated financial statements of Tri-City Healthcare District
- Feasibility study (still ongoing)

Auditor Report on the Financial Statement

Unmodified Opinion

- Consolidated financial statements are presented fairly and in accordance with US GAAP.



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Communication with *Those Charged with Governance*

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Our Responsibility Under US Generally Accepted Auditing Standards and Government Auditing Standards

1 To express our opinion on whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2 To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, Government Auditing Standards issued by the Comptroller General of the United States, and the California (CA) Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for CA Special Districts and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

3 To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4 To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

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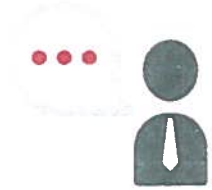
COMMUNICATION WITH GOVERNING BODY

Planned Scope & Timing of the Audit



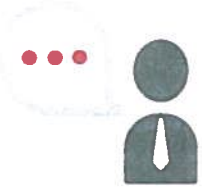
It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing and extent of procedures necessary to obtain sufficient appropriate audit evidence and to communicate with those charged with governance an overview of the planned scope and timing of the audit.

Our Comments

- The planned scope and timing of the audit was communicated to the District's audit committee at the audit entrance meeting and was included in the engagement letter for the year ended June 30, 2016.

COMMUNICATION WITH GOVERNING BODY

Significant Accounting Policies



The auditor should determine that the audit committee is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the audit committee is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Our Comments

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in the Footnotes to the consolidated financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2016.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

COMMUNICATION WITH GOVERNING BODY

Management Judgments & Accounting Estimates

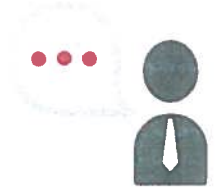
The audit committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

Our Comments

- Management's judgments and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the consolidated financial statements.
- Significant management estimates impacting the consolidated financial statements include the following: Patient accounts receivable allowances; accrual for medical claims; accruals for workers' compensation and medical malpractice liabilities; and accruals for third party settlements.
- We deemed them to be reasonable.

COMMUNICATION WITH GOVERNING BODY

Management Judgments & Accounting Estimates



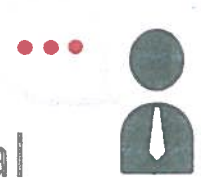
Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures.

Our Comments

- The disclosures in the consolidated financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. We call your attention to the following notes:
  - Note 3 – Patient Service Revenue, Third-Party Reimbursement Programs and Non-Operating Revenue
  - Note 7 – Short-term Debt
  - Note 8 – Long-term Debt
  - Note 13 – Commitments and Contingencies
  - Note 15 – Subsequent Events

COMMUNICATION WITH GOVERNING BODY

Significant Audit Adjustments & Unadjusted Differences Considered by Management To Be Immaterial



The audit committee should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the District's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future consolidated financial statements to be materially misstated.

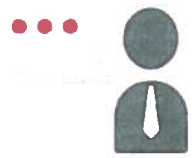
The audit committee should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the consolidated financial statements as a whole.

Our Comments

- There were no corrected or uncorrected audit adjustments.

COMMUNICATION WITH GOVERNING BODY

Deficiencies in Internal Control



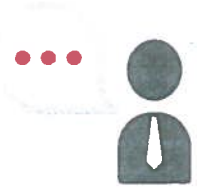
Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the audit committee.

Our Comments

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

COMMUNICATION WITH GOVERNING BODY

Potential Effect on the Consolidated Financial Statements of Any Significant Risks & Exposures



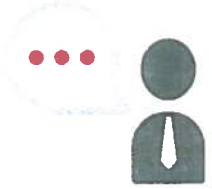
The audit committee should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the financial statements.

Our Comments

- The District is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.
  - Eminent Domain Proceeding - Contingencies related to Eminent Domain matter have been disclosed in the consolidated financial statements as of and for the year ended June 30, 2016.

COMMUNICATION WITH GOVERNING BODY

Difficulties Encountered in Performing the Audit



The audit committee should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the District's consolidated financial statements, or the auditor's report.

Our Comments

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

MOSS-ADAMS LLP

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

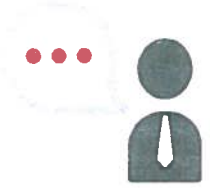
Any doubt regarding the entity's ability to continue, **as a going concern**, should be communicated to the audit committee.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the consolidated financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

Our Comments

- No such matters came to our attention.

- We have not become aware of any instances of fraud or noncompliance with laws and regulations.



COMMUNICATION WITH GOVERNING BODY

Other Material Written Communications

We requested certain representations from management that are included in the management representation letter.

Report to the audit committee significant written communications between the auditor and client management.

Our Comments

- See Exhibit 1 for management representation letter.

- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

COMMUNICATION WITH GOVERNING BODY

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the District's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

Our Comments

- We are not aware of any significant accounting or auditing matters for which management consulted with other accountants.

MOSS-ADAMS LLP

Accounting Update

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

2016 Health Care Conference:
Thought Leadership & Engaged Conversation

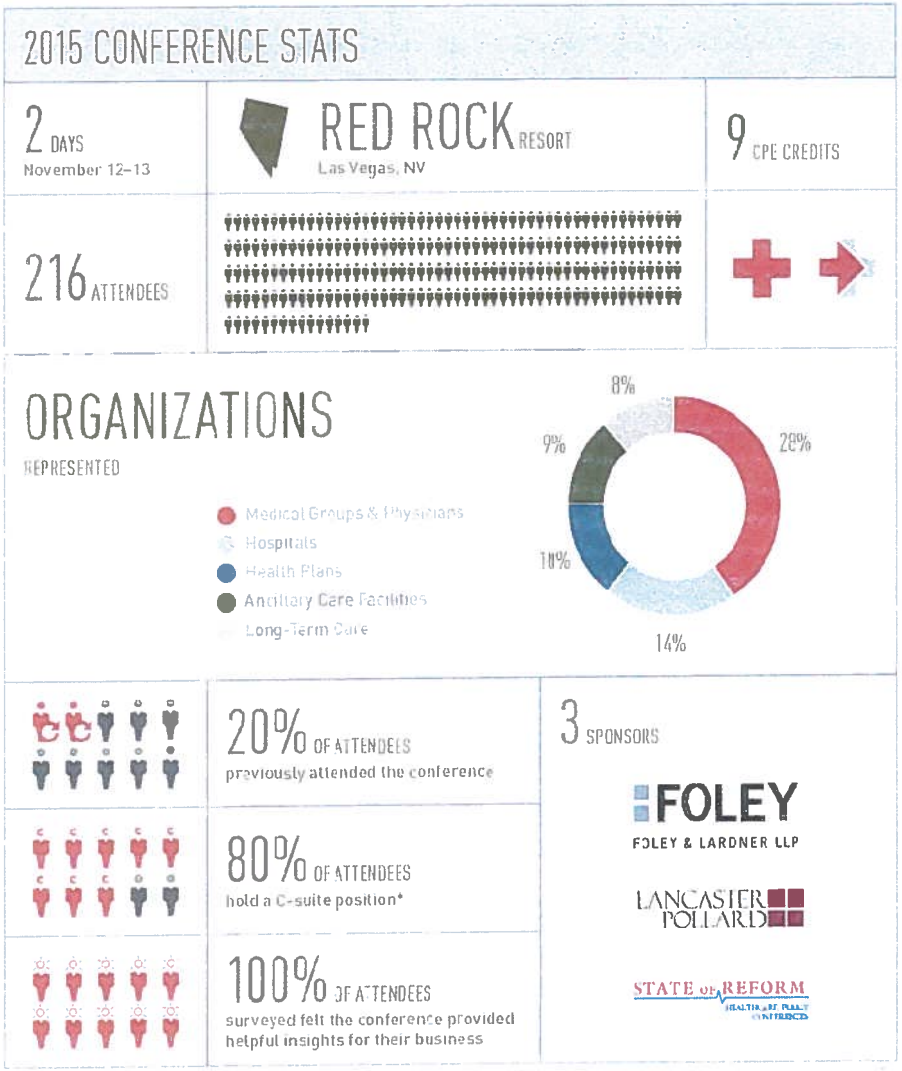
SAVE THE DATE: Nov. 3 & 4, 2016

Red Rock Resort, Spa and Casino | Las Vegas, NV

Moss Adams holds an annual two-day health care conference designed for our clients. The conference brings together C-suite health care professionals and provides a forum to discuss the latest topics that executives are facing – from shifting reimbursement models, population health, to retail health care. This annual platform enables executives to network, share industry best practices, and hear from industry experts.

2016 Keynotes Include:

- The **Honorable Newt Gingrich** & **Senator Joe Lieberman** give their predictions on health care policy following the election.
- **Dr. Lisa Bielamowicz**, Executive Director and Chief Medical Officer at The Advisory Board Company.
- **Roni Zeiger, M.D.**, former Chief Health Strategist at Google and founder of Smart Patient.



MOSS-ADAMS LLP

Keeping You Informed

Keeping you informed about changes in the financial landscape is one of our top priorities. We closely monitor regulatory agencies, participate in industry and technical forums, and write about a wide range of general as well as industry-specific accounting, tax, and business issues. The goal? To provide you with actionable information and guidance to help your organization succeed.

Continuing education is vitally important to us, and we're happy to share our knowledge with you and your staff. We frequently offer a wide range of topical online seminars, many of which are archived and available on demand, allowing you to watch them on your schedule.

Our Services for Healthcare Organizations

ASSURANCE

- Agreed-upon procedures
- Audits and reviews
- Circular Single Audits
- Compliance examinations pursuant to federal reporting requirements.
- Employee benefit plan services
- Written acknowledgments and agreed-upon procedure engagements in connection with tax-exempt bond offerings.

GENERAL CONSULTING

- Fraud investigation and forensic accounting
- IT consulting
- Strategic business planning
- Sustainability services
- Wealth services

HEALTHCARE CONSULTING

- ACOs and integrated delivery models
- 5010 readiness
- ICD-10 road map
- Chargemaster management
- Claims review and processing
- Coding and chart reviews
- Contract review
- Data analytics
- Dependent care audits
- Financial modeling and forecasting
- Hospital feasibility studies
- Litigation support
- Managed care operations
- Practice operation assessments
- Process improvement
- Regulatory compliance
- Reimbursement services
- Revenue cycle assessments
- Revenue recovery and enhancement
- Strategic planning

MOSS-ADAMS LLP

Moss Adams by the Numbers

HEALTH CARE CLIENTS
in the Western United States

Our team of dedicated professionals has served clients across the health care continuum for 38 years.

2,000
hospitals, health systems, independent practices, care centers, and more

200
professionals that focus on the health care sector*

265
partners

4.9
staff-to-partner ratio

84%
staff retention rate

101
years in business

403
million dollars in revenue

largest firm headquartered in the west

Data as of October 2014
*Includes staff accountants serving other additional sectors.

MOSS-ADAMS LLP

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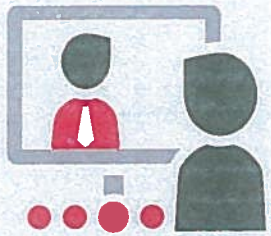

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6.d.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
Physician Recruitment Proposal

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

Physician Name: Anton M. Kushnaryov, MD
Areas of Service: Otolaryngology

Key Terms of Agreement:

Effective Date:	February 1, 2017 or the date Dr. Kushnaryov 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 an Otolaryngologist
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:	None
Sign-on Bonus:	$25,000
Relocation:	$10,000
Total Not to Exceed:	$35,000 Loan Amount

Unique Features:

- Dr. Kushnaryov will join the group practice of North County Ear, Nose, Throat, Head & Neck Surgery, in Vista, CA headed by Dr. Mark Lebovits, a long time Tri-City Otolaryngologist, and Dr. Julie Berry.
- This agreement does not include an income guarantee; however, the amount provided (sign-on bonus and relocation) will be in the form of a loan. The total amount loaned will be forgiven over a two-year period provided Dr. Kushnaryov continues his practice in the service area, observes good business practices and complies with the terms of the agreement.

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	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 $35,000, in order to facilitate this Otolaryngology physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement with North County Ear, Nose, Throat and Head & Neck Surgery and Anton Kushnaryov, MD.

Anton M. Kushnaryov, M.D.
OTOLARYNGOLOGY
5495 Old Redwood Hwy
Santa Rosa, CA 95403
Telephone: (734) 657-5678 Email: antonmkushnaryov@gmail.com

CURRICULUM VITAE

PROFESSIONAL EXPERIENCE

9/2015 - Present — Santa Rosa Head and Neck Surgical Group
1701 4th Street, Suite 120
Santa Rosa, CA 95404

EDUCATION

7/2010 – 6/2015 — Residency in Otolaryngology/Head and Neck Surgery
University of California - San Diego Medical Center

7/2011 - 6/2012 — Research Fellow
Cartilage Tissue Engineering Lab
University of California - San Diego Medical Center

7/2009 - 6/2010 — Internship in General Surgery
University of California - San Diego Medical Center

8/2005 – 6/2009 — Doctor of Medicine
University of Minneapolis Medical School - Twin Cities
Minneapolis, MN
-Clinical rotation in Oto-Rhino-Laryngology
Karolinska Institutet
Stockholm, Sweden 5/2009-6/2009
-Quie-Farbstein Healthcare in Israel Program
Baruch Padeh Medical Center
Poriya, Israel 5/2008

8/2002 – 6/2004 — Post Baccalaureate Medical Studies
University of Wisconsin
Milwaukee, WI

8/1997 – 12/2001 — Bachelor of Science in Art, Concentration in Oil Painting
University of Wisconsin
Madison, WI

LICENSURE AND CERTIFICATION

California State Medical License (active/current)

Controlled Substance Registration Certification (DEA) (active/current)

American Board of Otolaryngology Written Exam passed 9/2015

American Board of Otolaryngology Oral Exam pending 4/2016

MEDICAL STAFF APPOINTMENTS

9/2015 - Present	Santa Rosa Memorial Hospital 1165 Montgomery Drive Santa Rosa, CA 95405	Active
9/2015 - Present	Sutter Medical Center of Santa Rosa 3325 Chanate Road Santa Rosa, CA 95404	Active
9/2015 - Present	Advanced Surgery Institute 1739 Fourth Street Santa Rosa, CA 95404	Active

PROFESSIONAL MEMBERSHIPS

2015 - present	Member, Sonoma County Medical Association
2010 - present	Member, American Academy of Otolaryngology-Head and Neck Surgery
2008 - present	Member, Alpha Omega Alpha
2011 - 2012	Member, California Otolaryngology Society
2006 - 2007	Board Member, Community Advisory Board, Phillips Neighborhood Clinic
2005 - 2009	Member, American Medical Association
2005 - 2006	President, Surgery Interest Group, University of Minnesota Medical School
2003 - 2004	Member, American Medical Student Association
2001	Member, Wisconsin Union Directorate Art Committee

GRANTS, SCHOLARSHIPS & AWARDS

2012	American Academy of Otolaryngology-Head and Neck Surgery Resident Travel Grant
2011, 2012	American Academy of Otolaryngology-Head and Neck Surgery Resident Research CORE Grant
2010 - 2012	Synthes Resident Travel Grant
2012	Stryker Resident Travel Grant
2008	Alpha Omega Alpha
2008	Maimonides Scholarship for Study in Israel
2007	Betty Ford Center Summer Institute for Medical Students Scholarship
2006	Minnesota Medical Foundation Summer Research Grant
2005	Walter and Elva Lovell Scholarship, Minnesota Medical Foundation
1997,2000,2001	Dean's List, UW-Madison
2000	UW-Madison Study Abroad Scholarship

SELECTED WORK EXPERIENCE

2011 - 2012	Examining Physician Compensation and Pension Clinic VA Medical Center, San Diego, CA
2011 - 2012	Physician Family Health Centers of San Diego Logan Heights Clinic, San Diego, CA
2007	Gross Anatomy Teaching Assistant University of Minnesota Medical School Minneapolis, MN
2004	Clinical Research Coordinator VA Medical Center Minneapolis, MN
2003	Laboratory Technologist Medical College of Wisconsin Milwaukee, WI
2001	Art Instructor Ann Arbor Art Center Ann Arbor, MI
2001 - 2002	Assistant to the Registrar Madison Arts Center Madison, WI

COMMUNITY SERVICE

2005 - 2008 2006 - 2007	Student Clinician Community Advisory Board Member Phillips Neighborhood Clinic, Minneapolis, MN
2004	University of Minnesota Anatomy Memorial Service Planning Committee Member University of Minnesota, Minneapolis, MN
2003 - 2004	Volunteer Compassionate Companion Columbia Hospital, Milwaukee, WI
2003 - 2004	Volunteer Reader for the Blind and Disabled Student Accessibility Center, Milwaukee, WI

PUBLICATIONS & PRESENTATIONS

1. Lopez, **A. Kushnaryov**, AM, Weisman, RA. Sudden Enlargement of Facial Mass. Submitted (2016)

2. Miller M, Harris JP. Illustration for Autoimmune Inner Ear Disease. In: Paparella, da Costa, Singh eds. International Textbook of Otolaryngologic Principles and Practice. Jaypee Medical Publishers. 2014.

3. **Kushnaryov AM**, Yamaguchi T, Briggs KK, Wong VW, Reuther MS, Neuman M, Lin, Sah RL, Masuda K, Watson D. "Evaluation of Autogenous Engineered Septal Cartilage Grafts in Rabbits- A Minimally Invasive Preclinical Model" Advances in Otolaryngology, vol. 2014, Article ID 415821, 7 pages, 2014. doi:10.1155/2014/415821

4. Caffrey JP, **Kushnaryov AM**, Reuther MS, Wong VW, Briggs KK, Masuda K, Sah RL, Watson D "Flexural properties of native and tissue-engineered human septal cartilage". Otolaryngol Head Neck Surg. 2013 Apr;148(4):576-81.

5. Singh JA, Mahowald ML, **Kushnaryov A**, Goelz E, Dykstra DJ "Evaluation of Repeated Intra-articular Botulinum Toxin A Injections for Sustained Pain Relief". J Clin Rheumatol. 2009; 15:35–38.

6. "Evaluation of Autogenous Engineered Septal Cartilage Grafts in Rabbits- A Minimally Invasive Preclinical Model" **Kushnaryov AM**, Yamaguchi T, Briggs KK, Wong VW, Reuther MS, Neuman M, Lin, Sah RL, Masuda K, , Watson D. Oral Presentation at the Annual meeting of the American Academy of Otolaryngology – Head and Neck Surgery, Vancouver BC. (2013)

7. "Flexural properties of native and tissue-engineered human septal cartilage" Caffrey JP, **Kushnaryov AM**, Reuther MS, Wong VW, Briggs KK, Masuda K, Sah RL, Watson D. Oral Presentation at the Annual meeting of the American Academy of Otolaryngology – Head and Neck Surgery, Washington D.C. (2012)

8. "Repeat injections of intra-articular botulinum toxin A for the treatment of chronic arthritis joint pain". Singh JA, Mahowald ML, **Kushnaryov A**, Goelz E, Dykstra D. J Clin Rheumatol. 2009 Feb;15(1):35-8. Poster Presentation at the 2007 American College of Physicians Internal Medicine Annual Conference, National Medical Student Research Poster Competition Finalist. Poster presentation at the 6th Annual Alfred E. Michael Students' Research Colloquium at University of Minnesota Medical School (2007)

PROFESSIONAL MEETINGS & COURSES

2/2014	ACS Thyroid and Parathyroid Ultrasound Skills- Oriented Course, Palm Springs, CA
6/2012,2014	UCSD Temporal Bone Course, San Diego, CA
2/2013	AO North America Advance Symposium: Refinements in Facial Trauma and Reconstructive Surgery, Vail, CO
9/2013	Stryker Senior Residents Temporal Bone and Skull Base Hands-on Surgical Workshop, Tampa, FL
9/2012	AO North America Craniomaxillofacial Surgery- Orbital Approaches and Fundamentals with Human Anatomic Specimens, New Orleans, LA
11/2011	8th State of the Arts Concepts in Laryngeal Conservation Surgery Course, Loma Linda, CA
11/2011	9th Annual Western Residents' Advanced Functional Endoscopic Sinus Surgery Course, Loma Linda, CA
10/2011	Stryker Surgical Approaches, Techniques and Fixation in Craniomaxillofacial Trauma Surgery Course, Mawah, NJ
12/2010,2012	AO North America Principles of Operative Treatment of Craniomaxillofacial Trauma and Reconstruction, Los Angeles, CA and San Diego CA
7/2010	Dr. Hugh Greenway's 27th Annual Superficial Anatomy and Cutaneous Surgery Course San Diego, CA

PAINTING EXHIBITIONS

2005 Permanent Collection, University of Minnesota Medical School
2003 Turner Hall Annual, Milwaukee, WI
2002 First Time In Awhile, Ann Arbor, MI
2002 Late., Madison, WI
2001 108 Does Conceptual Art, Madison, WI
1999 Solo Exhibition, Madison, WI
1998 The 69th Annual Student Art Show, Madison, WI

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
September 14, 2016

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 10/01/2016- 9/30/2018)

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 10/01/2016 through 9/30/2018:

- ANAKWENZE, Okechukwu M.D./Orthopedic Surgery (Olympus Orthopedics)
- CURRY, Jason M.D./Physical Medicine & Rehabilitation (Orthopaedic Specialists of North County)
- QUESNELL, Tara D.O./Neurology (North County Neurology Associates)
- RIAD, Shareef M.D./Teleradiology (StatRad)
- SEIDEN, Grant M.D./Orthopedic Surgery (Orthopaedic Specialists of North County)
- SMITH, Christina M.D./Anesthesiology (ASMG)
- WATERS, Michael M.D./Family Medicine (e-Study Site - Oceanside)

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:

- SEIDEN, Grant M.D./Orthopedic Surgery (Orthopaedic Specialists of North County)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
September 14, 2016

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 10/01/2016 -9/30/2018)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 10/01/2016 through 9/30/18, 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:

- ALLEYNE, Neville, MD/Orthopedic Surgery/Active
- BEDROSIAN, Diane H.,, MD/ Pediatrics/Active
- CEPERO, Oscar A., MD/ Anesthesiology/Active
- ELLINI, Ahmad R, MD/ Pediatric Cardiology/Courtesy
- FERBER, Jeffrey M.D./Family Medicine/Consulting
- GUPTA, Anshu K., MD/ Plastic Surgery/Active
- PERRIZO, Nathan A., DO/ Pain Medicine/Active
- ROSENBERG, Jay H MD/Neurology/Active
- ROTUNDA, Sherry L., MD/ Dermatology/Affiliate
- TINIO, Stephen P., MD/ Family Medicine/Active
- WHITNEY, Janet L., DO/ Wound Care/Active
- ZIERING, Robert W., MD/Allergy & Immunology /Consulting
- ZUPANCIC, Michael J., MD/Neurology/Courtesy

RESIGNATIONS: (Effective date9/30/2016 unless otherwise noted)

Voluntary:

- Burzell, Linden J.,MD/Family Medicine/Active
- Gosalia, Nupur K.,, MD/Family Medicine/Active
- Valdivia, Leopoldo E., DO/ Obstetrics & Gynecology/Consulting

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
September 14, 2016

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

ADDITIONAL PRIVILEGE REQUEST

The following practitioners requested the following privileges

- KROENER, John MD — General and Vascular Surgery
- SHOWAH, Henry M.D. — Emergency Medicine
- STERN, Mark S MD — Neurosurgery

VOLUNTARY RELINQUISHMENT OF PRIVILEGES

The following practitioners voluntarily relinquished their privileges.

- Gunta, Sujana S, MD — Pediatrics
- Schmitter, Stephen P, MD — Radiology

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given six 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 9/30/16.

- Olonan, Christopher, MD — Internal Medicine

STAFF STATUS CHANGES

- None at this time

TRI-CITY MEDICAL CENTER
OCTOBER 31, 2016 REAPPOINTMENTS

As there is no Board meeting in October 2016 the Medical Staff is requesting the Board to approve the following time limited reappointments. The files are being brought forward to the Board of Directors on September 29, 2016 ahead of the Credentials Committee meeting on October 12, 2016, approval of a time limited reappointment for these files is being requested for the period of November 1, 2016 – November 11, 2016, these files will be brought back to the Board in November 2016 after the Credentials Committee reviews and makes their final recommendation.

Name	Status	Specialty
Barboza, Richard M., MD	Provisional	Anesthesiology
Bentley, Christian D., MD	Active	Orthopedic Surgery
Bharne, Anjali A., MD	Active	Oncology
Capella, Marina N., MD	Provisional	Pediatrics
Carr, Kenneth W., MD	Active	Cardiology
Chaturvedi, Sanjana, MD	Affiliate	Internal Medicine
Chiang, Pengta A., MD	Active	Emergency Medicine
Clarkson, Chunjai P., MD	Active	Obstetrics & Gynecology
Cooperman, Andrew M., MD	Active	Orthopedic Surgery
Daugherty, David L., MD	Active	Orthopedic Surgery
Davies, James A., MD	Consulting	Ophthalmology
Evans, David G., MD	Active	Nuclear Medicine
Evtimov, Stoimen S., MD	Active	Internal Medicine
Gandhi, Dhruvil P., MD	Active	Colon & Rectal Surgery
Garner, Darin S., MD	Active	Emergency Medicine
Glasser, Judd L., MD	Active	Emergency Medicine
Holmes, Russell C., MD	Active	Family Medicine
Iyengar, Srinivas S., MD	Provisional	Ophthalmology
Jurewitz, William H., MD	Provisional	Obstetrics & Gynecology
Lopez, Sandra, MD	Active	Obstetrics & Gynecology
McCammack, Bradley D., MD	Provisional	Pediatrics
Mehta, Ritvik P., MD	Courtesy	Otolaryngology
Miller, Jeffrey S., MD	Active	Diagnostic Radiology
Park, Christopher W., MD	Associate	Teleradiography
Parker, Sherine B., MD	Active	Pediatrics
Pendleton, Robert B., MD	Active	Ophthalmology
Penvose-Yi, Jan R., MD	Provisional	Obstetrics & Gynecology
Samady, Joseph A., MD	Affiliate	Dermatology
Shapiro, Mark, MD	Consulting	Nephrology
Showah, Henry F., MD	Active	Emergency Medicine
Slater, Madeline L., MD	Provisional	Infectious Disease
Urbanic, James J., MD	Provisional	Radiation Oncology
Vogel, Curt A., MD	Affiliate	Dermatology
Wolff, James D., MD	Associate	Teleradiography
Yoler, Katharine A., MD	Associate	Teleradiography
Zimmermann, Andres, MD	Affiliate	Internal Medicine

TRI-CITY MEDICAL CENTER
OCTOBER 31, 2016 REAPPOINTMENTS

As there is no Board meeting in October 2016 the Medical Staff is requesting the Board to approve the following time limited reappointments. The files are being brought forward to the Board of Directors on September 29, 2016 ahead of the Interdisciplinary Practice Committee meeting on October 17, 2016, approval of a time limited reappointment for these files is being requested for the period of November 1, 2016 – November 11, 2016, these files will be brought back to the Board in November 2016 after the Interdisciplinary Practice Committee reviews and makes their final recommendation.

Name	Status	Specialty
DiCaro, Audra V., PAC	Allied Health Professional	Physician Assistant
Elamparo, Kaye L., NP	Allied Health Professional	Nurse Practitioner
Forbes, Beth, RNFA	Allied Health Professional	Registered Nurse First Assistant
Hermann, Linda, PAC	Allied Health Professional	Physician Assistant
Willett, Brie A., PAC	Allied Health Professional	Physician Assistant

As there is no Board meeting in no October 2016 Board meeting the following resignations are being brought forward to the Board of Directors on September 29, 2016 ahead for approval of Voluntary resignation as requested for these providers effective October 31, 2016.

Name	Status	Specialty	
Camberos, Alfonso, MD	Active	Plastic Surgery	Voluntary resignation effective October 31, 2016 as requested by the provider. **Provider did not wish to reappoint.*
Grauer, Nancy M., MD	Active	Obstetrics & Gynecology	Voluntary resignation effective October 31, 2016 as provider did not return her reappointment application in a timely manner.
Novak, Georganne K., MD	Active	Family Medicine	Voluntary resignation effective October 31, 2016 as requested by the provider. **Provider did not wish to reappoint.*

_____ _____

Gene Ma, MD, Chief of Staff Date

_____ _____

Steve Dietlin, CEO Date

_____ _____

James J. Dagostino, PT, DPT, Chairman of the Board Date

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
September 22, 2016

Voting Members Present:	Chair Cyril Kellett, Director Laura Mitchell, Director Rosemarie Reno, Dr. Hamid Movahedian, Joe Quince, Gwen Sanders, Dr. Martin Nielsen, Dr. Gene Ma, Salvador Pilar
Non-Voting Members Present:	Steve Dietlin, CEO; Sharon Schultz, CNE Kapua Conley, COO; Cheryle Bernard-Shaw, CCO; Norma Braun, CHRO; Esther Beverly, VP of HR
Others Present:	Wayne Knight, CSO; Quinn Abler, Frances Carbajal
Members Absent:	Virginia Carson

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of September 22, 2016. Director Reno moved and Doctor Nielsen seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.	No public comments.	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the August 9, 2016 meeting. Director Mitchell moved and Director Reno seconded the motion. The motion was carried unanimously with date of next meeting correction from July to August.		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
5. Old Business	None		
6. New Business			
a. Review Employee Benefits	Norma Braun, CHRO presented current 2016 benefits and proposed 2017 benefits comparison in detail. Proposal to increase office visit/ED copays was presented. Wayne Knight, CSO explained current comparable market rates and outcomes- TCHD will continue to be on the lower side of copayment fees. The committee reviewed and discussed favorable outcomes.	Chair Kellett called for a motion to approve the proposed benefit changes. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.	Norma Braun
b. Policy Discussion/Action Policy 8610-415 Dress and Appearance Philosophy	The Committee reviewed Policy 8610-415. Chair Kellett called for a motion to send Policy 8610-415 with renewal date to the Board of Directors for approval as is. Director Mitchell moved and Doctor Nielsen seconded the motion. The motion was carried unanimously.	Policy 8610-415 to be sent to Board of Directors for approval.	Norma Braun
Policy 8610-424 Coaching & Counseling for Work Performance Improvement	The Committee reviewed Policy 8610-424. Chair Kellett called for a motion to send Policy 8610-424 with renewal date to the Board of Directors for approval as is. Director Mitchell moved and Doctor Nielsen seconded the motion. The motion was carried unanimously.	Policy 8610-424 to be sent to Board of Directors for approval.	
Policy 8610-430 Licensure- Monitoring Licenses, Registrations and Certificates- TCMC	The Committee reviewed Policy 8610-430. Chair Kellett called for a motion to send Policy 8610-430 with renewal date to the Board of Directors for approval as is. Director Mitchell moved and Doctor Nielsen seconded the motion. The motion was carried unanimously.	Policy 8610-430 to be sent to Board of Directors for approval.	
Policy 8610-437 Flex/Float to Activity	The Committee reviewed Policy 8610-437. Chair Kellett called for a motion to send Policy 8610-437 with renewal date to the Board of Directors for approval as is. Director Mitchell moved and Doctor Nielsen seconded the motion. The motion was	Policy 8610-437 to be sent to Board of Directors for approval.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
	carried unanimously.		
Policy 8610-474 Compensation for Education	The Committee reviewed Policy 8610-474. Chair Kellett called for a motion to send Policy 8610-474 with renewal date to the Board of Directors for approval as is. Director Mitchell moved and Doctor Nielsen seconded the motion. The motion was carried unanimously.	Policy 8610-474 to be sent to Board of Directors for approval.	
Policy 8610-478 Authorization to Hire New Employees & Engage Consultants	The Committee reviewed Policy 8610-478. Chair Kellett called for a motion to send Policy 8610-478 with renewal date to the Board of Directors for approval as is. Director Mitchell moved and Doctor Nielsen seconded the motion. The motion was carried unanimously.	Policy 8610-478 to be sent to Board of Directors for approval.	
Policy 8610-426 Performance Evaluations	The Committee reviewed Policy 8610-426. Chair Kellett called for a motion to send Policy 8610-426 with additions and revisions from the previous Compliance policies to the Board of Directors for approval as is. Director Mitchell moved and Gwen Sanders seconded the motion. The motion was carried unanimously.	Revised Policy 8610-426 to be sent to Board of Directors for approval.	
Policy 8610-485 Hiring & Employment; Screening Current Employees	The Committee reviewed Policy 8610-485. Chair Kellett called for a motion to send Policy 8610-485 with additions and revisions from the previous Compliance policies to the Board of Directors for approval as is. Director Mitchell moved and Gwen Sanders seconded the motion. The motion was carried unanimously.	Revised Policy 8610-485 to be sent to Board of Directors for approval.	
Policy 8610-486 Hiring & Employment; Pending Charges Against Current Employees	The Committee reviewed Policy 8610-486. Chair Kellett called for a motion to send Policy 8610-486 with additions and revisions from the previous Compliance policies to the Board of Directors for approval as is. Director Mitchell moved and Gwen Sanders seconded the motion. The motion was	Revised Policy 8610-486 to be sent to Board of Directors for approval.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
Policy 8610-487 Hiring & Employment; Conviction/Exclusion/License Revocation of Current Employees	carried unanimously. The Committee reviewed Policy 8610-487. Chair Kellett called for a motion to send Policy 8610-487 with additions and revisions from the previous Compliance policies to the Board of Directors for approval as is. Director Mitchell moved and Gwen Sanders seconded the motion. The motion was carried unanimously.	Revised Policy 8610-487 to be sent to Board of Directors for approval.	
Policy 8610-488 Hiring & Employment; Employee Requirements to Report Changes in Certification	The Committee reviewed Policy 8610-488. Chair Kellett called for a motion to send Policy 8610-488 with additions and revisions from the previous Compliance policies to the Board of Directors for approval as is. Director Mitchell moved and Gwen Sanders seconded the motion. The motion was carried unanimously.	Revised Policy 8610-488 to be sent to Board of Directors for approval.	
c. Work Plan	The work plan was reviewed.		Chair Kellett
d. Committee Communications			Chair Kellett
e. Date of next meeting	**October 11, 2016**		Chair Kellett
f. Adjournment	Chair Kellett adjourned the meeting at 1:15 p.m.		Chair Kellett

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 7/71

SUBJECT: Dress and Appearance Philosophy

REVISION DATE: 5/88; 7/97; 4/00; 3/03; 2/05, 7/05, 12/08, 7/09, 4/10, 9/10

POLICY NUMBER: 8610-415

Human Resources Committee Approval: 09/13
Board of Directors Approval: 09/13

A. POLICY:

1. The Tri-City Healthcare District ("TCHD") is a professional organization, and patients, visitors, vendors, and the general public frequently form their initial impressions of professional credibility based solely on employee appearance. Through this policy, TCHD seeks to ensure that every employee's appearance is in compliance with health and safety regulations, reflects TCHD's commitment to its service excellence initiative, conveys a positive image of the organization, and provides a comfortable environment for patients.
2. Employees shall exercise good judgment in personal dress, appearance and the use of fragrances to present a professional appearance appropriate to their job classifications. Department Directors or their designees shall ensure that employees are dressed appropriately, are groomed, and meet the fragrance control guidelines.
3. This policy is intended to provide standards for dress and appearance and is not meant to address all situations. The Chief Human Resources Officer retains authority to determine whether an individual is meeting the professional appearance standards as set forth in this policy.

B. GUIDELINES:

1. Employee Attire
   a. Employees will be required to wear the designated department uniform or appropriate business attire. Clothing should be clean, neat, without tears, business-like/business casual and of appropriate fit.
   b. The following clothing is unacceptable and therefore prohibited:
      i. Casual attire, including but not limited to, denim, athletic clothing, sweats, shorts, logo T-shirts/tank tops and similar items;
      ii. Revealing, low cut, see-through or tight clothing that presents an unprofessional appearance;
      iii. Pants shorter than calf-length, skirts more than 3 inches above the knee, and midriff-revealing clothing
   c. Undergarments must be worn& chosen appropriately regarding color of the uniform/clothing worn so as not to be visible through the outer clothing.
2. Accessories and Jewelry
   a. Photo identification badges must be worn above the waist line by all employees and the identification information must be visible in accordance with TCHD Policy # 436.
   b. All employees must remove facial, tongue and other piercings during working hours. Employees are limited to displaying two piercings per ear, unless wearing such piercings pose a safety or health risk for the employee or the patients.
   c. All jewelry must be appropriate, not detract from a professional appearance, and not constitute a potential safety hazard for the employee or others due to its characteristics or the manner in which it is worn. Such a determination shall rest in the discretion of the Department Director or Chief Human Resources Officer.
   d. Pursuant to Center for Disease Control (CDC) guidelines, TCHD employees who deliver

direct patient care cannot wear artificial fingernails or nail jewelry. Nails must be less than one fourth inch in length, clean and trimmed.

3. Shoes
   a. Pursuant to safety requirements and TCHD policy, closed-toe shoes may be required. Open-toe shoes (including sandals) may be worn when approval is obtained from the appropriate Director or Chief Human Resources Officer.
4. Grooming
   a. All employees must maintain a clean, presentable appearance.
   b. All employees should undertake to bathe regularly and to control body odor, including using deodorant or other odor controlling products as necessary.
   c. All employees must cover tattoos when possible, including wearing long sleeves, turtlenecks or opaque hose.
   d. Hair, beards, and moustaches must be trimmed, groomed and clean.
5. Hats/Head Coverings
   a. Personal hats and other personal head coverings are deemed not to be acceptable attire for TCHD employees.
   b. Unless approved by management, only hats or head coverings that are a part of a TCHD approved employee uniform, or that are worn for health or safety reasons may be worn during working hours.
   c. Management may approve head garb worn for religious reasons, so long as patient and/or employee safety is not compromised by the wearing of such head garb.
6. Fragrances
   a. When used, fragrances shall be applied in moderation. For purposes of this section, fragrances shall include any products that produce a scent strong enough to be perceived by others.

C. **GENERAL:**

1. Employees who are inappropriately dressed may be sent home and directed to return to work promptly, once suitably attired. Such employees will not be paid for this time. Disciplinary action, pursuant to Policy #424 will be taken with repeated violations of this policy.
2. TCHD-supplied uniforms or scrub attire for use in designated areas (Operating Room, Angiography Lab, Lift Team, etc.) are not to be worn for general purposes or as a substitute for personal attire.
3. TCHD employees shall not wear uniforms or scrub attire from other healthcare institutions on TCHD premises.
4. Individual departments may, with the approval of the department Director, establish more specific dress guidelines, which are appropriate to their unit.
5. The Chief Human Resources Officer or designee may grant exceptions to this policy for Special Hospital Initiatives or upon request as required by law to accommodate an employee's protected status.

6. This policy shall be provided to all new hires for review prior to the completion of the hiring process.7. TCHD will comply with all applicable laws relating to religious dress and grooming practices, including California Government Code sections 12926 and 12940.

ISSUE DATE:	**9/82**	**SUBJECT:**	**Coaching and Counseling for Work Performance**
REVISION DATE:	**9/90; 11/94; 12/00; 10/01; 3/03; 7/05, 2/09, 2/11; 09/13**	**POLICY NUMBER:**	**8610-424**
Human Resources Committee Approval:		**09/13**	
Board of Directors Approval:		**09/13**	

A. **PURPOSE:**

1. To provide supervisors with guidelines for implementing disciplinary and non-disciplinary procedures and to facilitate discussions with employees regarding work performance and/or work-related behavior and conduct. The objectives are:
   a. To exchange information
   b. To give and receive feedback
   c. To identify and resolve problems
   d. To explore topics related to successful work performance
   e. To provide opportunities for the employee to modify his/her behavior in order to perform effectively
   f. To ensure that corrective action is taken when and as appropriate

B. **POLICY:**

1. Employee discipline is intended to be corrective in nature with the objective of obtaining compliance with rules, orders, procedures, standards of conduct and competent job performance. Disciplinary action will be commensurate with the facts surrounding the alleged violation(s) and the past record of the employee. When coaching is not effective, then supervisors must engage in more formal counseling which may be disciplinary in nature. Examples of discipline are verbal counseling, written counseling, final written, or termination. Tri-City Healthcare District (TCHD) reserves the right to impose any of these forms of discipline at any time it deems appropriate at its discretion. Employees represented by a CBA must follow the terms and conditions of that agreement.
2. The following are examples of behavior that may warrant disciplinary action, including counseling, up to and including termination.
   a. Criminal conduct, a violation of federal, state or local law that is related to the employee's job duties, employee and patient safety, or impinges on TCHD's reputation, including but not limited to, fraud, theft, misrepresentation, and/or dishonesty including falsification of time records and misrepresenting reasons for any absence from work. Where violations of law are suspected, TCHD reserves the right to report such suspected violations to the appropriate law enforcement agency and the licensing board.
   b. Employees must report any criminal convictions under state or federal law, in writing to the Human Resources Department within five (5) working days of such conviction.
   c. Performing duties in an unsatisfactory or unacceptable manner.
   d. Insubordination, including but not limited to improper conduct toward a supervisor or refusal to perform a task assignment in an appropriate manner.
   e. Failure to treat other TCHD employees, officials, patients, or the public with respect and courtesy in accordance with the TCHD Service Standards, Mission and Values.
   f. Violation of TCHD policies, including but not limited to, TCHD Alcohol and Drug Testing for Employees (AP 429), Harassment policy (AP 403), Workplace Violence (AP 463), or any other TCHD policy.
   g. Failure to comply with all TCHD rules, standards, guidelines, and regulations including all safety regulations.
   h. Disruption of District Business.

i. Misuse and/or unauthorized use of property, including but not limited to, equipment or material owned by TCHD, employees, staff, physicians, patient or guests (AP 609 Disciplinary Action for Breach of Confidentiality, 257 Cellular Phone & Radio Transmission and pay practice 475.12 Meal and Rest Breaks).

j. Any unauthorized disclosure or use of TCHD's records, including but not limited to administrative files, documents, or data bases, patient information files or records, or employee information files or records. (AP 455-Confidentiality and AP 479 Social Media).

k. Possession of weapons while on TCHD property or while conducting TCHD, related business or TCHD sponsored events, including off-site (AP 463 Workplace Violence).

l. Failure to adhere to TCHD's procedure for safeguarding and preventing the waste of controlled drugs or an inappropriate or unauthorized use of TCHD's Pyxis Pharmacy override system (AP 429 Alcohol and Drug Testing of Employees).

m. Disclosure of any information deemed as confidential included but not limited to information received during an investigation, passwords and other secure codes and employee information (AP 455, Confidentiality).

3. TCHD's policy is not a progressive discipline policy. Certain types of unsatisfactory employee performance or misconduct may result in disciplinary action up to and including termination without other informal or formal disciplinary action.

C. **DEFINITIONS:**

1. Coaching:
   a. Informal discussions with employees to identify areas of employees' work performance that do not meet performance expectations and to provide guidance in developing skills, modifying behaviors and addressing undesirable conduct.
2. Counseling:
   a. Formal discussions implemented by supervisors when coaching is not successful at motivating an employee to change his/her work performance or when employee conduct or behavior violates TCHD policy or service standards, presents an immediate danger or threat of danger to other employees or to patients.
   b. Counseling will result in written documentation to the employee's file, and may result in termination of employment. Counseling sessions will be documented on a Work Performance Improvement Form (WPIF).
3. Administrative Leave:
   a. When an employee appears to have been involved in misconduct or performance deficiency, he/she may be placed on Administrative Leave in order to allow TCHD to conduct a comprehensive investigation. Human Resources must be notified when placing an employee on Administrative Leave.
   b. Human Resources will notify Information Technology and Security.
4. Supervisor:
   a. Supervisor refers to any level of leadership from supervisor to Chief level.

D. **COACHING AND COUNSELING PROCESS – WORK PERFORMANCE IMPROVEMENT FORM:**

1. Coaching consists of a documented verbal discussion between the manager or supervisor and the employee. Coaching is informal in nature and should be used when matters do not require formal counseling of an employee's performance. If coaching is unsuccessful in resolving an employee's identified deficiencies or if the nature of the deficiency warrants more than informal action, then supervisors should engage in the counseling process.
2. Counseling consists of a meeting involving the supervisor and employee to discuss deficiencies in the employee's conduct and/or performance expectations. Counseling should be documented on the WPIF and should include the following:
   a. A written description of the incident/event/deficiency including observable behaviors and comments as well as the date, time, place and the policy/policies violated or conduct to be improved.
   b. A copy of the policy, standard, practice, rule, or regulation that has been violated, if any.
   c. An action plan for improvement.
   d. A concise description of the consequence if the action plan is not followed and/or expectation is not met.
3. The employee will be given the opportunity to write a response to the work performance

improvement action during or after the meeting.

4. The supervisor will sign and date the WPIF.
5. The employee will sign and date the WPIF indicating that the supervisor has reviewed the incident with the employee.
   a. An employee's signature or initial does not signify admission or agreement with the work performance improvement action, but only that he/she has received a copy of the WPIF and has been counseled on the subject matter referenced therein. If an employee refuses to sign or initial the WPIF, the supervisor will state the same on the form to verify that the counseling occurred and that the employee refused to sign the form A completed copy of the WPIF is to be given to the employee at the time of the counseling and the original sent to HR.
6. Administrative Leave:
   a. When an employee appears to have engaged in misconduct or performance deficiency, he or she may be placed on Administrative Leave in order to allow a full and comprehensive investigation.
   b. TCHD employees may be placed on Administrative Leave.
   c. Administrative Leave requires the approval of a Human Resources Representative. Before an employee is placed on administrative leave, the supervisor will review his/her intended course of action with the Human Resources Representative, unless emergency conditions warrant otherwise.
   d. If an employee is on Administrative Leave, his/her badge, hospital keys, and any equipment (computer, pager), as deemed necessary, will be held by the supervisor.
   e. When an employee is placed on Administrative Leave, the Administrative Leave Form shall be completed including the beginning date of the leave.
   f. The supervisor updates the employees' Kronos record with the administrative leave paycode for the scheduled days.
   g. The employee is not allowed on TCHD property, unless for medical treatment, until the conclusion of the investigation.
7. Notice of Intent to Terminate Employment (Involuntary):
   a. Before an employee is terminated, the supervisor will review his/her intended course of action with the Human Resources Representative. In some circumstances the employee may be placed on administrative leave in order to investigate. The supervisor updates the employees' Kronos record with the administrative leave pay code for the scheduled days.
   b. The letter of intent to terminate defines the reason for the termination. This includes a statement of any policy, standard, practice, rule, or regulation that the employee has been found to have violated and a description of the evidence upon which the proposed action is based. The letter will state the effective date of termination. The letter will include information regarding the Fair Treatment/SKELLY Process policies AP 427 or 428, including any of TCHD's policies on which the termination is based. The intent to terminate letter must be reviewed by the Human Resources Representative before sending or giving the letter to the employee.

E. **FORMS REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:**

1. Administrative Leave form

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Human Resources

ISSUE DATE:	8/85	SUBJECT:	Monitoring Licenses, Professional Registrations, and Certificates
REVISION DATE:	9/24/91; 11/94; 10/97; 10/02; 2/03, 2/05; 2/06; 1/08, 4/09, 07/11, 9/13	POLICY NUMBER:	8610-430
Human Resources Committee Approval:		09/13	
Board of Directors Approval:		09/13	

A. PURPOSE:

1. To ensure that all licensed, professional, registered and certified personnel have and maintain their licensure, registrations or certifications and the appropriate documentation of the same is provided to Tri-City Healthcare District (TCHD).

B. APPLICATION OF POLICY:

1. The policy applies to all staff required to be licensed, or who have technical registrations or certifications, whether from a state agency, a state licensing board or from any other source.
2. Primary Source Verification – The Human Resources Department (HRD) must be able to verify licensure/certification/registration directly with the source providing the credential such as the State Licensing Board or agency designated by the State Licensing Board to provide verification. Secondary sources, such as letters, copies of letters, documents or copies of documents will not suffice for verification of licensure.
3. Employees and contractors are required to maintain all licenses required for their position and to provide proper notification as outlined below in the event of the suspension or revocation of a license.
4. Any employee or contractor found to be working with an expired license or required certification will be terminated.
5. Licensed staff employed by TCHD must notify the HRD if they have sanctions in California or any other states in which they are licensed within 5 days. Failure to notify the HRD constitutes grounds for disciplinary action up to and including termination.

C. PROCESS FOR VERIFICATION OF LICENSURE:

1. Initial Verification
   a. The Human Resources (HR) Representative is responsible for verifying the candidate's Primary Source for professional license/certification/registration as applicable prior to the start date.
   b. If HR is unable to verify licensure/certification/registration prior to the first day of employment, the candidate will not be able to commence employment until HRD is able to verify via Primary Source that a candidate's credentials are valid and current. If required pre-employment documents are not submitted timely, thereby delaying the start date, TCHD reserves the right to rescind the offer of employment.
2. Maintaining Current License After Hire
   a. Supervisors are responsible for ensuring that employees do not work without a valid license/certification/registration. Failure of the supervisor to comply with the preceding constitutes grounds for disciplinary action up to and including termination.
   b. All licensed personnel are responsible to maintain a current licensure/certification/registration for their position. Upon renewal, the supervisor will print, date and initial the online licensure/certification/registration and forward the original initialed documents to HR. The supervisor will retain a copy for the department file. Employees are

required to renew his/her license10 calendar days before it expires. If an employee does not renew his/her license in the appropriate timeframe, the employee may be terminated. If this is a 2nd violation of this policy, additional disciplinary action may be taken upon renewal.

c. In the event that any action is taken by any licensing agency or any credentialing body which might result in the accusation, sanction, revocation or suspension of a license/certification/registration then it is the employee's responsibility to notify his/her supervisor immediately following notice of any such activity by credentialing boards. Failure to comply may result in disciplinary action, up to and including termination of employment.

d. The HRD will notify the appropriate Department Supervisors of expiring licenses/certifications/registrations through email and reports.

D. **CONTRACT EMPLOYEES:**

1. Each nursing contract employee (i.e. traveler) will have Primary Source Verification of his/her license maintained in Staffing Resources.
2. The individual Departments and Staffing Resources track travelers or other contract employees in the same manner as all licensed personnel.
3. Registry personnel, utilized on a shift-by-shift basis, will have their license/certification verified by their agency prior to their first shift and this information will be noted on each Registry employees Letter of Competency (LOC). Copies of the LOC are maintained and filed in Staffing Resources for nursing.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 12/87

SUBJECT: Flex/Float To Activity

REVISION DATE: 10/12; 02/13; 09/13

POLICY NUMBER: 8610-437

Human Resources Committee: 09/13
Board of Directors Approval: 09/13

A. INTRODUCTION:

1. The District reserves the unrestricted right to engage in Flex/Float to Activity. No District employee, representative or agent has the authority to limit this right, and any attempt to do so shall be void.

B. PURPOSE:

1. Management is responsible for the daily monitoring activities to ensure adequate staffing. Once it has been determined scheduled staffing levels exceed anticipated activity, this procedure is to be implemented. In interpreting this procedure it should be reinforced that the principal criteria for any flex/float activity will be to retain those personnel necessary to meet the requirements of patient care. All other criteria for a flex/float activity are subject to, and limited by, that overriding consideration.

C. DEFINITIONS

1. Job Classification - The position an employee holds, i.e., secretary, food service worker, registered nurse, etc.
2. Unit Seniority - Employee with the longest length of District service in the specific department/unit.
3. Period of Service - The amount of time an employee spends in a particular job classification department. This date is specific to Reassignment flex-to-activity situation only.
4. Activity - Unique to each department, activity may be defined in areas as census, units, procedures, employees, etc., by which levels of staffing are determined.
5. Alternative Work Assignment - Work available in a department other than an employee's primary work area in which an employee holds credentials and experience.
6. PTO Payment Eligibility Requirement - As defined in the "Paid Time Off Program" (PTO).
7. Flex-to-Activity - The daily review of activities versus scheduled staffing, which may result in Hospital Requested Time Off (HRTO).
8. PTO-Flex Time - Time an employee is normally scheduled to work, which a manager determines, is not necessary due to a decrease in activities.

D. FLEX-TO-ACTIVITY:

1. Management is responsible to ensure the adequate provision of staffing. Once it is determined that planned levels are in excess of anticipated activity, this procedure is to be implemented.
2. Appropriate staffing needs are determined by job classification.
3. Once a job classification has been identified as being over staffed relative to activity, the management must investigate the staffing needs of other areas of the facility for alternative work options appropriate for the employee's skills and knowledge. In determining the priority of offering alternative work, the process below will prevail:
   a. There will be no seniority recognition in alternative work assignments.
   b. An employee accepting appropriate work assignment will be paid at their regular rate of pay.

4. If there is not appropriate alternative work available the following may occur:
   a. The hours the employee voluntarily takes off will be designated as PTO Flex Time (formerly) "Hospital Requested Time Off" on an employee's time record.
   b. Non-Exempt Employees on PTO Flex Time may choose to use PTO, PTO Flex zero pay, or go into the negative (up to 40 hours max). Non-exempt employees who choose to go into the negative must pay back the negative hours balance through future accruals before utilizing any further negative hours.
   c. If exempt employees are required to take a flex day they must use PTO or go into negative PTO.. Exempt employees may not use zero pay unless it is for a full week increment in which they did not do any work during that week.
5. If attempts to reduce extra staff by placing staff in alternate available positions or voluntary PTO Flex Time are not completely successful, then extra staff will be placed on non-voluntary PTO Flex Time based on the following criteria:
   a. The principal criteria for any reduction in force will be to retain those personnel necessary to meet the requirements of patient care. All other criteria for flex to activity is subject to, and limited by, that overriding consideration. The following priority of criteria, therefore, may be altered or modified consistent with that need and requirement or approved department specific criteria.
      i. The following is an example of status priority:
         1. 1st - Temporary, from least senior to most senior
         2. 2nd - Per Diem, from least senior to most senior
         3. 3rd - Benefited, from least senior to most senior
         4. 4th - Employee training period
6. Management will attempt to call employees at least two hours prior to the beginning of their shift to notify them of PTO Flex Time.
7. It is each employee's responsibility to provide his or her supervisor with a telephone number where he/she can be reached. This telephone number will be used to contact the employee when being placed on PTO Flex Time.
8. Employees who report to work after being called not to report within the appropriate time frame are not eligible for report-in pay but may use PTO.

All employees that are a member of a union must follow the terms of the collective bargaining agreement.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 3/04	SUBJECT: Compensation for Education
REVISION DATE: 6/04; 10/05; 01/09; 09/13	POLICY NUMBER: 8610-474
Human Resources Committee Approval:	09/13
Board of Directors Approval:	09/13

A. PURPOSE:

1. To establish a compensation plan to support training and education programs for Tri-City Healthcare District (TCHD) employees.

B. POLICY:

1. TCHD is committed to maintaining a work environment that encourages self-development and learning for all employees. As part of that commitment, TCHD has established a compensation plan to support opportunities for self-development through internal and external training and education programs. The compensation plan encompasses three major types of educational programming in order to accomplish these goals.
2. Mandatory Training and Continuing Education Programs – TCHD requires that each employee continue his/her own education to maintain a high level of job related competence and to ensure compliance with required education/certification. Attendance by employees at lectures, meetings, training programs, required skill certifications (e.g. ACLS, BCLS, PALS, and NRP) and similar activities will be paid as hours worked if the following apply:
   a. Attendance is mandatory.
   b. Management approval is received in advance for the class itself and the time commitment expected.
   c. Skills and knowledge are directly related to essential job functions.
3. Professional/Personal Growth – TCHD encourages employees to pursue professional and personal growth through attendance at workshops, seminars, and conferences. If job-related and management approval is received in advance, TCHD may, at the discretion of the department director, pay related fees and the attendance time as hours worked. If non-job-related, attendance time will not be paid and related fees may be eligible for reimbursement under the programs outlined in 4 below.
4. Tuition Reimbursement Loan Program – This program is established by TCHD to increase the applicant pool for certain critical positions and to provide opportunities for current employee career development. Bachelors, Masters and Doctoral programs are also supported if approved by the Department Director.
   a. All employees who have completed six months of employment may be eligible to receive education reimbursement loans. The employee must be actively employed at TCHD at the time of enrollment in the course of study. The employee will be eligible for loan forgiveness if he/she continues to work for TCHD one year for each year of benefit received. Eligible employees must be enrolled in an accredited program that will lead to licensure or certification in a position that TCHD has identified as requiring special recruitment efforts.
   b. Targeted positions and their specific eligibility requirements, maximum funds, and employment commitment required for loan forgiveness are established by the Vice President of Human Resources, with approval by the Chief Executive Officer, based upon organizational staffing needs and budget considerations.
5. Failure to successfully complete required educational programs may result in an employee's termination of employment in accordance with Policy # 424, Coaching and Counseling for Work Performance Improvement.
6. The Chief Operating Officer, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices, procedures, and budget to support the

administration of this policy will be developed by the Vice President of Human Resources in concert with the Director of Education, and Clinical Informatics.

C. **Compensation for Education:**

1. Compensation for Mandatory Education, Pay Practice 474.01.
2. Compensation for Education Activities Related to Professional/Personal Educational Activities, Pay Practice 474.03.
3. Tuition Reimbursement Loan Program, Pay Practice 474.04.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**07/10**	**SUBJECT: Authorization to Hire New Employees and Engage Consultants.**	
REVISION DATE:	**09/10; 09/13**	**POLICY NUMBER:**	**8610-478**
Human Resources Committee Approval:		**09/13**	
Board of Directors Approval:		**09/13**	

A. **PURPOSE:**

To define the approval process for hiring new employees and engaging consultants at Tri-City Healthcare District (TCHD) and ensure that TCHD complies with all applicable laws and regulations regarding the classification of employees and independent contractors.

B **DEFINITIONS:**

1. A consultant is an independent contractor retained to provide professional or technical services or advice or other consulting services to TCHD.
2. An employee is hired to render services to TCHD on a regular basis, is integrated into the operations of TCHD and works under the direction and control of TCHD.
3. An independent contractor is generally defined by the IRS by using a multi-factor common law test. An independent contractor generally is distinguished from an employee because the contractor retains the right to control the manner and means by which the work is accomplished. While it is impossible to describe every single independent contractor relationship, the IRS may recognize such a relationship where the contractor:
   a. offers services to the public on a consistent basis;
   b. provides specific services defined in a written agreement in return for a specified amount of compensation for a specified result;
   c. performs services in a manner that is not subject to TCHD direction and control as to the methods used to obtain the results;
   d. has the risk of profit or loss from operations;
   e. maintains insurance policies (professional liability, workers' compensation, general liability etc.)
   f. obtains and maintains appropriate business and/or professional licenses;
   g. is not entitled to TCHD employee health and welfare benefits, and is not subject to withholding of employment or other applicable taxes.

C **POLICY AND PROCEDURE:**

1. Employees and independent contractors must be properly classified to ensure that TCHD is in compliance with all applicable state and federal laws, regulations and requirements, including law and regulations regarding the issuance of 1099 forms and W-2 statements, the withholding of income, employment, Medicare, Social Security, state disability and other applicable taxes, and entitlement to TCHD health and welfare benefits.
2. Employee hiring.
   a. No position may be filled, and no position may be created, posted, or advertised until approved by the CEO.
   b. Employee hiring must comply with this Administrative Policy No. 8610-478.
3. Consultants/Independent Contractors.
   a. All proposed consultant and independent contractor engagements must be submitted to the responsible Director, Vice President,, or Chief (COO, CFO, CMO, CHRO, CNE, CCO) and then submitted to the CEO for his/her written approval.
   b. The engagement of a consultant or independent contractor also must comply with the legal and contract review process set forth in Policy Number 8610-278.
   c. It is the engaging manager or director's responsibility to obtain necessary approvals under 3.a. and 3.b. above, monitor the consultants performance and approve all hours worked.
4. No offers of employment are valid unless they emanate from Human Resources.
5. Employees violating this policy are subject to discipline up to and including the termination of employment.

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Human Resources

ISSUE DATE: 07/88 **SUBJECT:** Performance Evaluations

REVISION DATE(S): 10/12 **POLICY NUMBER:** 426

Human Resources Department Approval Date(s): 11/15
Administrative Policy and Procedure Committee Approval Date(s): 09/16
Human Resources Committee Approval Date(s): 11/15
Board of Directors Approval Date(s): 12/15

A. **PURPOSE:**

1. To ensure that all employees receive a periodic performance evaluation and competency assessment.

B. **POLICY:**

1. Department Managers will complete an annual performance evaluation for all employees.
2. All managers must have ongoing communication with the employee to discuss performance relative to specific competencies and manager's expectations.
3. The evaluation tool consists of pre-determined standards against which the employee's performance is measured based on essential functions and behaviors, adherence to the Compliance Program's Code of Conduct and Policies.
4. Employees covered under a recognized bargaining unit will be subject to the terms and conditions of their respective contract.
5. For individuals with clinical responsibility for the assessment, treatment, or care of patients, the job description and annual performance appraisals must address competencies appropriate to ages of the patients served. Employees must also have evidence of satisfactorily completing the minimal annual competency assessment.
6. Non-clinical employees must meet the annual competency assessment based upon the job description and performance appraisal.
7. Strict adherence to this policy is a management performance expectation. Noncompliance will be addressed in accordance with Administrative Human ResourcesPolicy: Coaching and Counseling for Work Performance - 424.

C. DOCUMENTATION:

1. Written performance evaluation reports shall reflect that the factors set forth in Section B. above were considered in evaluating the performance of employees. These reports shall be maintained in each employee's personnel file consistent with the District's document retention policies.

D. **RELATED DOCUMENTS:**

1. Administrative Human Resources Policy: Coaching and Counseling for Work Performance - 424

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
~~Compliance~~Human Resources

This policy is being split into a Compliance policy 539 and a new Human Resources policy 485.

ISSUE DATE: 05/12

SUBJECT: Hiring and Employment; Screening Current Employees/~~Covered Contractors~~

REVISION DATE(S):

POLICY NUMBER: ~~8750-539~~ 485

Human Resources Department Approval Date(s):	05/16
Administrative Policies and Procedures Approval Date(s):	09/16
Human Resources Committee Approval Date(s):	
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

1. ~~Policy 8750-539 provides (1)~~To provide ~~a statement~~guidance of the Tri-City Healthcare District's (TCHD'S) policy regarding screening current employees ~~and Covered Contractors~~.

~~B. DEFINITIONS:~~

~~1. Covered Contractor – an individual or entity that has a contractual relationship with TCHD (other than employment), including:~~

~~a. Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners.~~

~~b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to any federal or state health care program.~~

~~2. GSA EPLS – The General Services Administration's (GSA) Excluded Parties List System.~~

~~3. OIG LEIE – The U.S. Department of Health & Human Services, Office of Inspector General's (OIG) List of Excluded Individuals/Entities.~~

~~C.~~B. **SCREENING CURRENT EMPLOYEES/~~COVERED CONTRACTORS~~:**

1. Periodically, but at least on ~~an annual~~a monthly basis, ~~the District~~TCHD shall screen current employees/~~Covered Contractors~~ against the:
   a. Office of Inspector General List of Excluded Individuals/Entities (OIG LEIE), and
   b. United States General Services Administration Excluded Parties List System (GSA EPLS).
2. Periodically, but at least on an annual basis, the District shall require each employee to certify in writing that the employee:
   a. Has not been charged with or convicted of committing any criminal offense;
   b. Does not have any charges pending for violating any criminal law;
   c. Has not been debarred, excluded or otherwise deemed ineligible for participation in Federal health care programs;
   d. Is not the subject of or otherwise part of any ongoing federal or state investigation; and
   e. Possesses a current professional license, registration, or certification, as applicable, and is in good standing with, and has had no Adverse Action taken by, any and all authorities granting such license, registration or certification, as applicable.
3. In the event that the employee cannot provide the certification set forth in Section II.B above, the employee shall provide complete and accurate information with respect to the matters at issue.
4. In addition, as specified in 8750-542, employees ~~and Covered Contractors~~ are required to report any criminal convictions under state or federal law, in writing to the ~~District~~ Human Resources

Department within five (5) working days of such convictions as per Administrative Human Resource Policy: Coaching and Counseling for Work Performance 424. - ~~any changes relevant to the certification set forth in Section II.B above and/or Section II.F of Policy 8750-538 immediately upon becoming aware of any such change(s).~~

C. RETENTION:

1. Subject to legal constraints, ~~the District~~TCHD shall not knowingly retain any employee ~~or Covered Contractor~~ if the employee~~/Covered Contractor~~:
   a. Has been convicted of a criminal offense that has a bearing on the (a) trustworthiness of the employee~~/Covered Contractor~~, or (b) ability of the employee~~/Covered Contractor~~ to perform relevant job responsibilities; or
   b. Has been convicted of committing a health care fraud-related criminal offense; or
   c. Is currently debarred, excluded or otherwise ineligible for participation in Federal health care programs; or
   d. Does not have a current professional license, registration or certification as applicable, and/or is not in good standing with, and/or has had Adverse Action taken by, the relevant state authorities that grant such license, registration or certification, as applicable.

D. DOCUMENTATION:

1. ~~Tri-City Healthcare District~~TCHD ~~shall document compliance with 8750-539.~~ For employees, ~~such~~ documentation shall be maintained in the employee's personnel file consistent with the ~~District's~~ TCHD's document retention policies. ~~For Covered Contractors, such documentation shall be maintained in the relevant Covered Contractor file consistent with the District's~~ TCHD's ~~document retention policies~~.

E. RELATED DOCUMENT(S):

1. Administrative Policy 8750-542 – Hiring and Employment, Employee~~/Covered Contractor~~ Requirements to Report Changes in Certification
2. Administrative Human Resource Policy: Coaching and Counseling for Work Performance 424

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
~~Compliance~~Human Resources

This policy is being split into a Compliance policy 540 and a new Human Resources policy 486.

ISSUE DATE: 05/12

SUBJECT: Hiring and Employment; Pending Charges against Current Employees~~/Covered Contractors~~

REVISION DATE:

POLICY NUMBER: ~~8750-540~~ 486

Human Resources Department Approval Date(s): 05/16
Administrative Policies and Procedures Approval Date(s): 09/16
Human Resources Committee Approval Date(s):
Board of Directors Approval Date(s): 05/12

A. **PURPOSE:**

1. ~~Policy 8750-540 provides (1)~~To provide ~~a statement~~guidance of ~~the~~ Tri-City Healthcare District's (TCHD's) policy regarding pending charges against its employees ~~or Covered Contractors~~.

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

1. Adverse Action – Adverse action means with respect to a professional license, registration, or certification, any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication. It includes, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, and initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed.

~~Covered Contractor – A Covered Contractor is an individual or entity that has a contractual relationship with TCHD (other than employment), including:~~

~~Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;~~

~~Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to a federal or state health care program.~~

2. Federal health care program – The phrase 'Federal health care program" shall have the same meaning as set forth at 42 U.S.C. 1320a-7b(f) and includes, by way of example, Medicare and Medicaid.

~~B.~~C. **ACTION PENDING RESOLUTION OF CHARGES:**

1. If ~~the District~~TCHD learns that:
   a. A current employee or ~~Covered Contractor~~ has been charged with a criminal offense bearing on trustworthiness, or the ability of the employee~~/Covered Contractor~~ to perform relevant job responsibilities,
   b. A current employee ~~or Covered Contractor~~ has been charged with a criminal offense related to health care fraud,
   c. A federal agency has issued a notice proposing to debar, exclude, or otherwise deem the current employee ~~or Covered Contractor~~ ineligible to participate in any Federal health care program, or;
   d. A state agency or authority has proposed to take an Adverse Action ~~(as defined in 8750-537)~~ against a professional license, certification or registration of a current employee~~, or Covered Contractor~~.

~~1.~~2. Then, pending resolution of the charges:

~~2.~~a. If the employee~~/Covered Contractor~~ is in a position that involves direct responsibility for, or involvement in, patient care or billing any federal, state or private payer, then the employee shall be placed on Administrative Leave ~~and the Covered Contractor shall be removed from that position~~.

~~b.~~ If the employee~~/Covered Contractor~~ is not in a position that involves direct responsibility for or involvement in, patient care or billing any federal, state or private payer, then the employee~~/Covered Contractor~~ shall not be appointed to such a position.

~~C.~~D. DOCUMENTATION:

1. ~~Tri City~~TCHD ~~shall document compliance with 8750-540~~ For employees, ~~such~~ documentation shall be maintained in the employee's personnel file consistent with the ~~District's~~ TCHD's document retention policies. ~~For Covered Contractors, such documentation shall be maintained in the relevant Covered Contractor file consistent with the District's TCHD's document retention policies~~.

~~D.~~E. RELATED DOCUMENTS:

1. 42 U.S. Code § 1320a–7b – Criminal penalties for acts involving Federal health care programs.

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
~~Compliance~~Human Resources

This policy is being split into a Compliance policy 541 and a new Human Resource policy 487.

ISSUE DATE: 05/12

SUBJECT: Hiring and Employment; Conviction/Exclusion/License Revocation of Current Employees~~/Covered Contractors~~

REVISION DATE(S):

POLICY NUMBER: ~~8750-541~~ 487

Human Resources Department Approval Date(s):	05/16
Administrative Policies and Procedures Approval Date(s):	09/16
Human Resources Committee Approval Date(s):	
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

1. ~~Policy 8750-541 provides (1)~~To provide ~~a statement~~guidance of the ~~District's~~ TCHD's policy regarding the criminal conviction, debarment or exclusion of employees ~~or Covered Contractors~~, or ~~the~~ revocation of the professional license, certification or registration of an employee ~~or Covered Contractor~~.

~~B. DEFINITION(S):~~

~~Covered Contractor – A Covered Contractor is an individual or entity that has a contractual relationship with TCHD (other than employment), including:~~

~~Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;~~

~~Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to a federal or state health care program.~~

~~C.~~ B. **ACTION FOLLOWING CONVICTION/PROHIBITION/LICENSE REVOCATION:**

1. If a ~~District~~ TCHD employee ~~or Covered Contractor~~:
   a. Has been convicted of a criminal offense that bears on trustworthiness, or the ability to perform relevant job functions or is related to health care fraud, or
   b. Has been debarred, excluded or otherwise deemed ineligible to participate in Federal health care programs, then, subject to legal constraints, ~~the District~~TCHD shall terminate the employee ~~or the Covered Contractor~~.
2. If a ~~District~~ TCHD employee ~~or Covered Contractor~~ has had his or her professional license, registration, or certification revoked, cancelled or otherwise removed or nullified, then (assuming that such license, registration or certification is needed to fulfill the duties and obligations of the employee ~~or Covered Contractor~~), subject to legal constraints, ~~the District~~TCHD shall terminate the employee ~~or Covered Contractor or suspend such person pending the reinstitution of his/her license, registration or certification~~.

~~D.~~ C. **DOCUMENTATION:**

1. ~~The District~~TCHD ~~shall document compliance with 8750-541~~. For employees, ~~such~~ documentation shall be maintained in the employee's personnel file consistent with the ~~District's~~ TCHD's document retention policies. ~~For Covered Contractors, such documentation shall be maintained in relevant Covered Contractor file consistent with the District's~~TCHD's ~~document retention policies.~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
~~Compliance~~Human Resources

This policy is being split into a Compliance policy 542 and a new Human Resource policy 488.

ISSUE DATE: 5/12

SUBJECT: Hiring and Employment; Employee/~~Covered Contractor~~ Requirements to Report Changes in Certification

REVISION DATE(S):

POLICY NUMBER: ~~8750-542~~ 488

Human Resources Department Approval Date(s):	05/16
Administrative Policies and Procedures Approval Date(s):	09/16
Human Resources Committee Approval Date(s):	
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

1. ~~Policy 8750-542 provides (1)~~To provide ~~a statement~~guidance of ~~the District's~~ Tri-City Healthcare District's policy regarding the requirement that employees~~/Covered Contractors~~ report changes to their last certification regarding criminal acts, Adverse Action, and other events, to ~~the District~~TCHD.

B. **GENERAL POLICY:**

1. ~~District~~ TCHD employees ~~and Covered Contractors~~ are required to report any changes to their most recent certification ~~made~~ per Administrative Policy 485~~8750-538 and/or 8750-539~~ to ~~the District~~ TCHD immediately.

C. **SPECIFIC POLICY:**

1. As provided in Administrative Policies ~~8750-537~~**538, and** -485 through 487 ~~8750-541~~, ~~the District~~TCHD screens prospective employees ~~and Covered Contractors~~ and requires current employees ~~and Covered Contractors~~ to certify to the absence of criminal activity, exclusion, or Adverse Action, etc.
2. In addition, each ~~District~~ TCHD employee~~/Covered Contractor~~ must report any criminal convictions under state or federal law, in writing to the Human Resources Department within five (5) working days of such conviction as per Administrative Human Resource Policy. Coaching and Counseling for Work Performance 424.~~is required to notify the District, through a written communication to his or her supervisor and the Chief Compliance Officer, immediately — but no later than two days — following a change in the information obtained by the District during the most recent screening, and/or the information provided by the employee/Covered Contractor on the most recent certification.~~

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

1. Administrative Policy 8750-538 – Hiring and Employment; Screening for Eligibility of Prospective Employees
2. Administrative Policy **485** – Hiring and Employment; Screening Current Employees
3. Administrative Policy **486** – Hiring and Employment; Pending Charges Against Current Employees
4. Administrative Policy **487** – Hiring and Employment; Conviction/Exclusion/License Revocation of Current Employees
5. Administrative Policy: Coaching and Counseling for Work Performance 424

Employee Fiduciary Subcommittee
(No meeting held in September, 2016)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 15, 2016
Assembly Room 1

MEMBERS PRESENT: CHAC Chair Julie Nygaard, Director Larry Schallock, Dr. Victor Souza MD, Bret Schanzenbach, Carol Brooks, Carol Herrera, Gigi Gleason, Linda Ledesma, Marge Coon, Mary Donovan, Mary Lou Clift, Mary Murphy, Roma Ferriter, Sandy Tucker

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; David Bennett, Chief Marketing Officer; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO; Audrey Lopez, Fernando Sanudo

NON-VOTING MEMBERS ABSENT: N/A

MEMBERS ABSENT: Board of Directors Chairman Jim Dagostino; Barbara Perez, Don Reedy, Dung M. Ngo, Guy Roney, Jack Nelson, Marilou de la Rosa Hruby, Rosemary Eshelman, Ted Owen, Xiomara Arroyo

OTHERS PRESENT: Chris Megison, Solutions for Change; Susan Lawson, Solutions for Change; Gwen Sanders, Celia Garcia-CHAC Coordinator, Susan McDowell-CHAC Coordinator

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The September 15, 2016, Community Healthcare Alliance Committee meeting was called to order at 12:36 pm by Director and CHAC Chair Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Member Sandy Tucker motioned to approve the September 15, 2016 meeting agenda. The motion was seconded by Gigi Gleason and unanimously approved.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 15, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments or 2announcements were made.		
RATIFICATION OF MINUTES	Bret Schanzenbach motioned to approve the July 21, 2016 CHAC meeting minutes. The motion was seconded by Carol Herrera and unanimously approved.		
PRESENTATION: Solutions For Change	Chris Megison, Founder of Solutions for Change, gave a presentation about the program located in N. San Diego County that has successfully addressed the issue of family homelessness by assisting over 750 families and 1,450 children since its inception in 1999. Chris noted the history of how the program began, the success rate of the program, and the recent governmental funding challenges it faces. Two program participants gave personal testimony of their lives before and after graduating from the program and their stories were very compelling. Chis noted that the organization is facing a $600,000.00 loss in government funding due to requested program changes that he felt were incompatible with the structure and goals of the Solutions for Change organization. Instead, the program is hoping to replace all government funding with social enterprise revenue.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 15, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION: Solutions For Change (con't)	Chris noted that the program is centered around Aquaponic farming, workforce development, purchasing and rehabbing depressed properties, transforming blighted neighborhoods and servant driven leadership. The group applauded the organization's efforts on behalf of the communities served.		
CEO UPDATE Steve Dietlin	CEO Steve Dietlin updated the group with the latest TCMC news, noting the following: • The TCMC/UCSD affiliation is finalized and TCMC is moving forward with co-branding efforts • Several MD's have become part of the TCMC team as a result of the affiliation and other recruitment efforts, including a Cardio Thoracic Surgeon and a Neurosurgeon, with others anticipated to follow soon • IORT has been successful since its launch and it expected to grow • The Crisis Stabilization Unit is now open. Steve noted that TCMC welcomes input and community feedback as the program is developed and refined in the weeks to come as we see how the unit is best utilized.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO UPDATE Steve Dietlin (con't)	• Campus redevelopment plans are moving forward with the recent positive HUD financing developments, combined with researching other long-term financing options • The NICU celebration went well with great community participation • The Community Breakfast meetings are scheduled to begin again in October		
COO UPDATE Kapua Conley	COO Kapua Conley referenced the recently received SANDAG award grant and noted that more information will be available at the October meeting.		
CHIEF MARKETING OFFICER UPDATE David Bennett	Chief Marketing Officer David Bennett reported as follows: • The recent NICU reunion was very successful with over 1,000 in attendance. • David confirmed the co-branding efforts underway between TCMC and UCSD • Marketing is currently working on the creation of a commercial featuring Kathleen McCartney, an Ironman winner, who was debilitated with pain until treated by Dr. Neville Alleyne, MD, and is now able to compete again • The affiliation with the American Heart Association is complete and marketing is beginning its promotional efforts in the community		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 15, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CHIEF MARKETING OFFICER UPDATE David Bennett (con't)	• The 2016 Annual Report to the Community is wrapping up and will be mailed to district residents in the very near future.		
POSITION TO BE FILLED	Chair Julie Nygaard noted that the committee is seeking a candidate to fill the vacated Vista Fire Department representative position. Bret Schanzenbach agreed to reach out to Vista Mayor Judy Ritter to see if she can make a recommendation.	Follow up with Mayor Ritter	Bret Schanzenbach
OLD BUSINESS	It was noted that the committee has received many letters of thanks from recipients of grant funds during the 2016 cycle. It was suggested that the letters be copied and brought to a future meeting to be read to the group. Julie Nygaard extended thanks to Gigi Gleason for all her hard work in making the 2016 grant year so successful.		
COMMITTEE SIGN IN SHEET	Chair Julie Nygaard asked that the members of the committee remember to sign in at each meeting so that accurate attendance records can be maintained.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 15, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS	No public comments.		
COMMITTEE COMMUNICATIONS	Carol Herrera announced to the group that the Vista Unified School District just received a grant for $10,000,000.00 from the Steve Jobs Foundation for "innovation in high schools." Vista was selected as one of three California schools to receive a grant from this Foundation. Roma Ferriter announced that NCHS will be putting on their 5K Wellness Expo in October. Fernando Sanudo thanked TCMC for attending the recent "Community Report" event for Mira Costa College. Larry Schallock noted that the Vista Viking Festival will be held on September 24 & 25.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 15, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Next Meeting	The next meeting is scheduled for Thursday, October 20, 2016.		
Adjournment	The September 2016 CHAC Committee meeting was adjourned at 1:38pm.		

DRAFT

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
September 20, 2016

Members Present	Director James Dagostino, Director Cyril Kellett, Dr. Marcus Contardo, Dr. Frank Corona, Kathleen Mendez, Steve Harrington, Wayne Lingenfelter, Tim Keane
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Wayne Knight, Chief Strategy Officer, Cheryle Bernard-Shaw, CCO
Others Present	Director Laura Mitchell, Tom Moore, Jane Dunmeyer, David Bennett, Glen Newhart, Jeremy Raimo, Sharon Schultz, Charlene Carty, Terry Moede, Tara Eagle, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Director Julie Nygaard, Dr, John Kroener, Carlo Marcuzzi

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:32 pm. At the outset of the meeting, Chairman Dagostino announced that Chief Compliance Officer Cheryle Bernard-Shaw is out of town and would be attending the meeting via conference phone.		
2. Approval of Agenda	Director Dagostino announced that the agenda would be amended to reflect the Finance, Operations and Planning Charter would be moved from item 6.h., under the Work Plan, and would now be reflected as an action item, under item 6.g.	**MOTION** **It was moved by Director Kellett, Dr. Corona seconded, and it was unanimously approved to accept the agenda of September 20, 2016.**	

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of August 16, 2016	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Kellett, Dr. Corona seconded, that the minutes of August 16, 2016, are to be approved without any requested modifications.**	
5. Old Business			
6. New Business			
a. Physician Agreement for ED On-Call Coverage • Cardiothoracic Surgery	Kapua Conley explained that this agreement was to add UCSD physicians Dr. Daniel L. Gramins, Dr. Eugene Golts, Dr. Steven Howe, Dr. Michael Madani, Dr. Anthony Perricone, Dr. Travis Pollema, Dr. Gert Pretorius and Dr. Patricia Thistlethwaite to the current ED On-Call panel for Cardiothoracic Surgery. There would be no additional remuneration or expense.	**MOTION** **It was moved by Director Kellett, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Daniel L. Gramins, MD, Eugene Golts, MD, Steven Howe, MD, Michael Madani, MD, Anthony Perricone, MD, Travis Pollema, MD, Gert Pretorius, MD, Patricia Thistlethwaite, MD to the currently existing ED On-Call Coverage Panel for Cardiothoracic Surgery for a term of 22 months, beginning September 1, 2016 and ending June 30, 2018.**	Sherry Miller
b. Physician Agreement for ED On-Call Coverage • Urology Surgery	Kapua Conley conveyed that this agreement was to add Dr. Aaron Boonjindasup to the ED On-Call panel for Urology Surgery. There would be no additional remuneration or expense.	**MOTION** **It was moved by Director Kellett, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Dr. Aaron G.**	Sherry Miller

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Boonjindasup to the currently existing ED On-Call Coverage Panel for Urology Surgery for a term of 12 months, beginning October 1, 2016 and ending September 30, 2017.	
c. Physician Agreement for ED On-Call Coverage • OB-GYN	Kapua Conley detailed that this agreement was to add Dr. Jan Penvose-Yi to the ED On-Call panel for Urology Surgery. There would be no additional remuneration or expense.	**MOTION** **It was moved by Director Kellett, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Dr. Jan R. Penvose-Yi, MD to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 20 months, beginning November 1, 2016 and ending June 30, 2018.**	Sherry Miller
d. Physician Recruitment Proposal • Anton M. Kushnaryov, M.D.	Wayne Knight conveyed that this write-up was for a physician recruitment agreement with Dr. Kushnaryov, who is slated to join the otolaryngology of Drs. Marc Lebovits and Julie Berry. Discussion ensued.	**MOTION** **It was moved by Dr, Kellett, Ms. Mendez seconded, and it was unanimously approved that the 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 $35,000, in order to facilitate this Otolaryngology physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement with North County Ear, Nose, Throat and Head & Neck Surgery and Anton Kushnaryov, MD.**	Jeremy Raimo

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
e. Siemens Healthcare Diagnostics, Inc. Proposal • Replacement Blood Gas Instruments, Consumables & Cerner Interface	Tara Eagle conveyed that this proposal is for replacement of instruments that are nearing the end of their usable life, as well as 5 years of warranty/service on the instruments. Also included are 5 years of consumables as well as the Cerner interfaces, and necessary hardware. Discussion ensued.	**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 Siemens Healthcare Diagnostics, Inc. for Blood Gas Instruments and Consumables for a term of 5 years, beginning October 1, 2016 and ending September 30, 2021 for a total expected cost for the term of $798,527.**	Tara Eagle
f. Clinical Coverage & Medical Director Agreement Extension • North County Oncology Medical Clinic, Inc.	Wayne Knight explained that this agreement was for on-site clinical coverage and medical director services for the Oncology Medical Clinic and Chemotherapy Infusion Center. Significant discussion ensued and it was noted by Jody Root that a revised agreement is to be prepared prior to this item being presented at the Board of Directors meeting.	**MOTION** **It was moved by Dr. Contardo, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors extend the Clinical Coverage and Medical Director Agreement between TCHD and North County Oncology Medical Clinic, Inc. for a term of 36 months, beginning October 1, 2017 and ending September 30, 2020 as follows: Coverage Agreement, full time at $43,333.33 per month; Co-Medical Director Agreement at $6,666.67 a month (not to exceed 34 hours per month), for a total cost for the 36-month term of $1,800,000.**	Wayne Knight
g. Finance, Operations & Planning Charter	This item was tabled.		Chairman

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
h. Financials	Ray Rivas presented the financials ending August 31, 2016 (dollars in thousands) **TCHD – Financial Summary Fiscal Year to Date** Operating Revenue $ 55,899 Operating Expense $ 56,239 EBITDA $ 3,079 EROE $ 499 **TCMC – Key Indicators – FYTD** Avg. Daily Census 185 Adjusted Patient Days 19,511 Surgery Cases 1,102 Deliveries 462 ED Visits 11,271 **TCHD-Financial Summary – Current Month** Operating Revenue $ 28,134 Operating Expense $ 28,345 EBITDA $ 1,496 EROE $ 211 **TCMC – Key Indicators – Current Month** Avg. Daily Census 192 Adjusted Patient Days 10,196 Surgery Cases 557 Deliveries 239 ED Visits 5,544 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R (in millions) $ 43.6 Days in Net A/R 51.0 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable		Ray Rivas

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	• TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay • TCMC Emergency Department Visits		
i. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		Chairman
• Aionex Bed Board / Throughput	Sharon Schultz discussed the Aionex Dashboard report. She explained that there were a few unexpected factors that had negatively impacted the overall results		Sharon Schultz
• Dashboard	No report		Ray Rivas
• Meaningful Use	Terry Moede gave a brief update on Meaningful Use and discussed the handout that was distributed. She conveyed that TCMC is meeting the target objectives for compliance, throughout the organization. It was suggested that for the next update in March 2017, it would be helpful to have both a didactic and clinical updates on Meaningful Use.		Terry Moede
7. Comments by Committee Members		None	Chair

Topic	Discussions, Conclusions/ Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
8. Date of next meeting	October 18, 2016		Chair
9. Community Openings (none)			
10. Adjournment	Meeting adjourned 1:23 pm		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiothoracic Surgery

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

Physician's Names: Daniel L. Gramins, MD, Eugene Golts, MD, Steven Howe, MD, Michael Madani, MD, Anthony Perricone, MD, Travis Pollema, MD, Gert Pretorius, MD, Patricia Thistlethwaite, MD.

Area of Service: Emergency Department On-Call: Cardiothoracic Surgery

Term of Agreement: 22 months, Beginning, September 1, 2016 – Ending, June 30, 2018

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

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Cardiothoracic Surgery
New physicians to existing panel, no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
Cardiac: $375	FY17: 365	$136,875
Thoracic: $375	FY17: 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.

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

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 add Daniel L. Gramins, MD, Eugene Golts, MD, Steven Howe, MD, Michael Madani, MD, Anthony Perricone, MD, Travis Pollema, MD, Gert Pretorius, MD, Patricia Thistlethwaite, MD to the currently existing ED On-Call Coverage Panel for Cardiothoracic Surgery for a term of 22 months, beginning September 1, 2016 and ending June 30, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Urology Surgery

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

Physician's Name: Aaron G. Boonjindasup, MD

Area of Service: Emergency Department On-Call: Urology Surgery

Term of Agreement: 12 months, Beginning, October 1, 2016 – Ending, September 30, 2017

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

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Urology
New physician to existing panel, no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$350	FY17: 365	$127,750

Position Responsibilities:

- Provide 24/7 patient coverage for all Urology 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.

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

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 the TCHD Board of Directors add Dr. Aaron G. Boonjindasup to the currently existing ED On-Call Coverage Panel for Urology Surgery for a term of 12 months, beginning October 1, 2016 and ending September 30, 2017.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

Physician's Name: Jan R. Penvose-Yi, MD

Area of Service: Emergency Department On-Call: OB-GYN

Term of Agreement: 20 months, Beginning, November 1, 2016 - 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: OB/GYN
New physicians to existing panel, no increase in expense

Rate/Day – OB/GYN	Current Panel Days Per Year	Current Panel Annual Cost
Weekday $800	FY17: 253	$202,400
Weekend/holiday $1000	FY17: 112	$112,000
Weekday $800	FY18: 253	$202,400
Weekend/holiday $1000	FY18: 112	$112,000
	Total Term Cost:	**$628,800**

Position Responsibilities:

- Provide 24/7 patient coverage for all OB/GYN 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.

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

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 add Dr. Jan R. Penvose-Yi, MD to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 20 months, beginning November 1, 2016 and ending June 30, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
Siemens Healthcare Diagnostics, Inc. Proposal for
Replacement of Blood Gas Instruments, Consumables, and Cerner Interface

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

Vendor's Name: Siemens Healthcare Diagnostics, Inc.

Areas of Service: Laboratory, NICU, Cath Lab, O.R., PACU, Emergency Department

Term of Agreement: 5 years, Beginning, October 1, 2016 – Ending, September 30, 2021

Maximum Totals:	**Year 1**	**Years 2-5 per Year**	**5 Year Total**
Instrumentation Purchase with 5 years' service included	$100,077		$100,077
Cerner Interface	$30,000		$30,000
Hardware Peripherals for Interface	$5,000		$5,000
Annual Reagent & Consumables Spend *(current expenditure)*	$132,690	$132,690	$663,450
Total Financial Commitment for Project	**$267,767**	**$132,690**	**$798,527**

Description of Services/Supplies:

- The Siemens RapidPoint500 is our instrument of choice for point of care testing of arterial blood gases, electrolytes, and metabolites, such as glucose. This clinical information is vital to quality and timely patient care.
- These replacement instruments are produced by the same manufacturer of our current instruments. Our current instruments are nearing the end of usable life.
- This proposal includes (9) replacement instruments, 5 years of service/warranty on the instruments, 5 years of consumables, Cerner interfaces and necessary hardware. Among the consumables are reagents, quality control and calibration material, and specimen tips for sampling.
- This time-sensitive proposal is predicated on the following conditions: Instrument purchase orders must be received by 9/30/2016, and the instruments delivered no later than 12/31/2016.

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

Person responsible for oversight of agreement: Tara Eagle, Operations Manager, Lab / Kapua Conley, Chief Operating Officer

Motion: I move that Finance, Operations, and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Siemens Healthcare Diagnostics, Inc. for Blood Gas Instruments and Consumables for a term of 5 years, beginning October 1, 2016 and ending September 30, 2021 for a total expected cost for the term of $798,527.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
CLINICAL COVERAGE AND CO-MEDICAL DIRECTOR AGREEMENT with NORTH COUNTY ONCOLOGY MEDICAL CLINIC, INC.

Type of Agreement	X	Medical Directors		Panel	X	Other: Coverage
Status of Agreement	X	New Agreement	X	New Agreement		Same Rates that hospital paid previously

Practice Name: North County Oncology Medical Clinic, Inc.
Area of Service: Oncology Medical Clinic & Chemotherapy Infusion Center
Term of Agreement: 36 months
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Services	Monthly Cost	36-month (Term) Cost
Infusion Center Coverage	$43,333.33	$1,560,000.00
Co-Medical Director	$ 6,666.67	$ 240,000.00
TOTAL	**$50,000.00**	**$1,800,000.00**

Description:

- Clinic Coverage – The on-site presence of a physician is required by CDPH for TCMC to own and operate a chemotherapy infusion service.
- This was vetted in 2016 with HealthCare Appraisers, Inc., and was verified to be at fair market value.
- The Medical Directorship Services will be provided by **multiple physicians**.
- Initial approval from BOD on March 29, 2012. This is a new three-year agreement with no rate increase from 2012 rates.

Board Approved Physician Contract Template:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	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 extend the Clinical Coverage and Medical Director Agreement between TCHD and North County Oncology Medical Clinic, Inc. for a term of 36 months, beginning October 1, 2017 and ending September 30, 2020 as follows: Coverage Agreement, full time at $43,333.33 per month; Co-Medical Director Agreement at $6,666.67 a month (not to exceed 34 hours per month), for a total cost for the 36-month term of $1,800,000.00.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
September 8, 2016

Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Dr. Marcus Contardo, Dr. Gene Ma, 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: Rick Barton and Natalie Mueller, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Kathy Topp, Lisa Mattia, Rowena Okumura, Patricia Guerra and Karren Hertz.

Members Absent: Director Finnila and Dr. Scott Worman.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:05 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Contardo.	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 August 2016.	Director Mitchell called for a motion to approve the minutes from August 11, 2016 meeting.	Minutes ratified. Director Finnila moved and Dr. Contardo seconded the motion to approve the minutes from August 2016.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Chemotherapy Exposure, Spills, and Handling of Linens 2. Chemotherapy Extravasation Procedure 3. Chemotherapy Pre-Administration Reqts. And Transportation 4. Documentation in the Medical Record Policy	There was a clarification made on the chemotherapy waste and red waste materials. Kevin McQueen noted that both type of waste are being handled by a single company for cost-effective purposes. A recommendation was made to move section i to section d as it states that the antidote should be administered prior to attempting to aspirate the residual drug from the IV device. It was noted that the FIN is being generated by the Registration Department. There was also a mention of some CERNER interface glitches that affects Pyxis procedure. Some changes in the list of people who are authorized to document in the medical record:	**ACTION:** The Patient Care Services policies and procedures were approved. Dr. Contardo moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	• Medical doctor should be termed Doctor of Medicine. • The term "licensed" should be removed in Licensed physical/occupational/ speech/ recreational therapists should be removed. • Resident should be specified as Resident Physician.		
5. Influenza Nasopahryngeal Swab Testing Procedure	The swab is being used for this procedure since it is necessary to obtain accurate results for influenza testing.		
Administrative Policies and Procedures			
1. Student Clinical Rotattion Education 249	This policy will ensure consistency for establishing student clinical affliations. Other related information can be also found in the Clinical Affiliation Agreement.	**ACTION:** The Administrative policies and procedures were approved. Director Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Unit Specific Infection Control 1. Waste Management IC 101	Director Finnila commended that the chart on page 35 clearly indicates what type of waste and where it is supposed to go—whether it be red bag, regular bag or sharps container. It was noted that for additional information, staff should refer to the Infection Control manual.	**ACTION:** The Infection Control policies and procedures were approved. Director Schallock moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Neonatal Intensive Care 1. Peripheral Arterial Line Insertion, Maintenance and Removal of	This policy was pulled for further review because we needed to clarify the process for calibrating the transducer.	**ACTION:** Director Schallock moved, Director Finnila seconded and the NICU policies were approved to moved forward for Board approval.	Patricia Guerra
2. Peripheral Intravenous Infiltrations, Treatment For	There was no discussion on this policy.		
3. Skin to Skin Contact	There was a discussion if there is a need to change "patient" into "infant" for the whole policy since this policy specifically caters to infants. After some discussion, it was decided not to make the change.		
4. Umbilical Catheters, Insertion, Management, and Discontinuation of	There was no discussion on this policy.		
Oncology 1. Chemotherapy Administration Procedure	Chemoptherapy administration in the units is done in conjunction with the floor pharmacist. This policy clearly outlines the responsibility of a chemotherapy nurse when administering chemotherapy outside the oncology unit.	**ACTION:** The Oncology procedure was approved. Dr. Contardo moved and Director Schallock seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Outpatient Infusion Center 1. Ambulatory Infusion Pump (AIP) Policy	It was further clarified while the inpatient and outpatient uses different infusion pumps, the quality of care is the same; the patient's best interest is often the deciding factor on	**ACTION:** The Outpatient Infusion Center policies and procedures were approved. Director Schallock moved and Dr.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Chemotherapy Administration Procedure Infusion Center	which type of pump is going to be used.	Contardo seconded the motion to approve the policies moving forward for Board approval.	
3. Chemotherapy Exposure Spills and handling of Linens Contaminated with Chemotherapeutic Agents	This policy is a deletion.		
4. Chemotherpay Extrvasation	This policy is a deletion.		
5. Chemotherapy Writing and Preparation	This policy is a deletion.		
6. Disposal of Chemotherapy Waste	This policy is a deletion.		
Pharmacy 1. Chemotherapy Prescribing, Processing and Preparation	This policy is being moved from the Pharmacy Manual to Patient Care Services.	**ACTION:** The Pharmacy policy was approved. Dr. Ma moved and Director Schallock seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Women's and Newborn Services 1. Dinoprostone (Cervidil) 2. WNS Admission Registration Policy	There was no discussion on this policy. There was a brief discussion on the merge of pre-admit number and medical record number for the Women's and newborn Services Depratment.	**ACTION:** The Women's and Newbon Services policies and procedures were approved. Dr. Contardo moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
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.	Dr. Johnson moved, Director Schallock seconded and it was unanimously approved to go into closed session at 12:50 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:15 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
September 8th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents Procedure	Practice change	Forward to BOD for approval
2. Chemotherapy Extravasation Procedure	3 year review, practice change	Forward to BOD for approval with revisions
3. Chemotherapy Pre Administration and Transportation Procedure	DELETE	Forward to BOD for approval
4. Documentation in the Medical Record Policy	3 year review, practice change	Forward to BOD for approval with revisions
5. Influenza Nasopharyngeal Swab Testing Procedure	3 year review	Forward to BOD for approval
Administrative Policies & Procedures		
1. Student Clinical Rotation Education 249	3 year review, practice change	Forward to BOD for approval with revisions
Unit Specific		
Infection Control		
1. Waste Management IC 101	3 year review, practice change	Forward to BOD for approval
Neonatal Intensive Care (NICU)		
1. Peripheral Arterial Line Insertion, Maintenance and Removal of	2 year review, practice change	Pulled for further review
2. Peripheral Intravenous Infiltrations, Treatment for	DELETE	Forward to BOD for approval
3. Skin to Skin Contact **Tracked Changes** Skin to Skin Contact **Clean Copy**	2 year review, practice change	Forward to BOD for approval
4. Umbilical Catheters, Insertion, Management, and Discontinuation of	DELETE	Forward to BOD for approval
Oncology		
1. Chemotherapy Administration Procedure **Tracked Changes** Chemotherapy Administration Procedure **Clean Copy**	3 year review, practice change	Forward to BOD for approval
Outpatient Infusion Center		
1. Ambulatory Infusion Pump (AIP) Policy	NEW	Forward to BOD for approval
2. Chemotherapy Administration Procedure Infusion Center	DELETE	Forward to BOD for approval
3. Chemotherapy Exposure Spills and Handling of Linens Contaminated with Chemotherapeutic Agents	DELETE	Forward to BOD for approval
4. Chemotherapy Extravasation	DELETE	Forward to BOD for approval
5. Chemotherapy Writing and Preparation	DELETE	Forward to BOD for approval
6. Disposal of Chemotherapy Waste	DELETE	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
September 8th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Pharmacy		
1. Chemotherapy, Prescribing, Processing, and Preparation	3 year review, practice change	Forward to BOD for approval
Women and Newborn Services		
1. Dinoprostone [Cervidil]	3 year review, practice change	Forward to BOD for approval
2. WNS Admission Registration Policy **Tracked Changes** WNS Admission Registration Policy **Clean Copy**	3 year review, practice change	Forward to BOD for approval

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXPOSURE, SPILLS, AND HANDLING OF LINENS CONTAMINATED WITH CHEMOTHERAPEUTIC AGENTS AND BODY FLUIDS, ACCIDENTAL EXPOSURE TO RADIOACTIVE BODY FLUIDS**
Purpose:	To outline staff responsibility and management of chemotherapy spills, radioactive body fluid exposures, and handling of contaminated linens.
Supportive Data:	To prevent staff exposure to chemotherapy and radiopharmaceuticals
Equipment:	Chemotherapy Spill Kit

A. **POLICY:**

1. Many drugs used in the treatment of cancer are considered to be hazardous to health care workers.
   a. The term hazardous refers to drugs/chemicals requiring special handling because of potential health risks.
2. Staff working with chemotherapy drugs and the body fluids of patients that have received chemotherapy shall adhere to this procedure and reference Patient Care Services Disposal of Chemotherapy Waste procedure.
   a. Body fluid includes sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.
3. Do not use chemical inactivators due to the potential for dangerous by-products.
   a. Exception: Sodium thiosulfate is used to inactivate nitrogen mustard.

B. **PROCEDURE FOR SPILL MANAGEMENT:**

1. For chemotherapy spills greater than 400 mL in any department:
   a. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in kit).
   b. Remove personnel and patients from the immediate area.
      i. Immediate area is approximately 20-foot perimeter.
   c. If spill occurs in a patient's room, evacuate patient(s) from the room and close door.
   d. Nursing to contact Environmental Services (EVS) supervisor at 760-644-6973.
      i. EVS to contact EOC Safety Officer regarding the chemotherapy spill at 760-590-0352.
2. For chemotherapy spills less than 400 mL:
   a. Non-Oncology Nursing Units Responsibilities for spills on hard surfaces estimated at less than 400 mL
      i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
      i. Contact EVS Supervisor of the chemotherapy spill 760-644-6973.
   b. EVS Responsibilities for spills on hard surfaces estimated at 400 mL or less:
      i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
      ii. Don personal protective equipment in the following order:
         1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
         2) First pair of chemotherapy gloves
         3) Chemotherapy gown with the cuffs over the first pair of gloves
         4) Second pair of chemotherapy gloves over the cuffs of the gown
         5) Splash goggles or face shield
         6) Protective Shoecovers
      iii. Place spill pillows from spill kit in a "V" position on outer perimeter of spill to prevent spreading of fluid.
      iv. Place one towel from the spill kit over spill to absorb fluid.

Department Review	Clinical Policies & Procedures	Nursing Executive Council Committee	Division of Oncology	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/00, 10/06, 5/09, 2/12, 9/15	4/12, 8/15, **6/16**	4/12, 09/15, **7/16**	4/12, 09/15, **07/16**	09/15, **6/16**	5/12. 10/15, **08/16**	6/12, 11/15, **09/16**	6/12, 12/15

v. Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
vi. Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
vii. Use the DIMENSION 3 procedure of the EVS guidelines to complete the cleaning.
viii. After DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
ix. Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
x. Remove personal protective equipment in the following order.
1) Outer pair of gloves
2) Chemotherapy gown
3) N95 mask
4) Splash goggles or face shield
5) Protective Shoecovers
6) Final pair of gloves
xi. Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
xii. Place sealed bag in the designated chemotherapy waste area on the unit.
xiii. Complete the Hazardous Drug Exposure Report and give to the supervisor of the EVS department.
xiv. The EVS supervisor shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the EOC Officer.

c. Oncology Unit/**Outpatient Infusion Center**/Pharmacy **r**~~R~~esponsibilities for spills on hard surfaces <u>estimated between 200 mL and 400 mL:</u>
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Delegate to a co-worker to contact EVS Supervisor of the chemotherapy spill. and/or EOC Safety Officer regarding the chemotherapy spill. EVS is responsible for spills on the oncology and pharmacy units that is between 200 mL and 400 mL.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
4) 760-590-0352 (EOC Officer)

d. Oncology Unit/**Outpatient Infusion Center**/Pharmacy ~~(~~responsibilities for spills on hard surfaces <u>estimated at less than 200 mL:</u>~~)~~
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Contact or delegate a co-worker to contact Environmental Services (EVS) Supervisor of the chemotherapy spill.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
iii. Don personal protective equipment in the following order:
1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
2) First pair of chemotherapy gloves
3) Chemotherapy gown with the cuffs over the first pair of gloves
4) Second pair of chemotherapy gloves over the cuffs of the gown
5) Splash goggles or face shield
6) Protective Shoecovers

iv. To clean up a spill from a hard surface estimated as less than 200 mL:
1) Place spill pillows in a "V" position on outer perimeter of spill to prevent spreading of fluid.
2) Place one towel from the spill kit over spill to absorb fluid.
3) Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
4) Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
5) EVS must use the DIMENSION 3 procedure of their EVS guidelines to complete the cleaning.
6) After EVS has completed the DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
7) Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
8) Remove personal protective equipment in the following order:
a) Outer pair of gloves
b) Chemotherapy gown
c) N95 mask
d) Splash goggles or face shield
e) Protective Shoecovers
f) Final pair of gloves
9) Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
10) Place sealed bag in the designated chemotherapy waste area on the unit.
11) Complete the Hazardous Drug Exposure Report and give to the clinical manager on the nursing unit.
12) The clinical manager shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the Environment of Care (EOC) Safety Officer.

C. **PROCEDURE -- EXPOSURE AND PREVENTION RELATED TO CHEMOTHERAPY AGENTS AND BODY FLUIDS:**

1. In the event of skin exposure to chemotherapeutic agent; remove any contaminated garment and immediately wash contaminated skin with soap and water.
2. In case of eye exposure, immediately flush the eye with saline solution or water for at least five minutes.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Contact EVS when chemo waste linen bag is 2/3 full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.
5. Place any disposable cytoxic contaminated materials into a sealed, leak proof chemo waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items and/or items that are saturated with body fluids. See Patient Care Services: Disposal of Chemotherapy Waste Procedure.
6. All containers will be clearly labeled citing the hazardous nature of the contents-Chemotherapy.
7. Report any cytotoxic exposures or spills to your supervisor.
8. Report any employee exposure to employee health services and/or emergency department.
a. Fill out Illness/Injury Investigation Report
9. Report any patient exposure to the patient's healthcare provider and per institution policy.

D. **PROCEDURE - PRECAUTIONS WHEN HANDLING BODY FLUIDS OF A PATIENT RECEIVING CHEMOTHERAPY(Precautions need to be taken during and 48 hours after last Chemotherapy Dose):**

1. Wear appropriate personal protective equipment (PPE) which may include the following:
   a. N-95 mask
   b. Double chemotherapy gloves
   c. Chemotherapy gown
   d. Splash goggles or face shield
   e. Protective shoecovers
2. Disposing of body fluid
   a. Dispose of body fluids in the toilet.
   b. DO NOT USE THE TOILET SPRAYER. Rinse containers with a cup of water to prevent splashing
   c. Before flushing toilet, cover open toilet with chux. (New chux to be used with each flush).
   d. Flush toilet twice
   e. Place personal protective equipment and chux in chemotherapy waste bag.
   f. Non-Oncology contact EVS to dispose of chemo waste bag when they become ¾ of the way full.
   g. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Skin care of incontinent adult receiving chemotherapy
   a. Clean patients skin well after voiding or having a bowel movement
   b. Apply protective barrier ointment or cream before diapering
5. All disposable equipment (i.e. foley catheter, bedpan, graduated cylinder, and diapers) used in caring for chemotherapy patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

E. **PROCEDURE - RADIOACTIVE BODY FLUIDS, EXPOSURE RELATED TO:**

1. In the event of exposure from the body fluid, immediately remove any contaminated garment or shoes being careful to avoid contact with substance.
2. Place contaminated articles in red radioactive marked containers in room.
3. Place as much distance from contaminated articles and self as possible.
4. Immediately wash contaminated skin with soap and water.
5. Alert Radiation Safety Officer and manager via in room phone or call light, of radiation exposure.
6. Do not leave room unless cleared by Radiation Safety Officer.
7. Report any employee exposure to employee health department or emergency department.
   a. Fill out appropriate injury form
8. Report any patient exposure to the patient's healthcare provider and per institution policy.

F. **RELATED DOCUMENTS:**

1. PCS Disposal of Chemotherapy Waste Procedure

G. **REFERENCES**

1. ONS Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, 20~~11~~**14**, Fourth Edition
2. Center for Disease Control and Prevention. Occupational Exposure to Antineoplastic Agents and Other Hazardous Drugs. http://www.cdc.gov/niosh/topics/antineoplastic/December 12, 2014

3. Medical Waste Management Act January 2015 California Health and Safety Code Sections 117600 – 118360
4. "Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings." National Institute for Occupational Safety and Health (NIOSH), 2014. http://www//cdc/gov/niosh/docs/2004-165/#c. "Kendall Chemobloc Procedure." Tyco Healthcare. 2006 www.tycohealthcare.com
5. Oncology Nursing Society. Manual for Radiation Oncology Nursing Practice and Education, 4th Edition, 2012. Print

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXTRAVASATION**
Purpose:	To outline the responsibility of the registered nurses in the event of chemotherapy extravasation
Supportive Data:	The Oncology Nursing Society Chemotherapy Biotherapy and Guidelines sets the standard for best practice in the care of oncology patients.
Equipment:	Extravasation Kit

A. **DEFINITIONS:**

1. Extravasation: Passage or escape into tissue of antineoplastic drugs. Tissue slough and necrosis may occur.
   a. Extravasation is a medical emergency. Immediate intervention must occur if extravasation is suspected.
2. Flare Reaction: A local allergic reaction to an agent, manifested by streaking or red blotches along the vein, but without pain.

B. **POSSIBLE SIGNS AND SYMPTOMS OF EXTRAVASATION:**

1. Swelling (most common)
2. Stinging, burning, or pain at the injection site (not always present)
3. **Intravenous (**IV) flow rates that slow or stop
4. Lack of blood return (extravasation can occur with the presence of a blood return)
5. Erythema, inflammation, or blanching at the injection site (not always immediately evident)
6. Induration
7. Vesicle formation ~~or Ulceration (1-2 week's if extravasation is not treated)~~
~~7.~~**8. Ulceration**
9. Necrosis -- Tissue damage may progress for six months after the incident
10. **Sloughing**
~~8.~~**11. Damage to tendons, nerves and joints**

C. **CHEMOTHERAPEUTIC VESICANTS AND IRRITANTS THAT CAN CAUSE TISSUE DAMAGE**

1. **Vesicants**
   a. Alkylating Agents
      i. CISplatin **(only at concentrations ≥0.5 mg/ml)**
      ii. Mechlorethamine Hydrochloride
   b. Antitumor Antibiotic
      i. DOXOrubicin
      ii. DAUNOrubicin
      iii. Mitomycin
      iv. Dactinomycin
      v. Epirubicin ~~(non-formulary)~~
      ~~v.~~**vi. Idarubicin**
   c. Vinca Alkaloid or Micro-tubular Inhibiting Agent
      i. vinCRIStine
      ii. vinBLAStine
      iii. Vindesine (non-formulary)
      iv. Vinorelbine
   d. Topoisomerage II Inhibitor
      i. Mitoxantrone
   e. Miscellaneous
      ~~iv.~~**i. Amsacrine**
   ~~d.~~**f.** Taxane

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/07; 2/10; 1/13, **5/16**	3/07; 2/10;2/13, **6/16**	4/07; 2/10;2/13; **7/16**	**07/16**	**06/16**	4/07;3/10;5/13, **08/16**	4/07; 4/10, 6/13, **09/16**	4/07; 4/10, 06/13

i. PACLItaxel **(irritant with vesicant-like properties)**

2. **Irritants**
   a. Alkylating Agents
      i. CARBOplatin
      ii. Dacarbazine
      iii. Ifosfamide
      iv. Melphalan
      ~~v. Mitoxantrone~~
      ~~vi.~~**v.** OXALIplatin
   b. Nitrosourea
      i. Carmustine
   c. Antitumor Antibiotic
      i. DAUNOrubicin liposomal
      ii. Bleomycin
   d. Epipodophyllotoxin
      i. Etoposide
      ii. Teniposide (non-formulary)

D. **PROCEDURE:**
1. Initial management
   a. Stop administration and IV fluids immediately.
   b. Don two (2) pairs of chemotherapy gloves.
   c. Disconnect the IV tubing from the IV device (central or peripheral IV site). DO NOT REMOVE the **peripheral** IV ~~device~~ or noncoring port needle.
   d. Attempt to aspirate the residual drug from the IV device or port needle by using a 1-3 ml syringe.
   e. **Administer antidote if ordered by physician per the manufacturers recommendations.**
   f. Remove the **peripheral** IV device or port needle
   g. Assess the site of the suspected extravasation and photograph site.
   ~~f.~~**h. Assess symptoms experienced by patient.**
   i. Notify the physician and report the patient's symptoms, amount of extravasation and the extent of the extravasation. **Review Vesicant Extravasation Management Guidelines with physician and obtain orders for treatment.**
      ~~g.~~**i.** For central lines, collaborate with physician regarding **the need to** discontinu~~eation of~~ the central line, need for a radiographic flow study to determine the cause of the extravasation and future plans for IV access.
      ii. ~~The efficacy of extravasation antidotes and treatments is unknown with the exception of dexiazoxane for injection (TOTECT ®) which has 98.2% overall efficiency.~~
   ~~h. If an **antidote** is ordered, administer the antidote per the manufacturer's recommendations.~~
   ~~i.~~**j.** Apply a hot or cold compress per Vesicant Extravasation Management Guidelines. ~~(available on the Intranet under Clinical References)~~
   ~~j.~~**k.** Document the following information in the medical record:
      i. Description of the events that occurred
      ii. Drug
      iii. Dilution
      ~~iv. Description of quality of blood return before/during vesicant administration.~~
      ~~v.~~**iv.** Amount of Drug Infiltrated
      ~~vi.~~**v.** Method of Drug Administration
      ~~vii.~~**vi.** Type of IV device
      ~~viii.~~**vii.** ~~Symptoms reported by patient~~
      ~~ix.~~**viii.** Description of Site

1) Size
2) Color
3) Texture

~~x. Photographs of administration site (see below post-extravasation care)~~
~~xi. Immediate nursing intervention~~
~~xii.~~**I.** Document Physician Notification
~~xiii.~~**i.** ~~Patient teaching and follow up care.~~

2. Post–Extravasation Care
   a. Photograph the initial extravasation site including:
      i. Measuring guide for size or length / width / depth
      ii. Date of photograph
      iii. Patients initials
      iv. Medical record number
      i. Location
   b. ~~Repeat photographs weekly.~~**Photograph every Monday, Wednesday and Friday.**
   c. Instruct the patient to rest and elevate the site for 48 hours and then may resume normal activity.
   d. Give patient written instructions regarding what symptoms they should report immediately, local care of the site, pain management and the plan for follow up. Document all patient education in the Cerner Education All Topics Powerform.
   e. Educate patient to ensure that no medications are given distally to an extravasation injury~~, the need to protect extravasation site from sunlight, monitor the site, report fever, chills, blistering, skin sloughing and worsening of pain.~~.
   ~~f. Notify risk management per Administrative Policy Incident Report – Quality Review Report (QRR).~~

~~E~~. **RELATED DOCUMENTS:**

1. **PCS Procedure: Chemotherapy Administration**
2. **Vesicant Extravasation Management Guidelines**

~~E.~~**F. REFERENCES:**

1. Infusion Nursing Society (January/February 201~~106~~). Infusion Nursing Standards of Practice. Journal of Infusion Nursing, Vol. **3~~429~~**, Number 1S.
2. The Oncology Nursing Society (**2014**). ONS Chemotherapy and Biotherapy (23 ed.), p. 1~~05-110.~~**55-160**
3. **Chu E, DeVita VT, Jr., Copur MS et al. Physicians' Cancer Chemotherapy Drug Manual 2008. Sudbury: Jones and Barlett, 2008**
4. **Dorr RT and Von Hoff DD. Cancer Chemotherapy Handbook. 2 ed. Norwalk: Appleton and Lange; 1994:109-18**
5. **Goolsby TV and Lombardo FA. Extravasation of Chemotherapeutic Agents: Prevention and Treatment. Seminars in Oncology. 2006; 33(1): 139-43**

~~2.~~**6. Clamon GH. The Chemotherapy Source Book. 4th ed. Philadelphia. Lippincott Williams & Wilkins, 2008: 148-51**

~~Attachment A~~

Vesicant Extravasation Management Guidelines

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Alkylating agent • Mechlorethamine hydrochloride (nitrogen mustard, Mustargen®)	Apply ice for 6–12 hours following sodium thiosulfate antidote injection (Lundbeck, 2012).	Antidote: Sodium thiosulfate Mechanism of action: Neutralizes mechlorethamine to form nontoxic thioesters that are excreted in the urine Preparation: Prepare 1/6 molar solution. • If 10% sodium thiosulfate solution: Mix 4 ml with 6 ml sterile water for injection. • If 25% sodium thiosulfate solution: Mix 1.6 ml with 8.4 ml sterile water. Storage: Store at room temperature between 15°C–30°C (59°F–86°F).	Inject 2 ml of the sodium thiosulfate solution for each milligram of mechlorethamine suspected to have extravasated. Inject the solution SC into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain. Instruct the patient with peripheral extravasations to report arm or hand swelling and stiffness.
Anthracenedione • Mitoxantrone (Novantrone®)	Apply ice pack for 15–20 minutes at least four times a day for the first 24 hours.	No known antidotes or treatments	Extravasation typically causes blue discoloration of the infusion site area and may require debridement and skin grafting (EMD Serono, Inc., 2008). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the physician or advanced practice nurse, refer the patient for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Anthracyclines • Daunorubicin (Cerubidine®) • Doxorubicin (Adriamycin®) • Epirubicin (Ellence®) • Idarubicin (Idamycin®)	Apply ice pack (but remove at least 15 minutes prior to dexrazoxane treatment).	Treatment: Dexrazoxane for injection (Totect® Kit, Biocodex, Inc., 2011) Note: Totect is the U.S. Food and Drug Administration (FDA)-approved treatment for anthracycline extravasation, and its manufacturer maintains a patent for use on the product. Although Zinecard® and generic dexrazoxane are neither indicated nor FDA-approved for anthracycline extravasation treatment, their clinical efficacy in treating anthracycline extravasations has been documented in the literature (Arroyo et al., 2010; Conde-Estévez et al., 2010; Langer, 2007, 2008; Uges et al., 2006). Mechanism of action: Unknown Dose: The recommended dose of dexrazoxane is based on the patient's body surface area: • Day 1: 1,000 mg/m² • Day 2: 1,000 mg/m² • Day 3: 500 mg/m² The maximum recommended dose is 2,000 mg on days 1 and 2 and 1,000 mg on day 3. The dose should be reduced 50% in patients with creatinine clearance values < 40 ml/min. Preparation: Each 500 mg vial of dexrazoxane must be mixed with 50 ml diluent. The patient's dose is then added to a 1,000 ml normal saline infusion bag for administration. Storage: Store at room temperature between 15°C–30°C (59°F–86°F).	The first dexrazoxane infusion should be initiated as soon as possible and within 6 hours of the anthracycline extravasation. Dexrazoxane should be infused over 1–2 hours in a large vein in an area other than the extravasation area (e.g., opposite arm). The same arm should be used only when the patient's clinical status (e.g., lymphedema, loss of limb) precludes use of the unaffected arm, and a large vein distal to the extravasation site should be used for dexrazoxane administration. Dimethyl sulfoxide should not be applied to the extravasation area. Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness. Instruct the patient about treatment side effects (e.g., nausea/vomiting, diarrhea, stomatitis, bone marrow suppression, elevated liver enzyme levels, infusion-site burning). Monitor the patient's complete blood count and liver enzyme levels.
Antitumor antibiotics • Mitomycin (Mutamycin®) • Dactinomycin (actinomycin D, Cosmegen®)	Apply ice pack for 15–20 minutes at least four times a day for the first 24 hours.	No known antidotes or treatments	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the physician or advanced practice nurse, refer the patient for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).
Plant alkaloids and microtubule inhibitors • Vinblastine (Velban®) • Vincristine (Oncovin®) • Vinorelbine (Navelbine®)	Apply warm pack for 15–20 minutes at least 4 times per day for the first 24–48 hours. Elevate extremity (peripheral extravasations).	Antidote: Hyaluronidase Mechanism of action: Degrades hyaluronic acid and promotes drug dispersion and absorption Preparation: Available hyaluronidase preparations are • Amphadase™ (bovine, hyaluronidase injection) (Amphastar Pharmaceuticals, 2005): Vial contains 150 units per 1 ml; use 1 ml of solution. Do not dilute. Use solution as provided. Store in refrigerator at 2°C–8°C (36°F–46°F).	Administer 150 units of the hyaluronidase solution as five separate injections, each containing 0.2 ml of hyaluronidase, SC into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain.

Table 11. Vesicant Extravasation Management Guidelines

Drug Classification and Medication Name	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Alkylating agents • Mechlorethamine hydrochloride (nitrogen mustard, Mustargen®)	Apply ice for 6–12 hours following sodium thiosulfate antidote injection (Merck and Co., Inc., 2005).	Antidote: Sodium thiosulfate Mechanism of action: Neutralizes mechlorethamine to form nontoxic thioesters that are excreted in the urine Preparation: Prepare 1/6 molar solution. • If 10% sodium thiosulfate solution: Mix 4 ml with 6 ml sterile water for injection. • If 25% sodium thiosulfate solution: Mix 1.6 ml with 8.4 ml sterile water. Storage: Store at room temperature between 15°–30°C (59°–86°F).	Inject 2 ml of the sodium thiosulfate solution for each milligram of mechlorethamine suspected to have extravasated. Inject the solution subcutaneously into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and ~~worsening~~ pain. ~~Instruct~~ patients with peripheral extravasations to report arm or hand swelling and stiffness.
Anthracyclines • Daunorubicin (Cerubidine®) • Doxorubicin (Adriamycin®) • Epirubicin (Ellence®) • Idarubicin (Idamycin®)	Apply [illegible] minutes prior to Totect® treatment).	U.S. Food and Drug Administration (FDA)-approved treatment for anthracycline extravasation (Topo-Target USA, 2007). Zinecard® and generic dexrazoxane are neither indicated nor FDA-approved for anthracycline extravasation treatment. There are no therapeutic equivalents to Totect (FDA, 2007). Mechanism of action: Unknown Dose: The recommended dose of Totect is based on the patient's body surface area: • Day one: 1,000 mg/m² • Day two: 1,000 mg/m² • Day three: 500 mg/m² The maximum recommended dose is 2,000 mg on days one and two and 1,000 mg on day three. The dose should be reduced 50% in patients with creatinine clearance values < 40 ml/minute. Preparation: Each vial of Totect 500 mg must be mixed with 50 ml diluent. The patient's dose of Totect is then added to a 1,000 ml normal saline infusion bag for administration. Storage: The Totect emergency treatment kit contains 10 vials of Totect 500 mg and 10 vials of 50 ml diluent and is stored at 25°C (77°F).	[illegible] first Totect infusion should be initiated [illegible] soon as possible and within 6 hours of the anthracycline extravasation. Totect should be infused over 1–2 hours in a large vein in an area other than the ~~extravasation area (e.g., opposite arm)~~. The same arm should be used only when the patient's clinical status (e.g., lymphedema, loss of limb) precludes use of the unaffected arm, and a large vein distal to the extravasation site should be used for Totect administration. Dimethyl sulfoxide should not be applied to the extravasation area. Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness. Instruct the patient about Totect treatment side effects (e.g., nausea/vomiting, diarrhea, stomatitis, bone marrow suppression, elevated liver enzyme levels, infusion site burning). Monitor the patient's complete blood count and liver enzyme levels.

(Continued on next page)

DELETE – Refer to Vesicant Extravasation Management Guidelines.

Table 11. Vesicant Extravasation Management Guidelines *(Continued)*

Drug Classification and Medication Name	Immediate Topical Therapy	Antidote or Treatment	Antidote or Treatment Administration, Patient Monitoring, and Follow-Up
Antitumor antibiotics • Mitomycin (Mutamycin®) • Dactinomycin (actinomycin D, Cosmegen®)	Apply ice pack for 15–20 minutes at least four times a day for the first 24 hours.	No known antidotes or treatments	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the physician or advanced practice nurse, refer the patient for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).
Plant alkaloid or microtubular inhibiting agents • Vinblastine (Velban®) • Vincristine (Oncovin®) • Vindesine • Vinorelbine (Navelbine®)	Apply warm pack for 15–20 minutes at least four times per day for the first 24–48 hours. Elevate extremity (peripheral extravasations).	Antidote: Hyaluronidase Mechanism of action: Degrades hyaluronic acid and promotes drug diffusion Preparation: Available hyaluronidase preparations are • Amphadase™ [bovine] (hyaluronidase injection (Amphastar Pharma- • Hydase® (hyaluronidase injection) – Vial contains 150 units per 1 ml. Do not dilute. Use solution as provided. Store in refrigerator at 2°–8°C (36°–46°F). • Hylenex® [recombinant] (hyaluronidase human injection (Baxter Healthcare Corporation, 2006) – Vial contains 150 units per 1 ml. Do not dilute. Use solution as provided. Store in refrigerator at 2°–8°C (36°–46°F). • Vitrase® [ovine] (hyaluronidase injection (ISTA Pharmaceuticals, 2007) – Vial contains 200 units in 2 ml vial. Dilute 0.75 ml of solution with 0.25 ml of 0.9% sodium chloride (final concentration is 150 units per 1 ml). Store in refrigerator at 2°–8°C (36°–46°F).	Administer 1 ml of the hyaluronidase solution as five separate injections, each containing 0.2 ml of hyaluronidase, subcutaneously into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, blister formation, and skin sloughing ...riodically as needed or in accordance ...th institutional policy. ...uct the patient to monitor the ex...vasation site and report fever, chills, ...stering, skin sloughing, and worsen...g pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.
Taxanes • Docetaxel (Taxotere®) • Paclitaxel (Taxol®)	Apply ice pack for 15–20 minutes at least four times a day for the first 24 hours.	No known antidote or treatment. Docetaxel extravasation may cause hyperpigmentation, redness, and tenderness (Sanofi-Aventis, 2007). Paclitaxel is a mild vesicant; extravasation may cause induration, blistering, and rarely tissue necrosis (Bristol-Myers Squibb, 2003; Stanford & Hardwicke, 2003).	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct the patient to monitor the extravasation site and report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.

DELETE – Refer to Vesicant Extravasation Management Guidelines.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEMOTHERAPY, PRE-ADMINISTRATION REC**
~~Purpose:~~	~~To outline the responsibility of pharmacy and nursi chemotherapy and pre-administration requirement~~
~~Supportive Data:~~	~~Oncology Nursing Society's Chemotherapy and Bi Recommendations for Practice 3rd 4th Edition 2014~~
~~Equipment:~~	~~Chemotherapy Spill Kit and a Labeled Chemotherapy transport receptacle~~

DELETE – incorporated into PCS Chemotherapy Prescribing, Processing and Preparation and Patient Care Services Policy Chemotherapy Administration

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

~~1. Pre-Administration Guidelines for Nursing and Pharmacy:~~

~~a. Chemotherapy may only be administered by a Chemotherapy Competent Registered Nurse (RN) **or physician**. A Chemotherapy Competent RN is defined by the following requirements:~~

~~i. Has taken and passed an Oncology Nursing Society approved chemotherapy course.~~

~~ii. Has completed competency validation by a Tri-City **Healthcare District (TCHD)** Medical Center (TCMC) chemotherapy competent nurse on all areas of the TCMC**TCHD**'s Advanced Oncology Chemotherapy Addendum Skills Checklist.~~

~~b. All chemotherapy orders from a physician must be written on the TCMC**TCHD** approved Chemotherapy Pre-Printed Order **(PPO)**(see attachment A)~~

~~i. Chemotherapy orders shall only be scanned to the pharmacy from the nursing units on a TCMC**TCHD** approved Chemotherapy Order Form to the pharmacy.~~

~~ii. All sections of the TCMC**TCHD** approved Chemotherapy Order Form must be completed for the chemotherapy order to be valid.~~

~~iii. Any chemotherapy orders from a physician that has been received verbally or via telephone shall not be recognized as a valid chemotherapy order.~~

~~iv. Only Pharmacists may receive clarification of a chemotherapy order verbally or via the telephone.~~

~~v. Chemotherapy orders received via fax on a TCMC**TCHD** approved Chemotherapy Order Form are acceptable.~~

~~Both the Oncology Unit and Pharmacy need to be aware when chemotherapy orders are received. When one department receives chemotherapy orders, they shall notify the other department of the orders.~~

~~vi. **See Pharmacy Policy: Chemotherapy, Prescribing, Processing and Preparation for exceptions to use of Pre-Printed Order for additional information and exceptions to use of Pre-Printed Order.**~~

~~c. Pharmacy must notify oncology unit as soon as possible when an order for a chemotherapy agent has been received from another nursing unit other than the oncology unit.~~

~~d. All units must notify the oncology unit's Assistant Nurse Manager or designee when a chemotherapy order has been written for a patient on a unit other than the oncology unit. Notification must be done as soon as the order is written and no later than a 12-hour notice so staffing can be adjusted appropriately for patient safety.~~

~~e. All patients at TCMC**TCHD** with orders for antineoplastic agents to be administered while in our care, must have a TCMC**TCHD** approved consent form completed in full prior to the administration of the antineoplastic agent.~~

~~2. Pharmacy and Nursing Responsibilities for Transporting Chemotherapy Agents:~~

~~a. Transport syringes containing chemotherapy with the luer lock end syringe capped and in a sealed container.~~

~~b. All chemotherapy agents shall be placed in a leak-proof; sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" prior to transporting from the pharmacy.~~

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Division of Oncology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/06, 5/09; 11/11,08/15, 5/16	12/11, 09/15, 6/16	12/11, 09/15, 7/16	09/15, 06/16	07/16	1/12, 08/16	02/12, 09/16	02/12

c. The pharmacyist **personnel** or RN transporting any chemotherapy agent shall carry a spill kit at all times in case of a potential chemotherapy spill.
   i. In case of an accidental spill or exposure please see Patient Care Service Procedure, Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids, Accidental Exposure to Radioactive I_{131} Body Fluids, as well as the Patient Care Service Procedure, Disposal of Chemotherapy Waste.

d. The Pharmacist and a Chemotherapy Competent RN shall check all Intramuscular (IM) and Intravenous (IV) chemotherapy orders and agents for accuracy at the time the agent is delivered to the nursing unit.

e. A Pharmacist shall co-sign with the Chemotherapy Competent RN on the Pharmacist/Nurse Chemotherapy Verification Form. Accuracy shall be determined by verifying:
   i. Date/Time of Administration
   ii. Patient Name
   iii. Chemotherapy Agent
   iv. Dose
   v. Diluents /Volume (If applicable)
   vi. Rate of Administration (If applicable)
   vii. Route
   viii. Patient's Height and Weight
   ix. Patient's body surface area (BSA)

3. Transporting patients that are receiving intravenous chemotherapy infusion (Nursing)
   a. Transporting a patient that is receiving intravenous chemotherapy infusion should be avoided if at all possible due to the potential risk of a chemotherapy spill, extravasation at the IV site, and physiological complications associated with chemotherapy administration.
   b. If a patient must be transported to another department the nurse must carry a chemotherapy spill kit at all times. The nurse must ensure that the IV site, IV bag(s) and IV lines that are connected to the chemotherapy and the patient are visible and secure to prevent extravasation and spillage of the chemotherapy agent during transport.
   c. Chemotherapy patients actively receiving IV chemotherapy infusion transported off the nursing unit must be accompanied by a chemotherapy competent RN.

B. ATTACHMENTS:

1. Attachment A: Chemotherapy Pre-Printed Order #8711-3222; available in the Copy Center and on-line at http://etcmc/PP_Orders/

C. REFERENCES

1. National Institute for Occupational Safety & Health (NIOSH). (2004). Preventing occupational exposure to antineoplastic and other hazardous drugs in health care settings. Retrieved (April 1, 2009) from http://www.cdc.gov/niosh/doces/2004-156/#c
2. Oncology Nursing Society (ONS). (2014**1**). Chemotherapy and biotherapy guidelines (4th3rd Ed.).
3. Patient Care Services Medication Administration Policy

DIAGNOSIS/REGIMEN/MNEMONIC: _____

ALLERGIES: _____

CURRENT Height: _____(in)_____(cm) Weight: _____(kg)_____(lbs) BSA _____(M^2) CrCl_____

CHEMOTHERAPY AGENTS

Note: Diluent/Volume/and Rate of Administration per Standard of Practice unless otherwise stated in Chemo Instructions

Start Chemo Date:	Agent	Mg/M^2 dose	Mg dose	Route of Administration	Frequency (continuous, every _ hrs, day 1,3,5, etc.)	Duration (X_days, X_doses)
				☐ Infusion ☐ IVPB ☐ PO ☐ Intraperitoneal (IP)		
				☐ Infusion ☐ IVPB ☐ PO ☐ Intraperitoneal (IP)		
				☐ Infusion ☐ IVPB ☐ PO ☐ Intraperitoneal (IP)		
				☐ Infusion ☐ IVPB ☐ PO ☐ Intraperitoneal (IP)		
				☐ Infusion ☐ IVPB ☐ PO ☐ Intraperitoneal (IP)		
				☐ Infusion ☐ IVPB ☐ PO ☐ Intraperitoneal (IP)		

Chemo instructions or reasons for dose modifications: _____

Pre-medications: _____

Hydration: _____

Anti-emetics: _____

Other Orders: _____

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056
8711-4010

CHEMOTHERAPY ORDERS

Page 1 of 1

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**12/01**	**SUBJECT:**	**DOCUMENTATION IN THE MEDICAL RECORD**
REVISION DATE:	**6/03, 12/03, 2/04, 8/04, 1/05, 2/07, 7/10, 8//12**	**POLICY NUMBER:**	**IX.I**

Department Approval:	**07/16**
Clinical Policies & Procedures Committee Approval:	**~~10/12~~07/16**
Nursing Executive Committee Approval:	**~~10/12~~07/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**08/16**
Professional Affairs Committee Approval:	**~~01/13~~09/16**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**

1. To maintain documented information for each patient that is accurate, timely, legible, readily accessible, and is performed by authorized personnel.
2. To ensure the medical record contains sufficient information to identify the patient, support the diagnosis, plan of care, continuity of care justify treatment and document the course and outcome of treatment.

B. **DEFINITIONS:**

1. Activity View: A set of clinical data elements related to a specific activity that may include required documentation elements.
2. Annotation: Ability to add a comment to documentation.
3. Authentication: Review process of documentation completed by a student or other caregiver requiring review by a licensed staff or instructor.
4. Carry forward functionality: fields which bring forward the last charted data.
5. Clinical Range Bar: Indicates the date range of displayed information.
6. CPOE: Computerized Provider Order Entry.
7. Duplicate Results: Allows clinician **in Iview** to copy and paste data to a different time column for review and signing.
8. Edit Fields: The ability to modify or delete documented fields.
9. ~~HER~~**EHR**: Electronic Health Record
10. Encounter: Each patient visit/admission is assigned a Financial (FIN)/encounter number.
11. Erasing fields: To delete or "unchart" information placed in a current field currently or from a carry forward function.
12. Iview: An interactive view for clinical documentation that allows direct charting.
13. MAR: Medication Administration Record.
14. Patient Access List (PAL)**/Care Compass**: An interactive screen available to the nursing staff to view and perform patient care tasks by selecting icons, which launch a form or screen for completion of the task.
15. PowerForm: Electronic forms with one or many sections. Each section provides data entry options for documenting assessments, procedures, and other patient care events.
16. Task List: An electronic list of tasks or reminders within a specified time frame that may be attached to a form or activity.

C. **POLICY:**

1. Documentation is the primary communication medium. Each practitioner is responsible for accurate documentation of care provided. All entries manual or computerized are permanent.
2. Documentation will be complete and reflect patient specific care, support the medical diagnosis, course of treatment, and Plan of Care.
3. Documentation shall be efficient with minimal to no duplication of charting.
4. Documented patient information must be readily accessible to all ~~care~~ providers **rendering care**.
5. Documentation in the Medical Record shall include key components such as:
   a. The patient's initial admission information, transfer information, and discharge summary, with a full and accurate description of the patient's condition and responses at the time.
   b. Any change in the patient's condition.
   c. A record of communication with physicians, patient or family.
   d. Upon discharge, clear documentation of understanding of all discharge education and instructions to patient/responsible party.
   e. When an unexpected event occurs, complete the following:
      i. Document the facts of occurrence in the Medical Record and completes an incident report/quality review report.
      ii. DO NOT document or reference **that an incident report/quality review report** ~~**Quality Review Report (QRR)**~~ has been completed in the medical record (~~reference~~ **See** Administrative Policy ~~275~~: **Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275).**
6. Documentation in the patient's record shall be complete, factual, accurate, and legible.
   a. When charting on paper, DO NOT pre-date or back date patient information. (See Late Entry into the Medical Record).
      i. In the manual record, document on the next available space.
      ii. Do not skip lines
7. ~~TCMC~~ **Tri-City Healthcare District (TCHD)** care providers shall document in Cerner when online documentation forms/screens/IView bands are available.
   a. Exceptions to the practices are areas using paper flow sheets or other hard chart forms. Refer to unit specific policies and procedures.
   b. Powerforms shall be accessed from the task or ~~Patient Access List (PAL~~ **Care Compass**~~)~~ when available. If not available on the task list or ~~PAL~~**via Care Compass**, access the forms from AdHoc. Some of the Powerforms titles may vary slightly to indicate a patient or area specific document.
   c. All access and documentation in Cerner shall be reflected by the user **identification**~~ID~~.
   d. Each user must define/update an encounter relationship to access a patient's chart.
      I. Some positions are assigned a default relationship.
   e. Users are required to use only their log-on to document in the patient's record.
8. Documentation shall be timed and dated to reflect the actual time events occurred.
   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 patient care and assessment as soon as reasonably able to do so.
   c. Activity Views in IView will be used to help guide required data documentation for key assessments and reassessments.
   d. Reasonable and timely manner may be defined as within 4 hours after completion of assessments or care provided or as defined in unit specific policies and/or procedures.
   e. Discharge documentation must be completed within four hours of discharging the inpatient.
9. Documentation in the patient record shall not include:

a. Issues affecting credibility, including inconsistency in documentation, contradiction or blaming of other practitioners
b. Issues affecting professionalism, including intentional documentation of inadequate care, unprofessional verbal communications among practitioner, judgment or emotional statements about patients or their families, or "sloppy" charting practices in the manual chart (squeezing in" an entry where there is not adequate space, or charting in advance of an intervention or treatment).
c. Issues which imply information or events are being hidden (i.e., obliterating a chart entry (in the manual chart), or failure to document an untoward event, such as a fall or change in vital signs).
~~c.~~**d. Duplication of results in IView.**

10. Late entry into the ~~l~~Medical Record (~~Reference~~**See**: **Patient Care Services (**PCS**)** ~~p~~**P**rocedure**:** "~~-~~Medical Record, Making Corrections in Documentation~~"~~)
    a. When a pertinent entry is missed or not written/entered into the EHR in a timely manner, a late entry shall be documented in the Medical Record.
11. If an entry is made for another practitioner (by proxy), the entry must include the original practitioner's name and reason for proxy entry.
    a. Name of person making revision, date and time of entry and practitioner's (proxy's) unique log-on will be tracked by the system.
12. Refer to departmental specific documentation procedures for unit or departmental documentation requirements.
13. Refer to PCS **Policy:** ~~policy~~ Cerner Downtime ~~Policy~~ for specific downtime documentation requirements.
14. Authenticating documentation is a process for authenticating the person, identified by name and relationship (discipline), who is responsible for ordering, providing or evaluating a clinical service rendered to a patient.
    a. The ~~TCMC~~ **TCHD** health care provider shall authenticate information entered into a powernote, powerform, IView or clinical note by students.
15. The following are authorized to document in the Medical Record:
    a. Advanced Care Technician~~s~~ (ACT)
    b. Audiologist
    c. Behavioral Health Liaison~~s~~ (BHL)
    d. Case Managers
    e. Certified Nurse Midwife (CNM)
    f. Chaplain
    g. Clinical Nurse Specialist~~s~~ (CNS)
    h. Dentist~~s~~
    i. Department Specific Technologist (i.e., Cath Lab, Cardiology, Radiology, etc.)
    j. Dietician~~s~~
    k. Doctor of Osteopathic Medicine (DO)
    l. Dosimetrist
    m. ~~Emergency~~ Technician~~s~~ ~~(ET)~~
    ~~n. Graduate Licensed Vocational Nurse (IPLVN)~~
    ~~o. Graduate Registered Nurse (IPRN)~~
    ~~p.~~**n.** Interpreter~~s~~
    ~~q.~~**o.** Lactation Consultant~~s~~
    ~~r.~~**p.** Licensed Vocational Nurse (LVN)
    ~~s.~~**q.** Marriage Family Therapist (MFT)
    ~~t.~~**r.** Marriage Family Therapist Intern
    s. Medical Assistant
    ~~u.~~**t. Doctor of Medicine**~~Medical Doctor~~ (MD)
    ~~v.~~**u.** Medical Physicist
    ~~w.~~**v.** Mental Health Worker (MHW)
    ~~x.~~**w.** Monitor Technicians (MT) per unit specific policy

~~y.~~**x.** Neurophysiologist
~~z.~~**y.** **Nursing Instructor**
~~aa.~~**z.** Nurse Practitioner (NP)
~~bb.~~**aa.** Nursing Assistant (NA)/Certified Nursing Assistants (CNA)/Student Nurse Technician
~~cc. Optometrist~~
~~dd.~~**bb.** Organ Procurement Representative~~s~~
~~ee.~~**cc.** Orthopedic Assistant
dd. **Opthamologist**
~~ff.~~**ee.** Pharmacist
~~gg.~~**ff.** ~~Licensed~~ Physical/Occupational/Speech/Recreational Therapist~~s~~ (~~L~~PT/OT/**ST/RT**)
~~hh.~~**gg.** Physician's Assistant (PA)
~~ii.~~**hh.** Podiatrist
~~jj. Psychiatric Technician~~
~~kk. Psychiatrist~~
~~ll.~~**ii.** Psychologist
~~mm.~~**jj.** **Respiratory Care Practitioner (RCP)**~~Pulmonary Technician~~
~~nn.~~**kk.** Recreational Therapist
~~oo.~~**ll.** Registered Nurse (RN)
~~pp.~~**mm.** Research Coordinator~~s~~ (credentialed by TCMC Medical Staff)
~~qq.~~**nn.** Resident **Physician**
~~rr.~~**oo.** ~~Scribes~~
~~ss.~~**pp.** Social Worker~~s~~
~~tt. Student/Extern RN~~
~~uu.~~**qq.** Student~~s under the direction of their Clinical Instructor~~**in approved clinical rotation.**
~~vv.~~**rr.** Transcriptionist~~s~~
~~ww.~~**ss.** Unit Secretar~~yies~~
~~xx.~~**tt.** Contracted services that have completed the process as outlined in the Administrative ~~p~~**P**olicy: ~~"~~Non-TCHD Workers' ~~Compensation~~ **Orientation** and Identification Badge Process~~"~~ **8610-**~~(~~#451~~)~~.

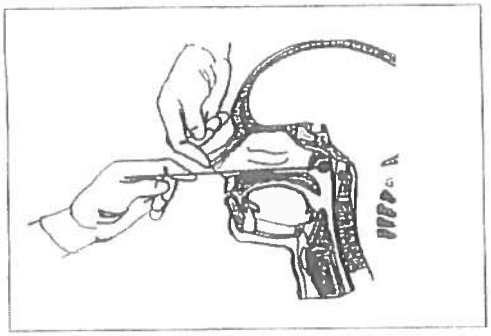
D. **RELATED DOCUMENTS:**

1. **Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275**
2. **Administrative Policy: Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employees 8610-451**
3. **PCS Policy: Cerner Downtime**
4. **PCS Procedure: Medical Record Making Corrections to Documentation**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**INFLUENZA NASOPHARYNGEAL SWAB TESTING**
Purpose:	To provide guidelines for Registered Nurses and Licensed Vocational Nurses testing patients for influenza. Patients requiring influenza testing will have nasopharyngeal swabs obtained in a timely manner using technique which will assure accurate results.
Equipment:	Dacron-tipped nasopharyngeal swab with flexible wire handle Mask Goggles or face shield Gloves and gown Tissues

A. **OBTAINING SPECIMEN:**

1. Don personal protective equipment.
2. Have patient sit with head against wall as patients have a tendency to pull away during this procedure.
3. Insert swab into one nostril **straight back** (not upwards) along the floor of the nasal passage for several centimeters until reaching the posterior wall of the nasopharynx (resistance will be met). The distance from the nose to the ear gives an estimate of the distance the swab should be inserted. Do not force the swab, if obstruction is encountered before reaching the nasopharynx, remove swab and try the other side.
4. Rotate the swab gently for 5-10 seconds to loosen the epithelial cells.



B. **TRANSPORT TO LAB:**

1. Specimen must be transported to the lab as soon as possible.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/12, **6/16**	12/12, **07/16**	12/12, **07/16**	n/a	n/a	01/13, **08/16**	02/13, **09/16**	02/13

Tri-City Healthcare District
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE:	**5/95**	**SUBJECT:**	**STUDENT CLINICAL ROTATION/EDUCATION**
REVISION DATE:	**4/98; 4/02; 12/02; 9/05; 11/08; 12/10**	**POLICY NUMBER:**	**8610-249**

Administrative Policies & Procedures Committee Approval:	**08/16**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~08/13~~09/16**
Board of Directors Approval:	**12/13**

A. **PURPOSE:**

1. To ensure a consistent policy for establishing student clinical affiliations.

B. **POLICY:**

1. A written clinical affiliation agreement must be approved before students are allowed to participate in clinical education. The clinical affiliation agreements are to be coordinated by the Education Department.
2. Tri-City Healthcare District (TCHD) utilizes **an** ~~two types of~~ education affiliation agreements for organizations requesting educational experiences (internships, shadowing, etc) for their students:
   a. Tri-City Medical Center (TCMC) Clinical Education Affiliation Agreement **will be completed for all clinical placements**: ~~This contract is used for the university/college requesting traditional clinical internships at TCMC (40+ Hours over several months).~~
   ~~b. TCMC Student/Intern Affiliation Agreement: This abbreviated (one page) agreement is designed primarily for the high school requesting a shorter educational experience at TCMC for their group or individual students in the form of a field trip, shadow day(s), etc. However, it may be used for a short college shadowing experience if deemed appropriate by the Education Director.~~
   b. All schools must ~~now~~ sign a copy of the Business Associate Agreement provided by the Compliance Department.
3. Education staff will review any requested changes to the standard Clinical Education Affiliation Agreement with **the Compliance Department**~~Legal Affairs~~ for appropriateness and legal concerns.
4. Any necessary changes will be communicated directly to the school for discussion and approval.
5. The Clinical Affiliation Agreement is then sent to Administration for final review and signature approval.
6. Copies of the approved agreement are retained in the Education Department**, the online contract database** and sent to the school.
7. Scheduling of clinical education for nursing students will be coordinated by the Education Department. Clinical education of all other students will be coordinated by the appropriate service or department.
   a. All students must complete TCMC orientation requirements prior to starting their internship/shadow experience. The Education Department provides a self-paced student orientation and maintains orientation paperwork.
8. The schools of Nursing are apprised on a continuing basis regarding census fluctuation and the availability of clinical opportunities for students.
   ~~b.~~**a.** All schools of Nursing are invited to participate in ~~the~~**a Nursing Faculty** ~~annual~~ meeting

at the Medical Center to discuss clinical schedules and current issues **as needed**.

~~8.~~**9.** Cancellation of Clinical Affiliation Agreements when requested by departments will be coordinated by the Education Department and approved by Administration.

C. **~~FORMS REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:~~**

1. Clinical Education Affiliation Agreement
2. ~~Student/Intern Affiliation Agreement~~**Business Associate Agreement Form**

D. **RELATED DOCUMENTS:**

1. **Patient Care Services (PCS) Policy: Nursing Students in Patient Care Areas**
2. **PCS Policy: Allied Health Students in Patient Care Areas**
3. **PCS Policy: Nursing Students in Advanced Practice**

Tri-City Health Care Distr
Oceanside, California

Delete from Infection Control Manual and Move to Environment of Care Manual

Environment of Care~~Infection Control Policy~~ Manual

ISSUE DATE: 9/01	**SUBJECT: Waste Management**
REVISED: 10/~~20~~03. 1/~~20~~07, 7/~~20~~09	~~STANDARD NUMBER: IC. 10.1~~
Department Approval Date(s):	**10/15**
Infection Control Committee Approval:	**~~10/12~~10/15**
Environmental Health and Safety Approval:	**07/16**
Medical Executive Committee Approval:	**~~11/12~~08/16**
Professional Affairs Committee Approval:	**09/16**
Board of Directors Approval:	**11/12**

A. **POLICY**~~Introduction~~

1. The Medical Waste Management Act provides the legislative definition of medical waste (California Health and Safety Code, Section 117690). In lay terms, waste must satisfy three critical criteria in order to be classified as medical waste. These three criteria are:
   a. The material must actually be a waste product.
      i. This precludes materials that have intrinsic value (such as outdated pharmaceuticals that are returned for credit) from being classified as a medical waste.
   b. The waste can be either biohazardous or sharps waste.
      i. Various forms of waste are defined as biohazardous because of the actual or presumed presence of pathogenic microorganisms. Such wastes as laboratory waste and fluid blood fall into this category and are therefore biohazardous waste. Trace amounts of chemotherapeutic agents, outdated pharmaceutical wastes and tissues with trace amounts of fixatives also fall into the category of biohazardous waste. Objects that have been used in invasive procedures such as hypodermic needles and broken glass items contaminated with blood or other biohazardous waste are considered to be sharps waste.
   c. The waste must be produced as a result of a specified action in the delivery of health care.
      i. The Medical Waste Management Act (section 117690) defines this as the "...diagnosis, treatment, or immunization of human beings..."

~~B. Biohazardous~~

~~1.~~**2.** Most waste generated during the direct patient care is not biohazardous. Examples of biohazardous waste that might be generated at our facility that requires special disposal includes:

- ~~2.~~**a.** Human specimen cultures, culture dishes and devices used to transfer, inoculate and mix cultures from medical and pathology laboratories.
- ~~3.~~**b.** Surgery specimens or tissues suspected of being contaminated with infectious agents known to be contagious.
- ~~4.~~**c.** Waste containing recognizable fluid blood, fluid blood products, and containers or equipment containing fluid blood.
- ~~5.~~**d.** Waste containing materials that are required to be isolated by the infection control staff, attending physician and surgeon or local health officer to protect others from highly communicable diseases (such as smallpox or the hemorrhagic fevers: Ebola, Lassa, Marburg, or Crimean-Congo).

~~C.~~**B. PROCEDURE**

1. Segregation of other medical waste is accomplished by staff (see Appendix A). All regulated medical waste will be collected within the area of origin in a biohazard bag or sharps container as appropriate.
2. Biohazardous bags are disposable, red in color, impervious to moisture with strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage and handling. They must pass the 165-gram dropped dart impact resistant test as prescribed by Standard D 1709-85 of the American Society for Testing and Materials and certified by the bag manufacturer.
   a. Red biohazardous bags shall be securely tied at the top so as to prevent leakage or expulsion of solid or liquid during storage, handling or transport.
   b. All items in a red bag must be managed as biohazardous. Red-bagged waste are handled by a contract service as biohazardous and never sent to the landfill.
3. Storage
   a. Red biohazardous bags shall be placed in rigid containers for storage, handling and transport.
   b. Containers holding red biohazardous bags shall be leak-resistant have tight fitting covers and are kept in good repair. These containers are not required to be red in color but must be labeled on the cover and sides with the words "Biohazard"
   c. The bag shall be legibly labeled with the hospital's name, address, and phone number and easily visible on the outside of the bag
   d. Any enclosure or designated collection area used for the storage of medical waste containers shall be secured so as to deny access to unauthorized persons. Signs worded "Caution-Biohazardous Waste Storage Area- Unauthorized Persons Keep Out" in English and Spanish. must be posted on the entry doors.
4. Transportation to Final Storage
   a. Covers are required where biohazardous material is being stored after collection or during transport.
   b. Intermediate holding areas for red-bagged wastes are located ~~on the floors~~ **in designated Patient care areas**. Daily, Environmental Services staff will check waste levels and when necessary, transport all wastes, including red-bagged wastes to the holding area for pick-up by the contract service, ~~Med-Serve Environmental~~**Stericycle**.
   c. Biohazardous wastes may be stored on the premises no longer than seven days.
   d. Biohazardous wastes stored for final disposition and transport offsite must be stored in secured storage area so as to deny access to unauthorized persons. Storage areas shall be marked with warning signs on or adjacent to exteriors of doors or gates and provide protection from animals, vermin and natural elements.
   e. This area will display prominent warning signs in English: "Caution: Biohazardous waste storage area. Unauthorized persons keep out." and in Spanish: "Cuidado: Zona de residos infectados. Prohibida la entrada a personas no authorizadas." Warning signs shall be readily legible during daylight from a distance of at least 25 feet. This area will be well ventilated and kept clean at all times.
   f. Unless protected by disposal liners, reusable rigid containers shall be washed and decontaminated by a hospital-approved disinfectant every time they are emptied.
   g. During transport, medical wastes shall be separated from other wastes in the same vehicle by use of containers or barriers.
5. Certain hazardous wastes may be solidified for disposal. An EPA approved product (i.e. Isosorb) is used to solidify contents of suction canisters. After treatment is done, this waste must be put in a red bag to be discarded.
6. Patients' rooms shall have waste containers lined with regular plastic bags. Environmental Services staff accomplishes disposal of waste from patients' rooms.
7. Sharps waste:
   a. All used needles and syringes will be disposed of at the point of origin in an appropriate sharps collection container. All sharps container will be checked for fill level daily and exchanged appropriately by our outside vendor or Environmental Services Department.

b. Sharps waste shall be contained in sharps containers, which are rigid, puncture-resistant, leak-resistant when, sealed, labeled with biohazard signs and red in color. Full sharps containers shall be tightly lidded. Tape may not serve as lid. Sealed sharps containers may be placed in red biohazard bags.

c. The container shall be legibly labeled with the hospital's name, address, and phone number and easily visible on the outside of the container.

8. Each newly hired Environmental Services employee will receive orientation to the procedure for the in-house collection, transportation, and storage of regulated and non-regulated waste at the medical center prior to ~~his/her first day on the job~~ **handling any waste materials.**. Training must include legal definitions, separation and proper storage, transportation, treatment and disposal of biomedical waste. Training will be the responsibility of the **manager** /supervisor in charge of this area.

~~D.~~C. RELATED DOCUMENTS:

1. **Administrative Policy: Handling of Pharmaceutical Waste, Expired Medications, and Expired Iv Solutions 276**

~~E.~~D. REFERENCES:

1. Ordinance No. 7646 of San Diego County, Department of Health Services regulating the storage and disposal of medical wastes
2. Medical Waste Management Act, Sections 117600-118360 in Chapter 6.1, California Health and Safety Code.
3. ~~Self-Assessment Manual for Proper Management of Medical Waste. Ca DHS and the California Healthcare Association, 2nd Ed., 1999~~
4. **3. Official California Code of Regulations (CCR), Title 22, Division 4.5**

Decision Table for Medical Waste

Type of Waste	Red Bag	Regular Bag	Sharps Container
Fluid blood, blood elements, vials of blood, specimens for culture, used culture media, and stock cultures.	X		
Bloody body fluids or disposable drapes **saturated and/or** dripping with bloody body fluids such as CSF, synovial, pleural, pericardial, amniotic.	X		
Bloody body fluid filled containers from nursing units, ED, PACU, outpatient areas not treated with Premicide.	X		
Materials used to clean up fluid blood or bloody body fluid spills that are dripping.	X		
Surgical specimens.	X		
Wound dressings, bandages, wrappings **saturated and/or** dripping with blood.	X		
Food waste such as soda cans, paper cups, cutlery, including food or service items from isolation rooms.		X	
Empty urine and stool containers, empty colostomy and urinary drainage bags, empty bedpans, breathing circuits, surgical drapes.		X	
Flexi-Seal Fecal Management Bags	X		
Gastric washings, dialysate, vomitus, feces, urine, diapers. Please empty in toilet.		X	
Tracheal and bronchial secretions, sputum, IV tubing without the needles.		X	
Soiled but not dripping items such as dressings, bandages, cotton balls, peripads, chux, cotton swabs.		X	
Suction Canisters, treated with solidifying agent.	X		
Used gloves, aprons, masks, goggles, respirators.		X	
Broken glass, guide wires.			X
Uncapped Needle/syringe units, needles, scalpels, vials from live or attenuated vaccines.			X

Tri-City Medical Center	Distribution: NICU
PROCEDURE:	**PERIPHERAL INTRAVENOUS INFILTRATIONS, TREATMENT FOR**
Purpose:	~~To outline the nursing responsibilities in the treatment of peripheral intravenous (PIV) infiltrations and extravasations to prevent tissue~~ when peripheral circulation is compromised.
Supportive Data:	
Equipment:	
Issue date: 7/07	~~Revision date(s): 9/08, 6/09, 6/11, 8/12~~

DELETE - use Mosby's Skill Intravenous Therapy: Line Insertion and Neofax for treatment guidelines

A. ~~**DEFINITIONS:**~~

1. ~~Vesicant agents are those that cause redness, pain, and blistering when infiltrated and can progress to ulceration and tissue necrosis.~~
2. ~~Intravenous infiltration is the inadvertent administration of nonvesicant solutions or medications into the surrounding tissue.~~
3. ~~Extravasations are the inadvertent administration of vesicant solutions or medications into the surrounding tissue.~~

~~* For the purpose of this policy, infiltration and extravagation may be interchanged.~~

B. ~~**POLICY:**~~

1. ~~A physician's order is required for administration of antidotes for infiltrations.~~
2. ~~Signs and symptoms of an infiltration or extravasation include (but may not be limited to): swelling at the site of infusion, redness, pain with infusion or palpation of site, blanching, coolness of surrounding skin or heat at site of infusion, blister or vesicle formation at injection site, or decreased pulses below injection site.~~
3. ~~The degree of tissue damage is related to the type and amount of medication or fluids absorbed by the tissue, length of exposure, and the site of extravasation.~~
4. ~~Methods of preventing infiltration or extravasations include: hourly site observation, administration of vesicant fluids through a central line if the infusion will last longer than 60 minutes and changing of the PIV site if any signs or symptoms of potential infiltration is noted.~~
5. ~~Treatment options include:~~
   a. ~~Non-pharmacological treatments:~~
      i. ~~Includes elevating the extremity for 24-48 hours post infiltration.~~
   b. ~~*Hyaluronidase (Hydase®):*~~
      i. ~~Most effective when administered within 1 hour of the infiltration, but may be administered up to 12 hours post infiltration.~~
      ii. ~~Hyaluronidase should be administered in a concentration of *150 units/ml.* Inject 0.2 ml subcutaneous in five locations around the periphery of the injury in a circular manner, changing the injection needle before each injection.~~
      iii. ~~Blanching should be alleviated within 10 minutes of administration and swelling should be markedly decreased within 30 minutes.~~
   c. ~~Phentolamine:~~
      i. ~~Indicated for vasopressor extravasations.~~
      ii. ~~It is most effective when administered within 1 to 2 hours of infiltration. Improvement should be apparent within 15 to 30 minutes after administration.~~
      iii. ~~Phentolamine should be administered in a concentration of 0.5 mg/ml and is administered in the same techniques as hyaluronidase (at 0.2 ml SQ in multiple locations around the injury.)~~
      iv. ~~May be repeated as necessary.~~

C. ~~**PROCEDURE**~~

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/16	04/16	06/16	08/16	09/16	

1. Stop the medication or fluids immediately if infiltration is suspected.
2. Remove the catheter.
3. Notify physician.
4. Initiate appropriate measures as ordered by physician or as indicated with use of a non-pharmacological treatment.
5. Observe the site frequently for signs/symptoms of worsening damage or necrosing of tissue. Notify physician if worsening or no improvement.
6. Document incident according to hospital policy and initiate QRR form.
7. Fill out quality review report (QRR) form per TCMC policy for all infiltrations, stages 1-4.

D. EXTERNAL LINKS:

E. REFERENCES

1. Alexander, M., et.al. (2006). Standards: Nursing Practice. *Journal of Infusion Nursing, 29(1S)*, S12-S61.
2. Pettit, J. (2003). Assessment of an infant with a peripheral intravenous device. *Advance Neonatal Care 3(5)*, 230-240.
3. Sawatzky-Dickson, D., & Bodnaryk, K. (2006). Neonatal intravenous extravasation injuries: Evaluation of a wound care protocol. *Neonatal Network, 25(1)*, 13-19.
4. Sundquist-Beauman, S., & Swanson, A. (2006). Neonatal infusion therapy: Preventing complications and improving outcomes. *Newborn & Infant Nursing Reviews, 6(4)*, 193-201.
5. Young, T.E. (2011). *Neofax, Edition 24*

F. APPROVAL PROCESS:

1. Clinical Policies & Procedures Committee
2. Nurse Executive Council
3. Medical Executive Committee
4. Professional Affairs Committee
5. Board of Directors

Peripheral Intravenous (PIV) Infiltrations Extent of Injury Reference Tool:

When determining the stage, based on the clinical symptoms, all of the symptoms may or may not be present. Choose most appropriate stage that reflects the injury.

Stage	Clinical Symptoms
0	No infiltration
	Site questionable
	IV pump registering occlusion
	With or without pain
	With or without leaking
1	Skin blanched/translucent
	Skin tight, leaking
	Skin discolored or bruised
	Gross edema
	Infiltration of any blood product, irritant or vesicant
	Pain at access site
2	Skin blanched
	Gross edema
	Cool to touch
	Pain at access site
3	Skin blanched
	Edema > 1 cm
	Cool to touch
	With or without pain
4	Skin blanched
	Edema < 1 cm in any direction
	Cool to touch
	With or without pain

Stage	Treatments
1	**Hyaluronidase** Best used for infiltrations caused by: • Antibiotics • Sodium Bicarbonate • Potassium • Calcium • Hyperalimentation • Dextrose • Aminophyllin • Blood
2	**Phentolamine** Best used for infiltrations caused by: • Dobutamine • Dopamine • Epinephrine
3	**Normal Saline** may be used when hyaluronidase or phentolamine is not available
4	**Non-pharmacological treatments** *Elevate extremity for 24-48 hours*

Tracking Sheet for Peripheral Intravenous (PIV) Infiltrations

Report for month of: _____

IV Site Code
1=Scalp
2=Right Arm
3=Left Arm
4=Right Hand
5=Left Hand
6=Right Leg
7=Left Leg
8=Right Foot
9=Left Foot
10=Other

Agent Description
1=Crystalloids – no additive
2=Crystalloids containing Calcium
3=Hyperalimantation solution only
4=HAL w/Lipids
5=Non-blood product colloidal
6=Blood product
7=Antibiotic only
8=Other*

Extent of Injury
1=Stage 1
2=Stage 2
3=Stage 3
4=Stage 4

Treatment
1=Hyaluronidase (Amphadase)
2=Phentolamine (Regitine)
3=Normal Saline
4=Non-pharmacologic treatment*
5=None

* Explain/Describe

Date	MRN	Patient Age (gestation/ days)	Weight	IV Site	Agent Description	Extent of Injury	Treatment

Tracked Changes Copy

PROCEDURE:	SKIN-TO-SKIN CONTACT
Purpose:	Promote caregiver-patient bonding, facilitate lactation, and increase confidence in providing patient care. Benefits to patient may include decreased oxygen requirements during holding, early breastfeeding; longer sleep periods, lowered caloric requirements and shortened hospitalization. Benefits to caregivers may include improved lactation, greater involvement and participation in patient's care and earlier readiness for discharge.
Supportive Data:	Skin-to-skin Contact literature supports that patients who are held skin to skin are able to maintain temperature, have regular heart rates and respirations, more deep sleep and alert states, less crying, ~~no increase in~~ **less** infections, greater weight gain and earlier discharge.
Equipment:	1. Comfortable chair 2. Front-opening shirt or patient gown for the caregiver 3. Foot stool (optional) 4. Privacy Screen (optional) 5. Blankets 6. Tape 7. Hat 8. Viewing mirror for the caregiver (optional)
Issue Date: 9/07	Revision Date(s): 5/08, 6/09, 6/11, 8/12

A. DEFINITIONS:

1. Skin-to-Skin Contact (SSC): Also known as Kangaroo Care.

~~A.~~B. POLICY:

1. **SSC provides both emotional and physiologic benefits to neonates and parents.**~~Before attempting skin to skin care assure the patient has stable vital signs~~
~~2. Patients on ventilators, vaso-pressor drips, shall be assessed individually~~
~~3. Patients with apnea/bradycardia episodes will be evaluated by RN for participation~~
~~4.~~**2.** There **is**~~are~~ no **patient** weight limitation**s for**~~on skin-to-skin contact~~**SSC**.
~~5.~~**3.** UAC's, UVC's, and PICC lines shall be assessed individually.
~~6. The patient's axillary temperature prior to initiation of skin-to-skin contact should be between 36.5 degrees and 37.2 degrees Centigrade.~~
   ~~a. A heat lamp is not necessary since the warmth of the caregiver's skin is sufficient to maintain the patient's temperature.~~
   ~~b. Literature has documented that a state of "thermal harmony" exists where the caregiver's temperature increases or decreases to maintain the patient's temperature in a thermoneutral range during skin-to-skin contact.~~
~~7.~~**4.** ~~Skin-to-skin contact~~**SSC** should be performed for a minimum of 60 minutes, especially for a ventilated patient. Two hours is ideal, to give the patient time to ~~settle down~~**acclimate** and promote **regulation of** the sleep cycle.
   a. ~~Skin-to-skin contact~~**SSC** may be done before, during or after a feeding.
   ~~b. Mother may also breastfeed per physician or nurse discretion.~~

~~B.~~C. PROCEDURE:

1. Preparation
   a. **Assess the family's understanding of the reasons for and the risks and benefits of the procedure.** ~~Review educational materials with the patient's caregivers.~~
   b. Confirm patient identity using two-identifier system.
   ~~b. . Refer to Patient Care Services "Identification, Patient" (IV.A) policy~~
   c. Provide privacy screen, comfortable chair and appropriate lighting.

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	05/16	05/16	n/a	08/16	06/13, 09/16	06/13

d. Have the caregiver/ wear a shirt or blouse that opens in front, or provide a hospital gown that opens in the front.

~~d.~~**e.** **Ask if the parent needs to use the restroom before beginning the procedure.**

~~e.~~**f.** Perform hand hygiene; have the caregiver perform hand hygiene.

2. Assessment

a. Before initiating ~~skin-to-skin~~ **SSC** document the patient's baseline assessment **and vital signs.**~~,~~

~~i. vital signs~~

~~ii. respiratory support,~~

3. Action Steps

~~a. Position caregiver comfortably with adequate support for back, elbows, and feet.~~

a. **Place the chair in optimal position with wheels locked.**

b. Have caregiver unbutton shirt or blouse, mother should remove bra.

~~i. If necessary assist in lifting patient into a vertical, prone position between breasts/chest or across the chest.~~

~~ii. , maintain a tucked position (shoulders, arms, and legs tucked up and in.~~

~~iii. Reposition the patient as needed~~

~~1) Head is turned to the side, with the ear resting above the caregiver's heart.~~

c. Dress patient in diaper and hat only.

d. **Transfer the patient to the parent using either of the following techniques:**

i. **Caregiver-assisted transfer**

1) **Have the parent stand as close to the isolette as possible.**

2) **Support the patient's head and any tubing as the parent supports the patient's back and buttocks by sliding hands under him or her.**

3) **With nurse and parent (or second nurse) moving at the same time, turn the patient to the vertical position, instruct the parent to lean over the isolette and gently lift the patient to the parent's chest.**

4) **Have the parent slowly sit down in the chair. Secure any tubing to the parent's shoulder.**

ii. **Staff-assisted transfer**

1) **Have the parent sit down in the chair.**

2) **Place a forearm under the patient and cup his or her head with the other hand. Have another nurse support any tubing during the patient's transfer**

3) **Lean over the isolette and gently lift the patient to the chest.**

4) **Guide the patient toward the parent along with any tubing, and place the patient prone on the parent's chest.**

5) **Secure any tubing to the parent's shoulder.**

e. **Reposition the patient, as needed, so his or her head is turned to the side with the ear resting above the parent's heart.**

f. **For an intubated patient, check and secure the ventilator tubing, auscultate breath sounds, suction as indicated, and visually verify ET tube placement.**

~~c.~~**g.** Place a light blanket over patient and tuck under caregiver's arm.

~~d. Provide privacy and dim lights.~~

~~e. Take vital signs prior to and on return to isolette.~~

h. **Check the patient's temperature within a few minutes of the transfer. Then, if is stable, check it at regular intervals.**

~~f. Take temperature when patient has been skin to skin for 1 hour.~~

i. **To transfer the patient back from the parent to the bed, use either of the following techniques:**

i. **Caregiver-assisted back transfer**

1) **Ask the parent to rise slowly to a standing position while containing the patient prone to the chest. Support the patient's head and buttocks and any tubing while the parent rises.**

2) **Continuing to support the patient's head and any tubing, have the parent support the patient's back and buttocks and, together, slowly lower the patient to the mattress. Place him or her in a supine or side-lying position.**
3) **Keep in mind that transfer may be easier to complete with two nurses, especially with a patient who is intubated.**

ii. **Staff-assisted back transfer**
1) **Lean over the parent and gently lift the patient, containing him or her prone to the chest while cupping the head.**
2) **Keep in mind that transfer may be easier to complete with two nurses, especially with a patient who is intubated.**
3) **Guide the patient and any tubing back to the bed, and place him or her in a supine or side-lying position.**

4. Monitoring
a. All patients in the NICU~~,~~ will be continuously monitored on a cardio-respiratory monitor and ~~when applicable,~~ a pulse oximeter.
b. **Hemodynamic stability of patient (temperature, heart rate, respiratory rate)** ~~Monitor the patient's physiologic cues (heart rate, color, respiratory rate, oxygen saturation).~~
c. Monitor the patient's behavioral cues (comfort level, agitation) frequently throughout SSC.
d. Allow the patient ~~approximately 5 minutes~~ **some time** after transfer from the isolette or bed to the caregiver's chest to ascertain tolerance.
e. Monitor the caregiver's comfort level during the ~~skin-to-skin process~~**SSC.**

5. Signs of intolerance:
a. Return patient to isolette if patient demonstrates changes in temperature, respiratory rate, ~~or~~ oxygen saturation **or increased apnea and bradycardia episodes that do not resolve with repositioning on the parent's chest**.
~~b. Return patient to isolette if patient demonstrates signs of stress:~~

~~MILD~~	~~MODERATE~~	~~SEVERE~~
~~Gaze aversion~~	~~Flushing~~	~~Pallor~~
~~Yawning~~	~~Mottling~~	~~Cyanosis~~
~~Hiccups~~	~~Sighing~~	~~Tachypnea~~
~~Grimacing~~	~~Emesis~~	~~Apnea~~
~~Closing Eyes~~	~~Finger splaying~~	~~Bradypnea~~
~~Tongue thrusting~~	~~Extension of arms/legs~~	~~Tachycardia~~
~~Bowel movements~~	~~Jitteriness~~	~~Brachycardia~~
~~Coughing~~	~~Jerky Movements~~	~~Arrhythmias~~
~~Sneezing~~	~~Limpness~~	~~Decreased O2 saturations~~

~~6. Explain to caregivers that the transition to skin-to-skin contact is a significant environmental change for their premature patient and that other stimuli such as stroking, talking to or trying to make eye contact may not be tolerated initially.~~
~~7. Reassure caregivers and provide support as needed, as many caregivers become very emotional during the initial skin-to-skin contact, especially with an extremely small patient.~~

~~C.~~D. DOCUMENTATION:

~~1. Temperature monitoring, signs of tolerance, signs of stress in medical record.~~
~~2.~~**1.** Patient **tolerance** ~~response to~~**of** ~~skin-to-skin contact~~**SSC.**~~, adverse/beneficial reactions.~~
~~3.~~**2.** Caregiver's response to ~~skin-to-skin contact~~**SSC**, including specific observations.
3. Caregiver education.
4. **Duration of SSC.**

~~D. EXTERNAL LINKS:~~

REFERENCES:

1. Altimier, L., Brown, B., & Tedeschi, L. (2006). *Neonatal nursing policies, procedures, competencies, and clinical pathways, 4th ed.* Glenview, IL: National Association of Neonatal Nurses.
2. Dodd, U.L. (2005). Implication of Kangaroo Care for the Growth and Development in Preterm Infants. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, 34(1), 218-232.
3. Fohe, K., Kropf, S., & Avenarius, S. (2000). Skin-to-skin contact improves gas exchange in premature neonates. *Journal of Perinatology*, 20, 311-315.
4. Galligan, M. (2006). Proposed Guidelines for Skin to Skin treatment of Neonatal Hypothermia. *The American Journal of Maternal Child Nursing*. September/October, 31(5), 298-304; quiz 305-306.
5. Ludington-Hoe, S.M. et al. (2004). Randomized controlled trial of kangaroo care: Cardiorespiratory and thermal effects on healthy preterms. *Neonatal Network*, 23, 39-48.
6. Merenstein, G. B. & Gardner, S. L. (2011). *Handbook of neonatal intensive care*, 7th ed. Mosby Elsevier.
7. **Mosby's Nursing Skills. (2016). Skin-to-skin Contact. Elsevier, Inc.**
~~7.~~**8.** Roller, C.G. (2005). Getting to Know You: Mother's Experiences of Kangaroo Care. *Journal of Obstetrics, Gynecologic, and Neonatal Nursing*, 34(1) 210-217.
~~8.~~**9.** Smith, K. M. (2007). Sleep and Kangaroo Care: Clinical Practice in the Newborn Intensive Care Unit: Where the Baby Sleeps [horizontal ellipsis]. *The Journal of Perinatal & Neonatal Nursing*, 21(2), 151-157.
~~9.~~**10.** Verger, J.T. **&**~~,~~ Lebet, R.M. (Eds.) (2007). *AACN procedure manual for pediatric acute and critical care.* St. Louis: Saunders.

~~APPROVAL PROCESS:~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Clean Copy

PROCEDURE:	SKIN-TO-SKIN CONTACT
Purpose:	Promote caregiver-patient bonding, facilitate lactation, and increase confidence in providing patient care. Benefits to patient may include decreased oxygen requirements during holding, early breastfeeding; longer sleep periods, lowered caloric requirements and shortened hospitalization. Benefits to caregivers may include improved lactation, greater involvement and participation in patient's care and earlier readiness for discharge.
Supportive Data:	Skin-to-skin Contact literature supports that patients who are held skin to skin are able to maintain temperature, have regular heart rates and respirations, more deep sleep and alert states, less crying, less infections, greater weight gain and earlier discharge.
Equipment:	1. Comfortable chair 2. Front-opening shirt or patient gown for the caregiver 3. Foot stool (optional) 4. Privacy Screen (optional) 5. Blankets 6. Tape 7. Hat 8. Viewing mirror for the caregiver (optional)
Issue Date: 9/07	Revision Date(s): 5/08, 6/09, 6/11, 8/12

A. **DEFINITIONS:**

1. Skin-to-Skin Contact (SSC): Also known as Kangaroo Care.

B. **POLICY:**

1. SSC provides both emotional and physiologic benefits to neonates and parents.
2. There is no patient weight limitation for SSC.
3. UAC's, UVC's, and PICC lines shall be assessed individually.
4. SSC should be performed for a minimum of 60 minutes, especially for a ventilated patient. Two hours is ideal, to give the patient time to acclimate and promote regulation of the sleep cycle.
   a. SSC may be done before, during or after a feeding.

C. **PROCEDURE:**

1. Preparation
   a. Assess the family's understanding of the reasons for and the risks and benefits of the procedure.
   b. Confirm patient identity using two-identifier system.
   c. Provide privacy screen, comfortable chair and appropriate lighting.
   d. Have the caregiver/ wear a shirt or blouse that opens in front, or provide a hospital gown that opens in the front.
   e. Ask if the parent needs to use the restroom before beginning the procedure.
   f. Perform hand hygiene; have the caregiver perform hand hygiene.
2. Assessment
   a. Before initiating SSC document the patient's baseline assessment and vital signs.
3. Action Steps
   a. Place the chair in optimal position with wheels locked.
   b. Have caregiver unbutton shirt or blouse, mother should remove bra.
   c. Dress patient in diaper and hat only.
   d. Transfer the patient to the parent using either of the following techniques:
      i. Caregiver-assisted transfer
         1) Have the parent stand as close to the isolette as possible.

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	05/16	05/16	n/a	08/16	06/13, 09/16	06/13

2) Support the patient's head and any tubing as the parent supports the patient's back and buttocks by sliding hands under him or her.
3) With nurse and parent (or second nurse) moving at the same time, turn the patient to the vertical position, instruct the parent to lean over the isolette and gently lift the patient to the parent's chest.
4) Have the parent slowly sit down in the chair. Secure any tubing to the parent's shoulder.

ii. Staff-assisted transfer
1) Have the parent sit down in the chair.
2) Place a forearm under the patient and cup his or her head with the other hand. Have another nurse support any tubing during the patient's transfer
3) Lean over the isolette and gently lift the patient to the chest.
4) Guide the patient toward the parent along with any tubing, and place the patient prone on the parent's chest.
5) Secure any tubing to the parent's shoulder.

e. Reposition the patient, as needed, so his or her head is turned to the side with the ear resting above the parent's heart.
f. For an intubated patient, check and secure the ventilator tubing, auscultate breath sounds, suction as indicated, and visually verify ET tube placement.
g. Place a light blanket over patient and tuck under caregiver's arm.
h. Check the patient's temperature within a few minutes of the transfer. Then, if is stable, check it at regular intervals.
i. To transfer the patient back from the parent to the bed, use either of the following techniques:

i. Caregiver-assisted back transfer
1) Ask the parent to rise slowly to a standing position while containing the patient prone to the chest. Support the patient's head and buttocks and any tubing while the parent rises.
2) Continuing to support the patient's head and any tubing, have the parent support the patient's back and buttocks and, together, slowly lower the patient to the mattress. Place him or her in a supine or side-lying position.
3) Keep in mind that transfer may be easier to complete with two nurses, especially with a patient who is intubated.

ii. Staff-assisted back transfer
1) Lean over the parent and gently lift the patient, containing him or her prone to the chest while cupping the head.
2) Keep in mind that transfer may be easier to complete with two nurses, especially with a patient who is intubated.
3) Guide the patient and any tubing back to the bed, and place him or her in a supine or side-lying position.

4. Monitoring
a. All patients in the NICU will be continuously monitored on a cardio-respiratory monitor and a pulse oximeter.
b. Hemodynamic stability of patient (temperature, heart rate, respiratory rate) .
c. Monitor the patient's behavioral cues (comfort level, agitation) frequently throughout SSC.
d. Allow the patient some time after transfer from the isolette or bed to the caregiver's chest to ascertain tolerance.
e. Monitor the caregiver's comfort level during the SSC.

5. Signs of intolerance:
a. Return patient to isolette if patient demonstrates changes in temperature, respiratory rate, oxygen saturation or increased apnea and bradycardia episodes that do not resolve with repositioning on the parent's chest.

D. **DOCUMENTATION:**

1. Patient tolerance of SSC.
2. Caregiver's response to SSC, including specific observations.
3. Caregiver education.
4. Duration of SSC.

E. **REFERENCES:**

1. Altimier, L., Brown, B., & Tedeschi, L. (2006). *Neonatal nursing policies, procedures, competencies, and clinical pathways, 4th ed.* Glenview, IL: National Association of Neonatal Nurses.
2. Dodd, U.L. (2005). Implication of Kangaroo Care for the Growth and Development in Preterm Infants. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, 34(1), 218-232.
3. Fohe, K., Kropf, S., & Avenarius, S. (2000). Skin-to-skin contact improves gas exchange in premature neonates. *Journal of Perinatology*, 20, 311-315.
4. Galligan, M. (2006). Proposed Guidelines for Skin to Skin treatment of Neonatal Hypothermia. *The American Journal of Maternal Child Nursing*. September/October, 31(5), 298-304; quiz 305-306.
5. Ludington-Hoe, S.M. et al. (2004). Randomized controlled trial of kangaroo care: Cardiorespiratory and thermal effects on healthy preterms. *Neonatal Network*, 23, 39-48.
6. Merenstein, G. B. & Gardner, S. L. (2011). *Handbook of neonatal intensive care*, 7th ed. Mosby Elsevier.
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PROCEDURE: **UMBILICAL CATHETERS, INSERTION, MANAGEMENT AND DISCONTINUATION OF**

DELETE – use Mosby's Skills Umbilical Vessel Catheter: Drawing Blood (Neonatal), Umbilical Vessel Catheter Vessel: Securing (Neonatal), Umbilical Vessel Catheter: Use of Double Lumen UVC (Neonatal)

Purpose:	~~To outline the nursing responsibilities assoc umbilical catheters, care of patients with um discontinuation of these catheters.~~
Supportive Data:	~~An umbilical artery catheter (UAC) is placed determinations, continuous monitoring of art required for infusion of fluids and medicatior for exchange transfusions, long-term IV acc for initial management of ELBW infants.~~
Issue date:11/08	Revision date(s): 6/09, 6/11, 8/12

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

~~1. Assisting with insertion~~

~~1. Ensure physician has obtained informed consent from parent or legal guardian.~~
~~2. Perform hand hygiene and assemble equipment.~~
~~3. Assess patient before procedure. Document any bruising or discoloration found before procedure begins.~~
~~4. Place on radiant warmer, cardio-respiratory monitor and pulse oximeter. Immobilize patient in supine position, restraining limbs. Position light source to illuminate umbilical area.~~
~~5. Set up tray using aseptic technique.~~
~~6. Universal protocol: everyone involved participates in "time out" to verify patient and procedure.~~
~~7. Assist by maintaining sterility of procedure, monitoring patient's condition and vital signs. Notify physician of areas of blanching, dusky toes or legs, or change in temperature, color and pulse.~~
~~8. During the procedure, *verify proper procedural practice by monitoring for appropriate hand hygiene, maximal sterile barriers, and skin preparation. Document this monitoring on the Central Line Insertion Procedural Checklist.*~~
~~9. Confirm placement with x-ray prior to fluid administration unless ordered by physician.~~
~~10. Maintain sterility of area until notified otherwise.~~
~~11. Wipe off Povidone-Iodine solution from skin using saline wipes.~~
~~12. Thirty minutes after procedure is complete, loosen the umbilical tie and observe for bleeding. The tie may be removed once hemostasis is assured. Umbilical tie should be removed within four (4) hours after catheter insertion.~~
~~13. Secure catheter(s) to abdomen using a transparent dressing.~~
~~14. Discard gloves and supplies in appropriate receptacle.~~
~~15. Document the procedure in the patient's medical record. Documentation of the procedure includes:~~
~~i. Date and time of insertion.~~
~~ii. Specifics of insertion (technique, draping, insertion site).~~
~~iii. Size of the catheter.~~
~~iv. Length of the catheter from insertion site to catheter tip.~~
~~v. Patient's tolerance of the procedure.~~
~~vi. Blood loss or complications with insertion.~~
~~vii. X-ray reading of tip location~~
~~viii. Adjustments made after the insertion, (e.g., catheter pulled back, additional x-rays needed).~~
~~ix. Completion of Central Line Insertion Procedural (CLIP)~~
~~16.~~

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/16	04/16	06/16	08/16	09/16	

B. **ONGOING ASSESSMENT: UACs AND UVCs:**

1. There will be a daily assessment by the physician of necessity to continue using an umbilical catheter. This will be documented in the Central Venous Catheter Assessment Progress Note.
2. Note centimeter (cm) mark at umbilicus every shift and after repositioning of patient. Notify physician if catheter has migrated.
3. Examine the dressing for adherence of occlusive, non-restrictive dressing and security of the catheter. Confirm that the hub is secure and that bending or twisting is not possible.
4. Observe the site for redness, swelling, or drainage.
5. Observe perfusion of lower body and presence and quality of lower extremity pulses, and any bleeding from umbilicus hourly.
6. If skin is discolored (blanched, mottled, dusky) distal to the catheter insertion site, it may be related to the catheter not being in correct position. Assess peripheral pulses and temperature distal to the catheter insertion site. If the skin discoloration is thought to be catheter related, apply warm compress to opposite extremity for fifteen (15) minutes and notify physician.
7. Assess the entire IV setup for security of connections.
8. Documentation in the medical record should be completed every shift and should include the following:
    1. Description of site; any edema or circulatory compromise
    2. Cm mark at umbilicus.
    3. Description of dressing and occlusiveness.
    4. Infusion rate and product
    5. Clinical status of patient.

C. **ONGOING ASSESSMENT: UACs**

1. All UAC lines will be attached to a transducer with the pressure waveform continuously displayed.
2. The transducer must be zeroed at least once per shift, and after repositioning of patient, or when warranted by unusual changes in pressure reading.
3. The UAC transducer should be kept at the level of the heart.
4. Monitor waveforms and blood pressure.
5. Blood pressure alarms must be set according to ordered parameters.
6. Correlate transducer blood pressure with peripheral blood pressure 1x/shift and PRN.

D. **CENTRAL LINE TUBING CHANGE:**

1. Equipment:
    1. Mask
    2. Cap
    3. Non-sterile gloves
    4. Sterile gloves
    5. IV tubing, filter, medication tubing (as needed)
    6. Sterile 3x3 or 4x4 gauze sponges
    7. 1:1 heparinized normal saline
    8. Transfer set
    9. 5ml or 10ml syringe
2. Procedure:
    1. Perform hand hygiene.
    2. Don mask, cap, and non-sterile gloves.
    3. Prime new IV tubing.
    4. Don sterile gloves.
    5. Set up sterile field utilizing glove wrapper. Place gauze sponges, 2% chlorhexidine gluconate swabs on field, and 10 ml syringe.
    6. Using sterile technique, draw up 1:1 heparinized normal saline into syringe.

7. Use sterile gauze sponges to hold tubing.
8. Swab connection sites with 2% chlorhexidine gluconate using friction for 30 seconds, and then let dry for 30 seconds.
9. Disconnect old IV tubing.
10. Turbulent flush each lumen with 1 ml of 1:1 heparinized normal saline in a 5 ml or 10 ml syringe using a start-stop motion.
11. Connect new IV tubing keeping all connections sterile.
12. Ensure IV fluids are running at proper rate.
13. Place appropriate date-change stickers on IV tubing.
14. Document tubing change in the medical record.

E. OBTAINING BLOOD SPECIMENS:

1. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
2. Perform hand hygiene.
3. Don clean gloves.
4. If the line has more than one lumen, stop infusions running through all lumens.
5. Place a sterile 4x4 gauze under the sampling port from which the blood will be drawn.
6. Close the distal shut off valve.
7. Slowly, smoothly and evenly pull up on the reservoir plunger to draw the required amount of clearing volume consistent with the patient's clinical condition and patient's size.
8. Close the proximal shut off valve.
9. Swab proximal sample site with alcohol prep pad.
10. Using 1 mL or 3 mL syringe with needleless blunt attachment, ensure plunger is fully depressed and push blunt attachment into proximal sample site.
11. Withdraw amount of blood required for performance of ordered lab tests.
12. Remove the syringe from the sampling site by pulling straight out.
13. Blood for laboratory testing will be placed into appropriate blood collection device and labeled correctly.
14. Open the proximal shut-off valve.
15. Slowly, smoothly and evenly, push down on reservoir plunger until it is fully closed.
16. Swab distal access port with alcohol prep pad.
17. Using 3 mL syringe of heparinized flush solution (as ordered by the physician) with needleless blunt attachment, ensure the syringe and cannula are free of air bubbles and insert blunt attachment into the distal access port.
18. Slowly flush the line with solution while monitoring for air bubbles.
19. Open the distal shut-off valve.
20. Discard syringes and gloves in appropriate receptacles.

F. DISCONTINUATION OF UMBILICAL CATHETERS:

1. Equipment:
    1. Suture removal kit
    2. Kelly clamp
    3. Umbilical tape
    4. Sterile 4x4 gauze
    5. Non-sterile gloves
2. Procedure:
    1. Verify physician's order to remove the catheter.
    2. Perform hand hygiene and gather supplies.
    3. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
    4. Turn off infusions or move the infusions to alternate catheters.
    5. Verify centimeter marking at umbilicus with those previously documented.
    6. Don non-sterile gloves.

7. Open suture removal set and sterile gauze.
8. Remove dressing.
9. Cut sutures, being careful not to cut catheter.
10. UACs: Grasp catheter firmly with one hand – use other hand to stabilize cord – gently pull until 5 cm mark is reached. Stop and observe for 5 – 15 minutes. The artery will usually spasm and close, but have hemostat and gauze ready in case needed. Gently withdraw remaining catheter, 1 cm/minute. If pulsations are present, delay withdrawal until they stop.
11. If bleeding occurs, apply pressure to umbilicus with sterile 4x4 gauze for 3 – 5 minutes until bleeding stops.
12. UVCs: slowly withdraw in one step.
13. Check that catheter is intact.
14. Observe for oozing or recurrence of bleeding.
15. Discard gloves and supplies in appropriate receptacle.
16. Perform hand hygiene.
17. Document removal, patient's tolerance of procedure, any blood loss or oozing, and evaluation of extremities and umbilicus after the procedure in the patient's medical record.

G. EXTERNAL LINKS:

H. REFERENCES:

1. Merenstein G.B. & Gardner S.L. (2011). Handbook of neonatal intensive care, 7th Ed. St. Louis, MO. Mosby Elsevier.
2. MacDonald M. & Ramagethu J. (2007). Atlas of procedures in neonatology, 5th Ed. Lippincott Williams & Wilkins.
3. Verklan, M.T. & Walden, M. (Eds.). (2009). Core curriculum for neonatal intensive care nursing, 4th ed. St. Louis: Saunders.

I. APPROVAL PROCESS:

1. Clinical Policies & Procedures Committee
2. Nurse Executive Council
3. Medical Executive Committee
4. Professional Affairs Committee
5. Board of Directors

Move from Oncology Manual to Patient Care Services

Tri-City Medical Center

Distribution: **Patient Care Services** ~~Oncology Unit~~

PROCEDURE: CHEMOTHERAPY ADMINISTRATION

Purpose: To outline the chemotherapy competent nurse's responsibility when administering a chemotherapeutic agent:

Tracked Changes Copy

A. Notification of a Chemotherapy Order
B. Safe Handling
C. Requirements Prior to Administering a Chemotherapeutic Agent
D. Patient Preparation
E. Documentation
F. Administrating Intravenous and Intramuscular Chemotherapy
   I. IV Push
   II. IV Continuous or Intermittent
   III. Intramuscular and Subcutaneous
G. Administering Oral Chemotherapy

Supportive Data: See References

Equipment: See Equipment Lists for specific administration methods

A. **NOTIFICATION OF A CHEMOTHERAPY ORDER:**

1. All **inpatient** units must notify the oncology unit's **Assistant Nurse Manager (ANM)** ~~clinical manager~~ or designee when a chemotherapy order has been written for a patient on a unit other than the oncology unit. Notification must be done as soon as the order is written and no later than a 12-hour notice. The oncology unit must be notified so staffing can be adjusted appropriately for patient safety.

~~1.~~**2. Nursing must notify Pharmacy via phone and by scanning the chemotherapy orders as soon as possible when a chemotherapy order is received.**

B. **SAFE HANDLING:**

1. Many drugs used in the treatment of cancer (i.e. chemotherapy) are considered to be hazardous to health care workers. The term hazardous refers to drugs/chemicals that require special handling because of potential health risks. Therefore, it is imperative that those who work with chemotherapy drugs adhere to this procedure, the pharmaceutical companies recommendations, the Material Safety Data Sheet that pertains to the particular hazardous agent and the Tri-City **Healthcare District**~~Medical Center~~'s (**TCHD**~~TCMC~~) **policies including but not limited to:**

a. Patient Care Services (PCS) Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids ~~procedure as well as the TCMC's procedure for~~

~~a.~~**b. PCS Procedure:** Disposal of Chemotherapy Waste.

2. Transporting Chemotherapy Agents
   a. Transport syringes containing chemotherapy in a sealed container, with the luer lock end syringe capped.
   b. All chemotherapy agents will be placed in a leak proof sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" before agent can be transported.
   c. The nurse transporting a chemotherapy agent will carry a spill kit at all times in case of a potential chemotherapy spill.
   d. In case of an accidental spill or exposure please see ~~Tri-City Medical Center's (TCMC)~~ **PCS Procedure:** Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the ~~TCMC's procedure for~~ **PCS Procedure:** Disposal of Chemotherapy Waste.
3. Transporting patients that are receiving intravenous chemotherapy

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09,8/09,8/10,11/13, 5/16	6/16	07/16	07/16	6/16	08/16	09/16	1/07, 08/09, 8/10;7/13

a. Transporting a patient that is receiving intravenous chemotherapy should be avoided if at all possible due to the potential risk of a chemotherapy spill, extravasation at the IV site and physiological complications associated with chemotherapy administration.

b. If a patient must be transported to another department the nurse must carry a chemotherapy spill kit at all times. The nurse must ensure that the IV site, IV bag(s) and IV lines that are connected to the chemotherapy and the patient are visible and secure to prevent extravasation and spillage of the chemotherapy agent during transport.

C. **REQUIREMENTS PRIOR TO ADMINISTERING A CHEMOTHERAPEUTIC AGENT:**

1. All inpatients receiving IV chemotherapy for the first time are required to have an Oncology Patient Care-Education Rounding completed 24 -36 prior to the first chemotherapy dose. See the PCS Policy: Oncology Patient Care-Education Rounding Policy.

2. At the Outpatient Infusion Center a physician must be on the premises at all times if chemotherapy is being infused into a patient(s).

~~1.~~**3.** Chemotherapy may only be administered by a **Chemotherapy Competent Registered Nurse (RN)**. A Chemotherapy Competent **RN**~~Registered Nurse~~ is defined by the following requirements:

a. Has taken and passed an Oncology Nursing Society approved chemotherapy course.

b. Has completed **Chemotherapy Administration** competency validation by a ~~TCMC~~**TCHD** chemotherapy competent nurse ~~on all areas of the Tri-City Medical Center's RN~~**(see example Acute Care Services** (ACS) 2 P Advanced Oncology-Chemotherapy Addendum Nursing Skills Checklist **or Outpatient Infusion Center Skills Checklist)**.

c. Completes Chemotherapy Administration competency annually

~~2.~~**4. A Chemotherapy Consent form must be signed by the patient or designee prior to the administration of the chemotherapy regimen.** ~~All patients at TCMC that have an order for any antineoplastic agent to be administered while in our care, must have a TCMC approved consent form completed in full prior to the administration of any antineoplastic agent~~.

~~3.~~**5. For** ~~All~~ chemotherapy orders **see PCS Policy: Chemotherapy Prescribing, Processing and Preparations** ~~from a physician must be written on the TCMC approved Chemotherapy Order Form. All sections of the TCMC approved Chemotherapy Order Form must be completed for the chemotherapy order to be valid. Verbal or telephone orders for any antineoplastic agents are not permitted at TCMC (TCMC Medication Administration policy IV.I). Chemotherapy Orders that are received via fax on a TCMC approved Chemotherapy Order Form are acceptable. Any chemotherapy order or clarification of a chemotherapy order from a physician that has been received verbally or via telephone will not be recognized as a valid chemotherapy order. Telephone orders from the physician related to start/stop times for the chemotherapy and pre-medications are acceptable~~.

D. **PATIENT PREPARATION:**

1. Set up continuous pulse oxymetry for all patients receiving monoclonal antibodies.
2. Explain to the patient and family/caregivers who will administer the chemotherapy, the route, and the planned sequence of events.

E. **DOCUMENTATION:**

1. The administering Chemotherapy Competent Nurse will complete a **Cerner**~~Compass~~ **Chemotherapy Administration AdHoc Form** on every chemotherapy agent administered.
2. All chemotherapy agents will require a second electronic signature by a Chemotherapy Competent ~~Registered Nurse~~**RN** ~~(preferred) or a Registered Nurse (if a second chemotherapy competent nurse is unavailable)~~ verifying accuracy of the chemotherapy agent and order on the **Chemotherapy Administration AdHoc Form (Verification #1) and the Cerner**~~Compass~~ **Electronic Medication Administration Record** (EMAR) by using their **Cerner**~~Compass~~ password **(Verification #2)**.

a. Off unit chemotherapy **Verification #1** can be witnessed by the **floor pharmacist if a second chemotherapy nurse is not available**~~Assistant Nurse Manager or Charge Nurse with the chemotherapy nurse from the oncology unit~~.

F. **ADMINISTERING INTRAVENOUS (IV), INTRAMUSCULAR (IM) AND SUBCUTANEOUS (SQ) CHEMOTHERAPY**

1. IV, IM and SQ chemotherapy orders and agents will be verified ~~three times~~**twice** for accuracy before administration. Accuracy will be determined by verifying:
2. **VERIFICATION # 1 - Chemotherapy Nurse/Chemotherapy Nurse** ~~**Pharmacy/ Nurse**~~
   a. **Verification for accuracy will be completed by two Chemotherapy Competent RNs when the chemotherapy agent arrives on the unit and documented in the Cerner Chemotherapy Administration AdHoc Form.**
      i. **A floor Pharmacist/ Chemotherapy Competent RN can do the #1 verification if two Chemotherapy Competent RNs are not available on the off unit areas.** ~~A TCMC pharmacist will co-sign with a Chemotherapy Competent Registered Nurse on the TCMC Pharmacy/Nurse Chemotherapy Verification Form that the chemotherapy agent that was delivered to the nursing unit is accurate.~~
   b. **Verification #1 will be determined by verifying:**
      i. Date /Time of Administration
      ii. Patient Name
      iii. Chemotherapy Agent
      iv. Dose
      v. Diluents /Volume (If applicable)
      vi. Rate of Administration (If applicable)
      vii. Route
      viii. Patient's Height and Weight
      ix. Patient's body surface area (BSA)-If applicable
      ~~ix.~~**x. Area under the curve (AUC) if applicable**
3. **VERIFICATION #2- Chemotherapy Nurse/ Chemotherapy Nurse or TCHD RN (IV, IM and SQ Chemo Only)**~~**Nurse/Nurse**~~
   a. **At the patient's bedside** a second verification for accuracy will be completed ~~by two Chemotherapy Competent Registered Nurses (preferred)~~ and documented on the **electronic medication administration record (EMAR)**~~Compass **Chemotherapy Administration AdHoc Form**. If a second Chemotherapy Competent Registered Nurse is not available a TCMC registered nurse may co-sign to verify the accuracy of the chemotherapy agent and order.~~
   b. **Verification #2 will be determined by verifying the 7 rights the following per the PCS Policy: Medication Administration:**
      i. **Verify correct:**
         1) **Patient**
         2) **Dose**
         3) **Time**
         4) **Medication**
         5) **Route/ Rate (if applicable)**
         6) **Documentation**
         ~~1)~~**7) Reason**
4. ~~**VERIFICATION #3 Nurse/Nurse**~~
   a. ~~At the patient's bedside a third verification for accuracy will be completed by two Chemotherapy Competent Registered Nurses (preferred) and documented on the witness section on the Caremobile device.~~
4. All intravenous **Vesicant Chemotherapy** will **only** be administered via a **Central Venous Catheter** and should **never** be administered peripherally.

~~b.~~**a. Exception- Paclitaxel may be administered via peripheral IV if the IV site is visually assessed every 15 minutes for signs and symptoms of extravasation (Inpatient ratio would be 2:1).**

5. All intravenous chemotherapy will be administered through an Alaris IV pump using the oncology profile and specific guardrail for the chemotherapy agent.

6. Peripheral **Non-Vesicant** Chemotherapy Administration**:**

a. Start a new peripheral IV if site is more than 24 hours old.

b. Avoid flexion joint sites.

c. Preferably select a large vein between wrist and elbow.

d. Avoid veins in the hand, wrist and antecubital fossa.

~~a.~~**e.** Tape IV site so it can be monitored.

~~6.~~**7.** Extravasation Prevention

a. Blood return must be checked prior to administration of any chemotherapy agent.

i. **Vesicants: Verify blood return and IV patency prior to, during and post administration of a vesicant.**

b. Inspect IV site for signs and symptoms of the following before administration:

i. Peripheral

1) Redness
2) Inflammation
3) Infiltration
4) Patient comfort level at IV site

ii. Central Venous Catheters (CVC)

1) Erythema
2) Swelling
3) Drainage
4) Leakage
5) Venous thrombosis of the ipsilateral chest (CVC located in the chest region).

~~7.~~**8.** Verify that the patient has signed a ~~TCMC~~**TCHD** approved consent form for chemotherapy administration.

~~8.~~**9.** Don **personal protective equipment (**PPE**)** in the following order before spiking a pre-filled chemotherapy IV bag or when manipulating a syringe that contains a chemotherapy agent:

a. Face shield or splash goggles
b. N-95 mask
c. First pair of chemo gloves
d. Chemo gown with the cuffs over the first pair of gloves
e. Second pair of chemo gloves over the cuffs of the gown

~~9.~~**10. Procedure:**

a. **<u>IV Push</u>**

i. Don two pair of chemotherapy safe gloves.

1) Examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.

ii. **Complete** Verification #1 ~~& #2 (see section F of this procedure) should be completed~~.

iii. Assemble equipment**.**

1) Extravasation Kit
2) ~~Personal Protective Equipment (~~PPE~~)~~ (face shield or splash goggles, N95 mask, chemotherapy gown, 2 pairs of chemotherapy gloves). It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
3) Chemotherapy puncture- proof waste disposal container
4) Leak-proof bag marked "Chemotherapy Waste"
5) Plastic –backed absorbent pad
6) Sterile gauze

7) 3 Alcohol Prep Pads

iv. Review all manufacture's recommendations (located in the ~~TCMC~~**TCHD** Drug Formulary or package insert) pertaining to the administration, pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow ~~TCMC's~~**PCS Procedure:** Chemotherapy Extravasation ~~Procedure~~.

vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion) , chemo safety for body fluids and when to notify the nurse for signs and symptoms of:

1) Extravasation
   a) Burning
   b) Pain
   c) Heat
   d) Ulceration
   e) Swelling~~)~~

2) Signs and symptoms of hypersensitivity and anaphylaxis
   a) Uneasiness
   b) Tightness of the chest
   c) Shortness of breath-with or without wheezing
   d) Hives or rash
   e) Local or generalized itching
   f) Periorbital or facial edema
   g) Lightheadedness or dizziness

vii. IV Chemotherapy shall be administered with no other IV medications or IV fluids running except for the mainline compatible IV fluid used during the IV push chemotherapy administration.

viii. Label the IV pump and the IV push chemotherapy syringe with a ~~TCMC~~**TCHD** approved "Chemotherapy" identification sticker before administration.

ix. Inspect IV site and check patient's IV for blood return.

x. Don PPE in the following order before administration:
1) Face shield or splash goggles
2) N-95 mask
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

xi. Place plastic –backed absorbent pad under the patient's arm to prevent drug contact with patient's skin.

xii. Using the **medication barcode scanning** ~~Caremobile~~ device at the patient's bedside, scan the patient and the ordered chemotherapy per the ~~Tricity Medical Center's Patient Care Service~~**PCS Policy:** Medication Administration ~~Procedure~~.

1) **Outpatient Infusion Center will complete the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.**

xiii. Complete Verification #2 ~~A second Chemotherapy Competent Registered Nurse (preferred) will verify the accuracy of the chemotherapy agent for a third time (see section F of this procedure for verification #3)~~ and ~~will~~ complete the witness section on the **medication barcode scanning** ~~Caremobile~~ device.

~~2)~~**1) Outpatient Infusion Center will document on the EMAR.**

~~xii.~~**xiv.** Using the alcohol prep pads, clean the patient's IV access port three times

~~xiii.~~**xv.** Wrap sterile gauze around IV ports during IV push to reduce the potential for spraying

~~xiv.~~**xvi.** Inject drug into distal port of IV with free flowing solution at the prescribed rate (minimum of 100ml/hour). Verify blood return every 2-3 m**L**~~l~~ of drug administration.

~~xv.~~**xvii.** Flush line with 10-20m**L**~~l~~ of IV solution between administration of drugs or prior to discontinuing IV.

1) Prevents incompatibility reaction and avoids exposure to anti-neoplastic agents.

~~xvi.~~**xviii.** Dispose of syringes in the puncture proof container labeled "Chemotherapy waste".

~~xvii.~~**xix.** Recheck IV lines to be sure lines are leading to patient and are connected to the correct IV port.

~~xviii.~~**xx.** Remove PPE in the following order and place in a chemotherapy waste bag and seal

1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) N-95 mask
5) Final pair of gloves

~~xix.~~**xxi.** See ~~TCMC~~**PCS Procedure:** Disposal of Chemotherapy Waste ~~Procedure~~ for proper disposal of contaminated materials

b. **IV Continuous or Intermittent**

i. Donning two pair of chemotherapy gloves, examine the Chemotherapy pre-filled IV bag and tubing for leakage or damage in the medication room before administration.

ii. **Complete** Verification #1 ~~& #2 (see section F of this procedure) should be completed~~.

iii. Assemble equipment for use during administration.

1) Extravasation Kit
2) Personal Protective Equipment (PPE) (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
3) Chemotherapy puncture proof waste disposal container
4) Leak-proof bag marked "Chemotherapy Waste"
5) "Chemotherapy" identification stickers
6) Disposable plastic –backed absorbent liner
7) Plastic tape
8) 3 Alcohol Prep Pads

iv. Review all manufacture's recommendations pertaining to the administration (located in the ~~TCMC~~**TCHD** Drug Formulary or package insert), pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow ~~TCMC~~**TCHD**'s Chemotherapy Extravasation Procedure.

vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:

1) Extravasation
   a) Burning
   b) Pain
   c) Heat
   d) Ulceration
   e) Swelling

2) Signs and symptoms of hypersensitivity and anaphylaxis
   a) Uneasiness
   b) Tightness of the chest
   c) Shortness of breath-with or without wheezing
   d) Hives or rash
   e) Local or generalized itching
   f) Periorbital or facial edema
   g) Lightheadedness or dizziness

vii. IV Chemotherapy shall be administered on a single Alaris IV pump with no other IV medications or IV fluids running except for the mainline compatible flush bag for the IV chemotherapy agent.

viii. Don PPE in the following order before administration:
1) Face shield or splash goggles
2) N-95 mask
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

ix. Prime all IV tubing with a compatible IV fluid before administering the chemotherapy intravenously if not already done by pharmacy.

x. At the patient's bedside, program the Alaris pump using the appropriate chemotherapy drug guardrail profile with the witnessing second Chemotherapy Competent Nurse (preferred) **or TCHD RN**.
1) Power on the Alaris IV pump and select **New Patient**.
2) Select the **Oncology Profile.**
3) Enter the patient's **medical record number**.
4) Select Channel letter that will be used.
5) Select **Guardrail Drugs**.
6) Select the appropriate chemotherapy agent to be administered from the Alaris Oncology Drug Guardrail List.
7) Verify and confirm correct dosing program.
8) Review **Clinical Advisory Warning** on the Alaris IV pump and **Confirm** when read.
9) Input the **Drug Amount**, **Diluent Volume**, **BSA** (if applicable). Verify dose and select **Next.**
10) Input **Rate** and Volume to be infused (**VTBI**).

xi. Using the ~~Caremobile~~**medication barcode scanning** device **at the patient's bedside**, scan the patient and the ordered chemotherapy IV bag per the ~~Tricity Medical Center's Patient Care Service~~**PCS Policy:** Medication Administration ~~Procedure~~.
~~11)~~**1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.**

xii. Complete Verification #2 ~~A second Chemotherapy Competent Registered Nurse (preferred) will~~ **including** verify**ication of** the Alaris infusion guardrail set up and rate as well as the chemotherapy agent for accuracy at the patient's bedside ~~for a third time~~ and ~~will~~ complete the witness section on the **medication barcode scanning** ~~Caremobile~~ device (see ~~section F of this procedure for~~ verification #~~23~~).
~~12)~~**1) Outpatient Infusion Center will document on the EMAR.**

~~xi.~~**xiii.** Label the IV pump and the IV chemotherapy bag with a ~~TCMC~~**TCHD** approved "Chemotherapy" identification sticker before administration.

~~xii.~~**xiv.** Inspect IV site and check patient's IV for blood return.

~~xiii.~~**xv.** Use disposable plastic –backed absorbent liner under the IV

~~xiv.~~**xvi.** Using the alcohol prep pads, clean the patient's IV access port three times.

~~xv.~~**xvii.** Securely attach the IV tubing to the patient's venous access device or, if using a secondary set, to the primary tubing

~~xvi.~~**xviii.** Tape the two IV connections together

~~xvii.~~**xix.** Review dose and then select **Start** to begin infusion on the Alaris pump.

~~xviii.~~**xx.** When infusion is complete, don PPE as instructed~~(viii)~~.

~~xix.~~**xxi.** Dispose of contaminated IV tubing and IV bags in a sealed chemotherapy waste bag and place in a puncture- proof chemotherapy waste container

~~xx.~~**xxii.** Remove PPE in the following order and place in a chemotherapy waste bag and seal:

1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) N-95 mask
5) Final pair of gloves

~~xxi.~~**xxiii.** See ~~TCMC~~**PCS Procedure:** Disposal of Chemotherapy Waste ~~Procedure~~ for proper disposal of contaminated materials

c. **Intramuscular (IM) and Subcutaneous (SQ)**

i. Donning two pair of chemotherapy gloves, examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.

ii. **Compete** Verification #1 ~~& #2 (see section F of this procedure) should be completed~~.

iii. Assemble equipment for use during administration.

1) ~~Personal Protective Equipment (~~PPE~~)~~ (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
2) Chemotherapy puncture- proof sharps waste container
3) Leak-proof bag marked "Chemotherapy Waste"
4) "Chemotherapy" identification sticker
5) Appropriate size sterile needle (Use smallest needle possible)
6) 2x2 **gauze pads**
7) Alcohol Prep Pads
8) Band-Aid

iv. Review all manufacture's recommendations pertaining to the administration (located in the ~~TCMC~~**TCHD** Drug Formulary or package insert), pre-medication, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

v. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:

1) Signs and symptoms of hypersensitivity and anaphylaxis
   a) Uneasiness
   b) Tightness of the chest
   c) Shortness of breath-with or without wheezing
   d) Hives or rash
   e) Local or generalized itching
   f) Periorbital or facial edema
   g) Lightheadedness or dizziness

vi. Label chemotherapy syringe with a ~~TCMC~~**TCHD** approved "Chemotherapy" identification sticker before administration.

vii. Don PPE in the following order before administration:

1) Face mask or Splash Goggles
2) N-95 mask
3) First pair of chemo gloves

4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

viii. Remove cap and connect sterile needle of the appropriate size for administering the drug.

ix. Do not expel air from the syringe or prime the needle.

x. Using the ~~Caremobile~~**medication barcode scanning** device at the patient's bedside, scan the patient and the ordered chemotherapy per the ~~Tricity Medical Center's Patient Care Service~~ **PCS Policy:** Medication Administration ~~Procedure~~.

1) **Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.**

xi. Complete Verification #2 and complete the witness section on the medication scanning device. ~~A second Chemotherapy Competent Registered Nurse (preferred) will verify the accuracy of the chemotherapy agent for a third time (see section F of this procedure for verification #3) and will complete the witness section on the Caremobile device.~~

~~2)~~**1) Outpatient Infusion Center will document on the EMAR.**

~~x.~~**xii.** Review the manufacturers injection site recommendation

~~xi.~~**xiii.** Cleanse injection site with alcohol prep pads

~~xii.~~**xiv.** After administering the drug, do not re-cap and do not message injection site.

~~xiii.~~**xv.** Place the syringe with the needle attached directly into the puncture- proof chemotherapy waste container.

~~xiv.~~**xvi.** Remove PPE in the following order and place in a chemotherapy waste bag and seal

1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) N-95 mask
5) Final pair of gloves

~~xv.~~**xvii.** See ~~TCMC~~ **PCS Procedure:** Disposal of Chemotherapy Waste ~~Procedure~~ for proper disposal of contaminated materials

~~xvi.~~**xviii.** Monitor injection site every hour for signs and symptoms of infection and bleeding post injection.

~~xvii.~~**xix.** Educate patients going home after injection to **assess**~~access~~ the injection site twice a day for bleeding and signs and symptoms of infection.

G. ADMINISTERING ORAL CHEMOTHERAPY

1. Oral Chemotherapy may **not** be **crushed, scored** or **capsules opened** on the nursing units. All oral chemotherapy agents that need to be altered in this manner must only be done by the pharmacy in a controlled environment. If patient is unable to take the chemotherapy agent orally in a whole form and an alternative route (Nasogastric tube, gastric tube etc.) is available, notify the pharmacy **as soon as possible (**ASAP**)** so alterations can be made to the original medication form so the agent can be administered safely.
2. **Procedure**
   a. **Oral Chemotherapy**
      i. Verify that the patient has signed a ~~TCMC~~**TCHD** approved consent form for chemotherapy administration.
      ~~ii. Oral chemotherapy orders and agents will be verified for accuracy before administration. Accuracy will be determined by verifying:~~
      ~~1) Date /Time of Administration~~
      ~~2) Patient Name~~
      ~~3) Chemotherapy Agent~~
      ~~4) Dose~~
      ~~5) Route~~

~~6) Patient's Height and Weight (If applicable)~~
~~7) Patient's body surface area (BSA) (If applicable)~~

~~iii.~~**ii.** **Complete** Verification #12 ~~(see section F of this procedure) should be completed~~.

~~iv.~~**iii.** **Oral chemotherapy must be initially checked for accuracy on the first dose by two chemotherapy nurses using the Verification #1 and all subsequent doses can be checked by a chemotherapy nurse and a TCHD RN following the PCS Policy: Medication Administration 7 rights (see Verification #2).**

~~v.~~**iv.** Assemble disposal equipment for use during administration
1) Personal Protective Equipment (PPE)
2) Two pairs of chemotherapy gloves.
3) If administering an oral chemotherapeutic agent that is in a liquid or powder form, a face shield or goggles, N-95 mask, and chemotherapy disposable gown is recommended. It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
4) Leak-proof bag marked "Chemotherapy Waste"

~~vi.~~**v.** Review all manufactures recommendations pertaining to the administration, pre-medication, labs and potential side effects (located in the ~~TCMC~~**TCHD** Drug Formulary or package insert), of the specific chemotherapeutic agent before agent is administered.

~~vii.~~**vi.** Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
1) Hypersensitivity and anaphylaxis
   i) Uneasiness
   ii) Tightness of the chest
   iii) Shortness of breath-with or without wheezing
   iv) Hives or rash
   v) Local or generalized itching
   vi) Periorbital or facial edema
   vii) Lightheadedness or dizziness

~~viii.~~**vii.** Assess patient's ability to swallow prior to administration

~~ix.~~**viii.** Don two chemotherapy gloves before handling the oral chemotherapy agent and during administration.

ix. Using the ~~Caremobile~~**medication barcode scanning** device at the patient's bedside, scan the patient and the ordered chemotherapy per the ~~Tri-City Medical Center's Patient Care Service~~ **PCS Policy:** Medication Administration ~~Procedure~~.
1) **Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physician's order).**

x. **Complete Verification #2**~~A second Chemotherapy Competent Registered Nurse (preferred) will verify the accuracy of the chemotherapy agent for a second time (see section F of this procedure for verification #3)~~ and ~~will~~ complete the witness section on the ~~Caremobile~~**medication barcode scanning** device.
~~2)~~**1) Outpatient Infusion Center will document on the EMAR.**

~~x.~~**xi.** Dispose of all materials that came into contact with the chemotherapeutic agent (i.e. medication cup, manufacturer's container or packaging) in a leak-proof chemotherapy waste bag and seal
1) See ~~TCMC~~**PCS Procedure:** Disposal of Chemotherapy Waste ~~Procedure~~ for proper disposal of contaminated material.

H. RELATED DOCUMENTS:

1. **Acute Care Services (ACS) 2 P Advanced Oncology- Chemotherapy Addendum Nursing Skills Checklist**
2. **Outpatient Infusion Center Skills Checklist**
3. **PCS Policy: Chemotherapy Prescribing, Processing and Preparations**
4. **PCS Policy: Oncology Patient Care-Education Rounding**
5. ~~1.~~ PCS Policy: Medication Administration
6. ~~2.~~ PCS Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids
7. **PCS Procedure: Chemotherapy Extravasation**
8. **PCS Procedure: Disposal of Chemotherapy Waste**

I. REFERENCES

1. Mafrica, Leonard. Safe Handling of Hazardous Drugs. Oncology Nursing Society. (2003)
2. National Institute for Occupational Safety and Health, (2004). Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Retrieved from the NIOSH website at http://www.cdc.gov/niosh/docs/2004-165/#c
3. **Oncology Nursing Forum: Vol.39, No.1 (Jan 2012) Revisions to the 2009 American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards: Expanding the Scope to Include Inpatient Settings**
4. Oncology Nursing Society, (201~~0~~). Chemotherapy and Biotherapy Guidelines, **Fourth**~~Third~~ Edition.

Move from Oncology Manual to Patient Care Services

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEMOTHERAPY ADMINISTRATION**
Purpose:	To outline the chemotherapy competent nurse's responsibility when administering a chemotherapeutic agent: A. Notification of a Chemotherapy Order B. Safe Handling C. Requirements Prior to Administering a Chemotherapeutic Agent D. Patient Preparation E. Documentation F. Administrating Intravenous and Intramuscular Chemotherapy I. IV Push II. IV Continuous or Intermittent III. Intramuscular and Subcutaneous G. Administering Oral Chemotherapy
Supportive Data:	See References
Equipment:	See Equipment Lists for specific administration methods

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A. **NOTIFICATION OF A CHEMOTHERAPY ORDER:**

1. All inpatient units must notify the oncology unit's Assistant Nurse Manager (ANM) or designee when a chemotherapy order has been written for a patient on a unit other than the oncology unit. Notification must be done as soon as the order is written and no later than a 12-hour notice. The oncology unit must be notified so staffing can be adjusted appropriately for patient safety.
2. Nursing must notify Pharmacy via phone and by scanning the chemotherapy orders as soon as possible when a chemotherapy order is received.

B. **SAFE HANDLING:**

1. Many drugs used in the treatment of cancer (i.e. chemotherapy) are considered to be hazardous to health care workers. The term hazardous refers to drugs/chemicals that require special handling because of potential health risks. Therefore, it is imperative that those who work with chemotherapy drugs adhere to this procedure, the pharmaceutical companies recommendations, the Material Safety Data Sheet that pertains to the particular hazardous agent and the Tri-City Healthcare District's (TCHD) policies including but not limited to:
   a. Patient Care Services (PCS) Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids
   b. PCS Procedure: Disposal of Chemotherapy Waste.
2. Transporting Chemotherapy Agents
   a. Transport syringes containing chemotherapy in a sealed container, with the luer lock end syringe capped.
   b. All chemotherapy agents will be placed in a leak proof sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" before agent can be transported.
   c. The nurse transporting a chemotherapy agent will carry a spill kit at all times in case of a potential chemotherapy spill.
   d. In case of an accidental spill or exposure please see PCS Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the PCS Procedure: Disposal of Chemotherapy Waste.
3. Transporting patients that are receiving intravenous chemotherapy

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09,8/09,8/10,11/13, 5/16	6/16	07/16	**07/16**	6/16	08/16	09/16	1/07, 08/09, 8/10;7/13

a. Transporting a patient that is receiving intravenous chemotherapy should be avoided if at all possible due to the potential risk of a chemotherapy spill, extravasation at the IV site and physiological complications associated with chemotherapy administration.
b. If a patient must be transported to another department the nurse must carry a chemotherapy spill kit at all times. The nurse must ensure that the IV site, IV bag(s) and IV lines that are connected to the chemotherapy and the patient are visible and secure to prevent extravasation and spillage of the chemotherapy agent during transport.

C. **REQUIREMENTS PRIOR TO ADMINISTERING A CHEMOTHERAPEUTIC AGENT:**

1. All inpatients receiving IV chemotherapy for the first time are required to have an Oncology Patient Care-Education Rounding completed 24 -36 prior to the first chemotherapy dose. See the PCS Policy: Oncology Patient Care-Education Rounding Policy.
2. At the Outpatient Infusion Center a physician must be on the premises at all times if chemotherapy is being infused into a patient(s).
3. Chemotherapy may only be administered by a **Chemotherapy Competent Registered Nurse** (RN). A Chemotherapy Competent RN is defined by the following requirements:
   a. Has taken and passed an Oncology Nursing Society approved chemotherapy course.
   b. Has completed Chemotherapy Administration competency validation by a TCHD chemotherapy competent nurse (see example Acute Care Services (ACS) 2 P Advanced Oncology- Chemotherapy Addendum Nursing Skills Checklist or Outpatient Infusion Center Skills Checklist).
   c. Completes Chemotherapy Administration competency annually
4. A Chemotherapy Consent form must be signed by the patient or designee prior to the administration of the chemotherapy regimen..
5. For chemotherapy orders see PCS Policy: Chemotherapy Prescribing, Processing and Preparations.

D. **PATIENT PREPARATION:**

1. Set up continuous pulse oxymetry for all patients receiving monoclonal antibodies.
2. Explain to the patient and family/caregivers who will administer the chemotherapy, the route, and the planned sequence of events.

E. **DOCUMENTATION:**

1. The administering Chemotherapy Competent Nurse will complete a Cerner Chemotherapy Administration AdHoc Form on every chemotherapy agent administered.
2. All chemotherapy agents will require a second electronic signature by a Chemotherapy Competent RN verifying accuracy of the chemotherapy agent and order on the Chemotherapy Administration AdHoc Form (Verification #1) and the Cerner Electronic Medication Administration Record (EMAR) by using their Cerner password (Verification #2).
   a. Off unit chemotherapy Verification #1 can be witnessed by the floor pharmacist if a second chemotherapy nurse is not available.

F. **ADMINISTERING INTRAVENOUS (IV), INTRAMUSCULAR (IM) AND SUBCUTANEOUS (SQ) CHEMOTHERAPY**

1. IV, IM and SQ chemotherapy orders and agents will be verified twice for accuracy before administration. Accuracy will be determined by verifying:
2. **VERIFICATION # 1 - Chemotherapy Nurse/Chemotherapy Nurse**
   a. Verification for accuracy will be completed by two Chemotherapy Competent RNs when the chemotherapy agent arrives on the unit and documented in the Cerner Chemotherapy Administration AdHoc Form.
      i. A floor Pharmacist/ Chemotherapy Competent RN can do the #1 verification if two Chemotherapy Competent RNs are not available on the off unit areas.
   b. Verification #1 will be determined by verifying:
      i. Date /Time of Administration

ii. Patient Name
iii. Chemotherapy Agent
iv. Dose
v. Diluents /Volume (If applicable)
vi. Rate of Administration (If applicable)
vii. Route
viii. Patient's Height and Weight
ix. Patient's body surface area (BSA)-If applicable
x. Area under the curve (AUC) if applicable

3. **VERIFICATION #2- Chemotherapy Nurse/ Chemotherapy Nurse or TCHD RN (IV, IM and SQ Chemo Only)**
   a. At the patient's bedside a second verification for accuracy will be completed and documented on the electronic medication administration record (EMAR)
   b. Verification #2 will be determined by verifying the 7 rights the following per the PCS Policy: Medication Administration:
      i. Verify correct:
         1) Patient
         2) Dose
         3) Time
         4) Medication
         5) Route/ Rate (if applicable)
         6) Documentation
         7) Reason
4. All intravenous Vesicant Chemotherapy will only be administered via a Central Venous Catheter and should never be administered peripherally.
   a. Exception- Paclitaxel may be administered via peripheral IV if the IV site is visually assessed every 15 minutes for signs and symptoms of extravasation (Inpatient ratio would be 2:1).
5. All intravenous chemotherapy will be administered through an Alaris IV pump using the oncology profile and specific guardrail for the chemotherapy agent.
6. Peripheral Non-Vesicant Chemotherapy Administration:
   a. Start a new peripheral IV if site is more than 24 hours old.
   b. Avoid flexion joint sites.
   c. Preferably select a large vein between wrist and elbow.
   d. Avoid veins in the hand, wrist and antecubital fossa.
   e. Tape IV site so it can be monitored.
7. Extravasation Prevention
   a. Blood return must be checked prior to administration of any chemotherapy agent.
      i. Vesicants: Verify blood return and IV patency prior to, during and post administration of a vesicant.
   b. Inspect IV site for signs and symptoms of the following before administration:
      i. Peripheral
         1) Redness
         2) Inflammation
         3) Infiltration
         4) Patient comfort level at IV site
      ii. Central Venous Catheters (CVC)
         1) Erythema
         2) Swelling
         3) Drainage
         4) Leakage
         5) Venous thrombosis of the ipsilateral chest (CVC located in the chest region).

8. Verify that the patient has signed a TCHD approved consent form for chemotherapy administration.
9. Don personal protective equipment (PPE) in the following order before spiking a pre-filled chemotherapy IV bag or when manipulating a syringe that contains a chemotherapy agent:
    a. Face shield or splash goggles
    b. N-95 mask
    c. First pair of chemo gloves
    d. Chemo gown with the cuffs over the first pair of gloves
    e. Second pair of chemo gloves over the cuffs of the gown
10. **Procedure:**
    a. **<u>IV Push</u>**
        i. Don two pair of chemotherapy safe gloves.
            1) Examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.
        ii. Complete Verification #1 .
        iii. Assemble equipment.
            1) Extravasation Kit
            2) PPE (face shield or splash goggles, N95 mask, chemotherapy gown, 2 pairs of chemotherapy gloves). It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
            3) Chemotherapy puncture- proof waste disposal container
            4) Leak-proof bag marked "Chemotherapy Waste"
            5) Plastic –backed absorbent pad
            6) Sterile gauze
            7) 3 Alcohol Prep Pads
        iv. Review all manufacture's recommendations (located in the TCHD Drug Formulary or package insert) pertaining to the administration, pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
        v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow PCS Procedure: Chemotherapy Extravasation.
        vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion) , chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
            1) Extravasation
                a) Burning
                b) Pain
                c) Heat
                d) Ulceration
                e) Swelling
            2) Signs and symptoms of hypersensitivity and anaphylaxis
                a) Uneasiness
                b) Tightness of the chest
                c) Shortness of breath-with or without wheezing
                d) Hives or rash
                e) Local or generalized itching
                f) Periorbital or facial edema
                g) Lightheadedness or dizziness
        vii. IV Chemotherapy shall be administered with no other IV medications or IV fluids running except for the mainline compatible IV fluid used during the IV push chemotherapy administration.

viii. Label the IV pump and the IV push chemotherapy syringe with a TCHD approved "Chemotherapy" identification sticker before administration.
ix. Inspect IV site and check patient's IV for blood return.
x. Don PPE in the following order before administration:
    1) Face shield or splash goggles
    2) N-95 mask
    3) First pair of chemo gloves
    4) Chemo gown with the cuffs over the first pair of gloves
    5) Second pair of chemo gloves over the cuffs of the gown
xi. Place plastic –backed absorbent pad under the patient's arm to prevent drug contact with patient's skin.
xii. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
    1) Outpatient Infusion Center will complete the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.
xiii. Complete Verification #2 and complete the witness section on the medication barcode scanning device.
    1) Outpatient Infusion Center will document on the EMAR.
xiv. Using the alcohol prep pads, clean the patient's IV access port three times
xv. Wrap sterile gauze around IV ports during IV push to reduce the potential for spraying
xvi. Inject drug into distal port of IV with free flowing solution at the prescribed rate (minimum of 100ml/hour). Verify blood return every 2-3 mL of drug administration.
xvii. Flush line with 10-20mL of IV solution between administration of drugs or prior to discontinuing IV.
    1) Prevents incompatibility reaction and avoids exposure to anti-neoplastic agents.
xviii. Dispose of syringes in the puncture proof container labeled "Chemotherapy waste".
xix. Recheck IV lines to be sure lines are leading to patient and are connected to the correct IV port.
xx. Remove PPE in the following order and place in a chemotherapy waste bag and seal
    1) Outer pair of gloves
    2) Chemo gown
    3) Face Shield or splash goggles
    4) N-95 mask
    5) Final pair of gloves
xxi. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials

b. **IV Continuous or Intermittent**
i. Donning two pair of chemotherapy gloves, examine the Chemotherapy pre-filled IV bag and tubing for leakage or damage in the medication room before administration.
ii. Complete Verification #1.
iii. Assemble equipment for use during administration.
    1) Extravasation Kit
    2) Personal Protective Equipment (PPE) (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
    3) Chemotherapy puncture proof waste disposal container

4) Leak-proof bag marked "Chemotherapy Waste"
5) "Chemotherapy" identification stickers
6) Disposable plastic –backed absorbent liner
7) Plastic tape
8) 3 Alcohol Prep Pads

iv. Review all manufacture's recommendations pertaining to the administration (located in the TCHD Drug Formulary or package insert), pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCHD's Chemotherapy Extravasation Procedure.

vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
1) Extravasation
   a) Burning
   b) Pain
   c) Heat
   d) Ulceration
   e) Swelling
2) Signs and symptoms of hypersensitivity and anaphylaxis
   a) Uneasiness
   b) Tightness of the chest
   c) Shortness of breath-with or without wheezing
   d) Hives or rash
   e) Local or generalized itching
   f) Periorbital or facial edema
   g) Lightheadedness or dizziness

vii. IV Chemotherapy shall be administered on a single Alaris IV pump with no other IV medications or IV fluids running except for the mainline compatible flush bag for the IV chemotherapy agent.

viii. Don PPE in the following order before administration:
1) Face shield or splash goggles
2) N-95 mask
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

ix. Prime all IV tubing with a compatible IV fluid before administering the chemotherapy intravenously if not already done by pharmacy.

x. At the patient's bedside, program the Alaris pump using the appropriate chemotherapy drug guardrail profile with the witnessing second Chemotherapy Competent Nurse (preferred) or TCHD RN.
1) Power on the Alaris IV pump and select New Patient.
2) Select the Oncology Profile.
3) Enter the patient's medical record number.
4) Select Channel letter that will be used.
5) Select Guardrail Drugs.
6) Select the appropriate chemotherapy agent to be administered from the Alaris Oncology Drug Guardrail List.
7) Verify and confirm correct dosing program.
8) Review Clinical Advisory Warning on the Alaris IV pump and Confirm when read.

9) Input the Drug Amount, Diluent Volume, BSA (if applicable). Verify dose and select Next.
10) Input Rate and Volume to be infused (VTBI).

xi. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy IV bag per the PCS Policy: Medication Administration.
1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.

xii. Complete Verification #2 including verification of the Alaris infusion guardrail set up and rate as well as the chemotherapy agent for accuracy at the patient's bedside and complete the witness section on the medication barcode scanning device (see verification #2).
1) Outpatient Infusion Center will document on the EMAR.

xiii. Label the IV pump and the IV chemotherapy bag with a TCHD approved "Chemotherapy" identification sticker before administration.

xiv. Inspect IV site and check patient's IV for blood return.

xv. Use disposable plastic –backed absorbent liner under the IV

xvi. Using the alcohol prep pads, clean the patient's IV access port three times.

xvii. Securely attach the IV tubing to the patient's venous access device or, if using a secondary set, to the primary tubing

xviii. Tape the two IV connections together

xix. Review dose and then select Start to begin infusion on the Alaris pump.

xx. When infusion is complete, don PPE as instructed.

xxi. Dispose of contaminated IV tubing and IV bags in a sealed chemotherapy waste bag and place in a puncture- proof chemotherapy waste container

xxii. Remove PPE in the following order and place in a chemotherapy waste bag and seal:
1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) N-95 mask
5) Final pair of gloves

xxiii. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials

c. **Intramuscular (IM) and Subcutaneous (SQ)**

i. Donning two pair of chemotherapy gloves, examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.

ii. Compete Verification #1 .

iii. Assemble equipment for use during administration.
1) PPE (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
2) Chemotherapy puncture- proof sharps waste container
3) Leak-proof bag marked "Chemotherapy Waste"
4) "Chemotherapy" identification sticker
5) Appropriate size sterile needle (Use smallest needle possible)
6) 2x2 gauze pads
7) Alcohol Prep Pads
8) Band-Aid

iv. Review all manufacture's recommendations pertaining to the administration (located in the TCHD Drug Formulary or package insert), pre-medication, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

v. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
   1) Signs and symptoms of hypersensitivity and anaphylaxis
      a) Uneasiness
      b) Tightness of the chest
      c) Shortness of breath-with or without wheezing
      d) Hives or rash
      e) Local or generalized itching
      f) Periorbital or facial edema
      g) Lightheadedness or dizziness

vi. Label chemotherapy syringe with a TCHD approved "Chemotherapy" identification sticker before administration.

vii. Don PPE in the following order before administration:
   1) Face mask or Splash Goggles
   2) N-95 mask
   3) First pair of chemo gloves
   4) Chemo gown with the cuffs over the first pair of gloves
   5) Second pair of chemo gloves over the cuffs of the gown

viii. Remove cap and connect sterile needle of the appropriate size for administering the drug.

ix. Do not expel air from the syringe or prime the needle.

x. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
   1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.

xi. Complete Verification #2 and complete the witness section on the medication scanning device.
   1) Outpatient Infusion Center will document on the EMAR.

xii. Review the manufacturers injection site recommendation

xiii. Cleanse injection site with alcohol prep pads

xiv. After administering the drug, do not re-cap and do not message injection site.

xv. Place the syringe with the needle attached directly into the puncture- proof chemotherapy waste container.

xvi. Remove PPE in the following order and place in a chemotherapy waste bag and seal
   1) Outer pair of gloves
   2) Chemo gown
   3) Face Shield or splash goggles
   4) N-95 mask
   5) Final pair of gloves

xvii. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials

xviii. Monitor injection site every hour for signs and symptoms of infection and bleeding post injection.

xix. Educate patients going home after injection to assess the injection site twice a day for bleeding and signs and symptoms of infection.

G. **ADMINISTERING ORAL CHEMOTHERAPY**

1. Oral Chemotherapy may **not** be **crushed, scored** or **capsules opened** on the nursing units. All oral chemotherapy agents that need to be altered in this manner must only be done by the

pharmacy in a controlled environment. If patient is unable to take the chemotherapy agent orally in a whole form and an alternative route (Nasogastric tube, gastric tube etc.) is available, notify the pharmacy as soon as possible (ASAP) so alterations can be made to the original medication form so the agent can be administered safely.

2. **Procedure**
   a. **Oral Chemotherapy**
      i. Verify that the patient has signed a TCHD approved consent form for chemotherapy administration.
      ii. Complete Verification #1 .
      iii. Oral chemotherapy must be initially checked for accuracy on the first dose by two chemotherapy nurses using the Verification #1 and all subsequent doses can be checked by a chemotherapy nurse and a TCHD RN following the PCS Policy: Medication Administration 7 rights (see Verification #2).
      iv. Assemble disposal equipment for use during administration
         1) Personal Protective Equipment (PPE)
         2) Two pairs of chemotherapy gloves.
         3) If administering an oral chemotherapeutic agent that is in a liquid or powder form, a face shield or goggles, N-95 mask, and chemotherapy disposable gown is recommended. It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
         4) Leak-proof bag marked "Chemotherapy Waste"
      v. Review all manufactures recommendations pertaining to the administration, pre-medication, labs and potential side effects (located in the TCHD Drug Formulary or package insert), of the specific chemotherapeutic agent before agent is administered.
      vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
         1) Hypersensitivity and anaphylaxis
            a) Uneasiness
            b) Tightness of the chest
            c) Shortness of breath-with or without wheezing
            d) Hives or rash
            e) Local or generalized itching
            f) Periorbital or facial edema
            g) Lightheadedness or dizziness
      vii. Assess patient's ability to swallow prior to administration
      viii. Don two chemotherapy gloves before handling the oral chemotherapy agent and during administration.
      ix. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
         1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physician's order).
      x. Complete Verification #2 and complete the witness section on the medication barcode scanning device.
         1) Outpatient Infusion Center will document on the EMAR.
      xi. Dispose of all materials that came into contact with the chemotherapeutic agent (i.e. medication cup, manufacturer's container or packaging) in a leak-proof chemotherapy waste bag and seal
         1) See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated material.

H. RELATED DOCUMENTS:

1. Acute Care Services (ACS) 2 P Advanced Oncology- Chemotherapy Addendum Nursing Skills Checklist
2. Outpatient Infusion Center Skills Checklist
3. PCS Policy: Chemotherapy Prescribing, Processing and Preparations
4. PCS Policy: Oncology Patient Care-Education Rounding
5. PCS Policy: Medication Administration
6. PCS Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids
7. PCS Procedure: Chemotherapy Extravasation
8. PCS Procedure: Disposal of Chemotherapy Waste

I. REFERENCES

1. Mafrica, Leonard. Safe Handling of Hazardous Drugs. Oncology Nursing Society. (2003)
2. National Institute for Occupational Safety and Health, (2004). Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Retrieved from the NIOSH website at http://www.cdc.gov/niosh/docs/2004-165/#c
3. Oncology Nursing Forum: Vol.39, No.1 (Jan 2012) Revisions to the 2009 American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards: Expanding the Scope to Include Inpatient Settings
4. Oncology Nursing Society, (2014). Chemotherapy and Biotherapy Guidelines, Fourth Edition.

Tri-City Medical Center	Distribution: Outpatient Infusion Center
PROCEDURE:	**AMBULATORY INFUSION PUMPS**
Purpose:	To safely manage care of patients who start medication infusion via ambulatory infusion pump.
Supportive Data:	AIPs are commonly used to deliver a variety of medications, including chemotherapy. Patient safety can be jeopardized if the devices are mishandled when filling, programming, attaching and monitoring.
Equipment:	External ambulatory infusion pump

A. **DEFINITIONS:**

1. Ambulatory Infusion Pump (AIP): an external medical device used to deliver medications to a patient in a controlled manner in an outpatient setting.

B. **POLICY:**

1. AIP will be handled according to manufacturer's Operation Manual.
2. All patients will be educated prior to initiation of AIP for drug infusion.
3. Patients will come no less than once weekly for monitoring while on the AIP.
   a. This may include AIP discontinuation appointment.
   b. Monitoring will include inspection of AIP operation and assurance that drug volume is infusing correctly.

C. **PROCEDURE:**

1. Patient Education
   a. Patients will sign a consent outlining the risks and responsibilities.
   b. Patients will be instructed to call prescribing clinician or phone number located on AIP with questions.
   c. For pumps containing chemotherapy: Patients will be instructed on how to use a chemotherapy spill kit and given a kit to take home.
2. Programming
   a. The AIP will be programmed by pharmacy.
      i. The AIP will be reprogrammed and battery will be replaced at each refill.
      ii. AIP will be set to patient lock-out before dispensing to patient.
3. Preparing/Refilling
   a. Pharmacy to dispense/verify the medication or solution used for refills.
   b. Pharmacy is to dispense no more than 5 days' worth of drug infusion to limit risk of drug errors.
   c. Chemotherapy only: Pharmacy will follow Pharmacy Policy: Chemotherapy Prescribing, Processing and Preparation.
      i. This is to include priming line in Compounding Aseptic Containment Isolator.
4. Administration
   a. RN to install reservoir and tubing set into AIP per Operation Manual.
   b. 2 RNs will independently check pump settings against reservoir label before attaching AIP to patient.
   c. Chemotherapy only: Nursing will follow the Oncology Procedure: Chemotherapy Administration.
5. Discontinuing Use of the AIP
   a. Nursing will ensure all drug is delivered before stopping device.

Department Review	Pharmacy & Therapeutics Committee	Division of Oncology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/16	06/16	07/16	08/16	09/16	

i. Pharmacy/MD will be notified immediately of any evidence of over or under infusion.

b. The AIP will be stopped, clamped and disconnected.
c. Reservoir/tubing set will be disposed of per TCHD policies and procedures.
d. Battery will be disposed of properly.
e. AIP will be cleaned with isopropyl alcohol (all medications) and sodium hypochlorite/neutralizer (hazardous drug leaks/spills only) prior to being returned to pharmacy.

6. Documentation
   a. Drug, dose, rate, total volume to be infused, start and stop time, and actual volume infused (after AIP disconnection) will be recorded on eMAR.
   b. Tracking of AIP serial number dispensed to patient will be performed by entering on Cerner medication label.
7. Maintenance
   a. AIPs shall be sent back to manufacturer upon request for maintenance or according to the manufacturers' maintenance schedule.
      i. The AIP shall not be used if due for maintenance.
   b. Manufacturer will perform all functional verification tests prior to shipping back to TCHD.
   c. If an AIP is suspected to be dysfunctional for any reason, it will be quarantined and sent back to manufacturer for repair.

D. RELATED DOCUMENTS:

1. Oncology Procedure: Chemotherapy Administration
2. Patient Care Services Policy: Patient Owned/Supplied Equipment Brought Into the Facility
3. Patient Care Services Policy: Chemotherapy Prescribing, Processing and Preparation

E. REFERENCES

1. Institute for Safe Medication Practices. 2015. *ISMP*. [ONLINE] Available at: https://www.ismp.org. [Accessed 24 December 15].
2. Infusion Pumps. 2015. *U.S. Food and Drug Administration.* [ONLINE] Available at: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/InfusionPumps/ [Accessed 24 December 15].

Tri-City Medical Center	Distribution: Outpatient Infusion Center
PROCEDURE:	**CHEMOTHERAPY ADMINISTRATION**
~~Purpose:~~	~~To outline the chemotherapy competent nurse's re~~ ~~chemotherapeutic agent:~~ ~~A. Notification of a Chemotherapy Order~~ ~~B. Safe Handling~~ ~~C. Requirements Prior to Administering a Chemotherapeutic Agent~~ ~~D. Patient Preparation~~ ~~E. Documentation~~ ~~F. Administrating Intravenous and Intramuscular Chemotherapy~~ ~~I. IV Push~~ ~~II. IV Continuous or Intermittent~~ ~~III. Intramuscular and Subcutaneous~~ ~~G.~~**A.** ~~Administering Oral Chemotherapy~~
~~Supportive Data:~~	~~See References~~
~~Equipment:~~	~~See Equipment Lists for specific administration methods~~

DELETE – duplicate to Patient Care Services Procedure: Chemotherapy Administration

~~A.~~ ~~**SAFE HANDLING:**~~

~~1. Many drugs used in the treatment of cancer (i.e. chemotherapy) are considered to be hazardous to health care workers. The term hazardous refers to drugs/chemicals that require special handling because of potential health risks. Therefore, it is imperative that those who work with chemotherapy drugs adhere to this procedure, the pharmaceutical companies recommendations, the Material Safety Data Sheet that pertains to the particular hazardous agent and the Tri-City Medical Center's (TCMC) Patient Care Services (PCS) Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the TCMC's PCS procedure for Disposal of Chemotherapy Waste.~~

~~2. Transporting Chemotherapy Agents~~

~~a. Transport syringes containing chemotherapy in a sealed container, with the luer lock end syringe capped.~~

~~b. All chemotherapy agents will be placed in a leak proof sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" before agent can be transported.~~

~~c. A spill kit will be available at all times in case of a potential chemotherapy spill.~~

~~d. In case of an accidental spill or exposure please see TCMC PCS Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the TCMC's PCS procedure for Disposal of Chemotherapy Waste.~~

~~B.~~ ~~**REQUIREMENTS PRIOR TO ADMINISTERING A CHEMOTHERAPEUTIC AGENT:**~~

~~1. **A physician must be on the premises of the outpatient infusion center at all times if chemotherapy is being infused into a patient(s).**~~

~~2. Chemotherapy may only be administered by a **Chemotherapy Competent Registered Nurse**. A Chemotherapy Competent Registered Nurse is defined by the following requirements:~~

~~a. Has taken and passed an Oncology Nursing Society approved chemotherapy course.~~

~~b. Has completed competency validation by a TCMC chemotherapy competent nurse on all chemotherapy areas of the TCMC's RN Outpatient Infusion Center's Skills Checklist.~~

~~3. All chemotherapy orders from a physician must be written on the TCMC approved Chemotherapy Order Form. All sections of the TCMC approved Chemotherapy Order Form must be completed for the chemotherapy order to be valid. Verbal or telephone orders for any antineoplastic agents are not permitted at TCMC (per PCS Medication Administration policy).~~

Department Review	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/13, 10/14, **06 16**	11/14, **07/16**	01/15, **06/16**	3/13; 2/15, **08/16**	3/13; 3/15, **09/16**	3/13; 3/15

Chemotherapy Orders that are received via fax on a TCMC approved Chemotherapy Order Form are acceptable. Any chemotherapy order or clarification of a chemotherapy order from a physician that has been received verbally or via telephone will not be recognized as a valid chemotherapy order. Telephone orders from the physician related to start/stop times for the chemotherapy and pre-medications are acceptable. Pharmacy may verify chemotherapy drug and dose via phone per the TCMC Pharmacy policy Chemotherapy, Prescribing, Processing and Preparation.

4. All patients at TCMC that have an order for any antineoplastic agent to be administered while in our care, must have a TCMC approved consent form completed in full prior to the administration of any antineoplastic agent.

C. **PATIENT PREPARATION**

1. Set up continuous pulse oxymetry for all patients receiving monoclonal antibodies.
2. Explain to the patient and family/caregivers who will administer the chemotherapy, the route, and the planned sequence of events.

D. **DOCUMENTATION**

1. The administering Chemotherapy Competent Nurse will complete a Cerner Chemotherapy Administration AdHoc Form on every chemotherapy agent administered.
2. All chemotherapy agents will require a second electronic signature by a Chemotherapy Competent Registered Nurse (preferred) or a Registered Nurse (if a second chemotherapy competent nurse is unavailable) verifying accuracy of the chemotherapy agent and order on the Cerner Electronic Medication Administration Record (EMAR) by using their Compass password.

E. **ADMINISTERING INTRAVENOUS (IV), INTRAMUSCULAR (IM) AND SUBCUTANEOUS (SQ) CHEMOTHERAPY**

1. IV, IM and SQ chemotherapy orders and agents will be verified two times for accuracy before administration. Accuracy will be determined by verifying:
   a. Date /Time of Administration
   b. Patient Name
   c. Chemotherapy Agent
   d. Dose
   e. Diluents /Volume (If applicable)
   f. Rate of Administration (If applicable)
   g. Route
   h. Patient's Height and Weight
   i. Patient's body surface area (BSA) If applicable
2. **VERIFICATION # 1 -Pharmacy/ Nurse**
   a. A TCMC pharmacist will co-sign with a Chemotherapy Competent Registered Nurse on the TCMC Pharmacy/Nurse Chemotherapy Verification Form that the chemotherapy agent that was delivered to the nursing unit is accurate.
3. **VERIFICATION #2- Nurse/Nurse**
   a. A second verification for accuracy will be completed by two Chemotherapy Competent Registered Nurses (preferred) and documented on the Cerner Chemotherapy Administration AdHoc Form. After this the two chemotherapy competent nurses will verify two patient identifiers and the Alaris pump guardrails and settings for accuracy at the patient's bedside or chair before administration. If a second Chemotherapy Competent Registered Nurse is not available a TCMC registered nurse may co-sign to verify the accuracy of the chemotherapy agent and order.
4. All intravenous Vesicant Chemotherapy will only be administered via a Central Venous Catheter and should never be administered peripherally.
5. All intravenous chemotherapy will be administered through an Alaris IV pump using the oncology profile and specific guardrail for the chemotherapy agent.

6. If two chemotherapy drugs must run simultaneously, each drug must run through two different brains (A and B) on the Alaris pump.
7. Peripheral Non-Vesicant Chemotherapy Administration-Start a new peripheral IV if site is more than 24 hours old. Avoid flexion joint sites. Preferably select a large vein between wrist and elbow. Avoid veins in the hand, wrist and antecubital fossa. Tape IV site so it can be monitored.
8. Extravasation Prevention
   a. Blood return must be checked prior to administration of any chemotherapy agent.
   b. Inspect IV site for signs and symptoms of the following before administration:
      i. Peripheral
         1) Redness
         2) Inflammation
         3) Infiltration
         4) Patient comfort level at IV site
      ii. Central Venous Catheters (CVC)
         1) Erythema
         2) Swelling
         3) Drainage
         4) Leakage
         5) Venous thrombosis of the ipsilateral chest (CVC located in the chest region).
9. Verify that the patient has signed a TCMC approved consent form for chemotherapy administration.
10. Don PPE in the following order before spiking a pre-filled chemotherapy IV bag, when manipulating a syringe that contains a chemotherapy agent or anytime there is a risk for exposure to chemotherapy or body fluid containing chemotherapy:
    a. Face shield or splash goggles
    b. N-95 mask
    c. First pair of chemo gloves
    d. Chemo gown with the cuffs over the first pair of gloves
    e. Second pair of chemo gloves over the cuffs of the gown
11. **IV Push Procedure:**
    a. Don two pair of chemotherapy safe gloves.
    b. Examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.
    c. Verification #1 & #2 (see section E of this procedure) should be completed.
    d. Assemble equipment
       i. Extravasation Kit
       ii. Personal Protective Equipment (PPE) (Face shield or splash goggles, N95 mask, chemotherapy gown, 2 pairs of chemotherapy gloves). It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
       iii. Chemotherapy puncture- proof waste disposal container
       iv. Leak-proof bag marked "Chemotherapy Waste"
       v. Plastic –backed absorbent pad
       vi. Sterile gauze
       vii. 3 Alcohol Prep Pads
    e. Review all manufacture's recommendations (located in the TCMC Drug Formulary or package insert) pertaining to the administration, pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
       i. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCMC's PCS Chemotherapy Extravasation Procedure.
    f. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational

pamphlets located on 2 Pavilion) , chemo safety for body fluids and when to notify the nurse for signs and symptoms of:

i. Extravasation
   1) Burning
   2) Pain
   3) Heat
   4) Ulceration
   5) Swelling

ii. Hypersensitivity and anaphylaxis
   1) Uneasiness
   2) Tightness of the chest
   3) Shortness of breath with or without wheezing
   4) Hives or rash
   5) Local or generalized itching
   6) Periorbital or facial edema
   7) Lightheadedness or dizziness

g. Administer IV Chemotherapy with no other IV medications or IV fluids running except for the mainline compatible IV fluid used during the IV push chemotherapy administration.
h. Label the IV pump and the IV push chemotherapy syringe with a TCMC approved "Chemotherapy" identification sticker before administration.
i. Inspect IV site and check patient's IV for blood return.
j. Don PPE in the following order before administration:
   i. Face shield or splash goggles
   ii. N-95 mask
   iii. First pair of chemo gloves
   iv. Chemo gown with the cuffs over the first pair of gloves
   v. Second pair of chemo gloves over the cuffs of the gown
k. Place plastic –backed absorbent pad under the patient's arm to prevent drug contact with patient's skin.
l. Use two patient identifiers prior to administration per the TCMC's PCS Medication Administration Policy.
   i. A second Chemotherapy Competent Registered Nurse (preferred) will verify:
      1) Chemotherapy agent and order for accuracy
      2) Two patient identifiers at the patient's bedside or chair
      3) Document as a witness in Cerner on the EMAR.
m. Use alcohol prep padsto clean the patient's IV access port three times
n. Wrap sterile gauze around IV ports during IV push to reduce the potential for spraying
o. Inject drug into distal port of IV with free flowing solution at the prescribed rate (minimum of 100ml/hour). Verify blood return every 2-3ml of drug administration.
p. Flush line with 10-20ml of IV solution between administration of drugs or prior to discontinuing IV.
   i. Prevents incompatibility reaction and avoids exposure to anti-neoplastic agents.
q. Dispose of syringes in the puncture proof container labeled "Chemotherapy waste".
r. Recheck IV lines to be sure lines are leading to patient and are connected to the correct IV port.
s. Remove PPE in the following order and place in a chemotherapy waste bag and seal
   i. Outer pair of gloves
   ii. Chemo gown
   iii. Face Shield or splash goggles
   iv. N-95 mask
   v. Final pair of gloves
t. See TCMC PCS Disposal of Chemotherapy Waste Procedure for proper disposal of contaminated materials

12. **IV Continuous or Intermittent Procedure:**
    a. Don two pair of chemotherapy gloves, examine the Chemotherapy pre-filled IV bag and tubing for leakage or damage in the medication room before administration.
    b. Verification #1 & #2 (see section E of this procedure) should be completed.
    c. Assemble equipment for use during administration.
        i. Extravasation Kit
        ii. Personal Protective Equipment (PPE) (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
        iii. Chemotherapy puncture proof waste disposal container
        iv. Leak-proof bag marked "Chemotherapy Waste"
        v. "Chemotherapy" identification stickers
        vi. Disposable plastic –backed absorbent liner
        vii. Plastic tape
        viii. 3 Alcohol Prep Pads
    d. Review all manufacture's recommendations pertaining to the administration (located in the TCMC Drug Formulary or package insert), pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
        i. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCMC's PCS Chemotherapy Extravasation Procedure.
    e. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets located on 2 Pavilion), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
        i. Extravasation
            1) Burning
            2) Pain
            3) Heat
            4) Ulceration
            5) Swelling
        ii. Hypersensitivity and anaphylaxis
            1) Uneasiness
            2) Tightness of the chest
            3) Shortness of breath-with or without wheezing
            4) Hives or rash
            5) Local or generalized itching
            6) Periorbital or facial edema
            7) Lightheadedness or dizziness
    f. Administer IV Chemotherapy on a single Alaris IV pump with no other IV medications or IV fluids running except for the mainline compatible flush bag for the IV chemotherapy agent.
    g. Don PPE in the following order before administration:
        i. Face shield or splash goggles
        ii. N-95 mask
        iii. First pair of chemo gloves
        iv. Chemo gown with the cuffs over the first pair of gloves
        v. Second pair of chemo gloves over the cuffs of the gown
    h. Prime all IV tubing with a compatible IV fluid before administering the chemotherapy intravenously if not already done by pharmacy.
    i. Program the Alaris pump at the patient's bedside, using the appropriate chemotherapy drug guardrail profile with the witnessing second Chemotherapy Competent Nurse (preferred).
        i. Power on the Alaris IV pump and select New Patient.

ii. Select the Outpatient Profile.
iii. Enter the patient's medical record number.
iv. Select Channel letter that will be used.
v. Select Guardrail Drugs.
vi. Select the appropriate chemotherapy agent to be administered from the Alaris Oncology Drug Guardrail List.
vii. Verify and confirm correct dosing program.
viii. Review Clinical Advisory Warning on the Alaris IV pump and Confirm when read.
ix. Input the Drug Amount, Diluent Volume, BSA (if applicable). Verify dose and select Next.
x. Input Rate and Volume to be infused (VTBI).

j. Use two patient identifiers prior to administration TCMC PCS Medication Administration Policy.
i. A second Chemotherapy Competent Registered Nurse (preferred) will verify:
1) Chemotherapy agent and order for accuracy
2) Two patient identifiers at the patient's bedside or chair
3) Verifying the Alaris guardrail settings for accuracy
4) Document as a witness in Cerner on the EMAR.

k. Label the IV pump and the IV chemotherapy bag with a TCMC approved "Chemotherapy" identification sticker before administration.
l. Inspect IV site and check patient's IV for blood return.
m. Use disposable plastic –backed absorbent liner under the IV
n. Use the alcohol prep pads to clean the patient's IV access port three times.
o. Securely attach the IV tubing to the patient's venous access device or, if using a secondary set, to the primary tubing
p. Tape the two IV connections together
q. Review dose and then select Start to begin infusion on the Alaris pump.
r. When infusion is complete, don PPE as instructed .
s. Dispose of contaminated IV tubing and IV bags in a sealed chemotherapy waste bag and place in a puncture- proof chemotherapy waste container
t. Remove PPE in the following order and place in a chemotherapy waste bag and seal:
i. Outer pair of gloves
ii. Chemo gown
iii. Face Shield or splash goggles
iv. N-95 mask
v. Final pair of gloves
u. See TCMC PCS Disposal of Chemotherapy Waste Procedure for proper disposal of contaminated materials

13. **Intramuscular (IM) and Subcutaneous (SQ) Procedure**
a. Don two pair of chemotherapy gloves, examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.
b. Verification #1 & #2 (see section E of this procedure) should be completed.
c. Assemble equipment for use during administration.
i. Personal Protective Equipment (PPE) (Face shield or goggles, N-95 mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
ii. Chemotherapy puncture- proof sharps waste container
iii. Leak-proof bag marked "Chemotherapy Waste"
iv. "Chemotherapy" identification sticker
v. Appropriate size sterile needle (Use smallest needle possible)
vi. 2x2
vii. Alcohol Prep Pads
viii. Band-Aid

d. Review all manufacture's recommendations pertaining to the administration (located in the TCMC Drug Formulary or package insert), pre-medication, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
e. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent (Patient information located in Micromedix and educational pamphlets), chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
    i. Signs and symptoms of hypersensitivity and anaphylaxis
        1) Uneasiness
        2) Tightness of the chest
        3) Shortness of breath with or without wheezing
        4) Hives or rash
        5) Local or generalized itching
        6) Periorbital or facial edema
        7) Lightheadedness or dizziness
f. Label chemotherapy syringe with a TCMC approved "Chemotherapy" identification sticker before administration.
g. Don PPE in the following order before administration:
    1) Face mask or Splash Goggles
    2) N-95 mask
    3) First pair of chemo gloves
    4) Chemo gown with the cuffs over the first pair of gloves
    5) Second pair of chemo gloves over the cuffs of the gown
h. Remove cap and connect sterile needle of the appropriate size for administering the drug.
i. Do not expel air from the syringe or prime the needle.
j. Use two patient identifiers prior to administration TCMC's PCS Medication Administration Policy.
    i. A second Chemotherapy Competent Registered Nurse (preferred) will verify:
        1) Chemotherapy agent and order for accuracy
        2) Two patient identifiers at the patient's bedside or chair
        3) Document as a witness in Cerner on the EMAR.
k. Review the manufacturers injection site recommendation
l. Cleanse injection site with alcohol prep pads
m. After administering the drug, do not re-cap and do not massage injection site.
n. Place the syringe with the needle attached directly into the puncture- proof chemotherapy waste container.
o. Remove PPE in the following order and place in a chemotherapy waste bag and seal
    i. Outer pair of gloves
    ii. Chemo gown
    iii. Face Shield or splash goggles
    iv. N-95 mask
    v. Final pair of gloves
p. See TCMC PCS Disposal of Chemotherapy Waste Procedure for proper disposal of contaminated materials
q. Monitor injection site for signs and symptoms of bleeding, redness, and rash post injection.
r. Educate patients going home after injection to access the injection site twice a day for bleeding and signs and symptoms of infection.

E. RELATED DOCUMENTS:

1. PCS Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids Procedure
2. PCS Chemotherapy Extravasation Procedure

3. PCS Disposal of Chemotherapy Waste Procedure
4. PCS Medication Administration Policy
5. Pharmacy Chemotherapy, Prescribing, Processing and Preparation Policy

G. **REFERENCES:**

1. National Institute for Occupational Safety and Health, (2004). Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Retrieved from the NIOSH website October 2014, at http://www.cdc.gov/niosh/docs/2004-165/#c.
2. Oncology Nursing Society, (2014). Chemotherapy and Biotherapy Guidelines, Fourth Edition.
3. Mafrica, Leonard. Safe Handling of Hazardous Drugs. Oncology Nursing Society. (2011)

Tri-City Medical Center	Distribution: Outpatient Infusion
PROCEDURE:	**CHEMOTHERAPY EXPOSURE, SPILLS, AND HANDLING OF LINENS CONTAMINATED WITH CHEMOTHERAPEUTIC AGENTS AND BODY FLUIDS, ACCIDENTAL EXPOSURE TO RADIOACTIVE I_{131} BODY FLUIDS**
Purpose:	~~To outline staff responsibility and management of exposures, and handling of contaminated linens.~~
Supportive Data:	~~To prevent staff exposure to chemotherapy and ra~~
Equipment:	~~Chemotherapy Spill Kit~~

DELETE – duplicate to Patient Care Services Policy Chemotherapy Exposure, Spills, and Handling of Linens Contaminated With Chemotherapeutic Agents and Body Fluids, Accidental Exposure to Radioactive I_{131} Body Fluids

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

~~1. Many drugs used in the treatment of cancer are considered to be hazardous to health care workers.~~

~~a. The term hazardous refers to drugs/chemicals requiring special handling because of potential health risks.~~

~~2. Staff working with chemotherapy drugs and the body fluids of patients that have received chemotherapy shall adhere to this procedure and reference Patient Care Services Disposal of Chemotherapy Waste procedure.~~

~~a. Body fluid includes sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.~~

~~3. Do not use chemical inactivators due to the potential for dangerous by-products.~~

~~a. Exception: Sodium thiosulfate is used to inactivate nitrogen mustard.~~

~~B. **PROCEDURE FOR SPILL MANAGEMENT:**~~

~~1. For chemotherapy spills greater than 400 mL in any department:~~

~~a. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in kit).~~

~~b. Remove personnel and patients from the immediate area.~~

~~i. Immediate area is approximately 20-foot perimeter.~~

~~c. Nursing to contact Environmental Services (EVS).~~

~~i. EVS to contact EOC Safety Officer regarding the chemotherapy spill at 760- 926-0225 (pager).~~

~~2. For chemotherapy spills less than 400 mL:~~

~~a. EVS Responsibilities for spills on hard surfaces estimated at 400 mL or less:~~

~~i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).~~

~~ii. Don personal protective equipment in the following order:~~

~~1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)~~

~~2) First pair of chemotherapy gloves~~

~~3) Chemotherapy gown with the cuffs over the first pair of gloves~~

~~4) Second pair of chemotherapy gloves over the cuffs of the gown~~

~~5) Splash goggles or face shield~~

~~6) Protective shoe covers~~

~~iii. Place spill pillows from spill kit in a "V" position on outer perimeter of spill to prevent spreading of fluid.~~

~~iv. Place one towel from the spill kit over spill to absorb fluid.~~

~~v. Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.~~

~~vi. Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.~~

~~vii. Use the hospital approved disinfectant 3 procedures of the EVS guidelines to complete the cleaning.~~

~~viii. After hospital approved disinfectant 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.~~

Department Review	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/13, 5/16	3/13, 07/16	06/16	08/16	3/13, 09/16	3/13

ix. Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
x. Remove personal protective equipment in the following order.
1) Outer pair of gloves
2) Chemotherapy gown
3) N95 mask
4) Splash goggles or face shield
5) Protective shoe covers
6) Final pair of gloves
xi. Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
xii. Place sealed bag in the designated chemotherapy waste area on the unit.
xiii. Complete the Hazardous Drug Exposure Report and give to the supervisor of the EVS department.
xiv. The EVS supervisor shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the EOC Officer.
b. Infusion Center/Pharmacy Responsibilities for spills on hard surfaces estimated between 200 mL and 400 mL:
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Delegate to a co-worker to contact EVS Supervisor of the chemotherapy spill. and/or EOC Safety Officer regarding the chemotherapy spill. EVS is responsible for spills on the oncology and pharmacy units that is between 200 mL and 400 mL.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
4) 760-926-0225 (EOC Officer pager)
c. Infusion Center/Pharmacy (responsibilities for spills on hard surfaces estimated at less than 200 mL)
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Contact or delegate a co-worker to contact Environmental Services (EVS) Supervisor of the chemotherapy spill.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
iii. Don personal protective equipment in the following order:
1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
2) First pair of chemotherapy gloves
3) Chemotherapy gown with the cuffs over the first pair of gloves
4) Second pair of chemotherapy gloves over the cuffs of the gown
5) Splash goggles or face shield
6) Protective shoe covers
iv. To clean up a spill from a hard surface estimated as less than 200 mL:
1) Place spill pillows in a "V" position on outer perimeter of spill to prevent spreading of fluid.
2) Place one towel from the spill kit over spill to absorb fluid.
3) Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
4) Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
5) EVS must use the hospital approved disinfectant 3 procedure of their EVS guidelines to complete the cleaning.

6) After EVS has completed the hospital approved disinfectant 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
7) Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
8) Remove personal protective equipment in the following order:
(i) Outer pair of gloves
(ii) Chemotherapy gown
(iii) N95 mask
(iv) Splash goggles or face shield
(v) Protective shoe covers
(vi) Final pair of gloves
9) Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
10) Place sealed bag in the designated chemotherapy waste area on the unit.
11) Complete the Hazardous Drug Exposure Report and give to the clinical manager on the nursing unit.
12) The clinical manager shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the Environment of Care (EOC) Safety Officer.

C. **PROCEDURE -- EXPOSURE AND PREVENTION RELATED TO CHEMOTHERAPY AGENTS AND BODY FLUIDS:**
1. In the event of skin exposure to chemotherapeutic agent; remove any contaminated garment and immediately wash contaminated skin with soap and water.
2. In case of eye exposure, immediately flush the eye with saline solution or water for at least 5 minutes.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Contact EVS when chemo waste linen bag is ¾ full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.
5. Place any disposable cytoxic contaminated materials into a sealed, leak proof chemo waste plastic bag. Use puncture proof containers for sharp or breakable items.
6. All containers will be clearly labeled citing the hazardous nature of the contents-Chemotherapy.
7. Report any cytotoxic exposures or spills to your supervisor.
8. Report any employee exposure to employee health services and/or emergency department.
a. Fill out Illness/Injury Investigation Report
9. Report any patient exposure to the patient's healthcare provider and per institution policy.

D. **PROCEDURE - PRECAUTIONS WHEN HANDLING BODY FLUIDS OF A PATIENT RECEIVING CHEMOTHERAPY(Precautions need to be taken during and 48 hours after last Chemotherapy Dose):**
1. Wear appropriate personal protective equipment (PPE) which may include the following:
a. N-95 mask
b. Double chemotherapy gloves
c. Chemotherapy gown
d. Splash goggles or face shield
e. Protective shoe covers
2. Disposing of body fluid

a. Dispose of body fluids in the toilet.
b. DO NOT USE THE TOILET SPRAYER. Rinse containers with a cup of water to prevent splashing
c. Before flushing toilet, cover open toilet with chux. (New chux to be used with each flush).
d. Flush toilet twice
e. Place personal protective equipment and chux in chemotherapy waste bag.
f. Infusion clinic will place sealed chemo waste bag in the designated chemotherapy waste area on the unit.

3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.

4. Skin care of incontinent adult receiving chemotherapy
a. Clean patients skin well after voiding or having a bowel movement
b. Apply protective barrier ointment or cream before diapering

5. All disposable equipment (i.e. Foley catheter, bedpan, graduated cylinder, and diapers) used in caring for chemotherapy patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

F. **REFERENCES:**

1. ONS Chemotherapy and Biotherapy Guidelines and Recommendation for Practice, 2011, Third Edition
2. Center for Disease Control and Prevention. Antineoplastic Agents – Occupational Hazards in Hospitals.2004 Print.
3. Health Waste Management (HCWM). *The 10 Categories of HCRW #9* Genotoxi/Cytotoxic Waste.2006 Print.
4. "Preventing Occupational Exposure to Antieoplastic and Other Hazardous Drugs in Health Care Settings." NIOSH. National Institute for Occupational Safety and Health, 2004. http://www/cdc/gov/niosh/docs/2004-165/#c. "Kendall Chemobloc Procedure." Tyco Healthcare. 2006 <www.tycohealthcare.com>
5. Leonard, Safe Handling of Hazardous Drugs. Oncology Nursing Society, 2003. Print.
6. Oncology Nursing Society. Manual for Radiation Oncology Nursing Practice and Education, 4th Edition, 2012. Print

Tri-City Medical Center	Distribution: Outpaient Infusion Center
PROCEDURE:	**CHEMOTHERAPY EXTRAVASATION**
Purpose:	To outline the responsibility of the registered nu extravasation
Supportive Data:	The Oncology Nursing Society Chemotherapy Biotherapy and Guidelines sets the standard for best practice in the care of oncology patients.
Equipment:	Extravasation Kit

DELETE – follow Patient Care Services Chemotherapy Extravasation

A. **DEFINITIONS:**

1. Extravasation -- Passage or escape into tissue of antineoplastic drugs. Tissue slough and necrosis may occur.
   a. Extravasation is a medical emergency. Immediate intervention must occur if extravasation is suspected.
2. Flare Reaction -- A local allergic reaction to an agent, manifested by streaking or red blotches along the vein, but without pain.

B. **POSSIBLE SIGNS AND SYMPTOMS OF EXTRAVASATION:**

1. Swelling (most common)
2. Stinging, burning, or pain at the injection site (not always present)
3. IV flow rates that slow or stop
4. Lack of blood return (extravasation can occur with the presence of a blood return)
5. Erythema, inflammation, or blanching at the injection site (not always immediately evident)
6. Induration
7. Vesicle formation
8. Ulceration
9. Necrosis -- Tissue damage may progress for six months after the incident
10. Sloughing
11. Damage to tendons, nerves and joints

C. **CHEMOTHERAPEUTIC VESICANTS AND IRRITANTS THAT CAN CAUSE TISSUE DAMAGE**

1. **Vesicants**
   a. Alkylating Agents
      i. CISplatin
      ii. Mechlorethamine Hydrochloride
   b. Antitumor Antibiotic
      i. DOXOrubicin
      ii. DAUNOrubicin
      iii. Mitomycin
      iv. Dactinomycin
      v. Epirubicin (non-formulary)
   c. Vinca Alkaloid or Micro-tubular Inhibiting Agent
      i. vinCRIStine
      ii. vinBLAStine
      iii. Vindesine (non-formulary)
      iv. Vinorelbine
   d. Taxane
      i. PACLItaxel
2. **Irritants**
   a. Alkylating Agents
      i. CARBOplatin
      ii. Dacarbazine
      iii. Ifosfamide

Department Review	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/13, 5/16	07/16	06/16	3/13, 08/16	3/13, 09/16	3/13

iv. Melphalan
v. Mitoxantrone
vi. OXALIplatin

b. Nitrosourea
i. Carmustine

c. Antitumor Antibiotic
i. DAUNOrubicin liposomal
ii. Bleomycin

d. Epipodophyllotoxin
i. Etoposide
ii. Teniposide (non-formulary)

D. **PROCEDURE:**

1. Initial management
a. Stop administration and IV fluids immediately.
b. Don two (2) pairs of chemotherapy gloves.
c. Disconnect the IV tubing from the IV device (central or peripheral IV site). DO NOT REMOVE the IV device.
d. If the patient has an implanted port, assess the site for proper needle placement using a 10 ml syringe.
e. Attempt to aspirate the residual drug from the IV device by using a 1-3 ml syringe.
f. Notify the physician and report the patient's symptoms, amount of extravasation and the extent of the extravasation. For central lines, collaborate with physician regarding discontinuation of the central line, need for a radiographic flow study to determine the cause of the extravasation and future plans for IV access.
g. If **no antidote** is ordered, gently remove needle from the implanted port or the peripheral IV catheter and dress the site.
i. Consult with physician before removing a central line or PICC per the TCMC Central Venous Access Procedure.
h. If an **antidote** is ordered, administer the antidote per the manufacturers recommendations, then gently remove needle from the implanted port or the peripheral IV catheter and dress the site.
i. Consult with physician before removing a central line or PICC per the TCMC Central Venous Access Procedure.
i. Apply a hot or cold compress per table in attachment A
j. Document the following information in the medical record:
i. Description of the events that occurred
ii. Drug
iii. Dilution
iv. Amount of Drug Infiltrated
v. Method of Drug Administration
vi. Type of IV device
vii. Description of Site
1) Size
2) Color
3) Texture
k. Document Physician Notification

2. Post-Extravasation Care
a. Photograph the initial extravasation site including:
i. Measuring guide for size or length / width / depth
ii. Date of photograph
iii. Patients initials
iv. Medical record number
i. Location

b. Adhere picture to a progress note and put it in the progress note section of the patient's chart. Repeat weekly if appropriate.
c. Instruct the patient to rest and elevate the site for 48 hours and then may resume normal activity.
d. Give patient written instructions regarding what symptoms they should report immediately, local care of the site, pain management and the plan for follow up. Document all patient education in the Cerner Education All Topics Powerform.
e. Educate patient to ensure that no medications are given distally to an extravasation injury.

E. REFERENCES:

1. Infusion Nursing Society (January/February 2006). Infusion Nursing Standards of Practice. *Journal of Infusion Nursing*, Vol. 29, Number 1S.
2. The Oncology Nursing Society (2005). ONS Chemotherapy and Biotherapy (2nd ed.), p. 78-83.

Table 13 Vesicants and Irritants from ONS Chemotherapy and Biotherapy Guidelines Second Edition, pp 79-81.

Vesicants

Classification	Medication(s)	Local Care	Nursing Considerations
Alkylating agent	Cisplatin (Platinol®)	Isotonic sodium thiosulfate may be used as an antidote. Prepare 1/6 molar solution. • If 10% sodium thiosulfate solution: Mix 4 ml with 6ml sterile water for injection. • If 25% sodium thiosulfate solution: Mix 1.6 ml with 8.4ml sterile water. Aspirate residual drug. Use 2 ml 10% sodium thiosulfate for each 100 mg cisplatin. Remove needle. Inject into subcutaneous (SQ) tissue.	Vesicant potential is seen when a concentration of more than 20 ml of 0.5 mg/ml extravasates. If less than this, drug is an irritant; no treatment is recommended (Dorr, 1994).
	Mechlorethamin hydrochloride (nitrogen mustard, Mustargen®)	Isotonic sodium thiosulfate may be used as an antidote. Prepare 1/6 molar solution. • If 10% sodium thiosulfate solution: Mix 4 ml with 6ml sterile water for injection. • If 25% sodium thiosulfate solution: Mix 1.6 ml with 8.4ml sterile water. Aspirate residual drug. Use 2 ml antidote for every 1 mg drug extravasated. Remove needle. Inject antidote into (SQ) tissue.	Sodium thiosulfate neutralizes nitrogen mustard, which is then excreted via the kidneys. Time is essential in treating extravasation. Heat and cold have not proven effective (Dorr, 1990, 1994).
Antitumor antibiotic	Doxorubicin (Adriamycin®)	Apply cold pad with circulating ice water, ice pack, or cryogel pack for 15 – 20 minutes at least four times per day for the first 24 – 48 hours (Harwood & Govin, 1994). Elevate site for 48 hours, then resume normal activity (Goodman, 2000).	Extravasations of less than 1 – 2 ml often heal spontaneously. If greater than 3 ml, ulceration often results (Goodman, 2000). Protect area of extravasation from sunlight and heat. Some studies suggest that 99% dimethyl sulfoxide (DMSO) 1-2 ml applied to site every six hours is beneficial (Bertelli, 1995; Olver et al., 1988; St Germain et al., 1994). Other studies show delayed healing with DMSO (Harwood & Bachur 1987).
	Daunorubicin (Cerubidine®)	=	Little information is known. In mouse experiments, topical DMSO afforded some benefit (Olver et al., 1988).
	Mitomycin (Mutamycin®)	=	Protect area of extravasation from sunlight. Delayed skin reactions have occurred in areas far from original IV site. Some research studies show benefit with use of 99% DMSO 1-2 ml applied to site every six hours for 14 days. More studies are needed (Alberts & Dorr, 1991).
	Dactinmycin (actinomycin-D, Cosmegen®)	Apply ice to increase comfort at the site. Elevate site for 48 hours, then resume normal activity (Goodman, 2000).	Application of heat may exacerbate tissue damage.
	Epirubicin (Ellence®) idarubicin (Idamycin®)	=	Local care measures are unknown. Cold, DMSO, and corticosteroids were shown to be ineffective in experiments with mice (Soble et al., 1987).
Vinca alkaloid or micro-tubular inhibiting agent	Vincristine (Oncovin®)	Apply warm pack for 15-20 minutes at least four times per day for the first 24-48 hours and elevate (Larson, 1985; Rudolph & Larson, 1987).	This method of treatment is very effective for rapid absorption of drug (Bellone, 1981; Dorr, 1994; Goodman, 2000; Laurie et al., 1984).
	Vinblastine (Velban®)	Same as above	Same as above
	Vindesine (Eldisine®) [in Canada]	Same as above	Same as above
	Vinorelbine (Navelbine®)	Same as above	Same as above
Taxane	Paclitaxel Taxol®)	Apply ice pack for 15-20 minutes at least four times a day for the first 24 hours.	Its vesicant potential has been documented (Ajani et al., 1994; Herrington & Figueroa, 1997). Paclitaxel has rare vesicant potential (probably because of dilution in 500 ml diluent) (Dorr et al., 1996). In a review of literature, Stanford and Hardwicke (2003) concluded that paclitaxel may be a mild vesicant. Ice has been effective in decreasing local tissue damage in a mouse model (Dorr et al.,

			1996). Conservative management with cold packs may be the most appropriate strategy (Sanford & Hardwicke, 2003).
Irritants			
Classification	**Medication Name(s)**	**Local Care**	**Nursing Considerations**
Alkylating agent	Carboplatin (Paraplatin®)	=	May cause phlebitis Local care measures are unknown.
	Darcarbazine (DTIC-Dome®)	=	May cause phlebitis Protect dacarbazine from sunlight.
	Ifosfamide (Ifex®)	=	May cause phlebitis Local care measures are unknown.
	Melphalan (Alkeran®)	=	May cause phlebitis Local care measures are unknown.
	Mitoxantrone (Novantrone®)	=	Administer with caution; may cause tissue damage if extravasation occurs. Local care measures unknown. Ulceration is rare unless a concentrated dose infiltrates (Dorr, 1990).
	Oxaliplatin (Eloxatin®)	=	Vesicant properties have been reported and the agent is at least an irritant (Ener et al., 2004; Kretzschmar et al., 2003). Extravasation of moderate to high doses led to pronounced symptoms of inflammation but without subsequent necrosis. High-dose dexamethasone should be considered as a therapeutic intervention (Kretzschmar et al., 2003).
Nitrosourea	Carmustine (BiCNU®)	=	May cause phlebitis Local care measures are unknown.
Antitumor antibiotic	Daunorubicin citrate liposomal (DaunoXome®)	=	May cause pain or burning at IV site Little information is known.
	Doxorubicin liposomal (Doxil®)	=	May produce redness and tissue edema Low ulceration potential If ulceration begins or if pain, redness, or swelling persists, treat like doxorubicin.
	Bleomycin (Blenoxane®)	=	May cause irritation to tissue Little information is known.
Epipodophyllotoxin	Etoposide (VP-16, Etopophos®, VePesid®)	Apply warm pack.	Treatment is necessary only if large amount of concentrated solution extravasates. In this case, treat like vincristine or vinblastine (Dorr, 1994). May cause phlebitis, urticaria, or redness
	Teniposide (VM-26, Vumon®)	=	Same as above

Tri-City Health Care District
Oceanside, California

DELETE – follow Patient Care Services Chemotherapy Prescribing, Processing and Preparation

OUTPATIENT INFUSION CENTER – POLICY MANUAL

ISSUE DATE: 2/13 **SUBJECT: CHEMOTHERAPY, WRITING, AND PREPARATION**

REVISION DATE:

Department Approval:	~~3/13~~05/16
~~**Director Approval:**~~	~~3/13~~
Division of Oncology Approval:	07/16
Pharmacy & Therapeutics Committee Approval:	06/16
Medical Executive Committee Approval:	08/16
Professional Affairs Committee Approval:	09/16
Board ~~O~~of Directors Approval:	03/13

~~A. **PURPOSE:**~~

~~1. All chemotherapy prescribed for Tri-City Medical Center patients will be processed according to the following policy to ensure accuracy in prescribing, preparing, and administering.~~

~~B. **POLICY:**~~

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

~~a. Written on the standard pre-printed "Chemotherapy Order Form"~~

~~i. Telephone and verbal orders will not be accepted~~

~~b. Filled out completely, including the patients name, 2nd identifier (medical record number or date of birth), diagnosis, allergies, height, weight, BSA, protocol or reference (if needed), regimen, cycle number, therapy start date, and adjunctive medications related to chemotherapy~~

~~c. Signed by a physician (MD or DO) in Oncology (and initialed by person penning order (if different person signing order) before processed by the pharmacy~~

~~d. Written using the generic name of the agent and free of any unapproved abbreviations used to identify the agent being prescribed. The pharmacist may clarify chemotherapy orders and write the generic name next to any commonly used abbreviation or brand names. Brand names must include the name in generic.~~

~~e. Free of any number prefixes such as "5-fluorouracil", which could be misinterpreted as part of the order dose or schedule requirements and free of trailing zeros~~

~~f. Written using the metric system: dose/m^2 or dose/kilogram or dose/AUC (area under the curve) and with the calculated dose included~~

~~g. Written as the amount per dose per day (e.g. cisplatin 20 mg/m^2 daily x 5 days, or cytarabine 3000 mg/m^2/dose every 12 hours on days 1,3, and 5) NEVER written as total amount needed per course of therapy~~

~~h. Accompanied by a copy and/or name of a readily available reference or the protocol name and number used in determining the prescribed regimen if the regimen is unfamiliar to the pharmacist.~~

~~i. The new protocol will be added to the pharmacy oncology literature file~~

~~i. Pharmacy will not accept orders from Nurse Practitioners (NPs) and Physician Assistants (PAs) for any chemotherapy agent regardless of indication or use.~~

~~C. **EXCEPTIONS FOR NON-CANCEROUS DIAGNOSIS**~~

1. Physicians that are without chemotherapy privileges may write for chemotherapy only if they have been granted privileges by the medical staff to do so as related to their specialty including but not limited to: ectopic pregnancy, rheumatoid arthritis, systemic lupus erythematosus, certain dermatologic conditions, certain ophthalmic procedures, other auto-immune conditions as identified in the literature.
2. Pharmacy shall request orders written outside a physicians specialty be co-signed by a physician specialist in that area.
3. These order may be written on a standard physician order form and are not subject to all other requirements stated above

D. **PROCESS:**

1. The pharmacist will confirm that the order has been prescribed according to the criteria above.
2. The pharmacist shall contact the physician to request that any order not meeting these criteria be changed.
3. Changes to regarding drug, dosing parameters, route, diagnosis, or patient name/2nd identifiers will only be accepted by pharmacy if re-written by the physician on the Chemotherapy Order Form.
4. A pharmacist may change the order with "verbal order read back" regarding the dose, infusion time, height/weight, dates of therapy.
5. If there is a discrepancy in the medication order, the nurse caring for the patient will be notified of the problem and the possible delay in the delivery of the medication.
   a. Base solution may be changed at the discretion of the pharmacist
   b. Corrected carboplatin doses (GYN service) based on AUC or GFR may be calculated by the pharmacist and documented on the original order by the pharmacist. The pharmacist must read back the change from the actual written transcription to the physician.
6. Once the prescribing criteria have been met, the pharmacist is responsible for verifying the accuracy of the order by (1) reviewing the diagnosis and prescribed regimen (2) calculating the patients BSA, unit conversions, patient-specific dose and frequency (3) reviewing base fluid, administration times, and supportive care medications.
7. All changes to original orders must be documented on a chemotherapy order form. Addendums or changes to orders must be documented according to hospital policy. A copy will be placed with the chemotherapy work sheet and original order.
8. Changes to the order made by the physician (as above) must be double checked by a second pharmacist.
9. Unless specified, the pharmacist will determine the vehicle and volume of the diluent to be used based upon the protocol or reference, drug stability, and infusion guidelines listed in the package insert or the literature.
10. The pharmacist will review all appropriate lab values and document these on the chemotherapy work card.
11. Upon completion of the verification process, the pharmacist or trained technician will prepare a chemotherapy work sheet for use in preparing the prescribed dose. One card must be filled out for each patient. The following information should be documented:
    a. Patient name and medical record number
    b. Date of birth, height weight, body surface area
    c. Diagnosis, allergies, protocol number
    d. Medication name, medication instructions (e.g. protect from light, glass only, etc.)
    e. The compounding technician or pharmacist must double check the calculation when preparing every dose and record the compounded dose on the inside of the work card.

f. Changes in subsequent doses should be noted on the card or a new card may be generated.
g. Explanation of reason for changing subsequent doses shall be documented.

12. A copy of the order shall be attached to the chemotherapy work card. The order shall be entered into the pharmacy computer system under the patient's medication profile.
13. Labels shall be double checked against the written order for accuracy by the compounding technician or pharmacist for all doses.
14. All syringe labels shall contain the final concentration of the product (e.g. doxorubicin 50 mg/25 mL).
15. All minibag or large volume parenteral labels must include the volume of each component as well as a total volume and rate of administration.
16. Two pharmacists must check the chemotherapy work card, computer entry, and labels for all new adult chemotherapy orders.
17. The second pharmacist shall review the computer entries against the original order and work card.
18. The pharmacist preparing the chemotherapy work card and the one double checking the order must record their initials on the chemotherapy order (for written orders) or electronically for CPOE.
19. The verification process must be followed completely before any dose can be prepared.
20. Chemotherapy work cards are then forwarded to the technician for dose preparation.

E. **PREPARATION:**

1. The technician responsible for preparing the doses must gather the order, chemotherapy work card, patient-specific labels, medication, and associated supplies.
2. The technician is responsible for completing the chemotherapy work card, indicating the following:
   a. Time and date the product was prepared
   b. Medication used, concentration, volume used, and lot number/expiration date from the medication vial
   c. The technician must initial the work card and perform all calculations associated with the compounding process.
3. If an oral chemotherapy drug is to be physically manipulated or repackaged into a larger gel cap the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.
4. All final parenteral chemotherapy medications need to be spiked and primed in the chemo hood.
   a. Excluding IV push syringes, leucovorin, and drugs that will not be spiked prior to administration (intra-arterial & intrathecal)
5. Upon completing the chemotherapy preparation process, the final product shall be labeled
6. All vials, minibags, and/or syringes used in the preparation of the dose must be checked by a pharmacist.
7. The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be pulled back to indicated the measured volume or shown to the pharmacist before injecting into IV solution.
8. All pharmacy-prepared chemotherapy agents must be double checked. If the pharmacist is involved in the preparation of the dose, a pharmacist who did not prepare the dose must perform the final check.
9. The pharmacist reviewing the prepared dose must check each prepared dose and associated supplies, and label against the original order and chemotherapy work card.

10. The pharmacist, working independently must verify the final preparation including:
    a. The correct medication has been used.
    b. The drug was reconstituted correctly using the correct volume and diluent
    c. The volume of drug used was accurately measured for the prescribed dose.
    d. The label is correct in regards to patient, dose number, unit, patient identifiers, drug components, route, rate, concentration, storage conditions, expiration date, caution statements (e.g. intrathecal use only)
    e. Final container integrity, correct type of final container (e.g. syringe/and or minibag type).
    f. All intrathecal doses must be placed in a separate transport bag
    g. Any IVP dose in syringe should be less than three quarters full to minimize the risk of chemo spill.
    h. Maximum syringe size dispensed should be 30 mL
    i. The pharmacist must sign their initials on the chemotherapy work card and label to signify product verification.
11. Following double check, the chemotherapy doses is place in a sealable chemotherapy transport bag.
12. A label with the patients first and last name and location shall be placed on the outside of the transport bag.
13. The pharmacist must initial the label on the outside of the transport bag to ver.ify they have matched the patient name on the final product to the transport bag.

Tri-City Medical Center	Distribution: Outpatient Infusion Center
PROCEDURE:	**DISPOSAL OF CHEMOTHERAPY WASTE**
~~Purpose:~~	~~To outline the nursing responsibility and managem~~ ~~chemotherapy waste.~~
~~Supportive Data:~~	~~Oncology Nursing Society's Chemotherapy and Bi~~ ~~Recommendations for Practice 3rd Edition, 2011.~~
~~Equipment:~~	~~➢ Chemotherapy safe personal protective equipment~~ ~~➢ Puncture proof container labeled "chemotherapy" container~~ ~~➢ Gloves specified for use with chemotherapy agents~~ ~~➢ Large yellow bag marked "chemotherapy waste"~~ ~~➢ Gown specified for use with chemotherapy agents~~

DELETE – duplicate to Patient Care Services Policy Disposal of Chemotherapy Waste

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

~~1. Place puncture proof chemotherapy container near patient upon initiating chemotherapy treatment.~~

~~2. Always use chemotherapy safe personal protective equipment when handling chemotherapy waste.~~

~~3. Place contaminated needles and syringes in a puncture proof container labeled "chemotherapy waste."~~

~~4. Place contaminated Intravenous (IV) tubing, IV bags, and all non-sharp materials in the large yellow plastic bag marked "chemotherapy waste." Tie off large yellow chemotherapy waste bag carefully gathering top portion of bag with one hand and slowly pull downward on gathered portion until internal air in bag resists further pulling down. Place yellow chemotherapy waste bag in puncture proof container labeled "chemotherapy waste." May place non-sharp chemotherapy waste directly into puncture proof chemotherapy container.~~

~~5. Upon completion of treatment, place puncture proof needle container in chemo waste room. If the container is less than 2/3 full, place lid gently on top.~~

~~Completely close lid when the container is 2/3 full or if a potential risk is perceived. Document on top of the container that the puncture proof waste containers are full. Chemotherapy containers must be removed from the chemo waste room within 24 hours.~~

~~6. **Outpatient Infusion Center staff shall notify currently contracted Waste Management provider to pick-up full chemo waste containers.**~~

Review/Revision Date	~~Medical Department~~ Review Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
3/13, 5/16	3/13,07/16	6/16	3/13, 08/16	3/13, 09/16	3/13

Move from Pharmacy Manual to Patient Care Services

Tri-City Health Care District
Oceanside, California

~~PHARMACY MANUAL~~Patient Care Services

ISSUE DATE:	**11/11**	**SUBJECT: Chemotherapy~~,~~ Prescribing, Processing~~,~~ and Preparation**
REVISION DATE:	**05/13, 06/14, 07/15**	

Department Approval:	**~~03/15~~05/16**
Clinical Policies and Procedure Approval:	**06/16**
Nurse Executive Council Approval:	**07/16**
Division of Oncology Approval:	**07/16**
Pharmacy and Therapeutics Committee Approval:	**~~03/15~~06/16**
Medical Executive Committee Approval:	**~~06/15~~08/16**
Professional Affairs Committee Approval:	**~~07/15~~09/16**
Board of Directors Approval:	**07/15**

A. **PURPOSE:**

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

B. **CHEMOTHERAPY PRESCRIBING ~~POLICY~~PROCEDURE:**

1. Chemotherapy will encompass ~~all~~ anti-neoplastic agents used to treat cancer including monoclonal antibodies, oral tyrosine kinase inhibitors as well as traditional cytotoxic chemotherapy.
2. Orders written for chemotherapy agents shall meet the following criteria:
   - **a.** Written on the standard, pre-printed "Chemotherapy Order Form"
     - **i. Exception: TCHD Outpatient Infusion Center (OIC) may use institution specific Chemotherapy Orders.**
     - ~~a.~~**ii. Outpatient chemotherapy orders are invalid for use upon hospital admission. Orders must be rewritten on the standard, pre-printed "Chemotherapy Order Form".**
     - ~~i.~~**iii.** Telephone and verbal orders between physicians and physician assistant/nursing will not be accepted unless to hold or stop chemotherapy administration.
     - ~~ii.~~**iv.** Changes to orders regarding **chemotherapy** drug **name**, dosing parameters, route, ~~diagnosis,~~ or patient name/2nd identifiers will only be accepted by pharmacy if re-written by the physician on the Chemotherapy Order Form~~ or template~~.
       - **1) Exception:** A pharmacist may ~~change the order~~**modify an existing Chemotherapy Order Form** with "verbal/**telephone** order read back"~~.~~ ~~regarding the dose, infusion time, height/weight, dates of therapy.~~
       - ~~iii.~~**2) Pharmacists may shorten multi day continuous infusions from over 24 hour to 22 hours for logistical purposes without a "verbal/telephone order read back".**
     - ~~iv.~~**v.** Corrected carboplatin doses based on ~~AUC and CrCl~~**the Calvert equation** may be calculated by the pharmacist and documented on the original order~~ by the pharmacist~~. The pharmacist must read back the change ~~from the actual written transcription~~ to the physician.
     - ~~v. New orders or changes to orders must be documented in the electronic medical record (if applicable).~~
   - b. Complete orders must include:
     - i. Patient's full name and second patient identifier (medical record number, DOB)
     - ii. Date

iii. Diagnosis
iv. Regimen name and cycle number
v. Protocol name ~~and number (if applicable)~~
vi. Appropriate criteria to treat (i.e based on relevant laboratory results and toxicities)
vii. Allergies
viii. Reference to the methodology of the dose calculation or standard of practice equations (i.e calculation of creatinine clearance)
  1) **For carboplatin calculated with the Calvert equation this includes:**
    a) **Target AUC**
    b) **Creatinine Clearance and equation used to calculate if different than Cockcroft-Gault**
    c) **Serum Creatinine used if different than current lab**
    ~~viii.~~**d) Actual, ideal or adjusted weight used to calculate dose**
ix. Height, weight and any other variables used to calculate the dose (i.e BSA)
  1) Inpatient chemotherapy: height and weight should be measured within 48 hours from the start of the new cycle.
  ~~ix.~~**2) Outpatient chemotherapy: weight should be measured at the beginning of each new cycle. Height must be measured at the beginning of each new regimen.**
x. Dosage
  1) Doses may not include trailing zeros; use a leading zero for doses less than 1 mg
  2) Doses will use the metric system and include dose/m2, dose/kilogram or AUC (area under the curve) ~~where~~ **when** appropriate. The actual calculated dose will be included
  3) Written as the amount per dose per day (e.g. cisplatin 20 mg/m^2 daily x 5 days, or cytarabine 3000 mg/m^2/dose every 12 hours on days 1,3, and 5)- NEVER written as total amount needed per course of therapy as this could be interpreted as daily dose
xi. Route and rate (if applicable) for administration
xii. Length of infusion (if applicable)
xiii. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors and hypersensitivity medications)
xiv. Sequence of drug administration (if applicable)
xv. Cumulative dose for medications with dose ceilings including daunorubicin, doxorubicin, doxorubicin liposomal, epirubicin, bleomycin, mitomycin C

c. Written using the generic name of the agent and free of any unapproved abbreviations used to identify the agent being prescribed. The pharmacist may clarify chemotherapy orders and write the generic name next to any commonly used abbreviation or brand names~~.~~
d. Free of any number prefixes such as "5-fluorouracil", which could be misinterpreted as part of the order dose or schedule requirements
e. Signed by a physician (MD or DO) ~~in~~ of Oncology or those who have been granted privileges to order chemotherapy–before processed by ~~the~~ pharmacy
  i. Signed by person drafting order if different then person signing order.
  ii. Note: Pharmacy will not accept orders from Nurse Practitioners (NPs) and Physician Assistants (PAs) for any chemotherapy agent regardless of indication or use.
  iii. New orders must be written prior to each new chemotherapy cycle.
    ~~iii.~~**1) Exception: Outpatient Infusion Center-** Orders must be reviewed and re-signed ~~every 6 months~~**yearly**.
f. Accompanied by a copy and/or name of a readily available reference or the protocol name and number used in determining the prescribed regimen if the regimen is unfamiliar to the pharmacist.
  i. ~~The new protocol will be added to the pharmacy oncology literature file=~~

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

C. **CHEMOTHERAPY PROCESSING PROCEDURE~~OLICY~~:**
1. The pharmacist will confirm that the order has been prescribed according to the criteria above.
2. The pharmacist shall contact the physician to request that any order not meeting these criteria be changed.
3. All addendums or changes to original orders must be documented on a Chemotherapy Order Form. ~~A copy will be placed with the chemotherapy work sheet and original order.~~
4. Changes to the order made by the physician (as above) must be double checked by a second pharmacist.
5. If there is a discrepancy in the medication order, nursing will be notified of the problem and the possible delay in the delivery of the medication.
6. Once the prescribing criteria have been met, the pharmacist is responsible for verifying the accuracy of the order by:
   a. Confirming the two patient identifiers
   b. Reviewing the diagnosis and prescribed regimen (drug name, dose, route and frequency)
   c. Calculating the patients' BSA, unit conversions and patient-specific dose
   d. Reviewing diluents, drug volumes, rate of administration, drug concentration requirements, drug stability, administration times, infusion guidelines and supportive care medications
   e. Verifying appropriate labs have been ordered and are within acceptable ranges for the ordered chemotherapy medications or if treatment modifications are indicated
   f. ~~Reviewing the date the patient was last treated and then next planned treatment date to ensure the appropriate interval has elapsed since last treatment was administered~~**Confirming correct time interval has elapsed between treatments**
   g. Reviewing drug allergies and sensitivities along with adverse drug effect histories
   h. Current medication profile should be evaluated for potential drug interactions with antineoplastic therapy

7. Upon completion of the verification process, the pharmacist will prepare a chemotherapy work sheet for use in preparing the prescribed regimen. One worksheet must be filled out for each patient. The following information should be documented:
   a. Patient name second identifier (i.e DOB and/or medical record number)
   b. Height, weight, body surface area~~, CrCl and any other pertinent labs~~
      ~~i. Diagnosis, allergies, doctor's name, regimen name and protocol number (if applicable)~~
   c. Diagnosis, allergies, doctor's name and regimen name
   ~~b.~~**d.** Full generic medication name, dose/m2 or AUC, route, frequency and any special medication instructions that are different then institutional standards
   ~~c.~~**e.** Appropriate cycle number and day along with corresponding date of treatment
   ~~d.~~**f.** Cumulative dose for medications with dose ceilings
8. The order shall be entered into the electronic medical record under the patient's medication profile.
9. A second pharmacist must verify the accuracy of the regimen, chemotherapy work sheet and corresponding entries in medication profile ~~with each new cycle~~ and initial the work sheet to signify approval.
   a. Changes in subsequent doses should be noted on the chemotherapy worksheet and must be double checked and initialed by a second pharmacist.
   b. Explanation of reason for changing subsequent doses shall also be documented.

~~10. If paper orders are used, a copy of the order shall be attached to the chemotherapy worksheet~~

~~11.~~**10.** On the day of treatment, the verifying pharmacist must check the following:
   a. Dose changes based on weight:
      i. Cytotoxic chemotherapy: The dose is within 5% of treatment plan dose based on the current weight.
      ~~a.~~**ii. Monoclonal antibodies: The dose is within 10% of treatment plan dose based on the current weight.**
      ~~i.~~**iii.** Any questions regarding weight that could affect the treatment regimen will be brought to the physician's attention.
   b. Chemotherapy orders have not changed between the original regimen verification and the actual day of treatment **and all computerized order entries are correct.**~~.~~
   c. Appropriate labs ~~that~~ are drawn within the appropriate time interval and are regimen specific.
      i. Labs will be evidence based when national guidelines (e.g ASCO/NCCN) exist or determined by practitioner
      ii. Guidelines for timing of labs:
         1) In chemotherapy naïve patients (no prior chemo)- lab results should be no older than 7 days.
         2) For patients currently receiving chemo with the following frequencies:
            a) Every 7 days – lab results should be within 2 calendar days
            b) Every 14 days and beyond – lab results can be within 3 calendar days (i.e. 72 hours)
         3) Daily (consecutive days of chemo)~~.~~ – labs should be drawn on day 1.
         ~~i.~~**4) Older labs may be accepted at the pharmacists' discretion.**
      ~~ii.~~**iii.** Any abnormal lab values that could affect the treatment regimen will be brought to the physician's attention.
      ~~iii.~~**iv.** In the absence of treatment parameters, the lab values of ANC ≤ 1500 cells/µL, platelets ≤ 100,000/uL total bilirubin ≥ 1.4 mg/dL, CrCl <60 mg/dl (if drug renally cleared) and any other laboratory values specific to prescribed chemotherapy that are not within normal limits will be approved with physician before preparation of dose.

~~d. Ensure that the computerized order entry matches the order from which it was transcribed, or in the case of computerized physician order entry (CPOE), that the entry was inputted correctly.~~
~~i. This includes drug name, dose, route, order of administration, diluent, volume, order comments and rate.~~

~~e.~~**d.** Confirm the cycle has been checked and signed off by two pharmacists.

~~f.~~**e.** The pharmacist that performs steps a-e above will initial the chemotherapy worksheet signifying that this part of verification has been done.

~~g.~~**f.** A second pharmacist will verify steps a-f above and initial chemotherapy worksheet.

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

12. Exceptions

~~12.~~**a. For TCMD OIC, the second pharmacist verification as outlined in C.11.f can be omitted.**

D. **CHEMOTHERAPY PREPARATION AND DISPENSING PROCEDURE~~OLICY~~:**

1. The technician responsible for preparing the doses must gather the order, chemotherapy worksheet, patient-specific labels, medication, and associated supplies.
2. The technician is responsible for ~~printing out a second "production" label for tracking purposes, indicating the following~~**recording the following for preparation records**:
   - **a. Patient name and one other identifier**
   - ~~a.~~**b.** Time and date the product was prepared
   - ~~b.~~**c.** Medication ~~used~~, concentration and volume used
   - ~~c.~~**d.** The lot number/expiration date from the medication vial **and IV diluent bag.**
3. The technician must initial the chemotherapy worksheet, product label and ~~production label~~**preparation records** and perform all calculations associated with the compounding process.
4. If an oral chemotherapy drug is to be physically manipulated or repackaged**,** ~~into a larger gel cap~~ the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.
5. All intravenous chemotherapy will be prepared using a Closed System Transfer Device (CTSD) whenever possible in a Biological Safety Cabinet using Hazardous Drug Preparation guidelines.
6. All parenteral chemotherapy medications ~~need to~~**will** be spiked and primed in the chemo hood if ~~to be~~ dispensed ~~in~~ **as** IV piggyback.
7. The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be pulled back to indicated the measured volume or shown to the pharmacist before injecting into IV solution.

~~7. The pharmacist reviewing the prepared dose must check each prepared dose must check the patient specific label against the chemotherapy worksheet and original order. If CPOE is used, the pharmacist may check the label against the chemotherapy worksheet.~~

~~8. The pharmacist must ensure that the current cycle and verification boxes have been signed off on the chemotherapy work sheet.~~

~~9.~~**8.** The pharmacist, working independently must verify the ~~final preparation includes~~**following**:

- **a. The current cycle and verification boxes have been signed off on the chemotherapy work sheet.**
- **b. The patient specific labels match the chemotherapy worksheet.**
- ~~b.~~**c.** The correct medication has been **chosen**~~used.~~
- ~~c.~~**d.** The drug was reconstituted correctly using the correct volume and diluent
- ~~d.~~**e.** The volume of drug used was accurately measured for the prescribed dose~~.~~
- ~~e.~~**f.** The label is correct and includes at least:
  - i. Patient's full name and second patient identifier (i.e DOB or medical record number)
  - ii. Full generic drug name
  - iii. Drug administration route
  - iv. Total dose to be given
  - v. Total volume required to administer dosage
  - vi. Date of administration

vii. Date and time of preparation
viii. Date and time of expiration if not for immediate use
ix. Special handling instructions and caution statements (i.e intrathecal use only)
x. Final concentration of product on syringe labels (i.e doxorubicin 50mg/ 25ml)
xi. All minibag or large volume parenterals include volume of each component as well as a total volume ~~and~~
~~xi.~~**xii. R**~~r~~ate of administration~~.~~

~~f.~~**g.** Final container integrity and correct type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.

~~g.~~**h.** All intrathecal doses
i. Must not be prepared during preparation of any other agents
ii. **L**~~Be uniquely l~~abeled with an identifiable intrathecal medication label
iii. Must be placed in a separate transport bag
iv. Be delivered ~~to the patient~~ only with other medications intended for administration intrathecally

~~h. Any IVP dose in syringe should be less than three quarters full to minimize the risk of chemo spill.~~

i. Maximum syringe size dispensed should be ~~30~~ **35** mL
i. **Any IV push dose in syringe should be less than three quarters full to minimize the risk of chemo spill.**

~~i.~~**j.** An overfill volume of 0.05 ml will be added to all subcutaneous doses

11. Upon completing the chemotherapy preparation process, the final product shall be affixed with patient specific labels
12. All ~~oral~~ **hazardous** chemotherapeutic agents regardless of **route and** indication shall be dispensed from the pharmacy with an auxiliary Chemotherapy Warning label
~~12.~~**13. Any IV line that has been primed with active drug will be dispensed from the pharmacy with appropriate auxiliary label**
~~13.~~**14.** The pharmacist must sign their initials on the chemotherapy work sheet, patient specific label and ~~tracking label~~**preparation records** to signify product verification.
a. The pharmacist must ensure the technician has initialed all aforementioned places as well.
15. ~~The~~ **All** chemotherapy doses are placed in a sealable chemotherapy ~~transport~~ bag
16. Delivery
a. Must be put into a chemotherapy cooler containing a spill kit for transportation out of pharmacy.
i. Chemotherapy leaving the hospital must be double bagged.
~~14.~~**b. Chemotherapy will only be delivered to designated oncology floors.**
~~15. If the chemotherapy is to leave the building, it must be double bagged and placed in a transport cooler with a spill kit inside.~~

E. REFERENCES

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

Tri-City Medical Center	Distribution: Women & Newborn Services
PROCEDURE:	**DINOPROSTONE (CERVIDIL)**
Purpose:	To outline the nursing management of a patient receiving Dinoprostone (Cervidil) placement for labor induction. Dinoprostone (Cervidil) may be used for ripening of the cervix and induction of labor. Cervical Ripening may be required when induction of labor is indicated and the cervix is unfavorable
Supportive Data:	Dinoprostone (Cervidil) is indicated for ripening an unfavorable cervix in pregnant women at or near term with a medical or obstetrical indication for induction of labor. Cervical ripening refers to the softening and effacement (thinning) of the cervix, and is thought to represent the maturation of the reproduction system in terms of labor induction readiness. Procedure may be done by either a provider or a Registered Nurse (RN).
Equipment:	1. Dinoprostone (Cervidil) 10mg vaginal suppository with an intact retrieval tape 2. Single sterile exam glove 3. Sterile, water soluble lubricant

A. **POSSIBLE INDICATIONS FOR USE:**

1. Post Term Gestation
2. Intrauterine Growth Restriction (IUGR)
3. Oligohydramnios
4. Gestational Hypertension/ Pre-Eclampsia
5. Obstetrical or medical indication for induction of labor (Diabetes, Hypertension)
6. Premature Rupture of Membranes (PROM)
7. Fetal Demise

B. **CONTRAINDICATIONS:**

1. Abnormal Fetal Lie
2. Patients with known hypersensitivity to prostaglandins/Asthma
3. Existing tachysystole or uterine hypertonus
4. Clinical suspicion or evidence of Category III tracing
5. Abnormal presentation
6. Non-cephalic presentations (breech)
7. Placenta previa, vasa previa/abruption
8. Prior uterine scar (previous cesarean section or uterine surgery)
9. Unexplained heavy vaginal bleeding in third trimester
10. Contracted pelvis
11. Active herpes

C. **USE CAUTION WHEN ADMINISTERING TO WOMEN WITH:**

1. History of:
   a. Asthma
   b. Glaucoma
   c. Hepatic Disease
   d. Pulmonary Disease
   e. Renal Disease
   f. Cardiac Disease
   g. Multiparous with > 6 pregnancies.
   h. Polyhydramnios

Department Review	Department of OB/GYN	Division of Neonatology	Department of Pediatrics	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
1/95;2/97;3/03; 5/09;12/12;**1/16**	01/13, **02/16**	**n/a**	**n/a**	**6/16**	**5/13, 08/16**	6/13, 09/16	6/13

D. **PROCEDURE/PREPARATION:**

1. The RN shall verify provider's order and ensure informed consent was obtained and signed by the patient.
2. The RN shall verify prenatal record is available for review.
3. Maternal-Fetal assessment
   a. Maternal Assessment:
      i. Assess baseline maternal temperature, pulse, respirations, and blood pressure.
      ii. In the absence of ruptured membranes assess cervical dilatation, effacement, station, consistency and position of cervix prior to insertion of Dinoprostone (Cervidil).
      iii. Assess uterine activity, including palpation of contraction(s).
   b. Fetal Assessment:
      i. Obtain a 20-30-minute fetal heart rate tracing.
      ii. Confirm fetal lie and vertex presentation for viable fetus.
      iii. Notify the provider of a Category II or III fetal heart rate tracing BEFORE placing Dinoprostone (Cervidil).
4. Start a large bore peripheral intravenous (IV) line 18 G or larger.
5. Obtain lab work as ordered by provider.
6. Dietary restrictions limited to sips of clear liquids and/or ice chips per provider order

E. **INSERTION:**

1. Have the patient empty her bladder
2. Obtain Dinoprostone (Cervidil) suppository.
   a. Never use Dinoprostone (Cervidil) vaginal suppository without its retrieval system.
3. Don sterile examination glove and apply a minimal amount of lubricant.
   a. Excessive amounts of lubricant can prevent optimal release of the Dinoprostone (Cervidil) from the vaginal suppository.
4. Insert Dinoprostone (Cervidil) vaginal suppository immediately after removing it from its packaging:
   a. Place Dinoprostone (Cervidil) vaginal suppository between index and middle finger of sterile gloved hand and insert into vagina.
   b. Advance suppository to the posterior fornix and place suppository transversely.
   c. Ensure that retrieval system (length of attached tape) is accessible.
5. Maintain patient in a lateral recumbent position with a left or right tilt, for at least two hours, or as ordered by provider.

F. **MONITORING:**

1. Assess fetal heart rate and uterine activity every 30-minute X 4, then at hourly intervals during the latent phase of labor (cervical dilatation less than or equal to 4 cm).
   a. The need for continuous verses intermittent monitoring is based on fetal well-being and is at the discretion of the provider.
2. Vital signs (VS) (pulse, respirations, and blood pressure): monitor VS every 30 minutes x 2 after each dose, then every 4 hours if stable and patient is not in active labor. When patient is in active labor, monitor VS (pulse, respirations, and blood pressure) hourly. If patient has an epidural, refer to VS protocol per procedure.

G. **REMOVAL OF THE DINOPROSTONE (CERVIDIL) INSERT:**

1. Upon the onset of active labor
2. With Spontaneous rupture of membranes.
3. Prior to amniotomy.
4. Within 12 hours of insertion.
5. At least 30 minutes prior to the initiation of oxytocin augmentation.
6. Removal should be considered if tachysystole occurs.
   a. If fetal heart rate tracing is a Category II progressing to a Category III appropriate

intrauterine resuscitation measures should be implemented, such as position change, administer oxygen via non-rebreather mask, and IV fluids.

i. If no immediate improvement is observed, notify provider
ii. Remove Dinoprostone (Cervidil)
iii. Anticipate provider order for tocolytics such as terbutaline

H. **DOCUMENTATION:**

1. Document fetal heart rate status, uterine activity, and cervical status in the medical record.
2. Document placement of Dinoprostone (Cervidil) suppository in the medication record.
3. Document events, VS, and interventions associated with this procedure in the medical record.

I. **REFERENCES:**

1. Simpson, K. R., & Creehan, P. A. (2014). AWHONN's Perinatal Nursing 4th Ed. Philadelphia, PA: Wolters Kluwer / Lippincott Williams & Wilkins

~~1.~~**2.** ACOG Committee on Practice Bulletins- Obstetrics ACOG Practice Bulletin No 107: Induction of labor. Obstetrics and Gynecology 2009; 114:386.

~~2.~~**3.** Kennedy, B.B., Ruth, E.J., Martin, E.J. (2009) Intrapartum Management Modules (3rd Ed.)
a. Lippincott Williams and Wilkins

~~3.~~**4.** Wing, D.A. (2008) Induction of labor in women with prior cesarean delivery. Retrieved from www.uptodate.com 4/06/09.

~~4.~~**5.** Wing, D.A., Lockwood, C.J., Barss, V. Induction of labor. Retrieved from www.uptodate.com 08/12

~~1. Simpson, K. R., & Creehan, P. A. (200). AWHONN's Perinatal Nursing. Philadelphia, PA:~~
a. ~~Wolters Kluwer / Lippincott Williams & Wilkins~~.

ISSUE DATE: 10/94

SUBJECT: WNS~~WSC~~ ADMISSION REGISTRATION POLICY

REVISION DATE: 1/00, 6/03, 6/06, 06/13

~~Clinical Policies & Procedures Committee Approval:~~	~~02/13~~
~~Nurse Executive Committee Approval:~~	~~02/13~~
~~Medical Department Approval:~~	~~01/13~~
Department Approval:	07/16
Department of OB/GYN Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/13~~ n/a
Professional Affairs Committee Approval:	~~06/13~~09/16
Board of Directors Approval:	06/13

A. **ADMISSION TO LABOR AND DELIVERY:**

1. All patients who have sent pre-admission forms to Tri-City Medical Center will have a pre-admit number issued by the admitting/registration department **for anticipated vaginal birth.**
   a. **Unit secretaries will use the pre-admit number when the patient comes to the L&D unit to be evaluated regardless of the reason for the visit.**
2. **Patient's scheduled for Cesarean Section will have a pre-admission number assigned to them by the surgery scheduling center.**
   ~~1.~~a. **Do not use this account until the patient comes in for pre-operative laboratory work.**

B. **ADMISSION TO A (LABOR-DELIVERY-RECOVERY LDR) ROOM:**

1. **The patient will be given an account number for this visit and if a medical record number is needed because the patient has not been pre-admitted, the unit secretary will use the OB quick registration option in Cerner.**
2. ~~Patient's~~**Patients who do not have updated information in the computer will be asked to complete a registration form and provide the unit secretary her insurance and identification card, if available.**
   a. **Copies of registration information and the cards shall be made and faxed to the appropriate department depending on these days and times:**
      i. **Registration notices are sent to the main hospital registration/ admitting department Monday – Friday from 0500-1800 and Saturday from 0730-1600.**
      ii. **Registration notices are sent to the Emergency Department (ED) Monday-Thursday 1800- 0500, Friday 1800-0730 and Saturday – Monday from 1600-0500.**
      iii. **The main hospital registration is closed on Sundays.**
      ~~1. Admit the patient through the hospital information system.~~
   ~~a. Admission notices generated between 0500 and 2100 are sent to main admitting.~~
   ~~b. Admission notices generated between 2100 and 055 are sent to ED registration.~~
~~2. Patients who have not been pre-admitted will be required to complete a pre-admission form.~~
   ~~a. This form will be faxed to the appropriate admitting/registration fax machine~~.
3. **The unit secretary will have** ~~Have~~ the patient sign**, date and time the conditions of admission (COA)**~~the following documents~~:
   a. ~~Conditions of admission f~~**For** herself and her infant(s).
      i. In the event of anticipated multiple deliveries, (e.g. twins), the mother is required to sign a **COA**~~conditions of admission~~ for each infant.

~~ii. HIPAA required documents.~~

4. **Obstetrical outpatient visits/ evaluation** ~~B Checks (obstetrical outpatient visits)~~
   a. **The**~~Each~~ **patient is assigned an account number by the unit secretary for each visit and if the patient is admitted this will continue to be her account number.**
   ~~a. OB check visit is given an OBCH designation and number (i.e., account number) via computer communication to admitting/registration.~~
      ~~i. Exception: if a visit that begins as an OB check becomes an admission.~~
   ~~b. A new OBCH number is issued for each visit.~~
   b. **When** ~~After~~ the patient **is** ~~has been~~ discharged **the paperwork should be returned to the unit secretary for coding and disassembly. Paperwork should include:**
      i. **Her signed conditions of admission**
      ii. **Her face sheet**
      iii. **Completed charge slip and visit classification**
      iv. **Prenatal record, if obtained, can be refiled for next visit**
   c. **If the patient returns for evaluation at another time, a new account number for the most current visit will need to be issued.**
5. **Obstetrical Admissions.**
   a. **Send the completed registration notice to the appropriate department**
   b. **Unit secretary will ready the patient's chart for admission and include applicable consents as indicated, prenatal record, signed, dated, and timed COAs.**
      i. **Update the chart with allergies and any other pertinent information.**
      ~~c. from her OBCH encounter, the OBCH chart is to be taken to the WCS control desk.~~
      ~~i. The record is to be stamped with the OBCH FIN number, the log entry completed. After this, the record is to be filled with the prenatal record filing in cabinet at the front desk.~~

~~5.~~**6.** Newborn Admission:
   a. When **the infant is born,** ~~the mother is admitted,~~ the infant will be issued **a medical record number and account number through the mom's record, which can connect the records.** ~~an admission number with the following information:~~
      ~~i. Mother's last name(s)~~
      ~~ii. The word "baby"~~
      ~~iii. Medical record number~~
      ~~iv. Account number~~
      ~~v. The admitting obstetrician~~
      ~~vi.~~**i.** ~~In the event of multiple deliveries, (e.g., twins), an additional designation will be added (e.g. Baby A, Baby B)~~
      ~~b. Once the infant is delivered, admit the infant through the hospital information system (see 3.a, 3.b).~~
   ~~i.~~**b. The Unit Secretary will** ~~V~~verify that the name of the pediatrician/neonatologist~~/family practice physician is correct~~ **assigned to the family, gender of the baby and birth time.**
      ~~ii. When the demographics and inpatient labels are issued by admitting/registration, discard the pre-admit labels in the approved manner.~~
      i. **For multiples, the use of Baby A, B or C should be used to register each baby separately**
   c. **The unit secretary shall print up the infant identification bands, face sheet, patient labels and give them to the primary nurse for review and verification.**
   ~~c.~~**d. The notice of admission/ registration will be sent to appropriate department.**

ISSUE DATE: 10/94

SUBJECT: WNS ADMISSION REGISTRATION POLICY

REVISION DATE: 1/00, 6/03, 6/06, 06/13

Department Approval:	**07/16**
Department of OB/GYN Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**09/16**
Board of Directors Approval:	**06/13**

A. **ADMISSION TO LABOR AND DELIVERY:**

1. All patients who have sent pre-admission forms to Tri-City Medical Center will have a pre-admit number issued by the admitting/registration department for anticipated vaginal birth.
   a. Unit secretaries will use the pre-admit number when the patient comes to the L&D unit to be evaluated regardless of the reason for the visit.
2. Patient's scheduled for Cesarean Section will have a pre-admission number assigned to them by the surgery scheduling center.
   a. Do not use this account until the patient comes in for pre-operative laboratory work.

B. **ADMISSION TO A (LABOR-DELIVERY-RECOVERY LDR) ROOM:**

1. The patient will be given an account number for this visit and if a medical record number is needed because the patient has not been pre-admitted, the unit secretary will use the OB quick registration option in Cerner.
2. Patients who do not have updated information in the computer will be asked to complete a registration form and provide the unit secretary her insurance and identification card, if available.
   a. Copies of registration information and the cards shall be made and faxed to the appropriate department depending on these days and times:
      i. Registration notices are sent to the main hospital registration/ admitting department Monday – Friday from 0500-1800 and Saturday from 0730-1600.
      ii. Registration notices are sent to the Emergency Department (ED) Monday-Thursday 1800- 0500, Friday 1800-0730 and Saturday – Monday from 1600-0500.
      iii. The main hospital registration is closed on Sundays.
3. The unit secretary will have the patient sign, date and time the conditions of admission (COA):
   a. For herself and her infant(s).
      i. In the event of anticipated multiple deliveries, (e.g. twins), the mother is required to sign a COA for each infant.
4. Obstetrical outpatient visits/ evaluation
   a. The patient is assigned an account number by the unit secretary for each visit and if the patient is admitted this will continue to be her account number.
   b. When the patient is discharged the paperwork should be returned to the unit secretary for coding and disassembly. Paperwork should include:
      i. Her signed conditions of admission
      ii. Her face sheet
      iii. Completed charge slip and visit classification
      iv. Prenatal record, if obtained, can be refiled for next visit

c. If the patient returns for evaluation at another time, a new account number for the most current visit will need to be issued.

5. Obstetrical Admissions.
   a. Send the completed registration notice to the appropriate department
   b. Unit secretary will ready the patient's chart for admission and include applicable consents as indicated, prenatal record, signed, dated, and timed COAs.
      i. Update the chart with allergies and any other pertinent information.
6. Newborn Admission:
   a. When the infant is born, the infant will be issued a medical record number and account number through the mom's record, which can connect the records.
   b. The Unit Secretary will verify that the name of the pediatrician/neonatologist assigned to the family, gender of the baby and birth time.
      i. For multiples, the use of Baby A, B or C should be used to register each baby separately
   c. The unit secretary shall print up the infant identification bands, face sheet, patient labels and give them to the primary nurse for review and verification.
   d. The notice of admission/ registration will be sent to appropriate department.

DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
September 6, 2016

Members Present:	James J. Dagostino, DPT, PT, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Dr. Cary Mells, Physician Member; Eric Burch, Community Member ; Dr. Paul Slowik; Community Member; Dr. Gene Ma, Chief of Staff
Non-Voting Members:	Steve Dietlin, CEO; Kapua Conley, COO; Sherry Miller, Manager, Medical Staff Office
Others Present:	Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Robin Iveson, Community Member; Laura Mitchell, Board Member; Julie Nygaard, Board Member; Greg Moser, General Counsel
Absent:	Dr. Marcus Contardo, Physician Member; Cheryle Bernard-Shaw, Chief Compliance Officer

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Dagostino.		
2. Approval of Agenda	**It was moved by Director Reno to approve the agenda as presented. Director Finnila seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Dagostino read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Finnila and seconded by Mr. Burch to ratify the minutes of the August 2, 2016 Governance & Legislative Committee. The motion passed with Director Reno voting no and Dr. Ma abstaining from the vote.**	Minutes ratified.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
5. Old Business – a. Review and discussion of Board Policy 14-020 – Business Expense Reimbursement: Ethics Training	Chairman Dagostino stated the Board referred Board Policy 14-020 – Business Expense Reimbursement: Ethics Training back to the committee for further discussion. General Counsel distributed a proposed revision to the Scope of the Policy to address concerns that were raised by the Board. Mr. Moser explained the proposed language allows travel arrangements to come through the CEO however does not allow reimbursement of expenses during the course of the travel such as parking, mileage. etc. Chairman Dagostino proposed additional language under section IV. to provide that "a Board member may request Board approval of expenses incurred for meetings, regulatory or business events extended prior to approval. Reimbursable events are as follows: 1. Meetings, Regulatory hearings or business events that may have been requested by Administration for Board attendance; 2. Follow-up events that relate to the above." Discussion also ensued as to whether expenses should be reimbursed for attending events within 30 miles. Mr. Moser stated Section IV related to Lodging provides that "lodging shall not be reimbursed or provided at TCHD expense if the meeting site is within 30 miles of the Director's legal residence without prior Board approval…." however the policy does not provide for any restrictions for parking and mileage reimbursement when the meeting site is within 30 miles of the Director's residence. Mr. Moser also noted request for reimbursement of such items is the prerogative of the Board member. Mr. Burch commented that common practice provides any business traveled on behalf of the business should be reimbursed without a threshold (such as 30 miles). Dr. Ma commented that he believes there are enough safeguards in the policy to prevent abuse of the policy.		

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	It was recommended that the title of the Policy be revised to read Business and Educational Expense Reimbursement; Ethics Training and state that it specifically applies to the Board of Directors. Mr. Moser explained by virtue of the caption of the policy "Tri-City Healthcare District Board of Directors Policy" it implies that it is a Board of Directors policy. **It was moved by Dr. Slowik to recommend approval of the policy with the three (3) amendments described related to the 1) name of policy, 2) Scope and 3) Post Approval of Expenses. Dr. Mells seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy Board 14-020 Business Expense Reimbursement: Ethics Training as amended; item to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations: 1) Department of Pediatrics	The committee reviewed the Department of Pediatrics Rules & Regulations. Ms. Miller explained per recommendation of General Counsel section VI B. has been struck from the Rules & Regulations for consistency with other Rules & Regulations. Ms. Miller also explained the Privileges have been extracted from the Rules & Regulations. Dr. Ma explained the decision was made to extract the Privileges from all Rules & Regulations as a time saving feature due to the fact that privileges are constantly changing and it is more efficient to revise the Privilege Card as necessary rather than the entire Rules & Regulations. Discussion was held regarding Section IX. Emergency Room Coverage. Dr. Ma stated that although there currently is no Pediatric Emergency Room call coverage it is recommended that the language remain in the Rules and Regulations to allow flexibility in the event Pediatric Emergency Room call is reinstituted at a later date. Dr. Ma also explained the language is included to address EMTALA issues. General Counsel noted the language as written reflects that the physician has a choice whether or not to provide follow-up care and it should not be elective. Director Finnila recommended section IX Emergency Room Coverage be omitted in its entirety		

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	as it does not apply to Pediatrics. Again, Dr. Ma recommended the section remain intact to allow flexibility. Dr. Ma suggested the committee recommend approval of the Rules & Regulations as presented and request that the Medical Executive Committee address the Emergency Room Coverage in the Rules & Regulations globally. **It was moved by Director Reno and seconded by Mr. Burch to recommend approval of the Department of Pediatric Rules & Regulations as presented. The motion passed unanimously.** .	Recommendation to be sent to the Board of Directors to approve the Department of Pediatrics Rules & Regulations; item to be placed on Board agenda and included in agenda packet. Emergency Room Call Coverage to be addressed globally by the Medical Executive Committee.	Ms. Donnellan Dr. Ma
2) Department of OBGYN	The committee reviewed the proposed Obstetrics/Gynecology Rules & Regulations. Ms. Miller stated again, the Privileges have been extracted from the Rules & Regulations and will become a separate document. Discussion was held regarding section I. B. related to the requirement that the physician obtain Board Certification if granted privileges on or after June 1, 1991. Dr. Ma explained that physicians who were granted privileges on or after June 1, 1991 have been "grandfathered" in. Dr. Miller questioned the significance of the 1991 date. Ms. Miller stated it is her understanding that it was a decision by the OB/GYN department at that time. **It was moved by Director Finnila to recommend approval of the Department of OBGYN Rules & Regulations as presented. Dr. Slowik seconded the motion.** Dr. Mells stated he had concerns with section XI, particularly items D. E. and F. Dr. Ma stated the		

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	language in section XI was drafted in an attempt to resolve an issue in the Emergency Department however acknowledged the language is still confusing. It was recommended the Department of OBGYN/Gynecology Rules & Regulations be referred back to the Department for clarification. Director Finnila withdrew her initial motion. **It was moved by Director Finnila to refer the Department of Obstetrics & Gynecology Rules & Regulations back to the Department for clarification related to Emergency Room Call. Mr. Burch seconded the motion. The motion passed unanimously.**	Recommendation to refer Rules & Regulations back to the Department for clarification.	Ms. Sherry Miller
b. OBGYN Revised Privilege Card	The committee reviewed the OBGYN Privilege card. She explained Salpingoplasty has been added to the card as that procedure is currently being performed. Dr. Ma commented that as we do more with UCSD we will need to document new privileges by updating the privilege cards. **It was moved by Director Finnila to recommend approval of the OBGYN Revised Privilege Card as presented. Dr. Slowik seconded the motion. The motion passed unanimously.** *Ms. Sherry Miller left the meeting at 1:34 p.m.*	Recommendation to be sent to the Board of Directors to approve OB/GYN Revised Privilege Card; item to be placed on Board agenda and included in agenda packet	Ms. Donnellan
c. Review and discussion of Committee Charter: 1) Professional Affairs Committee	The committee reviewed the Professional Affairs Committee Charter. Director Finnila stated the Committee would like to continue to review policies related to the implementation of healthcare as described in the Charter. **It was moved by Director Finnila to recommend approval of the Professional Affairs Committee Charter as presented. Dr. Mells seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Professional Affairs Committee Charter as amended; item to be placed on Board Agenda and appear in agenda	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

		packet.	
d. Purpose of Committee and Steps to Implementation	In follow-up to discussion at last month's meeting the committee reviewed the purpose of the committee. Discussion was held regarding the definition of a committee under Roberts Rules of Order. Director Finnila commented that many of the activities outlined in the committee Charter are not performed by the committee and the committee should take direction from the Board rather than vice versa. Director Reno commented on the importance of the committee remaining a standing committee of the Board. Following extensive discussion Mr. Moser suggested he draft revisions to the Charter based on today's discussion. It was recommended Mr. Moser provide committee members with a revised draft prior to next month's meeting and invite comments and suggestions through Ms. Donnellan.	General Counsel to draft revisions to Charter based on feedback from committee members and forward to members for comment. Ms. Donnellan to compile comments from members and provide to Mr. Moser prior to next month's meeting.	General Counsel Ms. Donnellan
7. Discussion regarding Current Legislation	Chairman Dagostino reported the Design Build bill has been signed by the Governor however the District will not need to utilize it as the City of Oceanside has approved the Joint Powers Agreement with the District which allows us to use their Design Build authority. Director Finnila commented on the issue of patient "dumping" and suggested dialogue with ACHD on this issue. The committee directed Mr. Kapua Conley to provide the Board with a confidential report on this issue.	Mr. Conley to provide report to the Board on patient "dumping".	Mr. Conley
8. Review of FY2017 Board Work Plan	The FY2017 Board Work Plan was included in today's meeting packet for reference. It was suggested the Committee develop a Work Plan following completion of the Charter and follow up with solicitations for the two vacant positions.	Committee Work Plan to be developed following completion of Committee Charter. Solicitation for two community member openings will be held following completion of the Charter and Committee's Work Plan.	Ms. Donnellan Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

9. Committee Communications	There were no committee communications.		
10. Committee Openings – Two	There are currently two openings on the committee		
11.Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, October 4, 2016 at 12:30 p.m.	The next meeting of the Committee is October 4, 2016.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 2:25 p.m.		

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-020

POLICY TITLE: Business Expense Reimbursement; Ethics Training

I. POLICY

In compliance with applicable provisions of the Health and Safety Code and the Government Code, including the provisions of AB 1234, as they may be revised from time to time, it is the policy of Tri-City Healthcare District ("TCHD") to reimburse all members of the Board of Directors ("Directors") and the Chief Executive Officer (CEO) for actual and necessary expenses incurred in the performance of official duties on behalf of the TCHD as approved by the Board of Directors. Each Director and the CEO is accountable for expenses incurred when conducting business on behalf of TCHD and will adhere to the policies and procedures adopted by the Board. Since Government Code section 53235 provides that if a local agency provides any type of compensation, salary, or stipend to a member of a legislative body, or provides reimbursement for actual and necessary expenses incurred by a member of a legislative body in the performance of official duties, then all local agency officials shall receive training in ethics, completion of such training is a prerequisite to the receipt of reimbursement under this policy.

II. PURPOSE

To provide consistent guidelines addressing the approval and documentation requirements for the reimbursement of actual and necessary business expenses to TCHD Directors and the CEO.

III. SCOPE

TCHD will reimburse Directors and the CEO for actual and necessary business expenses pursuant to the guidelines set forth in this Policy. In order to receive reimbursement for such expenses, Directors and the CEO must comply with all requirements set forth below, except as may otherwise be set forth in the CEO's employment agreement. This Policy does not limit the authority of the CEO to pay for the actual and necessary costs for a Director to attend a business meeting on behalf of the District at the invitation of the CEO where no reimbursement is involved, and any costs incurred are consistent with the limits of this Policy and reported to the Board at its next regular meeting.

IV. PROVISIONS

~~A.~~ Pre-Approval of Expenses.

In order to be eligible to receive reimbursement for expenses relating to an educational seminar or other external meeting, Directors must obtain Board approval pursuant to the following procedures prior to incurring such expenses:

1. The Director shall request Board approval at a regular meeting of the Board.

2. Prior to the regular meeting at which the Board will consider the approval, the Director must provide TCHD Administration with the following information, which shall be included on the Board Agenda:

   a. Name, purpose and location of meeting.

   b. Estimated reasonable cost of attendance (registration, travel/transportation, meals, lodging, etc.).

B. A Board member may request Board approval of expenses incurred for meetings, regulatory or business events attended prior to approval. Reimbursable events are as follows:

1. Meetings, Regulatory Hearings or business events that may have been requested by administration for board attendance.

2. Follow-up events that related to the above.

~~B.~~ C. Direct Billing/Travel Advances.

1. Direct Billing.

After Board approval has been obtained, the Executive Assistant may coordinate direct billing for advance registration fees for Directors using the TCHD's corporate credit. The Executive Assistant may designate a travel agency to handle such arrangements. Directors may pay expenses specifically authorized for reimbursement under this policy using their personal credit card to be reimbursed upon submittal of an Expense Report Form, as set forth in Exhibit "A." Directors may make their own airfare arrangements via the Internet using their personal credit cards, or may use the travel agency designated by the Executive Assistant or their own personal credit card, for such bookings.

2. Reconciliation of Direct Billing Expenses.

Directors shall satisfy the requirements of section C, below, as to all directly billed expenses. Expenses shall not exceed the amounts authorized in section D, below. Any failure to timely comply with such requirements may result in withdrawal of direct billing and credit card use privileges, in the sole discretion of the Board Chair.

~~C.~~ D. Reporting Requirements

1. Expense Form.

All requests by a Director or the CEO for reimbursement shall be submitted on TCHD's standard Expense Report Form (see Exhibit "A") with all required supporting documentation and receipts attached in the order they were incurred. This procedure will facilitate the auditing of the Expense Report Forms and provide for more efficient and timely processing. If there are any anticipated reimbursements from outside organizations, documentation of such should be noted on the Expense Report Form. If any such reimbursement is received following TCHD payment of expenses, the overpayment will be signed over to TCHD. TCHD follows the general rules of the IRS and California Government Code which requires i) that expenses be supported by receipts and that the persons involved and ii) that the business purpose of each expenditure be identified.

2. Supporting Documentation.

Supporting documentation should include, whenever applicable, the following:

a. Purpose/Reason for business expenses and identification of persons involved where applicable.

b. Airfare – reservation confirmation from Airlines or e-ticket.

c. Car Rental – car rental invoice.

d. Lodging – detailed hotel invoice.

e. Parking – receipt from parking garage/service.

f. Mileage – mileage report documenting miles traveled, origin and destination points and business purpose.

g. Meals – original itemized payment receipts, with persons included and business purpose noted on receipt.

h. Business Telephone/Fax – detailed telephone bill identifying business calls, to whom call was placed and the business purpose.

i. Cash Gratuities – Board Members shall document and turn in a receipt to be approved pursuant to the procedures for approval set forth in Section 6 below.

j. All other expenses - receipts shall be included.

3. Timely Submission.

The Expense Report Form showing actual expenses, together with actual receipts, must be submitted within 60 days following the completion of travel. More timely submission may be requested from time to time for example at fiscal year end to insure appropriate timely accounting to accrue. Reimbursement will not be made if the Expense Report Form is not submitted within 60 days of incurring the expense. In the case of travel advances, if the required documentation and receipts are not submitted within 60 days of incurring the expense, no further travel shall be approved until one year has elapsed from the date travel was completed and the appropriate expense report is received by TCHD.

4. Reports To TCHD Board.

Directors must prepare a written report (Seminar Evaluation Form) upon return from a seminar, conference or other form of event which the Director received or shall receive reimbursement from TCHD pursuant to this Policy. A verbal or written report must be presented at the next regular board meeting following the seminar, conference or other event. In the case of a written report, Directors shall make reasonable efforts to submit the report in time for inclusion in the next regular Board agenda packet. If an oral report is made, a written report shall be submitted within 60 days of the regular meeting.

5. Seminar Evaluation.

In addition to all other requirements set forth in this Policy, in order to share in the benefits of educational programs, each Director who attends an educational program (seminar, workshop, conference, etc.) at TCHD expense shall complete a Seminar Evaluation Form (see Exhibit "C"). The completed Seminar Evaluation Form shall be returned to the Executive Assistant for inclusion in the next regular Board agenda packet if possible, but in no event later than 60 days following the educational program.

6. One Over One Approval.

Once all of the foregoing requirements have been met, the requested reimbursement shall be approved. However, because no one is permitted to approve his or her own expenses, "One over One" approval, evidenced by the signature of the person responsible for such approval, must be given as follows:

a. TCHD Directors and CEO: TCHD Board Chairperson (or his or her designee) approval required.

b. TCHD Board Chairperson: Board Secretary or Board Assistant Secretary approval required.

7. Payment Of Reimbursement.

Completed Expense Request Forms meeting all of the foregoing requirements and approved by the appropriate TCHD Director or CEO will be processed and paid no later than two (2) weeks from the date of authorized submission of the completed Expense Request Forms to the Finance Department. Reimbursement will be directly, by check for actual and necessary business expenses incurred in the performance of official duties upon receipt of a properly documented Expense Report Form accompanied by receipts approved by the appropriate authorized person.

8. Reimbursement Of Excessive Advance.

If the amount advanced by TCHD for travel exceeds the actual expenditures set forth in the Expense Report Form, then the TCHD shall provide the TCHD Director or CEO with written notice that the travel advance exceeded actual expenses. Such notice shall set forth the amount overpaid and the date by which the travel advances must be repaid to the TCHD, which date shall be not more than 30 days from transmission or of the notice.

9. TCHD shall comply with the reporting requirements of California Government Code Section 53065.5.

10. Notwithstanding the foregoing, the Board may approve reimbursements when documentation or reports are submitted late or are unavailable, for good cause shown, so long as there is substantial compliance with the applicable provisions of state law.

~~D.~~ E. Reimbursement Rates.

Directors and CEO shall receive reimbursement at the rates set forth in IRS Publication 463, or any successor publication. Notwithstanding the rates specified in IRS Publication 463, or any successor publication, the government and/ or group rates offered by a provider of transportation or lodging services for travel and lodging are hereby deemed reasonable for purposes of this Policy. A Director or CEO may only be reimbursed for expenses that fall outside of this Policy or the rates set forth below, if the expense is approved at a public meeting of the Board before the expense is incurred, or the CEO's contract so provides.

TCHD will use the following guidelines to determine actual and necessary expense for reimbursement:

1. Airfare.

Coach or economy class airline tickets are considered ordinary business expenses; first or business class tickets are not reimbursable under the Policy. Each Director is expected to assist TCHD in acquiring the best rate and greatest discount on airline tickets. Reimbursement will be the actual necessary airline fare.

Note: If a Director chooses to travel in his or her private automobile, rather than by airline, the Director will be reimbursed for mileage at the rates specified in this Policy, provided that such reimbursement does not exceed the cost of coach or economy airfare, plus normal cost for transportation to and from the airport at the point of departure and the airport at the destination. If two or more Directors travel in the same private automobile, the Director whose private automobile is used, will get full mileage reimbursement, provided that said mileage meets the requirements above as to each Director traveling together, and does not exceed the cost of coach or economy airfare plus normal cost for transportation to and from the airport at the point of departure and the airport at the destination.

2. Lodging.

Choice of lodging shall be determined by convenience to the seminar, conference, or other form of event location within reasonable economic limits. Lodging shall not be reimbursed or provided at TCHD expense if the meeting site is within 30 miles of the Director's legal residence without prior Board approval based upon unusual circumstances which make it impractical to travel to the site of a meeting on the date scheduled. Association or governmental discounts should be requested based on whichever provides a lower cost. If lodging is in connection with a conference or other educational activity conducted in compliance with this Policy, lodging costs shall not exceed the maximum group rate published by the conference or activity sponsor provided that the group rate is available at the time of booking, which is hereby deemed reasonable for purposes of this Policy. If the group rate is not available, Directors shall use comparable lodging, either at a rate not more than the maximum group rate published by the conference or the activity sponsor or at a rate not more than the lowest rack rate available for a single room. If Directors wish to take a guest, they must pay any rate differential over the single room rate.

If it is not practical to travel to the site of a meeting on the date the meeting is scheduled, the extra days lodging will be reimbursed. An extra day(s) lodging will be reimbursed if airfare savings are greater than the total cost of staying over and extra day(s).

3. Car Rental.

The size of the car rental shall be appropriate to the number of individuals traveling in the group and the intended business of the group. Association or Governmental discounts should be requested to minimize cost.

4. Car Rental Insurance.

TCHD is insured for collision and comprehensive coverage when renting vehicles. Directors shall decline these coverages when renting vehicles.

5. Parking Expense.

Actual necessary parking expenses while on company business will be reimbursed.

6. Mileage.

The reimbursement rate for use of personal vehicles is consistent with the current IRS mileage reimbursement rate for business miles deduction. Mileage will be calculated as the actual mileage incurred assuming a reasonable and direct route between origin and destination point is taken. Mileage to and from TCHD shall not be reimbursed for participation at Board and Committee meetings or any other activities at TCHD.

7. Other Transportation Expenses.

Actual and necessary expenses for taxi, bus, shuttle, and tolls are reimbursable. Directors are expected to use hotel courtesy cars or shuttles where practical before using taxis or rental car services.

8. Meals and Gratuities.

Directors will receive reimbursement for reasonable actual meal related expenses for each day of authorized travel. Federal Government daily reimbursement rates, as they may be revised from time to time may be used as a guide, but shall not strictly limit reimbursements. Alcoholic beverages are considered a personal expense. Directors are expected to eat at scheduled group meal functions whenever possible.

9. Telephone/Fax.

Actual and necessary calls made in the performance of official duties will be reimbursed at cost and the business purpose of each call shall be identified. Business calls from home, car phones or cellular phones will be reimbursed at cost as identified on the appropriate monthly statement if submitted with a summary of the business purpose of each call. All telephone calls, including personal calls, while traveling on TCHD

business shall be of a reasonable number and short duration. All business and personal calls shall be documented as to name and purpose of the call.

10. Dues and Professional Organizations.

TCHD will reimburse Directors for membership in no more than one professional organization pertinent to the performance of official duties and mutually beneficial to TCHD and the Director. TCHD may pay for these dues directly to the vendor on behalf of the Director or reimburse the Director via the expense report process.

11. Certification and Licenses.

Individual certification and licenses are considered the responsibility of the Director and are not reimbursed.

12. Continuing Education.

As approved by the Board of Directors at a public meeting, continuing education related to the Directors' performance of official duties in the form of seminar, workshop fees, etc. (and within TCHD's budget) is eligible for reimbursement or may be paid directly to the vendor. This includes any seminar, conference, workshop, etc. registration fees.

13. Other Business-Related Expenses.

Actual and necessary business entertainment is allowable provided that the persons entertained shall have a reasonable direct relationship to TCHD and a clear business purpose is established. Such entertainment should be limited to numbers and occasions that directly facilitate the business purpose.

Directors will be reimbursed for the actual and necessary cost of luncheons and dinners during the course of TCHD meetings if meals are not provided by TCHD.

TCHD promotes health and wellness and will reimburse Directors for use of hotel health/wellness facilities when traveling. A maximum reimbursement of $10.00 per day is allowed.

14. Facsimile transmission equipment; Telephone line.

The Board finds that placement of facsimile transmission equipment ("fax machines") at the residences of Directors improves the efficiency and effectiveness of communications between the District and the Directors and communications by Directors with other parties regarding matters directly related to Board business. The District will, upon request, purchase and maintain at District expense a fax machine at the residence

of each Director during his/her term, subject to the requirements of law and this Policy.

The District will install and pay the cost of a telephone line for the residence of each Director. The telephone line should be used only for incoming and outgoing fax transmissions and local and long distance telephone calls which are directly related to District business. Neither the fax machine nor the telephone line should be used for personal business or any purpose not directly related to District business. Any charges for the telephone line or for local or long distance telephone calls using the line in excess of $25.00 per month will be deemed for non-District-related use by the Director and timely reimbursement to the District for the excess will be the responsibility of the Director.

The fax machine is to remain connected to the telephone line at all times. The telephone line may not be used for connection to a computer modem or for connection to the Internet.

Failure to adhere to the terms of this Policy will be grounds for terminating a Director's participation in this program and removal of the fax machine and telephone line. Failure to reimburse the District within 60 days indicates failure to adhere to the terms of this Policy and will be grounds for terminating a Director's participation in this program, resulting in removal of the fax machine and telephone line.

Directors shall return the District fax machine, or purchase the equipment at fair market value as determined by the CEO or Chief Financial Officer, within 14 calendar days of the expiration of their term or shall face all applicable civil and criminal penalties with respect to the unauthorized possession of equipment owned by another party.

15. Non-Reimbursable Expenses.

When traveling, charges for honor bars, dry cleaning, movies and personal items, are not reimbursable.

F. Penalties.

In accordance with applicable law, as it may be revised from time to time, penalties for misuse of public resources or falsifying expense reports in violation of this Policy may include, but are not limited to the loss of reimbursement and/or direct billing privileges, restitution to TCHD, civil penalties for misuse of public resources, and prosecution for misuse of public resources.

V. ETHICS TRAINING REQUIRED

A. Members of the Board of Directors and all committee members shall receive at least two (2) hours of ethics training every two (2) years, pursuant to the

provisions of Government Code section 53234 et seq. ("Ethics Training") in order to be eligible for compensation or reimbursement of expenses.

B. All Members of the Board of Directors and all committee members, shall provide a certificate to the Executive Assistant, indicating the dates upon which they attended an Ethics Training session(s), to satisfy requirements. Said certificate shall also include the name of the entity that provided the training. The Executive Assistant shall maintain the records, indicating the dates that each of the Members of the Board of Directors and each committee member, satisfied their requirements, and the entity which provided the training. These records shall be maintained for at least five (5) years after the training, and are subject to disclosure under the Public Records Act.

C. The CEO or Executive Assistant shall provide members of the Board of Directors and committee members, information on the Ethics Training available to meet these requirements.

Reviewed by the Gov/Leg Committee: 6/8/05
Approved by the Board of Directors: 6/23/05
Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 1/4/06
Approved by the Board of Directors: 1/26/06
Reviewed by the Gov/Leg Committee: 11/8/06
Reviewed by the Gov/Leg Committee: 6/13/07
Approved by the Board of Directors: 6/28/07
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07 & 11/07/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 07/15/09
Approved by the Board of Directors: 07/30/09
Reviewed by the Gov/Leg Committee: 8/12/09
Approved by the Board of Directors: 8/27/09
Reviewed by the Gov/Leg Committee: 5/5/10
Approved by the Board of Directors: 5/27/10
Reviewed by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 11/14/12
Approved by the Board of Directors: 12/13/12
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Approved by the Gov/Leg Committee: 8/2/16 & 9/6/16
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT

PROFESSIONAL AFFAIRS COMMITTEE CHARTER

The Professional Affairs Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to assist the Board in providing healthcare delivery oversight and make recommendations to the Tri-City Healthcare District Board of Directors ("Board") regarding quality, patient safety, performance improvement, and risk management policies; oversee development and implementation of the Quality Assurance, Quality Improvement, and Patient Safety (QA/QI/PS) Programs; and provide oversight of processes relating to the reporting, monitoring, investigation, and appropriate responsive/corrective actions taken in connection with any issues identified at the meetings, including the following:

1. Quality. The Committee will review reports regarding quality of patient care, including:

    a. Hospital operating unit and quality intervention programs;

    b. Core measures and performance measures;

    c. Review of Clinical Contract Performance;

    d. While Risk Management will retain responsibility for risk related issues, PAC will provide support and guidance for such issues; and

    e. While Patient Care related issues will remain the responsibility of the CNE, PAC will provide input and support regarding these matters.

2. Patient Safety. The Committee will review reports regarding patient safety, including:

    a. Patient safety improvement programs;

    b. Incidents reported to the California Department of Public Health (CDPH) including any findings;

    c. Surveys from The Joint Commission, Center for Medicare and Medicaid Services, and other regulatory agencies.

3. Performance Improvement. The Committee will review the following reports:

    a. Operating unit performance improvements;

4. Risk Management. The Committee will review the District's risk management program, including:

   a. Summaries of incident reports;

   b. Compliments and complaints;

   c. Surveys from Joint Commission, CMS, and CDPH visits;

   d. Sentinel Events/Root Cause Analyses;

   e. Professional liability claims and lawsuits.

5. Oversight Duties and Responsibilities. In addition, the Committee will:

   a. Recommend any proposed changes to the Board for approval, and review and publish this Charter every three years in accordance with applicable regulatory authorities;

   b. Review significant reports prepared by any individual performing significant quality assurance functions together with management's response and follow-up to these reports;

   c. Review the District's policies and procedures as necessary.

   d. Review the Medical Staff Office procedures.

   e. Review of hospital's clinical contracts.

   f. Consult with appropriate Consultants as necessary to inform the deliberations and committee decisions as necessary.

II. Membership

The Committee shall consist of three Directors and four physicians. The CEO, COO, Risk Manager, and CNE shall support the Committee without vote but be counted towards a quorum as alternates.

III. Meetings

The Committee may establish its own meeting schedule annually. The Committee will adjourn into closed session to meet with the legal counsel and to hear reports of the Hospital and QA/PI Committee.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all determinations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved by BOD: 9/29/11
Approved by BOD: 3/28/13
Approved by BOD: 5/29/14
Approved by BOD:

I. **MEMBERSHIP**

The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible; having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification. Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

II. **FUNCTIONS**

The general functions of the Department of Pediatrics shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee (MEC) guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions, and;
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/ or request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation (OPPE) indicators and formulate thresholds; and
Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS;**

The Department of Pediatrics meets quarterly and no less than three (3) times per year or at the discretion of the Chair

Twenty-five percent (25%) of the Active Department members, but not less than five (5) members, shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have 3 officers: a Chairperson, a Vice-Chairperson, and a Quality Review Representative. The officers must be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. The Vice-Chairperson shall be the Chairperson-Elect and may also serve as the Quality Review Representative.

B. The Chairperson and Vice-Chairperson shall be elected every year by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department. The notice for elections is given at least one month prior to the meeting date.

C. The Department Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses Medical Staff membership or clinical privileges in the department. Department officers shall be eligible to succeed themselves if elected.

D. The Vice-Chairperson succeeds the Chairperson after his/her term has expired unless there is an objection by a majority of the Active members of the Department who are eligible to vote.

E. The Quality Review Representative serves a one-year term and is elected by the Active members of the Department who are eligible to vote. The Quality Review Representative serves as the Chair of the Pediatric Quality Review Committee (QRC), and attends Medical Staff QA/PI/PSC meetings. Every effort will be made to appoint members to the QRC from each major group and a representative from the unassigned call panel for ED.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair shall assume the following responsibilities:

1. Be accountable for the professional and administrative activities of the Department;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
5. Recommend clinical privileges for each member of the Department;
6. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Other duties, as recommended from the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

~~B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~

C.B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

D.C. Requests for privileges in the Department of Pediatrics are evaluated based on the practitioner's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on department specified criteria. Recommendations for privileges are made to the Credentials Committee and to the Medical Executive Committee. Practitioners practice only within the scope of their privileges as defined within these Rules and Regulations.

E.D. **Nurse Practitioners:** Nurse practitioner means a registered nurse who posseses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse

practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a pediatrician will develop the standardized procedure or the protocols with the approval of the Department of Pediatrics.

EE. Classifications of Newborns:

1. Level 1: Newborns greater than 2000 grams and 35 6/7 weeks GA, without any of the diagnoses or symptoms listed in VI (E)(2).
2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
   - i. Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
   - ii. Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
   - iii. Hypoglycemia (without other risk factors such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
   - iv. Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
3. Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

If the infant status changes to meet the Level 3 criteria (per NICU unit-specific policy "Admission and Discharge Criteria for the NICU"), a neonatology consult is required. The consultation will be requested by the attending pediatrician who, in collaboration with the neonatologist, will determine if care should be transferred to a neonatologist.

~~Pediatrics Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients, Level 1 and Level 2 newborns~~	~~Training and evidence of current NRP/NALS or PALS certification~~	~~Six (6) cases~~	~~Evidence of current NRP/NALS or PALS certification~~
~~Consultation~~			
~~Newborn care, Level 1 and Level 2~~			
~~Perform medical history and physical examination (Newborn), including via telemedicine (F)~~	~~Training~~		~~N/A~~
~~Attendance at C-sections & vaginal deliveries, including newborn resuscitation~~	~~Training and evidence of current NRP/NALS certification~~	~~One (1)~~	~~Evidence of current NRP/NALS certification~~
~~Invasive Pediatrics Procedures~~			
~~Lumbar puncture~~	~~Training~~	~~Five (5) cases from Invasive Procedures category~~	~~N/A~~
~~Laryngoscopy~~	~~Training and evidence of current NRP/NALS~~		~~Evidence of current NRP/NALS certification~~

Pediatrics Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	certification		
Circumcision	Training		N/A
Intubation, Infant	Training and evidence of current NRP/NALS certification		Evidence of current NRP/NALS certification
Intubation, Pediatric	Training and evidence of current PALS certification		Evidence of current PALS certification
Suprapubic aspiration	Training		N/A
Pediatric Cardiology Privilege Category			
Consultation, Pediatric Cardiology, to include neonates	Successful completion of a residency in Pediatrics and a fellowship training program in Neonatology or Pediatric Cardiology	Two (2) cases from this category	Ten (10) cases from this category
Cardiac defibrilation, to include neonates			
Echocardiography, to include neonates			
Elective cardioversion, to include neonates			
Electrocardiography (EKG/ECG), to include neonates			
Pericardiocentesis, to include neonates			
Holter monitor – 12 years and older	Successful completion of a residency in Pediatrics and a fellowship training program in Pediatric Cardiology		
Treadmills - 12 years and older			
Pediatric Surgery Privilege Category			
Consultation, Pediatric Surgery, to include neonates	Board certified by the American Board of Surgery in Pediatric Surgery	One (1) case	Evidence demonstrating activity performing pediatric surgery at another healthcare facility
Other			

~~Pediatrics Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Moderate sedation~~	~~See Policy 8710-517 and evidence of current NRP/NALS certification~~	~~See Policy 8710-517~~	~~See Policy 8710-517 and evidence of current NRP/NALS certification~~

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). Colleagues who cover on-call for an assigned proctor should be aware, accessible, and amenable to providing proctoring in the place of that member, if needed.

C. ~~THE MONITOR MUST BE PRESENT FOR THE PROCEDURE FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.~~For invasive cases, proctor must be present for the procedure for a sufficient period of time to assure himself/herself of the member's competence. For noninvasive cases the proctor may review case documentation (i.e. H&P) entirely to assure himself/herself of the practitioner's competence.

D. In elective cases, arrangements shall be made prior to scheduling i.e., the proctor shall be designated at the time the case is scheduled.

E. The member shall have free choice of suitable consultants and assistants.

F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

I. Members of other departments, such as the Emergency Department or Anesthesiology Department, can proctor an appropriate procedure, but cannot proctor admissions.

J. It is the responsibility of the member to notify a proctor when one is needed.

IX. EMERGENCY ROOM COVERAGE

A. Department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

B. Any member who elects to provide follow-up care in his/her office must do so without regard to the patient's ability to pay and must provide a minimum level of care sufficient to respond to the patient's immediate needs.

C. Provisional or Courtesy Staff may participate on the unassigned call panel at the discretion of the Department chair.

X. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

The Department of Pediatrics will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The QRC chair is the Department's representative to the Medical Staff Medical Quality Peer Review Committee. QRC members are able to succeed themselves. The QRC will meet at least four (4) times per year. Refer to Section II "FUNCTIONS" above as applicable.

A. General Function

The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members and to pediatric patients in the hospital.

XI. NICU M&M COMMITTEE

The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that meets at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology and nursing shall be invited. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC.

APPROVALS:
Department of Pediatrics: 5/05/15
Medical Executive Committee: 5/18/15
Governance Committee: 6/01/15
Board of Directors: 6/25/15

Tri-City Medical Center

Delineation of Privileges

Obstetrics/Gynecology 11/14

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Department of Obstetrics and Gynecology consists of physicians who are board certified or actively progressing towards certification by the American Board of Obstetrics and Gynecology and have successfully completed an ACGME/AOA-accredited residency training program in Obstetrics and Gynecology.

SITES:
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.
All practitioners who currently hold the privilege to "consult" and/or "perform a history and physical examination" may also perform these privileges via telemedicine

___ Admit Patients ___

___ Consultation, including via telemedicine (F) ___

___ Perform history and physical examination (includes pelvic exam and cultures), including via telemedicine (F) ___

___ **OBSTETRICAL CATEGORY:** ___

By selecting this privilege, you are requesting the Obstetrical Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Initial:
1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN.
2. Documentation of fifty (50) cases reflective of the scope of privileges requested within the previous twenty-four (24) months.
Proctoring: Ten (10) cases, including five (5) concurrent vaginal deliveries, two (2) C-sections.
Reappointment: Fifty (50) cases to include: two (2) C-sections and ten (10) vaginal deliveries within the previous twenty-four (24) months.

Amniocentesis

Basic obstetrical ultrasound

Breech vaginal delivery

Cesarean Hysterectomy

Cesarean section

Episiotomy, vaginal repair, sphincter repair

Evacuation of hydatidiform mole

Evacuation of pelvic hematoma

External cephalic version

Hemorrhoid excision

Hypogastric artery ligation

Induction of labor

Management of intra-uterine fetal demise

Management of medical complications of pregnancy, preterm labor, pregnancy induced hypertension/eclampsia, pre-eclampsia, and multiple gestation

Provider Name:

Request	Privilege	Action MSO Use Only

Manual removal of placenta

Operative vaginal delivery - forceps/low-forceps/vacuum delivery

Perineal laceration, first (fourchette) & second-degree

Perineal laceration, third & fourth degree

Postpartum hemorrhage

Suction D&C for termination of pregnancy

Transvaginal cervical cerclage

Vaginal Deliveries (Spontaneous and precipitous term deliveries), and vaginal birth after previous C-section

___ **GYNECOLOGY CATEGORY** ___

Initial:
1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN.
2. Documentation of twenty-five (25) cases from the Gynecological Category (including at least five (5) major abdominal cases) reflective of the scope of privileges requested within the previous twenty-four months.
Proctoring: Ten cases (10) from the Gynecological Category,
including two (2) total vaginal hysterectomies, two (2) total abdominal hysterectomies, and two (2) diagnostic laparoscopies
Reappointment: Twenty-five (25) cases from the Gynecological
Category, including two (2) total vaginal hysterectomies, two (2) total abdominal hysterectomies, and two (2) diagnostic
laparoscopies reflective of the scope of privileges requested

___ **Gynecological Category: Vaginal/Vulvar Surgery** ___

By selecting this privilege, you are requesting the Gynecology Category: Vaginal/Vulvar Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Anterior/Posterior repair, with or without placement of mesh

Biopsy of cervix, vulva, vagina

Bladder neck suspension

Cervical cryotherapy

Closure of vaginal fistula

Conization of cervix

Culdocentesis

Cystoscopy

Dilation and curettage (D&C)

Dilation and evacuation (D&E)

Endometrial ablation

Provider Name:

Request	Privilege	Action MSO Use Only

Hymenectomy

Hymenotomy

Hysterosalpingogram (HSG)

I&D - Bartholin's Gland cyst, abscess, marsupialization

Incision and drainage wound abscess/hematoma

IUD insertion/removal

Loop electrical excision procedure (LEEP)

Perineoplasty

Repair incidental cystostomy

Repair of recto-vaginal fistula

Repair vesico-vaginal fistula

Sacrospinous ligament fixation

Simple vulvectomy

Total vaginal hysterectomy

Trachelectomy

Transvaginal enterocele repair

Urethral dilation

Urethral sling (ex. TVT, TVOT)

Urethroscopy

Vaginal bilateral tubal ligation

Vaginectomy

___ **Gynecological Category: Abdominal Surgery** ___

By selecting this privilege, you are requesting the Gynecology Category: Abdominal Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Abdominal sacrocolpopexy

Adhesiolysis

Bilateral tubal ligation

Evacuation of pelvic abscess

Evisceration repair

Exploratory laparotomy

Provider Name:

Request	Privilege	Action MSO Use Only

Incisional hernia repair, concomitant

Microtubal surgery

Myomectomy and metroplasty

Oophorectomy

Ovarian cystectomy

Paravaginal repair

Pelvic and/or Para-aortic Lymphadenectomy

Pelvic lymph-node sampling

Pre-sacral neurectomy

Repair of enterocele

Repair surgical rent of bladder/bowel

Retropubic urethropexy

Salpingo-oophorectomy

Salpingoplasty

Salpingostomy / Salpingectomy

Suprapubic cystotomy

Total abdominal hysterectomy

Tumor debulking

Wedge resection of ovaries

___ **Gynecological Category: Endoscopy/Hysteroscopy-Laparoscopic Surgery** ___

By selecting this privilege, you are requesting the Gynecology Category: Endoscopy/Hysteroscopy-Laparoscopic Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Appendectomy (incidental)

Aspiration of cyst

Bladder neck suspension

Colposuspension

Diagnostic laparoscopy

Endometrial ablation

Fulguration of lesions

Provider Name:

Request	Privilege	Action MSO Use Only

Laparoscopic Assisted Vaginal Hysterectomy (LAVH)

Laparoscopic Supracervical Hysterectomy (LSH)

Laparoscopic treatment of ectopic pregnancy

Laparoscopic Tubal Ligation

Lysis of adhesions

Myomectomy

Ovarian cystectomy

Removal of adnexal structure

Removal of Meckel's diverticulum (w/consultation)

Repair of cystotomy/enterotomy

Resection
of other uterine masses

Salpingoplasty

Surgical
with or without D&C

Thermal
balloon ablation

Total Laparoscopic Hysterectomy (TLH)

Treatment
of ectopic pregnancy

Tubal
occlusion for sterilization

___ **GYNECOLOGIC-ONCOLOGY SURGERY CATEGORY:** ___

By selecting this privilege, you are requesting the Gynecologic-Oncology Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Gynecologic-Oncology Surgery
Initial Criteria:
1. Successful completion of an ABOG- or AOA-approved fellowship in Gynecologic Oncology
2. Board certification in Gynecologic Oncology
3. Documentation of twenty-five (25) cases either from fellowship (if within previous twenty-four (24) months) or another acute care facility
Proctoring: Ten cases (10) from the Gynecologic-Oncology Surgery Category, including at least two (2) Diagnostic and four (4) Therapeutic procedures
Reappointment: Twelve (12) representative blend of cases from Diagnostic and Therapeutic categories

DIAGNOSTIC

Diagnostic Cytoscopy with biopsy

Provider Name:

Request	Privilege	Action MSO Use Only

Diagnostic Liver Biopsy

Diagnostic Proctoscopy with biopsy

Diagnostic Staging laparotomy

THERAPEUTIC

Bladder/ureter/urethra surgery, concomitant

Chemotherapy administration

Colpectomy

Cystectomy, concomitant

Cytoreduction for cancer

Exenteration

Flap closure of perineal defects, myocutaneous flaps, skin grafting

Gastrostomy, concomitant

Ileostomy, concomitant

Insertion of suprapubic tube

Intestinal Surgery, concomitant

Lymphadenectomy; pelvic, aortic, inguinal, femoral, scalene node

Medical management of the cancer patient

Radical hysterectomy

Radical vaginectomy

Radical vulvectomy

Repair of vascular injury

Salpingoplasty

Splenectomy, concomitant

Urinary diversion, concomitant

Ventral hernia repair, concomitant

___ **MATERNAL-FETAL MEDICINE (Perinatology)** ___

By selecting this privilege, you are requesting the Maternal-Fetal Medicine (Perinatology) Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Initial:
1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN, and;
2. Successful completion of an ABOG- or AOA-approved fellowship in Maternal-Fetal Medicine.
Proctoring: Two (2) cases from this category, not including Admit patient or Consultation

Provider Name:

Request	Privilege	Action MSO Use Only

Reappointment: Two (2) cases from this category, not including Admit patient or Consultation

Admit patients

Consultation

Genetic Amniocentesis

Chorionic villus sampling

Cordocentesis

Intrauterine fetal transfusion

OTHER:

___ Moderate Sedation - Refer to Medical Staff policy 8710-517 for Initial, Proctoring, and Reappointment credentialing criteria. ___

___ **INTRA-ABDOMINAL LASER SURGERY:** ___
Initial:
1. Documentation of completion of laser training for each wavelength requested
2. Documentation of clinical experience with specialized laser surgery or hands-on laboratory experience for each wavelength requested
Proctoring: One (1) case per wavelength
Reappointment: One (1) case per wavelength

CO2 Laser

Nd Yag Laser

___ **Robotic Surgery (da Vinci) (Refer to Credentialing Policy, Robotic Assisted Surgery #8710-563 for Initial, Proctoring, and Reappointment criteria)** ___

By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

___ Robotic surgery (da Vinci) - Multiple Port ___

___ Robotic surgery (da Vinci) - Single Port ___

___ Assist in robotic surgery (da Vinci) ___

___ **FORENSIC OUTPATIENT SITE-SPECIFIC PRIVILEGES** ___

By selecting this privilege, you are requesting the Forensic Outpatient Site-Specific privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Biopsy: Endometrial (F)

Biopsy: cervical, vulvar, vaginal (F)

Perform history and physical examination (includes pelvic exam and cultures) (F)

_____
Print Applicant Name

Tri-City Medical Center
Delineation of Privileges
Obstetrics/Gynecology 11/14

Provider Name:

Request	Privilege	Action MSO Use Only

_____
Applicant Signature

_____
Date

_____
Division/Department Signature

_____
Date

Tri-City Medical Center
Audit, Compliance & Ethics Committee
September 15, 2016
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; John Blakey, Managing Partner; Mary Nguyen, Senior Manager; Jane Dunemeyer, League of Women Voters; Charlene Carty, Director of Finance
Absent:	Barton Sharp, Community Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Finnila.		
2. Approval of Agenda	**It was moved by Director Mitchell and seconded by Director Schallock to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – July 14, 2016	Ms. Kathryn Fitzwilliam noted Ms. Mary's Nguyen's title was listed incorrectly. **It was moved by Director Schallock and seconded by Director Mitchell to approve the minutes as amended. The motion passed unanimously.**	**Correction made to master minutes.** **Amended minutes ratified.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
5. New Business			
A) Fiscal 2016 Financial Statement Audit Status	Mr. Jack Blakey, Engagement Reviewer stated he and Ms. Nguyen are here today to present the results of the FY2016 Financial Audit. Mr. Blakey confirmed the scope and timing of the audit was conducted as planned and there were no changes to significant accounting policies for the year ended June 30, 2016. Mr. Blakey stated they will issue an unmodified opinion which reflects the Consolidated Financial Statements are presented fairly and in accordance with US Generally Accepted Accounting Principles. Mr. Blakey reported the following: ➢ The disclosures in the financial statements are clear and consistent. ➢ There were no proposed or corrected or uncorrected audit adjustments. ➢ No material weakness was identified. ➢ There were no significant deficiencies. ➢ No significant difficulties were encountered during the audit of the District's financial statements. ➢ There were no disagreements with management. ➢ The auditors are not aware of any instances of fraud or noncompliance with laws and regulations; and ➢ The auditors are not aware of any significant accounting or auditing matters for which management consulted with other accountants.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Mr. Blakey explained Contingencies related to the Eminent Domain matter have been disclosed in the consolidated financial statements. Chairperson Finnila requested that Mr. Blakey explain what, if anything will change from an auditor standpoint with regard to the affiliation with UCSD. Mr. Blakey stated the Auditors have confirmed that there was no change in control and it is strictly an Affiliation Agreement. Mr. Dietlin explained that each entity would account individually. Ms. Fitzwilliam requested clarification on Note 13 related to Seismic Compliance. Mr. Blakey suggested the language be modified slightly to accurately reflect the status of Senate Bill 1953. Ms. Nguyen commented that the audit went well, staff were very cooperative and information was provided in a timely manner. *Ms. Kathy Topp, Director of Education, Clinical Informatics and Staffing joined the meeting at 9:10 a.m.* **It was moved by Mr. Leslie Schwartz to recommend the Board of Directors accept the FY2016 Financial Audit with the amendment as described to Note 13 related to Seismic Compliance. Ms. Kathryn Fitzwilliam seconded the motion. The motion passed unanimously.** Chairperson Finnila expressed her appreciation to the Audit Team as well as Mr. Rivas and Ms. Carty for their diligence in completing the audit on schedule.	**Recommendation to be sent to the Board of Directors to accept the FY2016 Financial Statement Audit as amended; item to be placed on Board agenda.**	Ms. Donnellan
	Mr. Blakey, Ms. Nguyen and Ms. Carty left the meeting at 9:19 a.m.		
B) Review and Discussion of Policies & Procedures:	Ms. Diane Racicot stated Policy 8760-573 is based on Stark law which is a strict liability law related to physicians and their family members. Ms. Racicot explained under certain		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1) 8760-573 – Business Courtesies to Physicians and Immediate Family Members	exceptions a certain amount of monetary compensation is allowed but Stark law requires a tracking mechanism. It was recommended Section D. 1. c. be struck in its entirety. With regard to Section E. e. i. Auditing and Monitoring, it was recommended the verbiage reflect that Auditing and Monitoring is delegated to the CCO who will monitor compliance with the policy and bring an annual report to the Audit, Compliance & Ethics Committee for approval. **It was moved by Director Mitchell to recommend approval of Policy 8760-573 – Business Courtesies to Physicians and Immediate Family Members with the revisions as described. Mr. Leslie Schwartz seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8760-573 – Business Courtesies to Physicians and Immediate Family Members; item to appear on next Board agenda and included in Board Agenda packet.**	Ms. Donnellan
2) 8760-576 – Controls and Monitoring of Payments to Physicians or Referral Sources	Ms. Racicot explained Policy 8760-573 is designed to track monies from referral sources. For consistency it was recommended section D. 1. c. be stricken in its entirety and that the words "The District's" be replaced with the word "TCHD's" in section E. 1. A. second sentence to read in part "TCHD's CFO, COO, and CCO, or their designee…". Ms. Bernard-Shaw stated the District does not perform the same tracking for vendors as physicians. She explained the annual report of vendors will ensure there have been no untoward events with the vendor and the vendor agreements (non-clinical contracts) are brought forward to the Audit, Compliance & Ethics Committee for consideration. Ms. Diane Racicot explained the Referral Source Payment Type form lists the types of contractual or business relationship that might be monitored.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	It was moved by Mr. Cumming to recommend approval of Policy 8760-573 – Controls and Monitoring of Payments to Physicians or Referral Sources with the revisions as described. Director Schallock seconded the motion. The motion passed unanimously. *Ms. Kathy Topp left the meeting at 9:40 a.m.*	**Recommendation to be sent to the Board of Directors to approve Policy 8760-576 –Controls and Monitoring of Payments to Physicians or Referral Sources; item to appear on next Board agenda and included in Board Agenda packet.**	Ms. Donnellan
C. Organizational Compliance Committee Report	Ms. Bernard-Shaw provided a sample of agendas over the last year for both the Organizational and Executive Compliance Committees. She explained that various departments provide the Organizational Compliance Committee with presentations on potential compliance issues and regulatory requirements. The committee also reviews the Values Line Reports, Privacy Reports and Security updates and reviews Compliance policies prior to being presented to the Audit, Compliance & Ethics Committee. Ms. Bernard-Shaw stated the committee reviews the OIG's Work Plan during the course of the year which lists items of focus or potential risks for hospitals. The Organizational Committee's focus is to look at areas of risk and the organization's readiness for review of outside laborers. Ms. Bernard-Shaw stated the various departments freely volunteer areas of concern and she is encouraged by the pro-activeness of staff.	**Information Only.**	

D. Executive Compliance Committee Report	Ms. Bernard-Shaw stated the Executive Compliance Committee oversees the work of the Organizational Compliance Committee and through feedback from discussion at the Organizational Compliance Committee determines areas of action. Ms. Bernard-Shaw stated minutes are maintained for both the Organizational and Executive Compliance Committees and are made available to any Regulator upon request. In terms of training, Ms. Bernard-Shaw stated a compliance related article is published once a month in the *Heart of Tri-City* newsletter and there is ongoing education for new hires and existing employees on an annual basis. Ms. Bernard-Shaw stated she intends to do more targeted training in the future.	**Information Only.**	
6. Old Business - None			
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and one matter of Potential Litigation.		
8. Motion to go Into closed session	**It was moved by Mr. Cumming and seconded by Director Mitchell to go into closed session at 9:58 a.m. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 10.16 a.m. with attendance as previously noted.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Finnila reported no action was taken in closed session.		
11. Comments from Committee Members	Mr. Cumming commented on the TV Doctors of America advertisement in which they teamed up with Cigna to encourage Americans to get an annual check-up.	**None**	Chairperson
12. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on October 20, 2016.	**The committee's next meeting is scheduled October 20, 2016.**	
13. Adjournment	Chairperson Finnila adjourned the meeting at 10:18 a.m.		

AUDIT AND COMPLIANCE COMMITTEE
September 15th, 2016

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Business Courtesies to Physicians and Immediate Family Members	573	3 year review	Forward to BOD for approval with revisions
2. Controls and Monitoring of payments to physicians or referral sources	576	3 year review	Forward to BOD for approval with revisions

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 01/13

SUBJECT: Business Courtesies to Physicians and Immediate Family Members

REVISION DATE(S):

POLICY NUMBER: 8750-573

Department Approval Date(s):	06/16
Administrative Policies and Procedures Approval Date(s):	06/16
Medical Executive Committee Approval Date(s):	07/16
Organizational Compliance Committee Approval Date(s):	08/16
Audit, Compliance and Ethics Committee Approval Date(s):	~~02/13~~09/16
Board of Directors Approval Date(s):	02/13

A. **PURPOSE:**

1. ~~The purposes of this policy are t~~To provide guidance with respect to treatment of compensation in the form of certain items and services under the non-monetary compensation exception and the medical staff incidental benefits exception of the Federal "Stark" law; and to incorporate relevant guidance issued by the Office of Inspector General of the Department of Health and Human Services with respect to certain arrangements that may potentially implicate the Federal "Anti-kickback" statute.

B. **GENERAL POLICIES:**

1. Except for *bona fide* employment arrangements, all business courtesies offered to Physicians and/or their immediate family members must meet the guidelines stated in this policy as well as applicable law. Nothing in this policy permits the use of a business courtesy that is intended to induce or reward the referrals of patients or that is intended to induce or reward the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by federal or state health care programs.

C. **DEFINITIONS:**

1. **Physician** – means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.
2. **Immediate family member or member of a physician's immediate family** – means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

D. **SCOPE OF POLICY:**

1. This policy applies to
   a. Tri-City Health Care District **(TCHD)** and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
   b. ~~a~~**A**ny other entity or organization in which ~~Tri-City Health Care District~~**TCHD** or an Affiliate owns a direct or indirect equity interest greater than 50%; and
   ~~c. a**A**ny hospital or healthcare facility in which Tri-City Health Care District**TCHD** or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tri-City Health Care District facility") (collectively, "Tri-City Health Care District**TCHD**").~~

E. **PROCEDURES:**

1. Applicable Stark Law:

a. Non-Monetary Compensation Exception:

i. A "financial relationship" as defined under the Stark Law is not created through the provision of compensation from an entity to a physician or his/her immediate family member in the form of items or services (not including cash or cash equivalents) that does not exceed an aggregate in the amount set for the current fiscal year (~~$380~~**$392** in ~~2013~~**2016, see Reference #5**), adjusted for inflation on an annual basis, if all the following conditions are satisfied:

1) The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician.

2) The compensation may not be solicited by the physician or the physician's practice (including employees and staff members).

3) The compensation arrangement does not violate the Federal anti-kickback statute, section 1128B(b) of the Act, or any Federal or State law or regulation governing billing or claims submission.

~~3)~~**ii. TCHD shall track the annual aggregate nonmonetary compensation provided to physicians or their immediate family members, if any, in accordance with TCHD Administrative Policy 8750-574.**

~~4)~~**iii.** Where an entity has inadvertently provided nonmonetary compensation to a physician in excess of the limit such compensation is deemed to be within the limit if (i) the value of the excess nonmonetary compensation is no more than 50 percent of the limit; and (ii) the physician returns to the entity the excess nonmonetary compensation (or an amount equal to the value of the excess nonmonetary compensation) by the end of the calendar year in which the excess nonmonetary compensation was received or within 180 consecutive calendar days following the date the excess nonmonetary compensation was received by the physician, whichever is earlier.

b. Medical Staff Incidental Benefits Exception:

i. A "financial relationship" as defined under the Stark Law is not created through the provision of compensation in the form of items or services (not including cash or cash equivalents) from a hospital to a member of its medical staff when the item or service is used on the hospital's campus, if all of the following conditions are met:

1) The compensation is provided to all members of the medical staff practicing in the same specialty (but not necessarily accepted by every member to whom it is offered) without regard to the volume or value of referrals or other business generated between the parties.

2) Except with respect to identification of medical staff on a hospital Web site or in hospital advertising, the compensation is provided only during periods when the medical staff members are making rounds or are engaged in other services or activities that benefit the hospital or its patients.

3) The compensation is provided by the hospital and used by the medical staff members only on the hospital's campus. Compensation, including, but not limited to, Internet access, **or cell phones** ~~pagers, or two-way radios~~, used away from the campus only to access hospital medical records or information or to access patients or personnel who are on the hospital campus, as well as identification of the medical staff on a hospital Web site or in hospital advertising, will meet the "on campus" requirements of this paragraph.

4) The compensation is reasonably related to the provision of, or designed to facilitate directly or indirectly the delivery of, medical services at the hospital.

5) The compensation is of low value (~~$32 in 2013~~ **$33 in 2016** and adjusted annually for inflation**, see Reference #5**) with respect to each occurrence of the benefit (for example, free cafeteria meals available to a physician while he or she is rounding in the hospital must be of low value).

6) The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.

7) The compensation arrangement does not violate the Federal Anti-kickback provision in section 1128B(b) of the Act, or any Federal or State law or regulation governing billing or claims submission.

c. Examples of Business Courtesies/Compensation:

i. Except as otherwise provided herein, examples of business courtesies that must be included as "compensation" under the Stark Law non-monetary compensation exception and tracked by TCHD include, but are not limited to, the following:

1) Business-related meals not furnished in connection with an executed, *bona fide* personal services arrangement as discussed in Section D.2.b.(5) and Section D.2.b.(6) herein;

2) ~~s~~**S**porting events or other similar events such as theater and concerts, including the cost of the tickets and a pro rata allocation of the cost of the meal**;**

3) ~~l~~**L**ocal recreational events, such as fishing, boating, hunting and golfing, including cart fees and meals, but excluding the value of the charitable contribution if the event is a charity event;

4) **Continuing Medical Education (**CME**)** seminars held off-campus and all CME seminars held on-campus if the value of the on-campus CME seminar is greater than ~~$32~~**$33** per invited physician per occurrence **(adjusted annually for inflation, see Reference #5)**;

5) ~~f~~**F**lowers or other gifts provided to physicians or their immediate family members when they are hospitalized or to recognize a special event, such as a birthday;

6) ~~r~~**R**oom allowances or other financial benefits provided to physician governing board members at a governing board retreat if the benefit is not offered to all governing board members and if the compensation or benefit is not listed as compensation for the member's services in his or her appointment letter;

7) ~~p~~**P**rizes and awards given on special days, such as "Doctor's Day;"

8) holiday gifts given to governing board members and Chiefs of Staff in recognition of the time and energy expended on behalf of the hospitals and communities they serve;

9) ~~s~~**S**ubject to Section D.2.b.(7) below, holiday parties for the hospital's employees and their spouses where all the physicians on the hospital's medical staff are invited; and

10) ~~s~~**S**ubject to Section D.2.b.(7) below, holiday parties only for the medical staff and their spouses where all members of the medical staff are invited.

ii. In no event can the hospital provide a Physician with cash or cash equivalents, such as gift certificates, under any of the above situations.

iii. Examples of business courtesies that meet the medical staff incidental benefits exception, the nonmonetary compensation exception, or that meet another Stark exception and thus do not need to be tracked include, but are not limited to, the following:

1) ~~f~~**F**ree or discounted meals (such as meals served in the physician's lounge), parking and computer/internet access provided in the hospital, so long as they are provided to all members of the medical staff without regard to the volume or value of referrals;

2) CME seminars held on campus provided the value of the CME seminar is less than ~~$32~~**$33** per invited physician per occurrence, or compliance training held in the local service area where the primary purpose of the seminar is compliance training, regardless of cost;

3) ~~w~~**W**hen allowed by California law, governing board retreats where the hospital pays for travel, food and lodging for all its governing board members and the benefit is included as compensation in the member's appointment letter. In addition, the hospital may pay for leisure activities of its physician governing board members and the physician's spouse provided the benefit is provided to all governing board members and the benefit is included as compensation in the member's appointment letter;

4) ~~m~~**M**eals served at governing board meetings, whether held on-campus or off-campus;

5) ~~m~~**M**eals provided to an existing member of the medical staff and their spouse where the purpose of the meal is to recruit a physician or other provider to the community and the meal is attended by a TCHD representative, the existing physician member and the recruit and is pursuant to an executed agreement furnished by TCHD's counsel;

6) ~~b~~**B**usiness related meals where the purpose is to discuss the physician's duties under a services agreement with the hospital where (i) the agreement specifically contemplates such business meals, and (ii) the meal is modest as judged by local standards and occurs in a venue conducive to conducting a meeting; and

7) ~~o~~**O**ne local medical staff appreciation event per calendar year for the entire medical staff, such as a holiday party. Any gifts or gratuities provided in connection with the medical staff appreciation event are subject to the nonmonetary compensation amount and must be tracked and logged.

d. Other Items:

i. TCHD's CEO or other administrative personnel, including senior management, are not barred from paying for social events such as meals or golf for physicians and the physician's immediate family members who are personal friends. The CEO or other administrative person may not submit the expenditure for reimbursement from TCHD and may not claim the expenditure as a business expense on their personal tax return. TCHD does not expect or encourage this activity as a way of avoiding the limitations otherwise set forth in this policy, and the administrative team and senior management should avoid the appearance of impropriety in this type of personal entertainment. TCHD anticipates that such events would be infrequent and reciprocal.

e. Auditing and Monitoring:

i. The ~~Audit, Compliance **and Ethics** Committee is responsible for auditing compliance with this policy.~~**Chief Compliance Officer will monitor compliance with this policy and will bring an annual report to the Audit, Compliance and Ethics Committee for approval.**

f. Enforcement:

i. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject the employees to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

F. **REFERENCE LIST:**

1. **TCHD Administrative Policy 8750-574 Tracking Non-Monetary Business Courtesies to Physicians and Immediate Family Members**
~~1.~~**2.** **42 U.S.C. Section 1320a-7b (Federal Anti-Kickback Law)**
~~2.~~**3.** 42 U.S.C. 1320a-7b; 42 C.F.R. 1001.952(a)-(a)
~~3.~~**4.** 42 U.S.C. 1395nn; 42 C.F.R. §§411.350-411.361 (Stark Regulations)

~~4.~~**5.** Office of Inspector General of the Department of Health and Human Services Draft Supplemental Compliance Program Guidance for Hospitals, dated June 8, 2004

~~5.~~**6.** **CPI-U Updates:**
https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/cpi-u_updates.html#

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE:

SUBJECT: Controls and Monitoring of Payments to Physicians or Other Referral Sources

REVISION DATE(S):

POLICY NUMBER: 8750-576

Department Approval Date(s):	**06/16**
Administrative Policies and Procedures Approval Date(s):	**06/16**
Medical Executive Committee Approval Date(s):	**07/16**
Organizational Compliance Committee Approval Date(s):	**08/16**
Audit, Compliance and Ethics Committee Approval Date(s):	**~~03/16~~09/16**
Board of Directors Approval Date(s):	**04/16**

A. **PURPOSE:**

1. ~~The purpose of this policy is t~~**T**o establish controls and routine monitoring of payments made to physicians and other actual or potential referral sources ("Referral Sources") through the vendor payment system. This policy does not apply to payments made to employed physicians or other employed referral sources.

B. **GENERAL POLICIES:**

1. Prior to issuing a payment to a new vendor or other third party payee (a "Vendor"), **Tri-City Healthcare District's** (TCHD's) **Chief Financial Officer** (CFO), **Chief Operations Officer** (COO), and **Chief** Compliance Officer (**C**CO) shall identify whether the Vendor is a Referral Source. Accounts Payable shall establish a written procedure for review and approval of all payments including Referral Source payments to ensure that payments made to Referral Sources are consistent with all laws, regulations and District policies.

C. **DEFINITIONS:**

1. Referral Source - ~~means~~ any individual or entity in a position to make or influence referrals to, or otherwise generate business for TCHD. Examples include physicians, medical device companies, pharmaceutical companies, ambulance companies, emergency services providers, etc.

D. **SCOPE OF POLICY:**

1. This policy applies to:
   a. TCHD and its wholly-owned subsidiaries and affiliates ~~(each, an "Affiliate")~~;
   b. Any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and
   ~~c. Any hospital or healthcare facility in which Tri-City Healthcare District~~**TCHD** ~~or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").~~

E. **PROCEDURE:**

1. New Vendors:
   a. New Vendors shall complete an Accounts Payable Vendor Addition Form, which, among other information, identifies whether the vendor is a Referral Source. The ~~District~~**TCHD**'s CFO, COO, and **C**CO, or their designees, are required to approve and sign all Vendor Addition Forms to ensure, among other things, that all Vendors are appropriately

categorized as Referral Sources or Non-Referral Sources. Accounts Payable requires the completion and approval of the Vendor Addition Form prior to adding a new Vendor to the Accounts Payable system or releasing any payment to a Vendor.

2. Auditing and Monitoring:
   a. The **C**CO, or designee, shall audit adherence to this policy in its routine audits.

3. Responsible Person
   a. The ~~Tri-City Health Care District~~**TCHD** CFO is responsible for the establishment and maintenance of controls for the processing of payments as outlined in this policy even if the CFO has delegated the review requirements of this policy to another member of the Finance staff.

4. Enforcement
   a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

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

1. **Referral Source Payment Type Form** ~~**Checklist – Attachment #1**~~

REFERRAL SOURCE PAYMENT TYPE FORM ~~CHECKLIST~~

~~Attachment #1~~

- ☐ Billing Services for Physician
- ☐ Certificate of Insurance Provided
- ☐ CME (for physician)
- ☐ Compliance Training (for physician)
- ☐ Computer Equipment Agreement
- ☐ Continuing Education Presentation (by physician)
- ☐ Cost of Insurance
- ☐ EHR and ERx Technology Subsidy
- ☐ Entertainment (event tickets, golf, etc.)
- ☐ Equipment Lease Agreements
- ☐ Free Meals at Hospital
- ☐ Free Parking at Hospital
- ☐ Gift Certificates
- ☐ Gifts (non-monetary compensation)
- ☐ Hospital Based Service Agreements
- ☐ Joint Venture Agreements
- ☐ Medical Office Space Provided
- ☐ Medical Staff Leadership Stipend
- ☐ Medical Staff Appreciation Dinner
- ☐ Medical Supplies Provided
- ☐ Payment for Peer Review Services
- ☐ Physician Consulting Agreements
- ☐ Physician Lease Agreements
- ☐ Physician Medical Director Arrangements
- ☐ Physician Marketing Assistance
- ☐ Physician On-Call Agreements
- ☐ Physician Recruitment Assistance
- ☐ Physician Services Agreements
- ☐ Physician Serving on ~~hospital~~ **TCHD** Board
- ☐ Professional Courtesy Discount
- ☐ Reimbursement of Expenses
- ☐ Room Rental Fee
- ☐ **Smart Devices**~~PDAs~~
- ☐ Soliciting Charitable Donation From Physician
- ☐ Space Lease Agreement
- ☐ Staffing Support for Physician Practice
- ☐ Uninsured Care Arrangements

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

August 25, 2016 – 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 August 25, 2016.

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

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, 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
Norma Braun, Chief Human Resource Officer
Ray Rivas, Acting Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
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

   Chairman Dagostino requested an additional item of Potential Litigation be added to the closed session and the addition of an Addendum to Delineation of Privileges for Emergency Medicine related to the Crisis Stabilization Unit (open session Medical Staff Reports).

   It was moved by Director Finnila to approve the agenda as amended. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the August 25, 2016 Regular Board of Directors Meeting Agenda.

There were no public comments.

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 August 25, 2016 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; two Reports Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding two (2) matters of Existing Litigation; three (3) matters of Potential Litigation and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Nygaard and seconded by Director Kellett 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.

7. 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 Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
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

8. Chairman Dagostino reported no action was taken in open session.

9. Director Finnila led the Pledge of Allegiance.

10. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

Chairman Dagostino reordered the agenda to reflect the Community Update would be presented first to accommodate arrival of our UCSD guests.

12. Community Update –

Intraoperative Radiation Therapy (IORT) – Dr. Katayoun Toosie

Mr. Wayne Knight, Chief Strategy Officer introduced Dr. Katayoun Toosie who attended today's meeting to talk about a new procedure (Intraoperative Radiation Therapy (IORT) that is only done at Tri-City Medical Center.

Dr. Toosie explained IORT is applying therapeutic levels of radiation to a target area, such as a cancer tumor, while the area is exposed during surgery. She described the differences in traditional treatment versus IORT, stating IORT provides same day treatment in as little as one hour! Advantages and benefits of IORT include the following:

- Maximum effect
- Spares healthy tissues and organs
- Shortened treatment times
- A "boost" for traditional radiation patients
- Saves time
- Convenience for patients
- Targeted radiation therapy
- Team approach
- Decreased side effects

Dr. Toosie further explained those individuals with early-stage disease, small tumors and typically those 45 years of age and older are candidates for IORT.

Dr. Toosie stated both she and Dr. James Urbanic, Radiation Oncologist were instrumental in bringing this therapy to Tri-City.

Mr. Knight stated IORT was made possible through our affiliation with UCSD and collectively, Drs. Toosie and Urbanic are offering a unique service to our community.

Director Reno questioned how IORT differs from the Cyberknife. Dr. Toosie explained IORT is a different concept that is used to clean up microscopic cancer seeds and the Cyberknife is used for localized tumors.

Director Finnila questioned Dr. Toosie's recommendation for frequency of mammogram screening. Dr. Toosie stated she recommends screening on an annual basis for individuals over 40.

No action was taken.

12. Special Presentation:

UCSD Master Affiliation – Ms. Patty Maysent, CEO and Dr. Thomas Moore

Mr. Knight introduced Ms. Patty Maysent, CEO of UCSD and Dr. Thomas Moore.

Ms. Maysent stated this is a great day for both UCSD and Tri-City Medical Center and she couldn't be more proud to be here today for this celebratory occasion. She stated this Affiliation Agreement opens the door to many opportunities and she looks forward to working collaboratively with our Management Team and the Medical Staff.

Dr. Thomas Moore congratulated the Board on their decision to enter into the Affiliation Agreement with UCSD. He stated under their vision, guidance and leadership they have brought the hospital to a great place. Dr. Moore stated he relishes the opportunity to identify how to keep babies and patients here at Tri-City.

Mr. Wayne Knight pointed out that since the Affiliation was finalized 9-10 days ago, two District residents have already received the benefits of IORT.

Mr. Steve Dietlin echoed the comments made by Ms. Maysent and Dr. Moore. He stated that solidifying the Affiliation Agreement with UCSD is in alignment with Tri-City's mission.

Chairman Dagostino, on behalf of the entire Board expressed his appreciation to UCSD for the opportunity to partner with them.

13. Report from TCHD Auxiliary – Pat Morocco, President

Mr. Pat Morocco stated the Auxiliary has their newly appointed officers in place and offer the hospital all the support they can.

Mr. Morocco reported on the following activities of the Auxiliary:

- The Chair of the Pet Therapy Department presented a check for $2,000 to the Oceanside Police Department K-9 Unit from proceeds of the 3rd Annual Tails on the Trails Charity Walk held on May 21st.
- On August 4th the Auxiliary escorted a Registered Nurse from Japan on the tour of the hospital.
- The July 4th Parade was a huge success with 35 volunteers participating.

Lastly, Mr. Morocco reported that during this past month he defeated cancer for the second time!

Director Schallock commented on the enthusiasm of the Auxiliary in the Parade. He also stated a neighbor commented to him on how much they appreciate the Auxilians and their dedication.

No action was taken.

14. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO reported the Auxiliary donates one of life's most precious gift, the gift of their time. He personally expressed his appreciation to Mr. Morocco and the entire Auxiliary.

With regard to the UCSD Affiliation Agreement, Mr. Dietlin recognized Dr. Gene Ma, Chief of Staff as well the Medical Staff of both UCSD and Tri-City for helping to bring the agreement to fruition.

Mr. Dietlin invited Dr. Ma to comment on the Affiliation.

Dr. Ma stated the synergy between Tri-City Medical Center and UCSD is outstanding and is translated to the patients of the community. Dr. Ma expressed his appreciation to the Board of Directors for having the foresight to approve the agreement, stating the Affiliation advances the health and wellness of our community.

Lastly, Mr. Dietlin reported Tri-City Healthcare District and the City of Oceanside have entered into a Joint Powers Agreement that will allow the District to use the City's Design Build concept in our Campus Redevelopment Plan. Mr. Dietlin commented on the outpour of support from the City Council, Mayor, Board members and community members who recently attended the City Council's meeting. Mr. Dietlin stated the agreement is a perfect example of two public agencies joining together to better serve our community.

No action was taken.

15. Report from Acting Chief Financial Officer

Mr. Rivas reported on the first month of FY 2017 as follows (Dollars in Thousands):

- Operating Revenue – $27,765
- Operating Expense – $27,895
- EROE - $288
- EBITDA - $1,583

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 179
- Adjusted Patient Days – 9,315
- Surgery Cases – 545
- Deliveries – 223
- ED Visits – 5,727

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $ 44.3
- Days in Net Accounts Receivable – 51.2

Mr. Rivas commented that both Net Patient Accounts Receivable and Days in Net Receivable are in a good range and we are on track to surpass that in the coming month.

Mr. Rivas presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

No action was taken.

In response to questions by Director Reno, Mr. Rivas stated the following:

- Days in Net A/R are a product of our cash collections in the month.
- Legal fees are lower than months past and he expects those fees to continue to decline.
- The $51 million is used to secure debt.
- We have approximately $30 million in cash on hand and he will follow-up with Director Reno as to the equivalent number of days cash on hand.

Mr. Rivas stated that Surgery Cases and census is comparable to the same time last year.

Director Reno reiterated her concern related to cash on hand. Mr. Rivas replied that the financials reflect only the first month of the new fiscal year and we are off to a good start.

16. New Business

a. Consideration to amend the Conflict of Interest Code

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the amended Conflict of Interest Code. Director Finnila seconded the motion.

Mr. Moser explained the amendments to the Conflict of Interest Code are essentially a "clean up" of titles that have changed over the past couple of years. Mr. Moser noted the title of the CNE should be amended to read "CNE/SVP".

Directors Nygaard and Finnila accepted the amendment to the motion to reflect the correct title of the CNE/SVP

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Approval of a Group Physician Recruitment Agreement with Dr. Himani Singh and North County Oncology

Mr. Wayne Knight, Chief Strategy Officer provided a brief summary of Dr. Singh's background and experience. He explained Dr. Singh is a Hematologist who will provide support for our Outpatient Infusion Center. Mr. Knight reviewed details of the recruitment agreement for Dr. Singh who will join Dr. Warren Paroly's group.

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment agreement with North County Oncology and Dr. Himani Singh, not to exceed $645,000 in order to facilitate this Hematology/Oncology physician practicing medicine

in the communities served by the District as approved by the Finance, Operations & Planning Committee. Director Finnila seconded the motion.

Chairman Dagostino noted these types of physician recruitment agreements are consistent with the District's Business Plan.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c. Approval of a Physician Recruitment Agreement with Dr. Wilson Liu.

Mr. Knight provided a brief summary of Dr. Liu's background and experience. He explained Dr. Liu is a Family Practitioner who will be joining the practice of Primary Health Partners. Mr. Knight reviewed details of the recruitment agreement for Dr. Liu.

It was moved by Director Finnila that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment agreement with Dr. Wilson Liu, not to exceed $514,000 in order to facilitate this Family Medicine physician practicing medicine in the communities served by the District as approved by the Finance, Operations & Planning Committee. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Due to time constraints related to Mr. Louis Montulli's schedule, Mr. Montulli was granted public comment time.

Mr. Montulli commented on the hospital's quality ratings, financials and legal expenses related to the termination of Mr. Larry Anderson.

d. Consideration to approve End of Life option policy

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the End of Life Board policy, as presented to the Board. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

17. Old Business

Report from Ad Hoc Committee on Electronic Board Portal

Director Mitchell reported she had nothing new to report at this time.

No action was taken.

18. Chief of Staff

a. Consideration of August 2016 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on August 22, 2016.

It was moved by Director Mitchell to approve the August 2016 Credentialing Actions involving the Medical Staff, as recommended by the Medical Executive Committee at their meeting on August 22, 2016. Director Finnila seconded the motion.

Chairman Dagostino stated an Addendum to Delineation of Privileges for Emergency Medicine related to the Crisis Stabilization Unit was added to the agenda at the beginning of today's meeting and is also on the table for consideration.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Dr. Ma commented on the NICU 30th year reunion which will be held on Saturday, September 10th.

19. Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Nygaard seconded the motion.

It was moved by Director Finnila to pull item 19 F. 1) Approval of Board Policy 14-020 – Business Expense Reimbursement; Ethics Training. Director Nygaard seconded the motion.

It was moved by Director Reno to pull items 19 D. 2) Approval of an agreement with Dr. Bilal Choudry for medical direction of the Neuroscience Institute Quality Committee for a term of 12 months, beginning September 1, 2016 through August 31, 2017, for an annual amount not to exceed $4,800, 19 D. 3) Approval of an agreement with Dr. Bilal Choudry for medical direction

of the Neuroscience Institute Operations Committee for a term of 12 months, beginning September 1, 2016 through August 31, 2017, for an annual amount not to exceed $4,800, 19 D. 7) Approval of an agreement with CloudMed for Coding Auditing for a term of 12 months beginning September 1, 2016 through August 31, 2017, for a total cost for the term of 40% of agreed upon, rebilled and collected accounts audited by CloudMed, not to exceed $400,000 and 19 D 8) Approval of an agreement with Siemens Medical Solutions for services on equipment in three IR Suites an d on one MRI system for a term of five (5) years, beginning October 23, 2016 through October 22, 2021 for a total term expense not to exceed $1,824,670. Director Kellett seconded the motion.

It was moved by Director Reno to pull 19 (4) Dues and Memberships – ACHD Annual Membership – $45,000. Director Kellett seconded the motion.

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Discussion of items pulled from Consent Agenda

Director Finnila who pulled item 19 F. 1) Approval of Board Policy 14-020 – Business Expense Reimbursement; Ethics Training stated the policy continues to be unclear related to reimbursement of expenses without prior approval.

It was moved by Director Finnila to refer the policy to the Governance & Legislative Committee for further clarification. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, and Reno**
NOES:	**Directors:**	**Schallock**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled items 19 D 2) and 19 D3) related to Dr. Choudry requested clarification on Dr. Choudry's role related to the Neuroscience Institute's Quality and Neuroscience Operations committees. Director Reno also expressed concern related to the cost.

Mr. Jeremy Raimo explained the Neuroscience Institute is divided into two parts, an Operations Committee and Quality Committee and Dr. Choudry provides oversight for the committees for four (4) hours per month. Director Kellett commented that discussion at the Finance, Operations & Planning Committee reflects the monies spent are minimal for the services provided by Dr. Choudry. Mr. Raimo also noted the hospital will be receiving good reimbursement related to the Neuroscience Institute.

It was moved by Director Kellett to approve Items19 D. 2) Approval of an agreement with Dr. Bilal Choudry for medical direction of the Neuroscience Institute Quality Committee for a term of 12 months, beginning September 1, 2016 through August 31, 2017, for an annual amount not to exceed $4,800, 19 D. 3) Approval of an agreement with Dr. Bilal Choudry for medical direction of the Neuroscience Institute Operations Committee for a term of 12 months, beginning September 1, 2016 through August 31, 2017, for an annual amount not to exceed $4,800. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Schallock and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled item 19 D 7) related to the agreement with CloudMed requested clarification on the services the District would receive from CloudMed.

Mr. Ray Rivas explained CloudMed will audit our claims for our DRGs and their software will help in determining if there is potential to bill more. CloudMed will receive 40% of rebilled and collected accounts which are audited by CloudMed.

It was moved by Director Schallock to approve an agreement with CloudMed for Coding Auditing for a term of 12 months beginning September 1, 2016 through August 31, 2017, for a total cost for the term of 40% of agreed upon, rebilled and collected accounts audited by CloudMed, not to exceed $400,000. Director Finnila seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Schallock and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled item 19 D) related to Siemens expressed concern with aging and obsolete equipment. She encouraged Administration to take a hard look at our MRI machines and consider spending more money on technology.

It was moved by Director Finnila to approve an agreement with Siemens Medical Solutions for services on equipment in three IR Suites and d on one MRI system for a term of five (5) years, beginning October 23, 2016 through October

22, 2021 for a total term expense not to exceed $1,824,670. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled item 19 4) Dues and Memberships – ACHD Annual Membership – $45,000 expressed concern with the cost of the membership.

Director Nygaard provided a high level summary of the benefits received through the membership which was also included in the agenda packet. Director Nygaard stated the subject of membership fees will be discussed at ACHD's Annual Meeting.

It was moved by Director Nygaard to approve the ACHD Annual Membership of $45,000. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Reports (Discussion by exception only)

22. Legislative Update

Chairman Dagostino reported the Design Build Bill is on the Governor's desk for signature which will allow healthcare districts to utilize the Design Build concept.

23. Comments by members of the Public

Mr. Irwin Schenker, homeowner and prior Board Committee community member criticized the actions taken against former CEO Larry Anderson. Mr. Schenker stated his concern is for the hospital, staff and community.

24. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

25. Board Communications

Director Schallock commented that the Joint Powers Agreement with the City of Oceanside and the Affiliation Agreement with UCSD will be beneficial for everyone.

Director Schallock also commented on the District's financial status and expressed his appreciation to Mr. Rivas and the Finance Department for their efforts.

Director Nygaard commented on the UCSD Affiliation Agreement and stated she believes we have chosen an outstanding partner to move forward with.

Director Mitchell echoed comments by Directors Schallock and Nygaard related to the UCSD Affiliation and Joint Powers Agreement with the City of Oceanside.

Director Reno reiterated her concern related to obsolete equipment and urged Administration to evaluate technology throughout the hospital for the good of our patients.

Director Reno commented on the Affiliation Agreement with UCSD, stating she is extremely happy that the agreement has been consummated.

Director Finnila expressed her appreciation to the City of Oceanside for their support and willingness to be our partner in the Design Build process. She stated the City also helped to widen the left hand turn lane to the hospital which is very much appreciated.

Director Finnila stated she was disappointed by the article in today's newspaper related to our Affiliation with UCSD. She commented on the importance of recognizing the differences between a private and public hospital. Director Finnila congratulated the Management Team and the Medical Staff for bringing the affiliation to fruition.

Director Kellett commented on a conversation he had with a physician related to the UCSD affiliation. He stated the physician gave a solid recommendation and is very pleased with UCSD's quality, experience and attention to detail.

26. Report from Chairperson

Chairman Dagostino stated we started out in 1961 as a community hospital to take care of our community. He commented that he believes our affiliation with UCSD will guarantee that our community will be better served and he is comfortable that the hospital will be in a better position two-three years from now.

Ms. Sharon Schultz stated she respects Board member comments related to our equipment. She explained that equipment and supplies are routinely checked and although a piece of equipment may not be state of the art we ensure that it functions properly and provides safe patient care.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:32 p.m.

_____
James J Dagostino, DPT
Chairman

ATTEST:

_____
Ramona Finnila, Secretary

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

September 6 2016 – 11:30 o'clock a.m.
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 11:40 a.m. on September 6, 2016.

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

Director James J. Dagostino, PT, DPT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno (arrived at 11:48 a.m.)
Director Larry W. Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Finance Officer
Marcia Cavanaugh, Senior Director, Risk Management
Dr. Gene Ma, Chief of Staff
Greg Moser, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 11:40 a.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Nygaard and seconded by Director Schallock to approve the agenda as presented. The motion passed (6-0-1) with Director Reno absent for the vote.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

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. Moser, made an oral announcement of items listed on the September 6, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session

which included one Report Involving Trade Secrets and Conference with Legal Counsel regarding one matter of Existing Litigation.

6. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Finnila to go into Closed Session. The motion passed (6-0-1) with Director Reno absent for the vote.

7. Chairman Dagostino adjourned the meeting to Closed Session at 11:41 a.m.

8. The Board returned to Open Session at 12:08p.m.

9. Chairman Dagostino reported no action was taken in Closed Session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 12:08 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

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

September 19 2016 – 7:30 o'clock p.m.
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 7:30 p.m. on September 19, 2016.

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

Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent were Chairperson Dagostino and Director Nygaard

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Finance Officer
Marcia Cavanaugh, Senior Director, Risk Management
Greg Moser, General Counsel
Scott D. Buchholz, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. In Board Chairman's absence, Director Kellett called the meeting to order at 7:30 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Kellett led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Schallock and seconded by Director Finnila to approve the agenda as presented. The motion passed (5-0-2) with Directors Dagostino and Nygaard absent.

3. Public Comments – Announcement

   Director Kellett read the Public Comments section listed on the Board Agenda. There were no public comments.

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

   Director Kellett deferred this item to the Board's General Counsel. General Counsel, Mr. Moser, made an oral announcement of item listed on the September 19, 2016 Special

Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Legal Counsel regarding one matter of Existing Litigation.

6. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Finnila to go into Closed Session. The motion passed (5-0-2) with Directors Dagostino and Nygaard absent.

7. Director Kellett adjourned the meeting to Closed Session at 7:32 p.m.

8. The Board returned to Open Session at 8:20 p.m.

9. Director Kellett reported no action was taken in Closed Session.

10. There being no further business, Director Kellett adjourned the meeting at 8:20 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

Stakeholder Experience

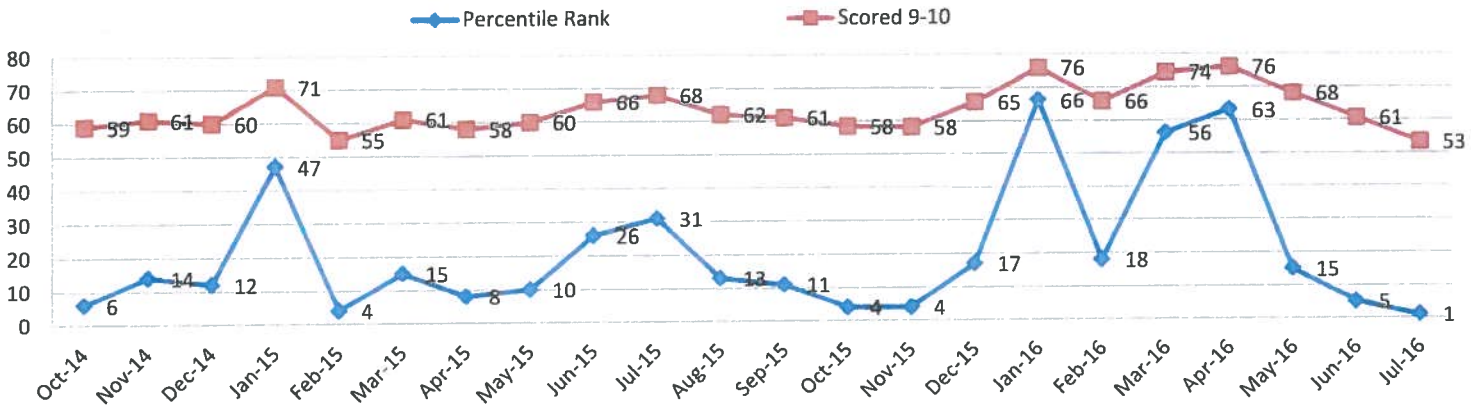
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

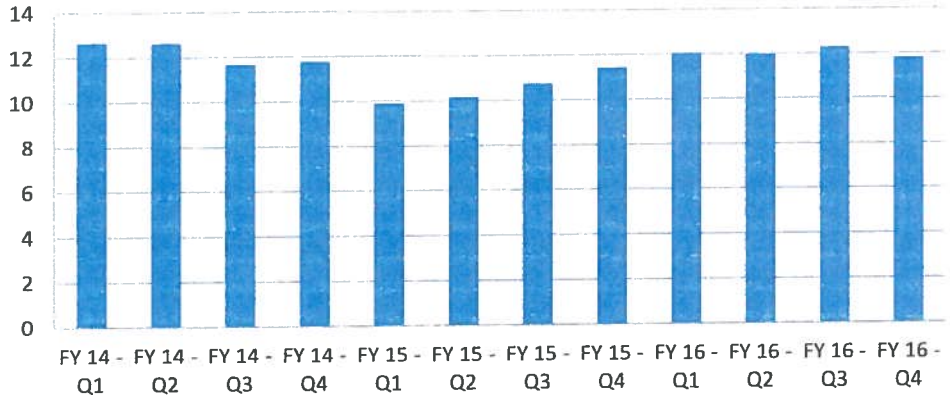
HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

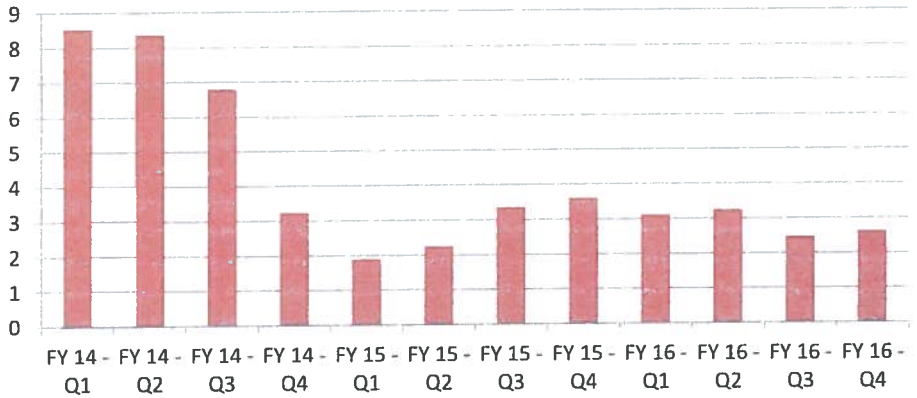
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

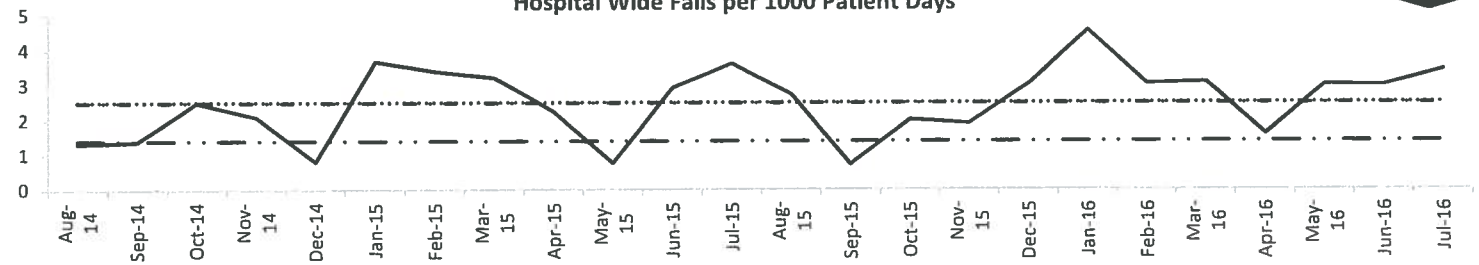


Fall & HAPU's

TCMC Rate Mean CA Mean TCMC Target

Better

Hospital Wide Falls per 1000 Patient Days

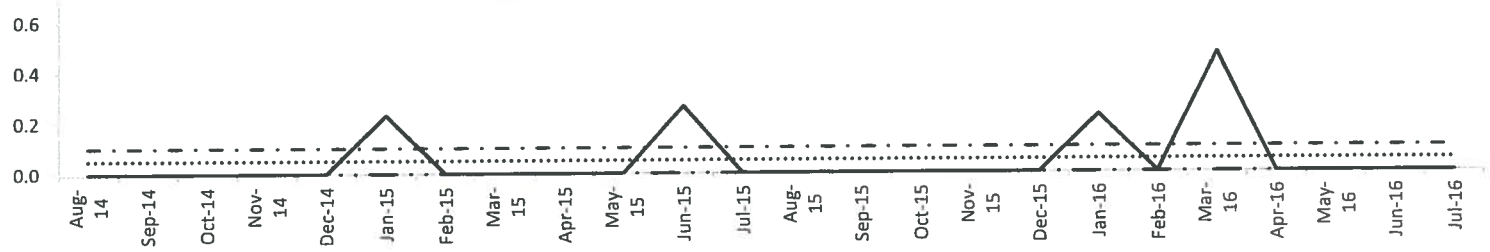


Action Plan

- Ortho started pilot May 2016. First fall in Aug. '- Contract for Cerner Patient Observer signed. '- Tele started pilot last month. 2P & 4P starting pilot this week. Prog Care to start by end of Sept.

Better

Hospital Wide Falls with Injury per 1000 Patient Days

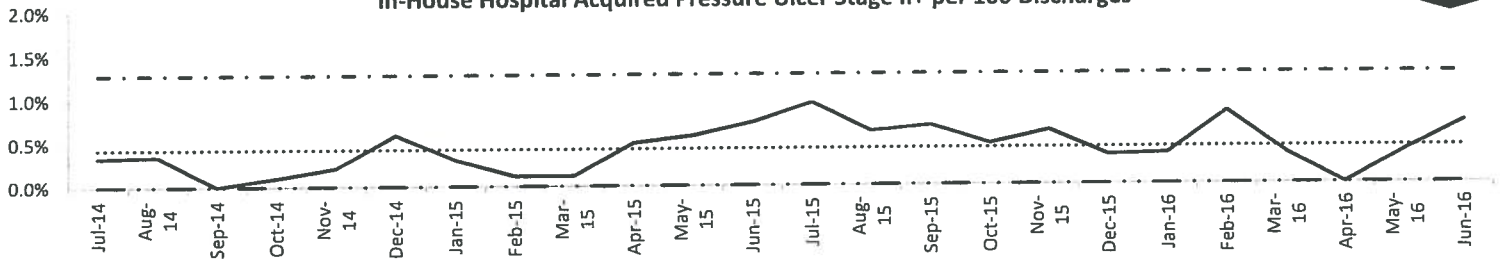


Action Plan

See above.

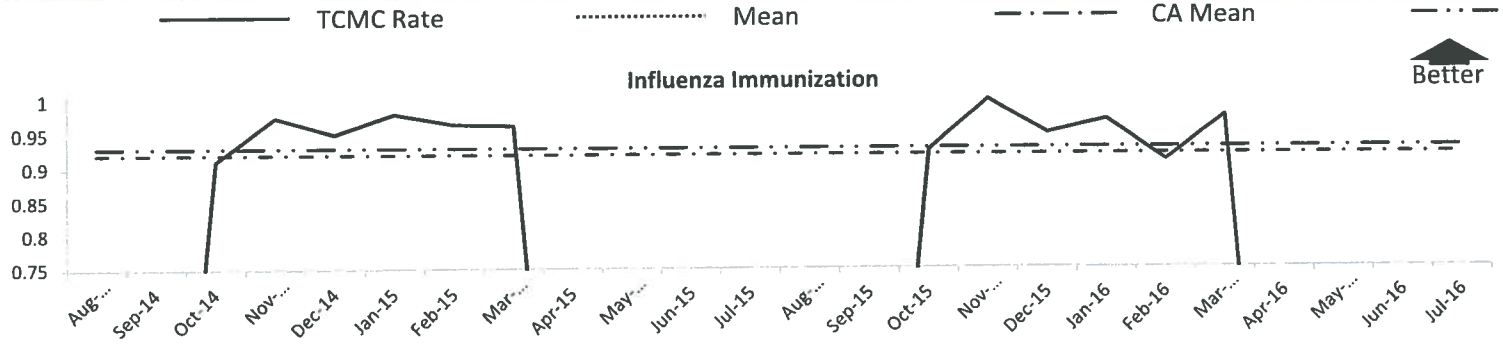
Better

In-House Hospital Acquired Pressure Ulcer Stage II+ per 100 Discharges



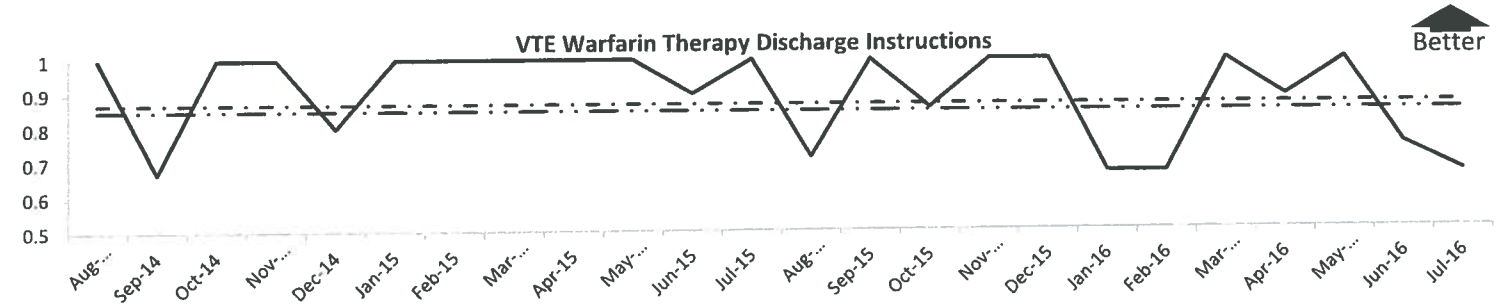
Action Plan

Core Measures



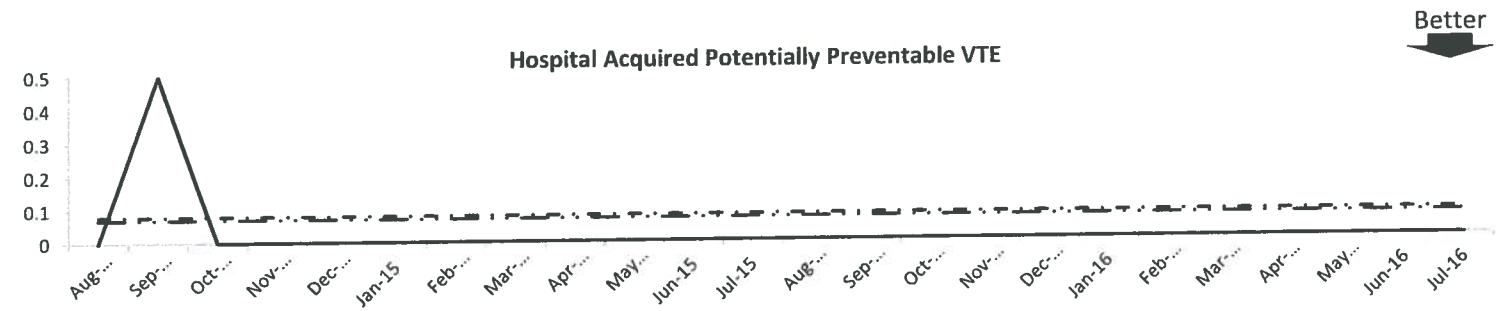
Action Plan

Only during Flu season.



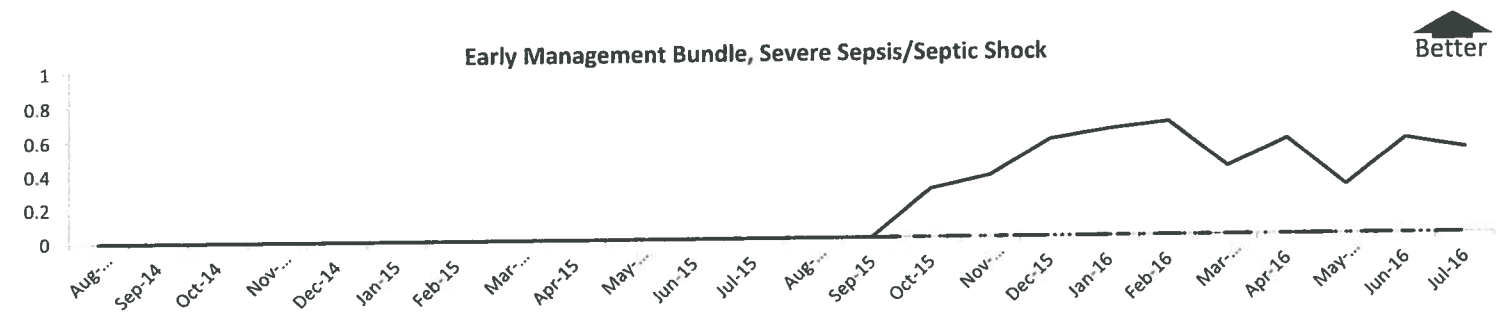
Action Plan

Another set back. Next step is to develop a daily warfarin use report and follow up with staff to document warfarin education to patients earlier in their stay.



Action Plan

Continued excellent compliance.



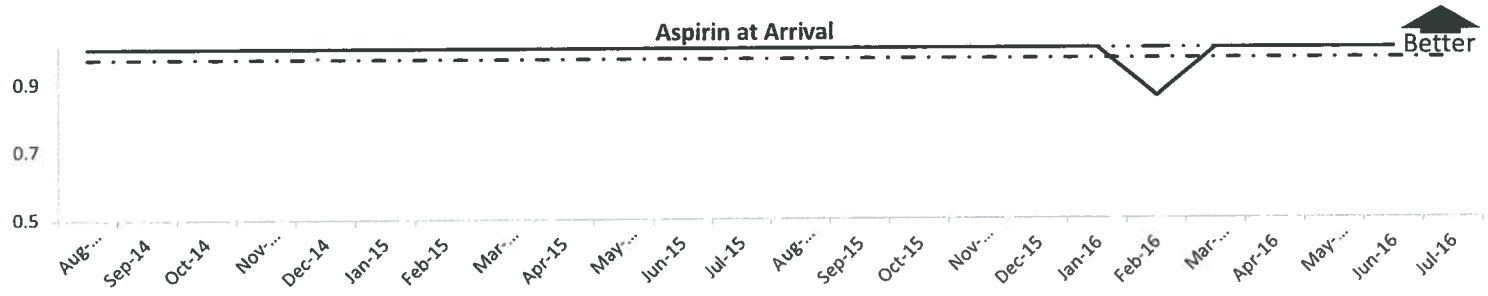
Action Plan

Renewed Code Sepsis in effect for 2 weeks. Redesigned to address documented failed elements. Will follow for improvement.

Core Measures

TCMC Rate — Mean — CA Mean — TCMC Target

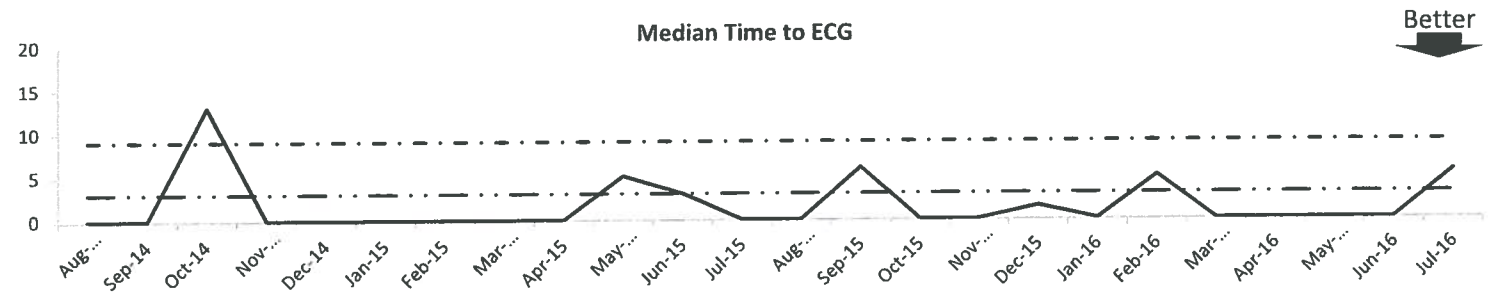
Aspirin at Arrival



Action Plan

Continued excellent compliance.

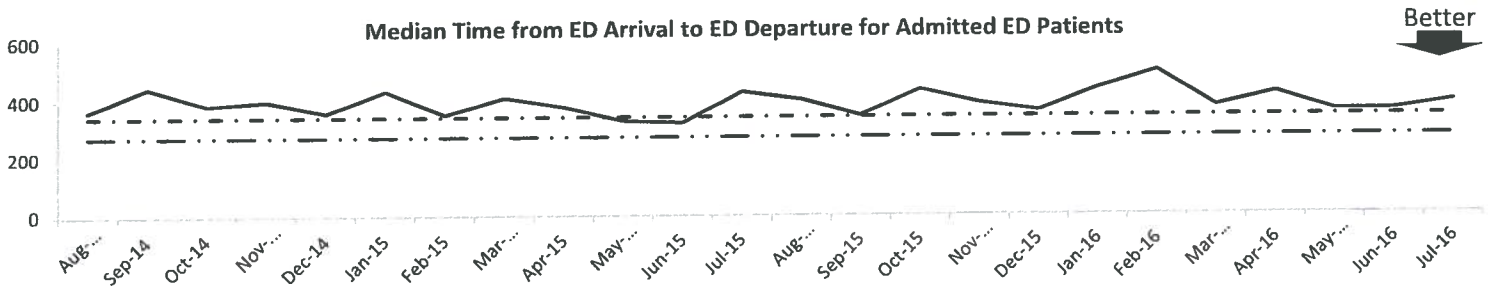
Median Time to ECG



Action Plan

Continued excellent compliance at or better than national Top 10%

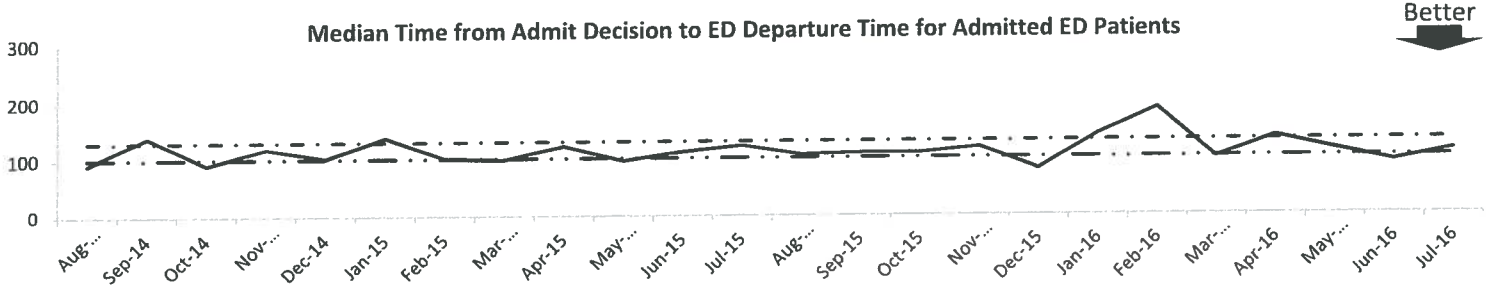
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

In new Hospital Compare data comparing hospitals of comparable (very high) volume, we are better (379 min) than CA mean (423 min) and slightly higher than Nation mean (344 min)

Median Time from Admit Decision to ED Departure Time for Admitted ED Patients

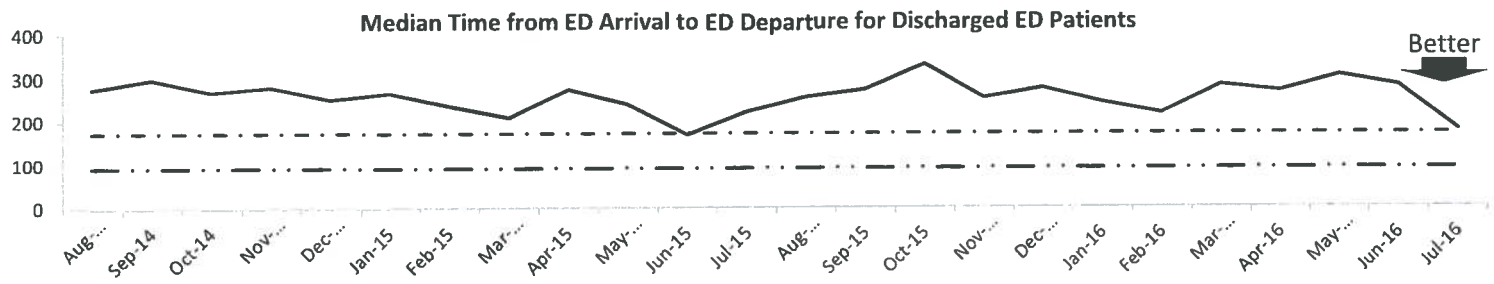


Action Plan

In new Hospital Compare data comparing hospitals of comparable (very high) volume, we are better (108 min) than both CA mean (180 min) and Nation mean (134 min).

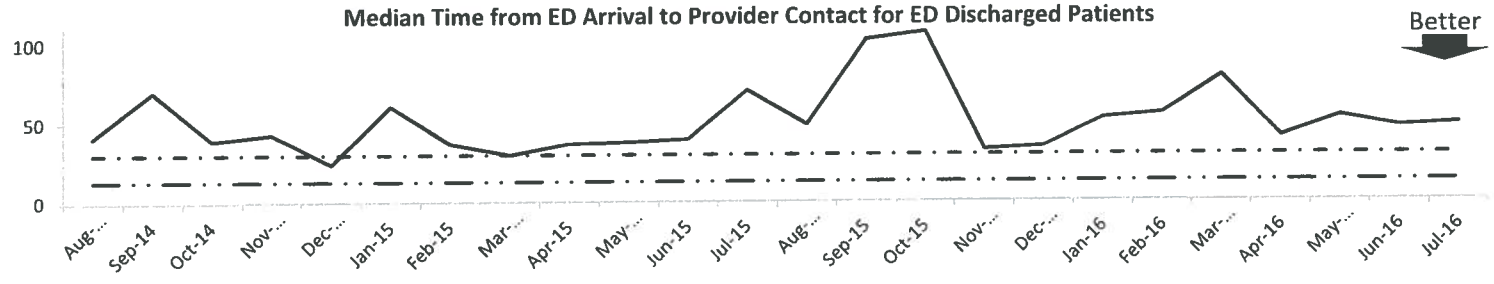
Core Measures

TCMC Rate ····· Mean — · — · — CA Mean — · — · · · TCMC Target



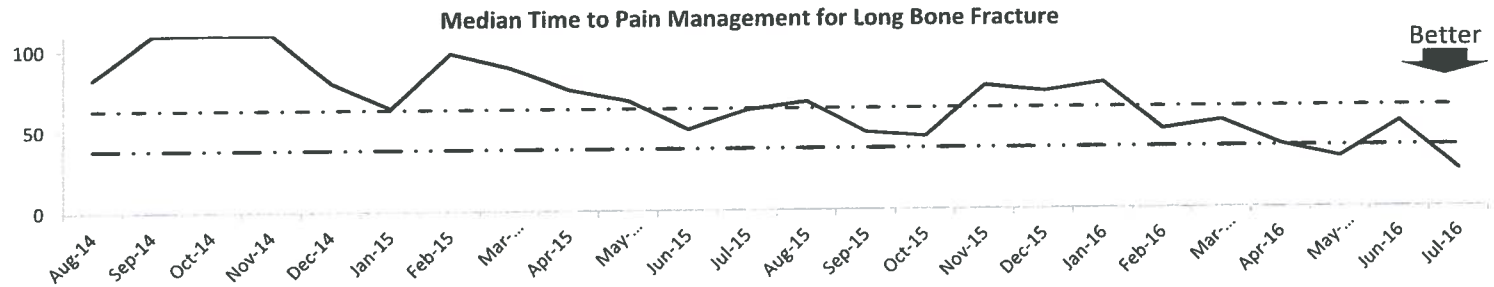
Action Plan

Team Triage for Level 4 and 5 pts is now staffed to stay open until 2am, seeing an overall Improvement in throughput for these pts.



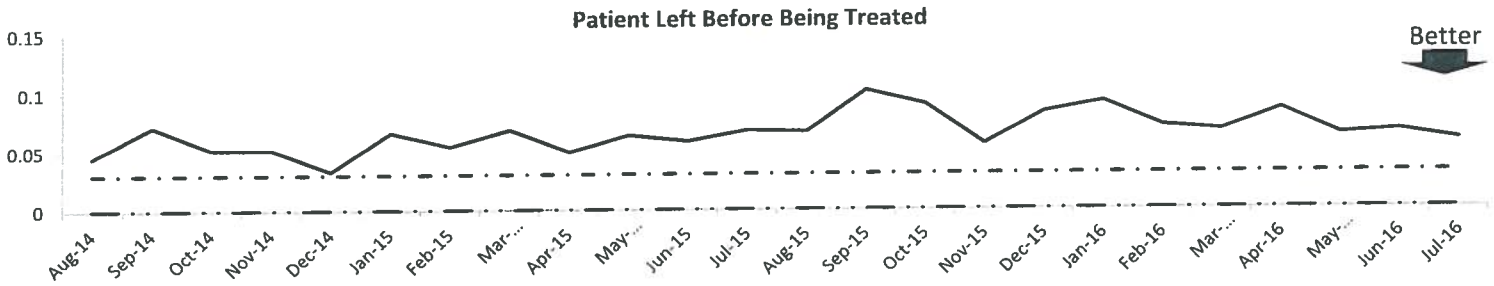
Action Plan

Working on Medical Screen Exam (MSE) process to improve timeliness of MD screening and registration of ED patients.



Action Plan

Staff education and revised ED Triage documentation having ongoing benefit. We are now better than our target of 40 minutes.



Action Plan

Team Triage hours expanded to 10 am - 2 am starting mid-July. Identified need to educate nursing staff on different statuses (LOWBS vs. LOWT vs. AMA vs. Elopement) documentation.

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										50
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										18
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										19
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										36
FY16	16	19	13	4	7	9	15	20	15	13	17	163

Performance compare Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	31	35										66
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	17	16										16.0
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										6.8
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										16.1
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	179	###										185
FY16	###	###	###	###	###	###	###	###	###	###	###	###

Performance compare Better Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	223	239										462
FY16	215	214	252	227	232	220	216	183	209	189	208	###

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	12	11										23
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										8
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										19
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										1.70
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 compare 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											50.7	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		46.2	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											80.3	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		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											$499	$75
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)	($220)	$331	$315		$1,474	

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%											0.89%	0.13%
FY16	3.03%	2.20%	0.66%	-0.68%	-2.00%	3.40%	-6.31%	-1.53%	-0.77%	1.13%	1.09%		2.62%	

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											$3,079	$2,717
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797	$1,019	$1,530	$1,598		$3,863	

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%											5.51%	4.72%
FY16	7.20%	6.53%	4.90%	3.65%	2.50%	7.58%	-2.10%	2.97%	3.56%	5.22%	5.55%		6.87%	

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											5.94	6.11
FY16	6.13	6.05	5.91	5.98	6.11	6.01	5.77	5.43	6.07	5.86	6.09		6.09	

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											1.10	
FY16	1.88	1.96	2.15	2.05	1.85	1.92	1.87	1.73	1.70	1.82	1.63		1.10	

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												
FY16	$30.7	$33.4	$36.1	$35.7	$31.8	$28.0	$26.3	$27.5	$24.8	$28.0	$37.6			

Building Operating Leases
Month Ending August 31, 2016

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.85	(a)	10,028.10	2/1/2015	10/31/18	**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	$2.56	(a)	19,672.00	2/1/2015	10/31/18	**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		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	08/31/16	**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)	9,753.93	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	$3.88	(a)	24,931.00	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)	5,434.83	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		7,803.83	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13		12,391.50	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056
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				**$359,207.60**			

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

Education & Travel Expense
Month Ending 8/31/16

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6183	CAL NOC ANNUAL MEETING	80416	1,126.93	79284	JENESSA FRENCH
8460	XCELERATE TRAINING	81816	109.08	81701	ROGER DICKINSON
8631	AFP GIVING WORKSHOP	83116	65.00	79486	GLEN NEWHART
8631	THOMPSON & ASSOC GIVING SEMINAR	83116	482.89	79486	GLEN NEWHART
8740	AHA ACLS RENEWAL	80416	150.00	80074	ARACELI MORALES
8740	ACMA 12TH ANNUAL CONFERENCE	80416	180.00	78664	TJ GRUNNAN RN
8740	ACLS COURSE	72816	185.00	82127	LAUREN CASTONGUAY
8740	VESTIBULAR ASSESES	72816	189.99	82775	KATHERINE BORDERS
8740	IDEA WORLD FITNESS CONVENTION	72816	200.00	78346	JENNIFER BROWN
8740	ACLS COURSE	81116	200.00	81191	JACQUE BENDER
8740	ONCOLOGY NURSING CERT COURSE	72816	200.00	82125	MARIA AVILEZ
8740	IDEA WORLD FITNESS CONVENTION	72816	200.00	82621	JANICE BACHAR
8740	BSN COURSES	80416	2,500.00	78630	SHELLY VINCENT-GUTIERREZ
8750	NATIONAL BAR ASSOC EDU CONFERENCE	80316	2,322.93	82462	CHERYLE BERNARD-SHAW

**This report shows payments and/or reimbursements to employees and Board Members in the Education & Travel expense category in excess of $100.00.

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