TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
October 26, 2017 – 1:30 o'clock p.m.
Assembly Room 1 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 2&3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators: (Authority: Government Code, Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: CNA		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2017		
	d. Approval of prior Closed Session Minutes		
	e. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 3 Matters)		
	f. Evaluation of Legal Counsel Services (Authority: Gov. Code section 54957)		

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
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	Educational Report Update	5 min.	Chair
13	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Public Hearing Regarding Draft Maps for Change from At Large to District Based Elections - Elections Code §10010(a)(2) *Pursuant to Elections Code Section 10010(a) (2), after maps are drawn, the political subdivision shall hold at least two additional hearings over a period of no more than 45 days at which the public is invited to provide input regarding the content of the draft map or maps and the proposed sequence of elections. This is the first of two public hearings, in addition to three local community meetings in each of the District's representative cities. Draft maps were published on the District's website beginning October 19, 2017.* b. Update on LAFCO Application/Annexations	1 hour 10 min.	Doug Johnson/ General Counsel General Counsel
	c. Consideration to waive Board policy #14-006 – Board of Directors Meeting Minutes related to waiving of audio or video taping for the three community public hearings.	10 min.	Chair
	d. Consideration to approve a Physician Recruitment Agreement with Dr. Malaygiri Aparnath, Pulmonologist and Critical Care Physician	10 min.	FOP/J. Raimo
	e. Discussion regarding 2018 Regular Board Meeting Schedule	10 min.	Chair
17	Old Business		
	a. Update on Board Portal	5 min.	Director Mitchell

	Agenda Item	Time Allotted	Requestor
	b. Board Retreat Follow-up 1. Board Committee Recommendations regarding committee composition and meeting frequency a. Audit, Compliance & Ethics Committee b. Community Healthcare & Alliance Committee c. Employee Fiduciary Subcommittee d. Governance & Legislative Committee e. Human Resources Committee	15 min.	BOD Committee Chairs
18	Chief of Staff a. Consideration of October 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 23, 2017 b. Consideration of Radiology Privilege Card	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. Approval of 2018 Employee Benefit Recommendations 2. Approval of Administrative Policies & Procedures: a) Alcohol and Drug Testing Policy b) Paid Time Off Program c) Annual Leave Bank/Extended Leave Bank **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 1 *(No meeting held in October)* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats - 2 *(Committee minutes included in Board Agenda packets for informational purposes)*	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) **Administrative Policies & Procedures:** a) Accounts Payable Check Processing b) Business Expense Reimbursement, Employees 2) Approval to add Drs. Ashish Kabra and Ryan Smith to the currently existing ED On-Call Coverage Panel for Cardiology, General for a term of 12 months, beginning November 1, 2017 through October 31, 2018. 3) Approval to add Dr. Logan Haak to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months, beginning November 1, 2017 through October 31, 2018. 4) Approval of the purchase of MX800 Patient Monitors with X21 Companion Transport Monitors to replace the current patient monitors in the ICU, for a total expected cost of $520,745. 5) Approval of an agreement with Roche Diagnostics Corporation for Instruments and Consumables for a term of seven (7) years beginning November 1, 2017 and ending October 31, 2024 for an annual cost not to exceed $782,064, and a total cost for the term not to exceed $5,483,978. 6) Approval of an agreement with San Diego Dialysis Services, Inc. dba Fresenius Medical Care North America for Dialysis and Apheresis Services for an average spend of $86,377 per month for Dialysis and Apheresis Services for a term of 36 months, beginning November 1, 2017 and ending October 31, 2020, for a total cost not to exceed $3,109,568. 7) Approval of a Co-Medical Director Agreement with Drs. Mark O'Brien and Bart Day for the Hospitalist program for a term of 12 month, beginning September 1, 2017 through June 30, 2019, for an average of 35 hours per month or 420 hours annually, at an hourly rate of $285, for an annual cost of $120,000, and a total cost for the term of $220,000.		FO&P Comm.
	E. Professional Affairs Committee Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* **1) Patient Care Policies and Procedures** a. Admission of Psychiatric Patients (LPS) Policy b. Admission to the Crisis Stabilization Unit (CSU) c. Central Venous Access Devices Procedure d. Collection of Blood Specimen by Skin Puncture e. Critical Results & Critical Tests- Diagnostic Procedures		PAC

	Agenda Item	Time Allotted	Requestor
	f. Epilepsy Monitored Unit (EMU) Procedure g. Medical Examiner Notification Policy h. Medications Brought In by the Patient Policy i. Off Unit Transfer Process Policy j. Quality and Operations Committee Structure (DELETE) k. Skin and Wound Care Policy l. Specimen Labelling, Nurse Collectibles Procedure m. Standards of Care Adult 2) **Unit Specific – Acute Care** a. Scope of Practice 3) **Unit Specific – Behavioral Health Services** a. 14 day Certification Review Hearings b. 5250- 14 day Involuntary Holds c. 5270- 30 days of Additional Intensive Treatment d. Administration of Zyprexa Relprevv e. Advisement of Legal Status 72 Hour Hold 4) **Unit Specific – Infection Control** a. Bloodborne Pathogen Exposure Control Plan 5) **Medical Staff** a. Physician Format Approval Process (DELETE) 6) **Outpatient Behavioral Health** a. Confidentiality (DELETE) b. Informed Consent (DELETE) c. Medical Record (DELETE) d. Medications (DELETE) e. Patient Neglect and Abuse (DELETE) f. Patient Rights (DELETE) g. Utilization Management (DELETE) 7) **Outpatient Infusion Center** a. Outpatient Specimen Transport **F. Governance & Legislative Committee** Director Dagostino, Committee Chair Open Community Seats - 1 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of Board Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms **G. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of Administrative Policies & Procedures: a. Conflicts of Interest (DELETE) b. Compliance Education & Training		Audit, Comp. & Ethics Comm.

	Agenda Item	Time Allotted	Requestor
	2) Approval to appoint Mr. Leslie Schwartz to an additional two-year term on the Audit, Compliance & Ethics Committee as recommended by the committee. 3) Approval to direct Administration to see an audit proposal with Moss Adams to conduct the FY2018 Financial Statement Audit with no increase in fees. (2) Minutes – Approval of: a) Regular Board of Directors Meeting – September 28, 2017 (3) Meetings and Conferences – NONE (4) Dues and Memberships a) HCCA Membership - $250.00/Board Member		Standard Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (September, 2017) (d) Reimbursement Disclosure Report – (September, 2017) (e) Seminar/Conference Reports 1) CHA Governance Forum – Director Dagostino	0-5 min.	Standard
22	Legislative Update	10 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	3.75 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		

Tri-City Medical Center

ADVANCED HEALTH CARE...FOR YOU

BOARD MEMBER ELECTION ZONES
INFORMATION REGARDING DRAFT MAPS

Tri-City Healthcare District is requesting public input and help in planning for by-zone Board of Director elections. TCHD is changing the process by which voters elect the District's Board Members.

In anticipation of the 2018 election cycle, voting for TCHD Board Members will be by zones, instead of the current at-large (also known as district wide) elections in which all voters have the opportunity to make a decision on each open seat. This change will allow voters to now vote for the one board member representing the zone where the voter lives once every four years.

Tri-City Healthcare District will be hosting two public hearings and three community meetings to give community members the opportunity to provide input on the composition of the zones as well as draft maps of district zones. These maps are drafts, not necessarily the final maps, and future versions may include revisions aimed at addressing concerns raised by community members. There are preliminary maps for the District's **current boundaries**, and preliminary maps for the District's **future boundaries**, assuming certain boundary changes are approved by LAFCO (the Local Agency Formation Commission).

Please review the draft maps, share your comments or questions in the feedback form located on the District's Board Member Election Zones website (https://www.tricitymed.org/about-us/board-of-directors/cvra-board-member-election-zones/), or attend one of the public hearings or community events mentioned below.

PUBLIC HEARINGS / COMMUNITY MEETINGS TO DISCUSS DRAFT MAPS

<u>Public Hearings</u>

Board of Directors Meeting
Date: Thursday, October 26, 2017
Time: 3:30pm
Location: Tri-City Medical Center

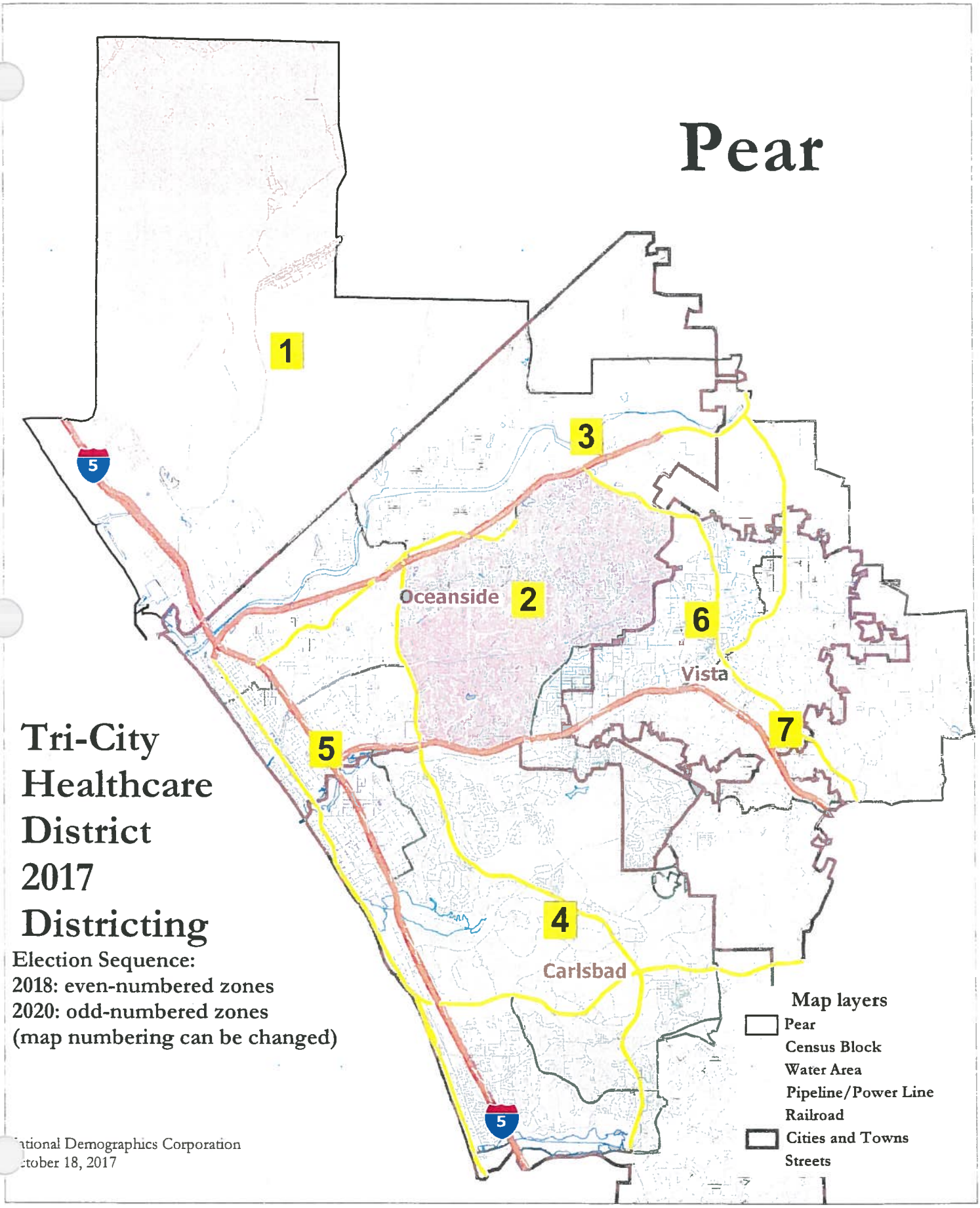
Board of Directors Meeting
Date: Thursday, December 7, 2017
Time: 3:00pm
Location: Tri-City Medical Center

<u>Community Meetings</u>

Date: Wednesday, November 29, 2017
Time: 5:00pm
Location: Oceanside location TBD

Date: Wednesday, November 29, 2017
Time: 7:00pm
Location: Carlsbad location TBD

Date: Thursday, November 30, 2017
Time: 5:30pm
Location: Vista location TBD


Pear
1
2
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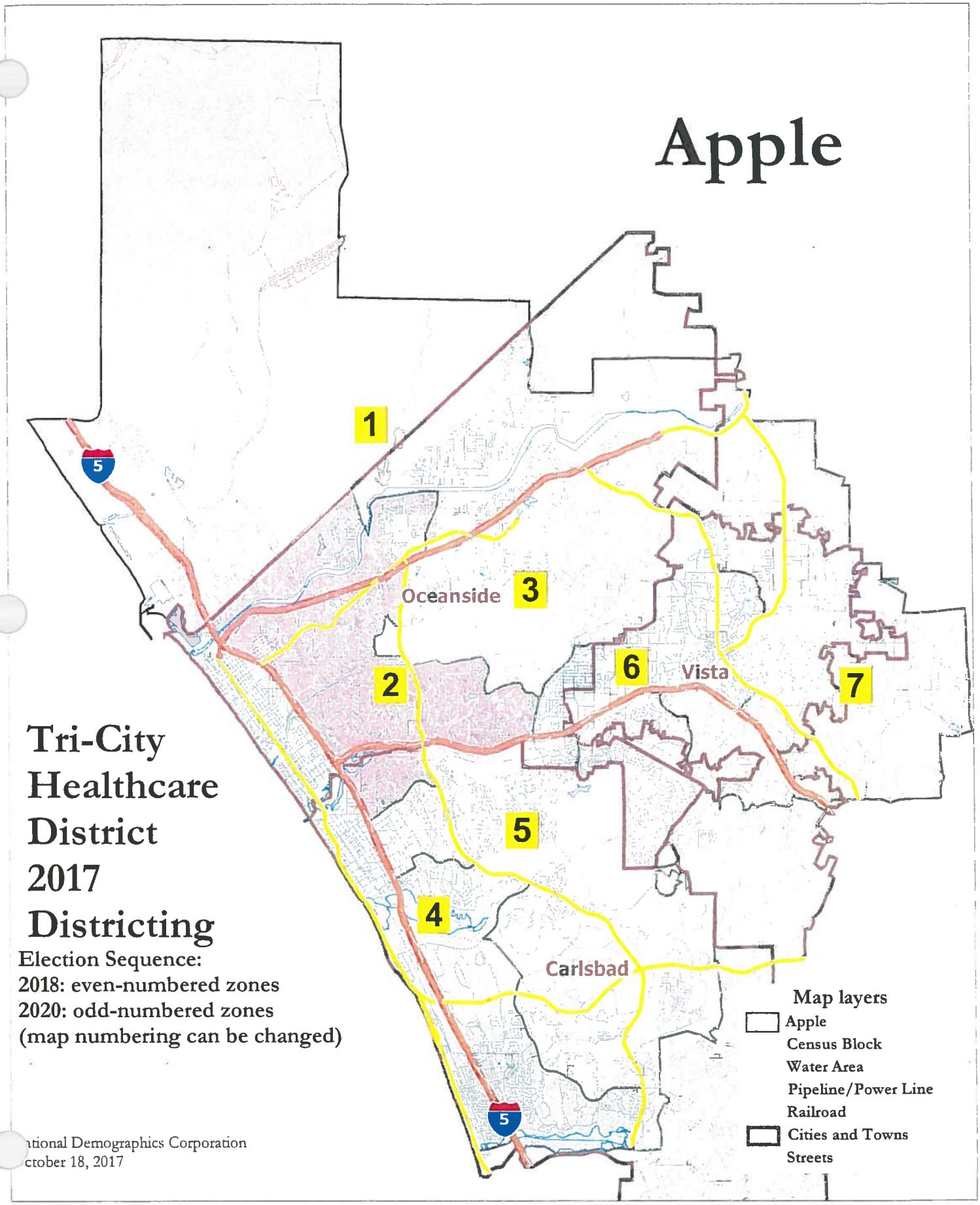
Oceanside
Vista
Carlsbad
5
5
5
Tri-City Healthcare District 2017 Districting
Election Sequence:
2018: even-numbered zones
2020: odd-numbered zones
(map numbering can be changed)
Map layers
Pear
Census Block
Water Area
Pipeline/Power Line
Railroad
Cities and Towns
Streets
ational Demographics Corporation
ctober 18, 2017

Tri-City Healthcare - Pear Map (Current Boundaries)									
District		1	2	3	4	5	6	7	Total
Ideal	Total Pop	49,248	50,019	48,218	48,741	49,157	48,574	47,885	341,842
48,835	Deviation from ideal	413	1,184	-617	-94	322	-261	-950	2,134
	% Deviation	0.85%	2.42%	-1.26%	-0.19%	0.66%	-0.53%	-1.95%	4.37%
Total Pop	% Hisp	42%	25%	43%	16%	18%	65%	37%	35%
	% NH White	43%	58%	40%	71%	72%	26%	53%	52%
	% NH Black	6%	5%	6%	2%	2%	3%	3%	4%
	% Asian-American	5%	9%	8%	9%	6%	4%	4%	7%
Voting Age Pop	Total	35,214	39,075	35,392	37,419	39,456	33,952	36,663	257,171
	% Hisp	37%	21%	37%	14%	16%	59%	31%	30%
	% NH White	48%	62%	45%	75%	75%	31%	59%	57%
	% NH Black	6%	5%	6%	2%	2%	3%	3%	4%
	% Asian-American	5%	9%	9%	8%	5%	5%	5%	7%
Citizen Voting Age Pop	Total	30,643	37,502	31,995	36,632	39,374	25,669	33,663	235,478
	% Hisp	29%	18%	29%	12%	14%	46%	25%	23%
	% NH White	56%	64%	51%	78%	76%	43%	66%	63%
	% NH Black	7%	8%	7%	1%	3%	4%	3%	5%
	% Asian/Pac.Isl.	6%	8%	11%	8%	5%	6%	4%	7%
Voter Registration (Nov 2014)	Total	13,587	27,224	22,269	29,662	29,042	15,730	23,078	160,592
	% Latino est.	27%	17%	27%	10%	11%	42%	19%	20%
	% Asian-Surnamed	2%	2%	2%	4%	2%	2%	2%	2%
	% Filipino-Surnamed	1%	2%	2%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	24%	16%	24%	9%	10%	38%	17%	18%
	% NH White est.	60%	73%	62%	85%	83%	50%	75%	72%
	% NH Black	6%	5%	7%	1%	2%	4%	2%	4%
Voter Turnout (Nov 2014)	Total	4,884	12,477	9,149	15,118	13,792	5,159	10,467	71,047
	% Latino	17%	12%	16%	7%	8%	28%	12%	12%
	% Asian-Surnamed	2%	2%	2%	3%	2%	2%	2%	2%
	% Filipino-Surnamed	1%	1%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	16%	11%	15%	6%	7%	26%	11%	11%
	% NH White est.	70%	79%	74%	89%	86%	63%	83%	81%
	% NH Black	6%	5%	7%	1%	2%	5%	2%	4%
Voter Turnout (Nov 2012)	Total	9,308	21,025	16,086	23,915	22,643	9,841	17,540	120,359
	% Latino	23%	15%	22%	8%	9%	35%	16%	16%
	% Asian-Surnamed	2%	2%	2%	3%	3%	2%	2%	2%
	% Filipino-Surnamed	1%	1%	2%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	21%	13%	20%	8%	8%	32%	14%	14%
	% NH White est.	66%	76%	67%	87%	85%	57%	79%	77%
	% NH Black est.	6%	5%	7%	1%	2%	5%	2%	4%
ACS Pop. Est.	Total	49,117	52,345	49,219	51,475	52,508	49,237	49,530	353,431
Age	age0-19	29%	24%	27%	24%	21%	30%	23%	25%
	age20-60	60%	55%	56%	51%	58%	58%	59%	57%
	age60plus	10%	22%	16%	25%	21%	12%	18%	18%
Immigration	immigrants	16%	16%	24%	16%	14%	29%	20%	19%
	naturalized	42%	54%	47%	63%	43%	30%	39%	44%
Language spoken at home	english	71%	78%	62%	80%	79%	45%	68%	69%
	spanish	23%	14%	29%	11%	15%	51%	26%	24%
	asian-lang	4%	5%	6%	5%	3%	3%	4%	4%
	other lang	2%	3%	3%	4%	3%	1%	2%	3%
Language Fluency	Speaks Eng "Less than Very Well"	14%	9%	18%	7%	10%	35%	19%	16%
Education (among those age 25+)	hs-grad	62%	61%	59%	46%	49%	56%	61%	56%
	bachelor	14%	20%	15%	29%	25%	9%	15%	19%
	graduatedegree	6%	10%	7%	20%	17%	3%	7%	11%
Child in Household	child-under18	40%	27%	34%	27%	25%	38%	28%	30%
Work (percent of pop age 16+)	employed	42%	56%	54%	55%	59%	58%	55%	54%
	Commute on Public Transit	4%	2%	3%	2%	3%	2%	1%	3%
Household Income	income 0-25k	22%	19%	19%	15%	17%	20%	21%	19%
	income 25-50k	33%	20%	22%	16%	21%	31%	25%	23%
	income 50-75k	20%	18%	19%	17%	16%	21%	18%	18%
	income 75-200k	23%	38%	36%	42%	36%	26%	32%	34%
	income 200k-plus	2%	5%	4%	10%	10%	1%	4%	6%
Housing Stats	single family	54%	72%	81%	76%	62%	69%	68%	69%
	multi-family	46%	28%	19%	24%	38%	31%	32%	31%
	vacant	15%	6%	6%	6%	11%	4%	4%	7%
	occupied	85%	94%	94%	94%	89%	96%	96%	93%
	rented	71%	41%	34%	34%	52%	53%	46%	47%
	owned	29%	59%	66%	66%	48%	47%	54%	53%

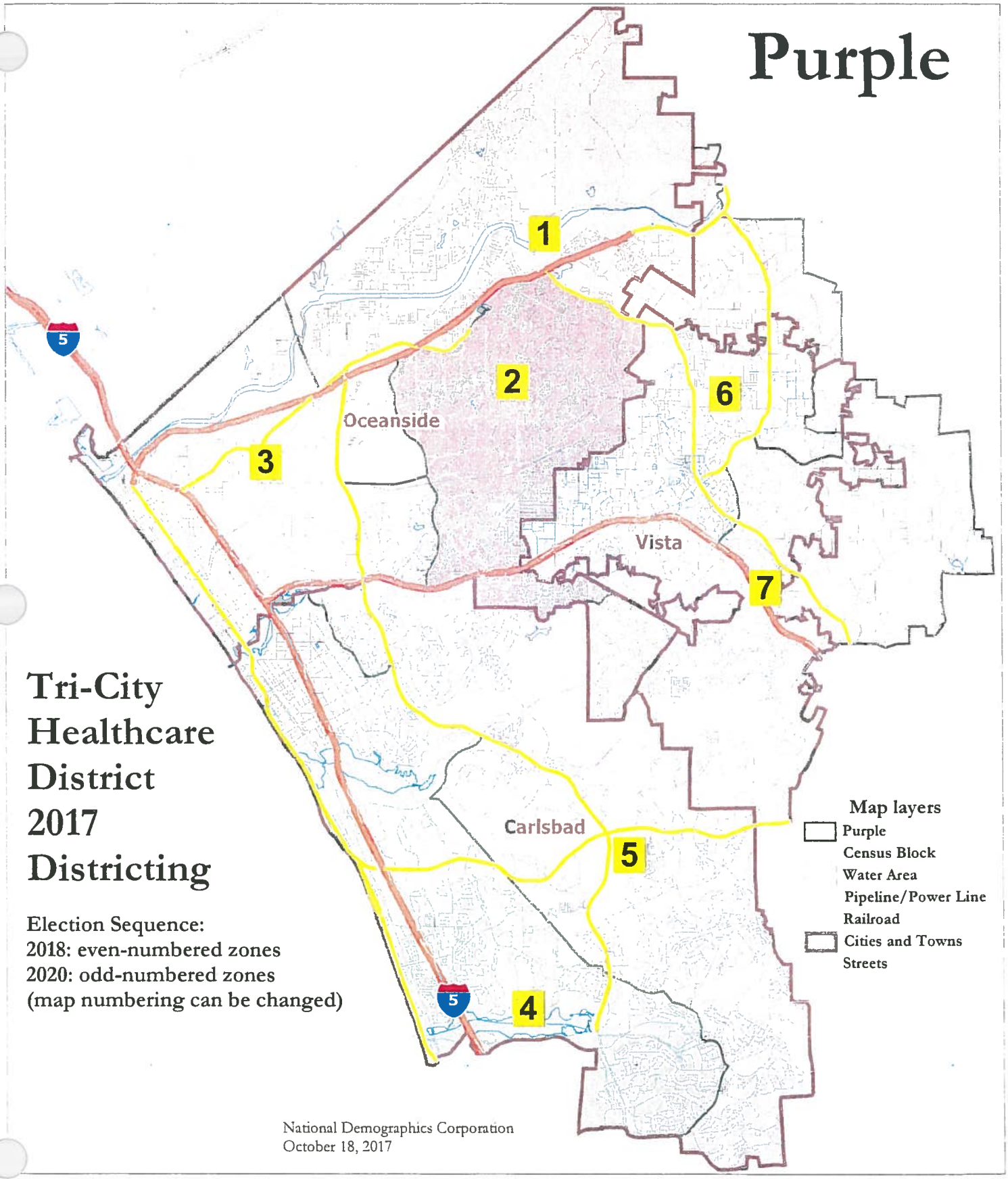
Total and Voting Age population data from the 2010 Decennial Census

Surname-based Voter Registration and Turnout data from the California Statewide Database

Latino voter registration and turnout data are Spanish-surname counts adjusted using Census Population Department undercount estimates. NH White and NH Black registration and turnout counts estimated by NDC. Citizen Voting Age Pop., Age, Immigration, and other demographics from the 2011-2015 American Community Survey and Special Tabulation 5-year data


Apple
1
2
3
4
5
6
7
Oceanside
Vista
Carlsbad
5
5
Tri-City
Healthcare
District
2017
Districting
Election Sequence:
2018: even-numbered zones
2020: odd-numbered zones
(map numbering can be changed)
Map layers
Apple
Census Block
Water Area
Pipeline/Power Line
Railroad
Cities and Towns
Streets
tional Demographics Corporation
ctober 18, 2017

Tri-City Healthcare - Apple Map (Current Boundaries)									
District		1	2	3	4	5	6	7	Total
Ideal	Total Pop	48,169	48,799	49,622	49,796	48,140	48,529	48,787	341,842
48,835	Deviation from ideal	-666	-36	787	961	-695	-306	-48	1,656
	% Deviation	-1.36%	-0.07%	1.61%	1.97%	-1.42%	-0.63%	-0.10%	3.39%
Total Pop	% Hisp	38%	37%	29%	23%	16%	65%	38%	35%
	% NH White	42%	49%	54%	68%	71%	26%	52%	52%
	% NH Black	8%	5%	5%	2%	2%	3%	3%	4%
	% Asian-American	8%	7%	9%	6%	9%	4%	4%	7%
Voting Age Pop	Total	33,825	37,732	37,855	39,719	36,900	33,951	37,189	257,171
	% Hisp	34%	32%	24%	19%	14%	59%	32%	30%
	% NH White	47%	54%	59%	72%	74%	31%	58%	57%
	% NH Black	7%	4%	5%	2%	2%	3%	3%	4%
	% Asian-American	8%	7%	9%	5%	8%	4%	4%	7%
Citizen Voting Age Pop	Total	31,172	33,979	35,573	38,480	36,455	25,327	34,491	235,478
	% Hisp	28%	24%	20%	16%	12%	46%	26%	23%
	% NH White	51%	59%	63%	75%	78%	44%	65%	63%
	% NH Black	9%	7%	6%	2%	1%	4%	4%	5%
	% Asian/Pac.Isl.	10%	9%	8%	5%	8%	5%	5%	7%
Voter Registration (Nov 2014)	Total	14,729	23,528	26,049	27,391	29,580	15,751	23,564	160,592
	% Latino est.	30%	21%	19%	11%	10%	43%	20%	20%
	% Asian-Surnamed	2%	2%	2%	3%	4%	2%	2%	2%
	% Filipino-Surnamed	2%	1%	2%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	27%	19%	17%	10%	9%	38%	18%	18%
	% NH White est.	56%	69%	72%	84%	84%	50%	75%	72%
	% NH Black	8%	6%	5%	2%	1%	4%	3%	4%
Voter Turnout (Nov 2014)	Total	5,453	10,033	11,710	12,911	15,119	5,037	10,784	71,047
	% Latino	19%	13%	13%	7%	7%	29%	12%	12%
	% Asian-Surnamed	2%	2%	2%	2%	3%	2%	2%	2%
	% Filipino-Surnamed	2%	1%	2%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	17%	12%	11%	7%	6%	26%	11%	11%
	% NH White est.	68%	77%	78%	88%	88%	63%	82%	81%
	% NH Black	8%	6%	5%	1%	1%	5%	3%	4%
Voter Turnout (Nov 2012)	Total	10,058	17,428	20,018	21,353	23,706	9,828	17,969	120,359
	% Latino	25%	17%	16%	9%	9%	36%	16%	16%
	% Asian-Surnamed	2%	2%	2%	3%	3%	2%	1%	2%
	% Filipino-Surnamed	2%	1%	2%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	23%	16%	14%	8%	8%	32%	14%	14%
	% NH White est.	62%	73%	75%	85%	86%	57%	79%	77%
	% NH Black est.	8%	6%	5%	1%	1%	4%	3%	4%
ACS Pop. Est.	Total	49,303	49,453	51,052	52,989	50,923	49,271	50,440	353,431
Age	age0-19	31%	24%	25%	22%	24%	30%	24%	25%
	age20-60	60%	57%	55%	57%	52%	58%	57%	57%
	age60plus	10%	19%	20%	21%	24%	12%	19%	18%
Immigration	immigrants	18%	21%	18%	14%	16%	29%	20%	19%
	naturalized	50%	43%	52%	43%	61%	29%	41%	44%
Language spoken at home	english	70%	68%	75%	78%	80%	46%	67%	69%
	spanish	22%	25%	16%	17%	10%	51%	27%	24%
	asian-lang	5%	4%	5%	2%	6%	2%	3%	4%
	other lang	2%	3%	3%	3%	5%	1%	2%	3%
Language Fluency	Speaks Eng. "Less than Very Well"	13%	16%	11%	11%	7%	35%	19%	16%
Education (among those age 25+)	hs-grad	60%	60%	61%	48%	47%	56%	62%	56%
	bachelor	16%	17%	19%	24%	28%	9%	14%	19%
	graduatedegree	7%	8%	9%	17%	19%	3%	7%	11%
Child in Household	child-under18	48%	26%	28%	24%	28%	37%	29%	30%
Work (percent of pop age 16+)	employed	41%	55%	56%	59%	54%	58%	56%	54%
	Commute on Public Transit	3%	3%	2%	4%	2%	2%	2%	3%
Household Income	income 0-25k	17%	20%	20%	18%	16%	22%	21%	19%
	income 25-50k	28%	25%	20%	22%	16%	30%	25%	23%
	income 50-75k	20%	20%	18%	17%	16%	21%	18%	18%
	income 75-200k	31%	31%	38%	34%	42%	26%	33%	34%
	income 200k-plus	4%	4%	5%	9%	10%	1%	4%	6%
Housing Stats	single family	79%	60%	75%	57%	74%	69%	72%	69%
	multi-family	21%	40%	25%	43%	26%	31%	28%	31%
	vacant	7%	8%	6%	14%	6%	3%	4%	7%
	occupied	93%	92%	94%	86%	94%	97%	96%	93%
	rented	52%	50%	38%	57%	34%	53%	43%	47%
	owned	48%	50%	62%	43%	66%	47%	57%	53%
Total and Voting Age population data from the 2010 Decennial Census									
Surname-based Voter Registration and Turnout data from the California Statewide Database									
Latino voter registration and turnout data are Spanish-surname counts adjusted using Census Population Department undercount estimates. NH White and NH Black registration and turnout counts estimated by NDC. Citizen Voting Age Pop., Age, Immigration, and other demographics from the 2011-2015 American Community Survey and Special Tabulation 5-year data									



Tri-City Healthcare District 2017 Districting

Election Sequence:
2018: even-numbered zones
2020: odd-numbered zones
(map numbering can be changed)

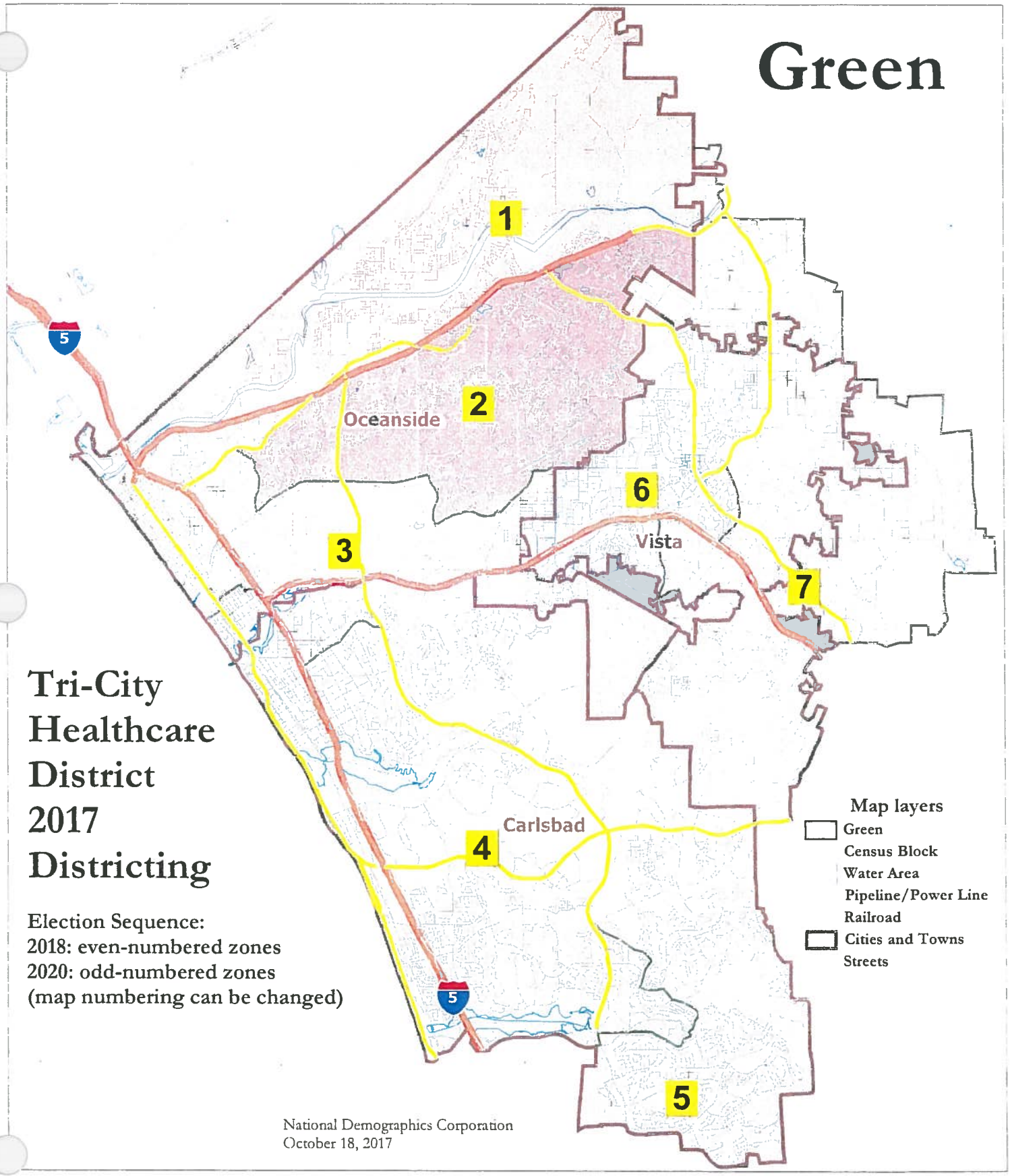
National Demographics Corporation
October 18, 2017

Tri-City Healthcare - Purple Map (Annexation Boundaries)									
District		1	2	3	4	5	6	7	Total
Ideal	Total Pop	53,461	53,264	53,187	54,926	54,896	55,094	55,510	380,338
54,334	Deviation from ideal	-873	-1,070	-1,147	592	562	760	1,176	2,323
	% Deviation	-1.61%	-1.97%	-2.11%	1.09%	1.03%	1.40%	2.16%	4.28%
Total Pop	% Hisp	42%	31%	39%	14%	13%	63%	27%	32%
	% NH White	40%	52%	49%	77%	73%	28%	62%	54%
	% NH Black	6%	5%	4%	1%	2%	3%	3%	3%
	% Asian-American	9%	9%	5%	7%	10%	4%	6%	7%
Voting Age Pop	Total	39,135	40,734	41,255	42,941	40,751	38,612	43,587	287,015
	% Hisp	37%	27%	33%	12%	12%	56%	23%	28%
	% NH White	45%	57%	55%	79%	76%	34%	66%	59%
	% NH Black	6%	5%	4%	1%	2%	3%	3%	3%
	% Asian-American	10%	9%	5%	7%	10%	4%	6%	7%
Citizen Voting Age Pop	Total	35,839	38,093	36,329	42,293	40,971	29,255	43,748	266,529
	% Hisp	28%	23%	23%	12%	12%	43%	19%	22%
	% NH White	51%	61%	62%	80%	76%	47%	72%	65%
	% NH Black	7%	6%	6%	1%	2%	4%	3%	4%
	% Asian/Pac.Isl.	12%	8%	6%	6%	9%	5%	6%	8%
Voter Registration (Nov 2014)	Total	24,960	27,648	24,502	34,733	33,062	17,884	30,406	193,195
	% Latino est.	27%	21%	20%	8%	9%	38%	15%	18%
	% Asian-Surnamed	2%	2%	2%	3%	4%	2%	2%	3%
	% Filipino-Surnamed	2%	2%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	24%	19%	18%	7%	8%	34%	13%	16%
	% NH White est.	62%	69%	71%	86%	84%	54%	80%	74%
	% NH Black	7%	5%	5%	1%	2%	4%	2%	3%
Voter Turnout (Nov 2014)	Total	10,334	11,968	10,384	17,633	15,979	6,191	14,797	87,286
	% Latino	16%	14%	13%	6%	6%	24%	9%	11%
	% Asian-Surnamed	2%	2%	2%	3%	4%	2%	2%	2%
	% Filipino-Surnamed	2%	1%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	14%	12%	11%	5%	6%	22%	8%	10%
	% NH White est.	73%	77%	79%	89%	87%	67%	86%	82%
	% NH Black	7%	5%	5%	1%	1%	5%	2%	3%
Voter Turnout (Nov 2012)	Total	18,137	20,982	17,707	28,339	26,468	11,597	23,938	147,168
	% Latino	22%	18%	17%	7%	8%	31%	12%	14%
	% Asian-Surnamed	2%	2%	2%	3%	4%	2%	2%	2%
	% Filipino-Surnamed	2%	2%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	20%	16%	15%	6%	7%	27%	11%	13%
	% NH White est.	67%	73%	75%	88%	86%	62%	83%	78%
	% NH Black est.	7%	5%	5%	1%	1%	4%	2%	3%
ACS Pop. Est.	Total	54,414	55,497	54,384	56,887	58,084	56,709	57,713	393,688
Age	age0-19	27%	26%	24%	22%	27%	29%	21%	25%
	age20-60	56%	56%	58%	54%	54%	58%	57%	56%
	age60plus	17%	19%	19%	24%	19%	13%	22%	19%
Immigration	immigrants	24%	18%	20%	14%	14%	28%	17%	19%
	naturalized	47%	49%	36%	61%	66%	31%	51%	46%
Language spoken at home	english	63%	72%	68%	83%	83%	49%	76%	71%
	spanish	28%	20%	27%	10%	8%	47%	17%	22%
	asian-lang	6%	5%	4%	3%	5%	3%	4%	4%
	other lang	3%	3%	2%	4%	5%	1%	3%	3%
Language Fluency	Speaks Eng "Less than Very Well"	17%	13%	17%	7%	6%	33%	12%	15%
Education (among those age 25+)	hs-grad	59%	61%	58%	42%	43%	57%	59%	54%
	bachelor	15%	18%	16%	30%	33%	9%	20%	21%
	graduatedegree	8%	9%	8%	23%	21%	4%	10%	12%
Child in Household	child-under18	34%	30%	25%	27%	34%	37%	25%	30%
Work (percent of pop age 16+)	employed	53%	56%	56%	58%	60%	58%	53%	56%
	Commute on Public Transit	3%	2%	4%	3%	2%	2%	1%	2%
Household Income	income 0-25k	19%	20%	22%	15%	13%	22%	21%	18%
	income 25-50k	22%	21%	28%	15%	13%	31%	21%	21%
	income 50-75k	19%	17%	20%	14%	14%	20%	18%	17%
	income 75-200k	36%	38%	27%	41%	44%	26%	37%	36%
	income 200k-plus	5%	4%	4%	15%	16%	2%	5%	8%
Housing Stats	single family	81%	73%	53%	70%	76%	67%	71%	70%
	multi-family	19%	27%	47%	30%	24%	33%	29%	30%
	vacant	6%	5%	13%	9%	6%	4%	4%	7%
	occupied	94%	95%	87%	91%	94%	96%	96%	93%
	rented	34%	40%	58%	41%	32%	53%	41%	43%
	owned	66%	60%	42%	59%	68%	47%	59%	57%

Total and Voting Age population data from the 2010 Decennial Census.

Surname-based Voter Registration and Turnout data from the California Statewide Database

Latino voter registration and turnout data are Spanish-surname counts adjusted using Census Population Department undercount estimates. NH White and NH Black registration and turnout counts estimated by NDC. Citizen Voting Age Pop., Age, Immigration, and other demographics from the 2011-2015 American Community Survey and Special Tabulation 5-year data.


Green
1
2
3
4
5
6
7
Oceanside
Vista
Carlsbad
5
5
Tri-City
Healthcare
District
2017
Districting
Election Sequence:
2018: even-numbered zones
2020: odd-numbered zones
(map numbering can be changed)
Map layers
Green
Census Block
Water Area
Pipeline/Power Line
Railroad
Cities and Towns
Streets
National Demographics Corporation
October 18, 2017

Tri-City Healthcare - Green Map (Annexation Boundaries)									
District		1	2	3	4	5	6	7	Total
Ideal	Total Pop	55,429	54,865	54,349	53,658	54,143	54,325	53,569	380,338
54,334	Deviation from ideal	1,095	531	15	-676	-191	-9	-765	1,860
	% Deviation	2.02%	0.98%	0.03%	-1.24%	-0.35%	-0.02%	-1.41%	3.42%
Total Pop	% Hisp	45%	30%	34%	16%	11%	60%	32%	32%
	% NH White	36%	53%	54%	74%	76%	31%	57%	54%
	% NH Black	6%	5%	4%	1%	2%	3%	3%	3%
	% Asian-American	9%	9%	5%	7%	10%	4%	6%	7%
Voting Age Pop	Total	40,461	41,884	42,901	42,221	39,786	38,939	40,823	287,015
	% Hisp	39%	25%	29%	13%	10%	53%	27%	28%
	% NH White	41%	58%	60%	77%	78%	37%	62%	59%
	% NH Black	6%	5%	3%	1%	1%	3%	3%	3%
	% Asian-American	10%	9%	5%	7%	9%	5%	6%	7%
Citizen Voting Age Pop	Total	35,965	38,950	40,373	40,833	40,675	29,967	39,766	266,529
	% Hisp	31%	20%	22%	13%	10%	40%	22%	22%
	% NH White	47%	64%	64%	79%	79%	49%	69%	65%
	% NH Black	8%	6%	5%	1%	1%	4%	3%	4%
	% Asian/Pac.Isl.	13%	8%	7%	6%	9%	5%	5%	8%
Voter Registration (Nov 2014)	Total	24,392	28,625	27,809	32,162	34,276	18,140	27,791	193,195
	% Latino est.	29%	19%	18%	9%	8%	37%	17%	18%
	% Asian-Surnamed	2%	2%	2%	3%	4%	2%	2%	3%
	% Filipino-Surnamed	2%	2%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	26%	17%	16%	8%	7%	33%	15%	16%
	% NH White est.	59%	71%	75%	86%	85%	56%	77%	74%
	% NH Black	7%	5%	4%	1%	1%	4%	2%	3%
Voter Turnout (Nov 2014)	Total	9,638	12,724	12,838	15,968	16,857	6,334	12,928	87,286
	% Latino	18%	13%	11%	7%	6%	24%	11%	11%
	% Asian-Surnamed	2%	2%	2%	3%	3%	2%	2%	2%
	% Filipino-Surnamed	2%	1%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	16%	11%	9%	6%	5%	21%	10%	10%
	% NH White est.	70%	78%	83%	89%	88%	68%	84%	82%
	% NH Black	7%	5%	4%	1%	1%	4%	2%	3%
Voter Turnout (Nov 2012)	Total	17,355	21,791	21,013	25,853	27,882	11,827	21,447	147,168
	% Latino	24%	16%	15%	8%	7%	29%	14%	14%
	% Asian-Surnamed	2%	2%	2%	3%	4%	2%	2%	2%
	% Filipino-Surnamed	2%	1%	1%	1%	1%	1%	1%	1%
	% Spanish-Surnamed	22%	14%	13%	7%	6%	26%	13%	13%
	% NH White est.	63%	75%	79%	87%	87%	63%	80%	78%
	% NH Black est.	7%	5%	4%	1%	1%	4%	3%	3%
ACS Pop. Est.	Total	55,026	56,229	58,573	55,825	56,909	55,677	55,451	393,688
Age	age0-19	27%	25%	23%	22%	27%	28%	23%	25%
	age20-60	56%	55%	55%	55%	53%	59%	58%	56%
	age60plus	16%	20%	22%	22%	20%	13%	19%	19%
Immigration	immigrants	24%	18%	19%	15%	13%	29%	17%	19%
	naturalized	50%	50%	39%	58%	69%	30%	47%	46%
Language spoken at home	english	62%	74%	70%	81%	85%	49%	73%	71%
	spanish	29%	18%	24%	12%	6%	46%	21%	22%
	asian-lang	7%	5%	3%	3%	5%	4%	3%	4%
	other lang	3%	3%	2%	4%	4%	1%	3%	3%
Language Fluency	Speaks Eng. "Less than Very Well"	18%	11%	16%	7%	5%	32%	15%	15%
Education (among those age 25+)	hs-grad	58%	61%	57%	44%	41%	57%	60%	54%
	bachelor	16%	19%	18%	29%	33%	9%	18%	21%
	graduatedegree	7%	9%	10%	22%	22%	4%	9%	12%
Child in Household	child-under18	33%	28%	24%	26%	35%	36%	27%	30%
Work (percent of pop age 16+)	employed	53%	56%	55%	59%	59%	57%	56%	56%
	Commute on Public Transit	3%	2%	3%	3%	2%	2%	2%	2%
Household Income	income 0-25k	19%	20%	21%	15%	13%	21%	21%	18%
	income 25-50k	23%	21%	25%	17%	12%	31%	21%	21%
	income 50-75k	18%	18%	20%	14%	13%	21%	17%	17%
	income 75-200k	35%	37%	30%	41%	44%	25%	36%	36%
	income 200k-plus	5%	4%	5%	13%	18%	1%	5%	8%
Housing Stats	single family	76%	74%	57%	66%	82%	65%	72%	70%
	multi-family	24%	26%	43%	34%	18%	35%	28%	30%
	vacant	7%	6%	10%	11%	4%	4%	4%	7%
	occupied	93%	94%	90%	89%	96%	96%	96%	93%
	rented	39%	39%	52%	46%	27%	54%	43%	43%
	owned	61%	61%	48%	54%	73%	46%	57%	57%

Total and Voting Age population data from the 2010 Decennial Census

Surname-based Voter Registration and Turnout data from the California Statewide Database

Latino voter registration and turnout data are Spanish-surname counts adjusted using Census Population Department undercount estimates. NH White and NH Black registration and turnout counts estimated by NDC. Citizen Voting Age Pop , Age, Immigration, and other demographics from the 2011-2015 American Community Survey and Special Tabulation 5-year data

Note: Zone numbers can (and likely will) be changed prior to final adoption of a map.

Zone	Apple	Pear	Green	Purple
	Current Borders	Current Borders	Annex Borders	Annex Borders
1 (2020)	Mitchell (2018)	Schallock (2020)	Mitchell (2018)	Mitchell (2018)
2 (2018)	Grass (2020) and Kellert (2018)	Reno (2020)	Reno (2020)	Reno (2020)
3 (2020)	Reno (2020)	Mitchell (2018)	Schallock (2020)	Schallock (2020)
4 (2018)	Schallock (2020)	Dagostino (2018) and Grass (2020)	Grass (2020) and Kellert (2018)	Kellert (2018) and Nygard (2020)
5 (2020)	Dagostino (2018) and Nygard (2020)	Kellert (2018) and Nygard (2020)	Dagostino (2018) and Nygard (2020)	Dagostino (2018) and Grass (2020)
6 (2018)	vacant	vacant	vacant	vacant
7 (2020)	vacant	vacant	vacant	vacant

California Health Code requires that the three even-numbered zones hold elections in 2018 and the four odd-numbered zones up in 2020.

At the time of map drafting, NDC did not reference which Director terms ended in which years. If adopted as-is, Districts would be renumbered to match individual resident Directors. The Board will have to decide on the numbering and election years for the vacant zones and for the zones with Director pairs who are up in different election years.

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AUSTIN
DEL MAR HEIGHTS
PHOENIX
SAN DIEGO
SILICON VALLEY

MEMORANDUM

TO: Board of Directors
Tri-City Healthcare District

FILE NO: 116569/000004

FROM: Greg V. Moser
Adriana R. Ochoa

CC: Steve Dietlin, CEO

DATE: October 19, 2017

RE: Agenda Items #16 a & b: Update Regarding Resolution No. 785, Intention to Transition to District-Based Elections, and Resolution No. 787, LAFCO Annexations

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CVRA

On May 25, 2017 the TCHD Board approved Resolution 785, a Resolution of the Board of Directors of Tri-City Healthcare District Outlining Intention to Transition from At-Large to District-Based Elections Pursuant to Elections Code 10010(e)(3)(A). Pursuant to Elections Code § 10010(a)(1), before drawing any draft map or maps of proposed districts, TCHD was required to hold at least two public hearings over a period of no more than 30 days, at which the public was invited to provide input regarding the composition of the district. Tri-City held these two public hearings at their regular Board meetings on August 31 and September 28, 2017.

Four draft maps and their corresponding sequences of elections were published on TCHD's website and available electronically or via hard copy on October 19, 2017, in accordance with Elections Code § 10010(a)(2). TCHD is required by law to hold at least two additional hearings over a period of no more than 45 days, at which the public is invited to provide input regarding the content of the draft map or maps and the proposed sequence of elections. The first of these public hearings is today.

The second public hearing is scheduled to occur at a special meeting of the Board of Directors on December 7, 2017 at 3 p.m. There will also be three community meetings held in each of the District's three cities to discuss the draft maps. TCHD will organize and host public community meetings in Oceanside, Vista and Carlsbad during the evening hours to accommodate members of the public and their respective work schedules. These community meetings are schedule to occur on November 29 (Oceanside – 5 pm; Carlsbad – 7 pm), and November 30 (Vista – 5:30 pm). Locations are being finalized and specifics will be made available on TCHD's website as soon as the venues are reserved.

LAFCO

Resolution 785 also directed the Chief Executive Officer to begin the LAFCO (Local Agency Formation Commission) annexation process upon the recommendation of LAFCO. On July 27, 2017, the TCHD Board approved Resolution 787, a Resolution of Application to San Diego Local Agency Formation Commission from the Board of Tri-City Healthcare District for the Annexation of Territory & Amendment of Tri-City Healthcare District's Sphere of Influence. This resolution of application proposes a number of annexations and detachments to change TCHD's current boundaries to be generally more coterminous with the three cities' boundaries.

TCHD resolved to move forward with the LAFCO annexations and the CVRA districting process concurrently so that both can be completed in a timely and efficient manner. TCHD believes it is prudent to process the annexations first in order to avoid having to go through the process of drawing election districts twice – saving time, money, and confusion. However, in an abundance of caution, TCHD is proceeding with drawing proposed maps for both scenarios – one contemplating the District's current boundaries, and one contemplating the District's projected boundaries after the annexations are approved. That way, TCHD can assure the public that it will have district-based elections for the November 2018 elections, irrespective of whether or not the LAFCO annexations are finalized before the next election cycle.

TCHD submitted its resolution, application, and processing payment to LAFCO on or about September 25, 2017. LAFCO has informed us that they are finalizing the Preliminary Staff Report for distribution by the end of the month. That will start the Assessor/Auditor processing of the proposal. Following the Auditor's report, the Board of Supervisors will process the property tax exchange associated with the proposal. Following the Board approval for the tax exchange, the proposal will be scheduled for a public hearing with LAFCO. There is a 30-day protest/reconsideration period following the Commission's approval, and once that period ends, the proposal will be recorded with the County Recorder. The recordation date will be the effective date of the new boundaries for TCHD.

In terms of timing, LAFCO meets monthly, on the morning of the first Monday. The Commission does not generally meet in January due to the holidays. That would leave February as the likely hearing date for the Tri-City proposal, which would allow for recordation during the **first week of March** (barring anything unforeseen).

If all goes as planned and TCHD's new boundaries are effective in March, the TCHD Board of Directors will have the time and ability to approve maps with the new boundaries for the November 2018 elections. The key issue for scheduling will be how quickly the Board of Supervisors' approval of the property tax exchange can be processed following the Assessor/Auditor. We are hoping to have a better understanding of the County's processing timing over the next week.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-006

POLICY TITLE: Board of Directors Meeting Minutes

Written minutes shall be produced for all official meetings of the Board of Directors, except for Special Board of Directors meetings that are called to hold a Closed Session and for which the Open Session portion contains only items of routine business of the type usually included in the consent portion of the Open Session agenda of Regular Board meetings. Minutes shall be formatted in accordance with Attachment A. The minutes shall include the following:

1. A record of the motion as stated by the Board member who is making the motion, and a record of the Board member seconding the motion.

2. A record of the vote taken. The recording shall reflect the vote of each Board member, and shall include all Ayes, Noes, Abstentions and Absent votes.

3. All Open Sessions of Board of Directors meetings shall be audio or video taped.

4. Because Open Sessions of Board of Directors meetings are audio or video taped, except for Special Board of Directors meetings called to hold a Closed Session and for which the Open Session portion contains only items of routine business, minutes containing statements by individual members "for the record" shall not be recorded and summary minutes are not required.

5. Board of Directors meeting minutes and transcripts of meetings will not be given out to any individual Board member for review, edit or revision prior to presentation to the whole Board.

6. Minutes of the Board of Directors shall be presented to the Board of Directors for review and approval by way of their Board Agenda packet.

7. All original video and/or audiotapes of Board meetings shall be secured, stored, and may be destroyed under the records retention policy of the District.

8. Minutes of closed sessions shall not be produced except as may be reasonably necessary to document consideration of matters for accreditation, compliance, licensing and similar purposes or as required by court order. Draft minutes should be transmitted for review by a secure method. Minutes of closed sessions shall be taken by Board Counsel and/or the Board Executive Secretary and presented for approval in closed session by the Board. A minute book of closed sessions shall be maintained by Board Counsel with a copy to be kept and secured by the Board Executive Secretary. Closed session minutes shall be kept confidential and may be released by the Board Chair or the Chief Executive Officer only after receiving advice of Board Counsel.

Reviewed by Gov/Leg Committee: 04/13/05
Approved by the Board of Directors: 4/28/05
Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 10/12/10
Approved by the Board of Directors: 11/04/10
Reviewed by the Gov/Leg Committee: 2/09/11
Approved by the Board of Directors: 2/24/11
Reviewed by the Gov/Leg Committee: 10/10/12, 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

(Attachment "A")
Tri-City Medical Center

Name of Committee
Date_____
Time_____
DRAFT

Members Present: Directors _____, _____, _____, Community Members, _____, _____, _____

Non-Voting Administrator Members: _____, _____, _____

Others Present: **Absent:**

Topic	Discussions/ Recommendations	Action or Recommendation to Board	Person(s) Responsible
1. Call to Order.	Chairman _____ called the meeting to order at _____.		
2. Comments by members of the public on any item of interest to the public before Committee's consideration of the item.	Chairman _____ invited comments from members of the public.	*There were no public comments.*	
3. Ratification of minutes-[date].	It was moved by _____ and seconded by _____ to approve the minutes of [date]. The motion carried _____.	*Minutes ratified*	
4. New Business			
A. Topic	**Motion/Recommendation**	*Send recommendation to Board for approval*	Chair

Topic	Discussions/ Recommendations	Action or Recommendation to Board	Person(s) Responsible
5. Motion to go into Closed Session.	_____ moved and _____ seconded and it was unanimously approved to go into Closed Session at [time].		Chair
a. Conference with legal council Anticipated Litigation (Authority: Government Code section 54956.9 (b) (1 matter)			
6.			
7. Open Session			
8. Report from Chairperson on Any action taken in closed Session (Authority: Government Code, Section 54957.1)			
9. Comments by committee Members.			
10. Date of next meeting.			
11. Adjournment			Chair

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
Physician Recruitment Proposal – Pulmonary / Critical Care

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

Physician Name: Malaygiri Aparnath, M.D.
Areas of Service: Pulmonary / Critical Care

Key Terms of Agreement:

Effective Date:	February 1, 2018 or the date Dr. Aparnath 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 Pulmonary/Critical Care
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:	$340,000 annually ($680,000 for two-years with a two-year forgiveness period)
Sign-on Bonus:	$15,000
Start-Up Cost:	$65,000 (Not To Exceed)
Total Not to Exceed:	$760,000 (Loan Amount)

Unique Features: Malaygiri Aparnath, M.D. will share space within the office of Drs. Yamanaka and Corona in Oceanside, CA.

Requirements:

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

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

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Steve Dietlin, Chief Executive 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 $760,000 in order to facilitate this Pulmonary/Critical Care physician practicing medicine in the communities served by the District. This will be accomplished through an Independent Physician Recruitment Agreement (not to exceed a two-year income guarantee with a two-year forgiveness period) with Dr. Malaygiri Aparnath.

Malaygiri J. Aparnath, M.D.
9300 Campus Point Dr, MC 7381
La Jolla, CA92037-7381
E-mail: maparnathmd@gmail.com; maparnath@ucsd.edu
Cell Phone: 714 478 4031

Education

Fellowship 07/2013 – 06/2016
Pulmonary Disease and Critical Care Medicine
Winthrop-University Hospital, Mineola, NY
Clinical Campus, Stony Brook University School of Medicine

Residency 07/2004 – 06/2007
Internship & Residency, Internal Medicine
Winthrop-University Hospital, Mineola, NY
Clinical Campus, Stony Brook University School of Medicine

Medical College 09/1994 – 08/2000
B. J. Medical College
Gujarat University
Ahmedabad, Gujarat, India
Degree: M.B.B.S. (Bachelor of Medicine & Bachelor of Surgery)

Residency Status

USA Citizen

Examinations and Certifications

ABIM Critical Care Medicine	10/2016
ABIM Pulmonary Diseases	10/2015
ABIM Internal Medicine	08/2007
ECFMG Certification	11/2003
USMLE Step III	08/2006
USMLE Step II	09/2003
USMLE Step I	02/2003

Professional License and Memberships

New York State Medical License # 260488, Active
California State Medical License # A 105370
Connecticut State Medical License
American College of Chest Physicians (ACCP)
American Thoracic Society (ATS)

Academic Appointments

Assistant Clinical Professor of Medicine 01/2011 -06/2013
University of California, San Francisco
San Francisco, CA

Professional Experience

Associate Physician Pulmonary Diseases, Critical Care and Sleep Medicine University of California -San Diego (UCSD) La Jolla, CA	07/2016- Todate
Pulmonary Diseases and Critical Care Medicine Fellow Winthrop University Hospital Mineola, NY	07/2013- 06/2016
Academic Hospitalist Assistant Clinical Professor of Medicine Community Regional Medical Center, UCSF – Fresno Fresno, CA	01/2011 - -6/2013
Internist Southern California Permanente Medical Group (SCPMG) La Mesa, CA	01/2009 – 12/2010
Academic Hospitalist Assistant Director, Department of Medicine Hartford Hospital Hartford, CT	07/2007 - 12/2008
Internal Medicine Internship and Residency Winthrop University Hospital Mineola, NY	07/2004 - 06/2007
Medical Officer/Hospitalist N.M.V. Hospital Rajkot, Gujarat, India	08/2000 - 08/2001

Teaching and Leadership

Winthrop University Hospital, New York

New York State Thoracic Society Meeting, NY, Feb. 2015
Best research project: *Comparison of In-hospital Length of Stay between Patients Taking Rivaroxaban and Conventional Anticoagulation for Newly Diagnosed Venous thromboembolism*

Cooperative Ultrasound Project (CUSP), NY, July 2015
Course faculty: hands-on instructor for critical care ultrasound course for all Critical Care and Pulmonary/Critical Care fellows in greater NY region

Simulation Center, July 2014-Present
Hands-on teaching for junior fellows, internal medicine residents and medical students in courses such as central venous catheterization and medical student skills course

Sign-out teaching sessions, July 2014-Present
Multiple brief lectures for medical residents and students on various topics such as interpretation of chest x-ray, congestive heart failure and many more.

Internal Medicine Residency Program, UCSF-Fresno, CA

First prize, UCSF-Fresno Research Fair, June 2013: *The Utility of Inferior Vena Cava (IVC) filter placement in management of Venous Thromboembolism*

Creation of an online "article bank" for Internal Medicine residents to serve as easy online resource tool pertaining to acute inpatient medicine: January 2013

Initiated and ensured that viewing images with a radiology attending became the standard of care for all post call Internal Medicine residents and hospitalist attending

In order to encourage active learning and assess the learning of the internal medicine residents, I used selected MKSAP questions prior to and after their inpatient ward rotations

Taught monthly at morning reports, noon lectures and journal clubs

Participation in various QI committees

Southern California Permanente Medical Group (SCPMG), CA

Among top 10% of internists based on various core measures at SCPMG, 2009 & 2010

Hartford Hospital, CT, July 2007- Dec 2008

Participated in Rapid Response Team (RRT) committee and helped implement RRT service

Research Experience

Winthrop-University Hospital, Mineola, NY:

A Phase 3 Randomized Double-blind Study Comparing TR 701 FA and Linezolid in Ventilated Gram-positive Nosocomial Pneumonia
Study Period: 05/2015 to Current,
Principal Investigator: G. Nair

A Prospective, Randomized, Double-Blind, Placebo-Controlled, Multicenter Study to Evaluate the Safety and Efficacy of BAY 41-6551 as Adjunctive Therapy in Intubated and Mechanically-Ventilated Patients with Gram-Negative Pneumonia
Study Period: 03/2013
Principal Investigator: G. Nair

A Randomized, Double–blind, Placebo–Controlled, Phase-3 Study to Assess the Safety and Efficacy of ART-123 in Subjects with Severe Sepsis and Coagulopathy
Study Period: 12/2012 to Current
Principal Investigator: J. Mathew

A Phase 2, Proof of Concept Study to Collect the Safety and Efficacy Data for Rifalazil in Treatment of Clostridium difficile-Associated Diarrhea
Study Period: 06/2005 to 09/2005
Principal Investigator: N. Berbari
Study period: 2/2005 to 5/2005

Selected Lectures:

Interpretation of Chest Tomography, Noon Conference, Winthrop-University Hospital, Jul 2015
Approach to Aneurysmal Subarachnoid Hemorrhage, Noon Conference, Winthrop-University Hospital, Jan 2015
EBUS: A Concise Review, Noon Conference, Winthrop-University Hospital, Dec 2014
Sarcoidosis: A Comprehensive Review, Noon Conference, Winthrop-University Hospital, Aug 2013
Providing High Value Cost Conscious Care, IM Noon Conference, UCSF-Fresno, Sep 2012
Myxedema Coma and Thyroid Emergencies, EM-IM Conference, UCSF-Fresno, Sep 2011

Publications/Presentations:

Non-thrombotic Pulmonary Embolism, (*Invited to author Book Chapter)
Book: Pulmonary Embolism, edited by Çobanoğlu. ISBN # 978-953-51-0233-5,
V. Balasubramanian, **M. Aparnath**, J. Mathur
Date of Publication: 03/14/2012
DOI: 10.5772/32700

Comparing Length of Stay between Patients Taking Rivaroxaban and Conventional Anticoagulants for Treatment of Venous Thromboembolism
AK Desai, A. Desai, R. Calixte, **M. Aparnath,** A. Hindenburg, S. Salzman, J Mathew
Lung. 2016 Aug;194(4):605-11
Date of Publication: 05/18/2016
DOI: 10.1007/s00408-016-9898-8

Diagnostic Accuracy and Complication Rates After Implementation of an Electromagnetic Navigation Bronchoscopy Program at an Academic Teaching Hospital
D.Osahan; M.**Aparnath;** A.K.Desai; D.Kurbanov; S. Salzman MD;
S.Chawla; P.Spiegler; and J.Mathew
Session Title: Procedures 1- EMN/BT/Rigid/Cryo

Session Type: Original Investigation Poster

Chest 2016;Volume 150, Issue 4, Supplement, Pages 1006A;

http://dx.doi.org/10.1016/j.chest.2016.08.1112
http://www.sciencedirect.com/science/journal/00123692/150/4/supp/S
Date of Publication: 10/26/2016 at ACCP in Los Angeles, CA

The HAS-BLED Score Identifies Patients with Acute venous Thromboembolism with High Risk of Major Bleeding Complications During the First Six months of Anticoagulant Treatment
Recommended Reading from Winthrop University Hospital Fellows
Am J Respir Crit Care Med.
A.K. Desai[1], J.Pang[1], **M.Aparnath**[1] and J.Ilowite
Date of publication: March 18, 2016 (Online)
DOI: 10.1164/ajrccm.201508-1565RR

A Rare Presentation of Central Airway Obstruction and Cardiac Arrest Secondary to Megaesophagus from Superior Mesenteric Artery Syndrome
G. Aristide, **M. Aparnath,** AK Desai, A. Matela, J. Mathew
ID # 8252, Critical Care Sessions I
Affiliate Case Report- Slide Presentation
ACCP-Chest, Montreal, Quebec, Canada October 25, 2015

Comparison of In-Hospital Length of Stay Between Patients Taking Rivaroxaban and Conventional Anticoagulants for Treatment of Newly Diagnosed Venous Thromboembolism
A.K.Desai, A.Desai, R. Calixte, **M. Aparnath,** A. Hindenburg, J. Mathew
Publication ID# A4871, Thematic Poster Session
ATS - Denver, Colorado, May 19, 2015

Failure to Optimize Cardiac Filling Prior to Adding a Second Vasopressor for Shock is Associated with a Longer Duration of Mechanical Ventilation
A. Desai, **M. Aparnath,** M. Niederman
Publication ID # A3996, Poster Discussion Session
ATS, Denver, Colorado, May 19, 2015

Bilateral Upper Lobe Atelectasis and Acute Respiratory Failure after Bronchial Thermoplasty
M. Aparnath, G. Aristide, R. Lieberman, D. Baram, J. Mathew
Publication # A4448, Case Reports in Interventional Pulmonology
ATS, San Diego, California, May 20, 2014

The Utility of Inferior Vena Cava (IVC) Filter Placement in Management of Venous Thromboembolism
M. Aparnath, H. Lee, B. Khatri, C. Venugopal, V. Balasubramanian
Annual Research Poster Presentation
UCSF-Fresno 06/2013

Awards and Honors

First prize - Oral Presentation for Affiliate Case Report
Megaesophagus – Size does matter!
ACCP-Chest, Montreal, Quebec, Canada –October 25, 2015

First prize - Annual Research Poster Presentation and Quality & Improvement Project
The Utility of Inferior Vena Cava (IVC) Filter Placement in Management of Venous Thromboembolism
UCSF-Fresno, Annual Research Poster Presentation 06/2013

Specialized Procedure Skills

Endobronchial Ultrasound (EBUS) with transbronchial needle aspiration (TBNA)
Flexible video and fiberoptic bronchoscopy
Endobronchial and transbronchial biopsy
Navigational Bronchoscopy – SuperDimension ENB
Endotracheal Intubation by Direct Laryngoscopy
Video Laryngoscopy assisted intubation for difficult airway (Glidescope)
Bronchoscopic intubation
Critical Care Ultrasonography: Lung, Pleural, Vascular and Basic Echocardiography
Central Venous Catheter placement
Hemodialysis catheter placement
Swan-Ganz catheter placement
Thoracentesis
Chest tube placement
Lumbar Puncture
Paracentesis
Therapeutic Hypothermia protocol

Volunteer Activities

Tzu-Chi International Medical Association: Volunteered in Mobile Clinic, Fresno, April, 2012

Pulse Polio Immunization Day, Gujarat, India: (1995-1999): Supervised a team of health care workers to provide oral polio vaccine to children; volunteered twice a year for five consecutive years (1995-1999). This led to 80 million children getting oral polio vaccine in a single day. In March 2014, WHO declared that India has successfully eradicated wild poliovirus

Language Proficiency

English, Hindi and Gujarati

Professional Correspondence

Email: maparnath@ucsd.edu; maparnathmd@gmail.com
Mailing address: 9917 Fox Valley Lane, San Diego, CA -92127
Phone: 001 714 478 4031

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2018

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m. Closed Session to begin at 1:30 p.m. and again immediately following Open Session, if needed

- January 25, 2018 (Last Thursday)
- February 22, 2018 (Last Thursday)
- March 29, 2018 (Last Thursday)
- April 26, 2018 (Last Thursday)
- May 31, 2018 (Last Thursday)
- June 28, 2018 (Last Thursday)
- July 26, 2018 (Last Thursday)
- August 30, 2018 (Last Thursday)
- September 27, 2018 (Last Thursday)
- October 25, 2018 (Last Thursday)

No Meeting in November due to Holiday

- December 13, 2018 (Second Thursday in December)

Special Board of Directors Meeting – TBD
Strategic Planning Workshop

Special Board of Directors Meeting –TBD.
Strategic Planning Update

Special Board of Directors Meeting – TBD
Closed Session to review biennial quality reports

Special Board of Directors Meeting – June 14, 2018 – 6:00 p.m.
Budget Workshop

Special Board of Directors Meeting –TBD
Closed Session to review biennial quality reports

BOARD COMMITTEE RECOMMENDATIONS

Audit, Compliance & Ethics Committee

- Reduce community members to a maximum of three and the option for a subject matter expert who would not be a voting member and whose term would not expire.

- Amend meeting schedule to six meetings per year as follows: January, April, July and October for the compliance component; May and September for the audit component.

Community Healthcare & Alliance Committee

- Recommend no changes at this time.

Employee Fiduciary Subcommittee

- Amend meeting schedule to meet quarterly beginning in January 2018; agree to call additional meeting if needed.

Finance, Operations & Planning Committee

- To be considered at the next meeting.

Governance & Legislative Committee

- Reduce community members to a maximum of two and the option for a subject matter expert who would not be a voting member and whose term would not expire.

- Reduce Physician members to a maximum of two.

- Amend meeting schedule to meet quarterly beginning in January 2018; agree to call additional meeting if needed.

Human Resoure

- Reduce community members to a maximum of three following the expiration of the fourth community member's term.

- Amend meeting schedule to meet quarterly beginning in January 2018; agree to call additional meeting if needed.

Professional Affairs Committee

- To be considered at the next meeting.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
October 11, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 10/27/2017 – 9/30/2019)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 10/27/2017 through 9/30/2019:

- **KABRA, Ashish MD /Cardiology (Blue Coast Cardiology)**
- **KINNAIRD, Patrick M.D. / Anesthesiology (ASMG)**
- **SMITH, Ryan A. M.D. / Cardiology (Carr Cardiology)**
- **WANG, Huan M.D. / Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
October 11, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 10/31/2017.

- **COOPERMAN, Andrew MD** — **Orthopedic Surgery**
- **DELGADO, George MD** — **Family Medicine**
- **HARTMAN, Andrew MD** — **Orthopedic Surgery**
- **PARKER, Sherine MD** — **Pediatrics**
- **SHOWAH, Henry MD** — **Emergency Medicine**

ADDITIONAL EQUIPMENT USE REQUEST

The following practitioners have previously met the initial criteria for the Robotics bundle and have turned in the certificate to utilize the Xi Robotics Equipment:

- **GRAMINS, Daniel M.D.** — **Cardiothoracic Surgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
October 11, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 10/27/17, unless otherwise specified)

• D'SOUZA, Geehan MD	Plastic Surgery
• EBRAHIMI ADIB, Tannaz MD	OB/GYN
• GABRIEL, Steven MD	Emergency Medicine
• GARNER, Darin MD	Emergency Medicine
• LEE, Jeanette MD	Anesthesiology
• MCGRAW, Charles MD	Radiology
• MILLER, Jessica MD	Emergency Medicine
• WARDA, Gregory MD	Neonatology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
October 11, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 11/01/2017 -10/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/01/2017 through 10/31/2019, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **AMANI, Ramin MD/Pediatrics/Active**
- **BHASKER, Kala MD/Family Medicine/Refer and Follow**
- **BUI, Hanh MD/Cardiology/Provisional**
- **HALIM, Neil MD/Family Medicine/Refer and Follow**
- **HALL, Andrew MD/Internal Medicine Medicine/Refer and Follow**
- **HARDY, Tyrone MD/Neurosurgery/Active**
- **LLOYD, Amanda MD/Dermatology/Refer and Follow**
- **MANNIS, Steven MD/Clinical Research/Refer and Follow**
- **MURPHY, Carmel MD/Pediatrics/Active**
- **PARK, Ronald MD/Pediatrics/Active**
- **PASHMFOROUSH, Mohammad MD/Cardiology/Active**
- **SAINI, Arvind MD/Ophthalmology/Provisional**
- **SHAHIDI-ASL, Mahnaz MD/Pathology/Active**

UPDATE TO PREVIOUS REAPPOINTMENT:

- **HOSALKAR, Harish MD/Orthopedic Surgery/Active**

RESIGNATIONS: (Effective date 10/31/2017 unless otherwise noted)

Automatic:

Attachment B

- **PLAXE, Steven MD/OB/GYN**

Voluntary:

- **NURSE, Lesley MD/OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
October 16, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
October 16, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 10/27/17, unless otherwise specified)

- COWAN, John PA-C — Allied Health Professional
- SCHILLINGER, Stephan PA-C — Allied Health Professional

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
October 16, 2017

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following AHPs have met the basic requirements of staff and are therefore recommended for appointment effective 10/27/2017 through 7/31/2019:

- **SAVIC, Jessica PA-C / Allied Health Professional - Neurology (The Neurology Center)**
- **TEBON, Renee PA-C / Allied Health Professional – Orthopedic Surgery (Orthopaedic Specialists of North County)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
October 16, 2017

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following AHPs have met the basic requirements of staff and are therefore recommended for appointment effective 10/27/2017 through 7/31/2019:

- **SAVIC, Jessica PA-C / Allied Health Professional - Neurology (The Neurology Center)**
- **TEBON, Renee PA-C / Allied Health Professional – Orthopedic Surgery (Orthopaedic Specialists of North County)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
October 16, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
October 16, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 10/27/17, unless otherwise specified)

• **COWAN, John PA-C** Release from Proctoring:	**Allied Health Professional** Assist during Robotic Surgery (daVinci) and Xi
• **SCHILLINGER, Stephan PA-C** Release from Proctoring:	**Allied Health Professional** Repair of Complex Lacerations, Paracentesis & Thoracentesis, Reduction of Joints, Central IV Access & Lumbar Puncture

Tri-City Medical Center

Delineation of Privileges

Radiology 10/17

Provider Name:

Request	Privilege	Action MSO Use Only

CRITERIA:
The Department of Radiology consists of physicians who have a contractual relationship with the hospital to practice Radiology and are board certified, or board eligible and actively progressing towards certification, in Diagnostic Radiology and/or Nuclear Medicine by the American Board of Radiology.

SITES:
All privileges may be performed at:

- 4002 Vista Way, Oceanside, CA
- 2095 W. Vista Way, Suite 111, Vista
- 2095 W. Vista Way, Suite 101, Vista

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Admit Patients ___

___ Consultation, including via telemedicine (F) ___

___ History and physical examination, including via telemedicine (F) ___

Proctoring: Six (6) cases

___ **General Diagnostic Radiology and Fluoroscopy (All Diagnostic Radiologists may remotely interpret (teleradiology) diagnostic images.)** - 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. ___

Initial:— Board certification or board eligible and actively progressing towards certification
Proctoring:— Twenty-five (25) representative blend of cases
Reappointment:— Fifty (50) representative blend of cases

Arthrography/Arthrocentesis/Injection

Breast biopsy

Computed tomography

General diagnostic/fluoroscopy

Hysterosalpingography

Lymphocintigraphy

Magnetic resonance imaging/spectroscopy

Mammography

Nuclear medicine (all routine)

Positron Emission Tomography (PET)

Radionuclide cysternography and shunt studies

Sialography

Ultrasonography/hysterosonography

Provider Name:

Request	Privilege	Action MSO Use Only

Vascular duplex ultrasound

Venography

Lumbar or C1-2 puncture/myelography

___ **Special Nuclear Medicine Procedures:** ___
Initial:— Board certification or board eligible and actively progressing towards certification
Proctoring—: Three (3) representative blend of cases
Reappointment—: Five (5) representative blend of cases

___ I-131 Therapy for tyroid cancer or for hyperthyroidism ___

___ Radionuclide therapy low dose < 33 mCi ___

___ Radionuclide therapy high dose > 33 mCi ___

___ P-32 Intravenous or intracavitary ___

___ Immune imaging (Zevalin, etc.) ___

___ **Teleradiology (for Stat-Rad only; all non-Stat-Rad practitioners use General Diagnostic Radiology and Fluoroscopy privileges.)** - 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. ___

Initial:— Twenty-five (25) cases General Radiology and ten (10) ultrasound, ten (10) tomography, ten (10) MRI, and ten (10) nuclear medicine.
Proctoring—: Twenty-five (25) representative blend of cases
Reappointment: —Fifty (50) representative blend of cases

Computed tomography

General radiology

General nuclear medicine

Magnetic resonance imaging

Ultrasound

___ **PERIPHERAL VASCULAR INTERVENTIONAL PROCEDURES** (Refer to Medical Staff Policy # 8710-504 for Initial, Proctoring, and Reappointment Criteria) ___

___ Peripheral Angiography - 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. ___

Carotid

Cerebral

Extremity

Pulmonary

Thoracic

Provider Name:

Request	Privilege	Action MSO Use Only

Visceral

___ Peripheral Intervention - 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. ___

Angioplasty

Chemoembolization

Drug infusion

Embolization

Stent graft

Stent placement

Thrombolysis

___ Venography and Venous Intervention - 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. ___

IVC filter

Stent

Tissue plasminogen activator (tPA)

Transjugular Intrahepatic Portosystemic Shunt (TIPS)

Venous Access Procedures (Ports, Tunneled Lines, Midline catheters)

Venous Sampling

Venous Thrombolysis

INTERVENTIONAL PROCEDURES:
Unless specified by policy, the following criteria shall apply for the following interventional procedures:
Initial - Completed fellowship training in interventional radiology or diagnostic radiology with appropriate experience and acceptable outcomes.
Proctoring - See below
Reappointment - Twenty (20) representative blend of cases

___ Endovascular AAA Repair ___
(Refer to Medical Staff Policy # 8710-503 for Initial, Proctoring, and Reappointment Criteria)

___ Vertebral Augmentation ___
(Refer to Medical Staff Policy # 8710-534 for Initial, Proctoring, and Reappointment Criteria)

___ Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders (including: Coil Occlusion of intracranial aneurysms, treatment of AV Malformation or Fistulas) ___
(Refer to Medical Staff Policy # 8710-530 for Initial, Proctoring, and Reappointment Criteria)

___ Genito-Urinary Intervention (includes Nephrostomy, Ureteral Stent, Stone Removal, Tract Dilation, Endopyelotomy, etc.) ___
Proctoring: Two (2) cases

Tri-City Medical Center

Delineation of Privileges

Radiology 11/14

Provider Name:

Request	Privilege	Action MSO Use Only

___ GI/Biliary Intervention (includes Gastrostomy/Enterostomy, GI Stent, Biliary Drain/Stone removal, Dilation, Stent, etc.) ___
Proctoring: Two (2) cases

___ Biopsy/Drainage Intervention (includes all biopsy, aspiration and drainage procedures) ___
Proctoring: Two (2) cases from either this privilege or Tumor Ablation Intervention

___ Tumor Ablation Intervention (includes ablation by injection or Rediofrequency probe, Brachytherapy with implantable seeds) ___
Proctoring: Two (2) cases from either this privilege or Biopsy/Drainage Intervention

___ **PAIN MANAGEMENT CORE PRIVILEGES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541 ___
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.

Epidural Procedures (i.e. Translaminar and transforaminal epidural injections (cervical, thoracic, lumbar), and epidural blood patch)

Joint injections (i.e. Facets, SI joint)

Sympathetic blocks

Chemo denervation (i.e. Stellate Ganglion block, peripheral nerve block, Botox injections, Intra-muscular phenol injections)

___ **PAIN MANAGEMENT SPECIAL PROCEDURES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541 ___

___ Discograms ___

___ Implantables ___

___ Intradiscal Electrothermal Annuloplasty ___

___ Radiofrequency Thermocoagulation Lesion Ablation (RFTC) ___

___ **SEDATION PRIVILEGES:** (Per Medical Staff policy #8710-517 for all initial, proctoring, and reappontment credentialing criteria) ___

___ Deep Sedation ___

___ Moderate Sedation ___

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Radiology 11/14

Provider Name:

Request	Privilege	Action MSO Use Only

_____

Division/Department Signature

_____

Date

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
October 10, 2017

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Director Leigh Anne Grass, Dr. Hamid Movahhedian, Joe Quince, Salvador Pilar, Dr. Martin Nielsen, Dr. Gene Ma, Virginia Carson, Gwen Sanders
Non-Voting Members Present:	Kapua Conley, COO; Sharon Schultz, CNE; Norma Braun, CHRO; Carlos Cruz, CCO; Esther Beverly, VP of HR
Others Present:	Frances Carbajal, Carmela Ford, Kandace Mccrae, BB&T; Denise Hujing, BB&T
Members Absent:	Steve Dietlin, CEO

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 October 10, 2017. Director Reno moved with agenda sequence change and Gwen Sanders seconded the motion. The motion was carried unanimously.	Start agenda sequence with 6.d. Dr. Kellett will need to exit the meeting early due to a personal apt.	Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the September 12, 2017 meeting. Director Reno moved with correction and Dr. Movahhedian seconded the motion. The motion was carried unanimously.	Correction- 9.12.17 HRC agenda to reflect as follows: 6.c. Ginny Carson does not wish to be appointed to a second term on the Employee Fiduciary Retirement Subcommittee due to her second term on HRC will end in 2018.	Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
		This committee recommends Mrs. Carson stay on the Employee Fiduciary Retirement Subcommittee until her term with HRC ends. Mrs. Carson agrees.	
5. Old Business	None		
6. New Business			
a. Review Employee Benefits	Denise Hujing and Kandace Mccrae from BB&T presented TCHD's Benefits program overview. Norma Braun, CHRO explained in detail current and proposed coverage changes for 2018. Proposal includes HMO copays for outpatient services; PPO copay increases, adding a three tier prescription drug copay and standardizing current plan. The committee reviewed and discussed comparable market data, employee and TCHD's financial impact as well as possible copay modifications. Director Reno called for a motion to approve the proposed benefit changes with three tier prescription copayment deduction modification from proposed $75.00 to $50.00. Director Grass moved and Director Reno seconded the motion. The motion was carried with majority vote- Director Reno, Director Grass, Sal Pilar, Ginny Carson and Dr. Movahhedian in favor. Gwen Sanders, Dr. Martin Nielsen and Joe Quince opposing.	Director Reno requests a copy of the Benefits renewal proposal grid.	Norma Braun
b. Policy Discussion/Action Policy 8610-433 Paid Time Off Program	The Committee reviewed Policy 8610-433. Director Reno called for a motion to send Policy 8610-433 with renewal dates at the end of the policy in addition to the first page to the Board of Directors for approval. Ginny Carson moved and Dr. Movahhedian seconded the motion. The motion was carried unanimously.	Policy 8610-433 to be sent to Board of Directors for approval.	Norma Braun

Topic	Discussion	Action Follow-up	Person(s) Responsible
Policy 8610-TBD Annual Leave Bank/ Extended Leave Bank	The Committee reviewed Policy 8610-TBD. Director Reno called for a motion to send Policy 8610-TBD with renewal dates at the end of the policy in addition to the first page to the Board of Directors for approval. Ginny Carson moved and Dr. Nielsen seconded the motion. The motion was carried unanimously with Gwen Sanders opposing.	Policy 8610-TBD to be sent to Board of Directors for approval.	
c. Manager and Director Roles	Nursing Directors vs. Managers overstaffing inquiry. Discussed different levels of job descriptions.	Director Reno requests samples of TCHD department organization charts	Director Reno
d. Leadership Development Plan	Committee discussion regarding future leadership development planning; career ladder process, internally post requisitions first, 2018 basic ED for leaders and succession planning.		Director Reno
e. Nurse/Allied Health Employee Forums	Suggest all employee forums twice a year. Discussion of how Benefits have been presented to employees through informational sessions, Brain Smart videos offered online and distribution of detailed booklets with all changes.		Director Reno
f. Review Quarterly Work Plan Draft	The newly drafted Work Plan to reflect new quarterly meeting schedule was reviewed & discussed.		Director Reno
7. 2017 Work Plan	The current 2017 Work Plan was reviewed & discussed.	HRC Meeting to be held quarterly unless need to meet prior to scheduled date is deemed.	Director Reno
8. Committee Communications	Director Reno inquired on the Employee Health & Wellness Program status. Norma Braun, CHRO explained new program in partnership with AHA on hold during Employee Health leadership search. Sharon Schultz, CNE informed the committee of newly established TCHD/AHA walking group in support of employee overall health & wellness ongoing efforts.		Director Reno
9. Date of next meeting	**December 12, 2017**		Director Reno

Topic	Discussion	Action Follow-up	Person(s) Responsible
10. Adjournment	Director Reno adjourned the meeting at 2:05 p.m.		Director Reno

Tri-City Medical Center 2018
Benefit Program Overview
Plans Effective January 1, 2018 (10.18.17)

Coverage	Current Plan	Change for Plan Year 2018	% Change	Increase/decrease from last fy (dollars)
Medical (UHC Option 8b)				
- UHC Adv HMO/Acu/Chiro	HMO Plan Design: - Outpatient surgery - No Charge - X-Ray Lab - No Charge - Hospitalization - No Charge (waived at TCMC) - Chiropractic/Acupuncture - $10 Copay	HMO Plan Design Changes: - Outpatient surgery - $100 Copay - X-Ray Lab - $15 Copay - Hospitalization $250 Copay (waived at TCMC) - Chiropractic/Acupuncture $20 Copay	5.59%	$797,119
- UHC Select+ PPO	PPO Plan Design: - $20 Specialist Copay - Out-of-Pocket $4,000 Ind/$12,000 Family - Coinsurance 40%	PPO Plan Design Changes: - $40 Specialist Copay - Out-of-Pocket $5,000 Ind. /$15,000 Family, change to out-of-network only - Coinsurance 50%, change to out-of-network only	7.45%	$174,770
- Optum Rx (HMO & PPO)	Prescription Drug: - Prescription Drug Copays: $15/$35 - Step Therapy (Basic)	Prescription Drug: - Prescription Drug Copays: $15/$35/$50 (specialty 25%, minimum $100, maximum $250) - Step Therapy (Broaden) - Mandatory Generic	13.51%	HMO: $170,711 PPO: $22,632
Dental				
- DeltaCare USA DHMO		Renewing Current Plan	5.00%	$6,757
- Delta ASO PPO (with claims)		Renewing Current Plan PPO Enhancements (contingent on going paperless; employees can opt-in for paper): - Cost Estimator Tool - Smileway Wellness Benefit	0.00%	$0
Vision				
- VSP Fully-Insured		Renewing Current Plan	-0.88%	-$1,521
Life & Disability				
- Hartford Basic Life		Renewing Current Plan	0.00%	$0
- Hartford AD&D		Renewing Current Plan	0.00%	$0
- Hartford NSRP LTD	- 60%/70% All Sources - 3 year Own Occupation	Standardizing Contract - Replaces 70% All Sources to 60% (standard plan design) - Reduce 3 year own occupation period to 2 year	0.00%	$0
- Hartford Survivor Income		Renewing Current Plan	0.00%	$0
- Hartford Supplemental Life		Renewing Current Plan	0.00%	$0
- Hartford Voluntary Accident		New Benefit		
- Hartford Voluntary Critical Illness		New Benefit Hartford SubsidizingTechnology ($10,000 for 2018 plus 3% of premium, Value $24,000+/year)		
EAP				
- Magellan EAP		Renewing Current Plan	-12.78%	-$7,600
ArmadaCare				
- Diamond Plan		Renewing Current Plan	-12.00%	-$50,028
Leave of Absence Management Sy	Administered in house	Outsourced to FMLASource at No Cost to TCMC. $63,641 Annual Value.		$0

Current Annual Premium	Renewal Premium (without additional savings)	Renewal Increase (without additional savings)	
$20,919,339	$22,032,179	5.32%	$1,112,840
	Renewal Premium (with additional savings below)	**Renewal Increase (with additional savings)**	
	$21,495,479	**2.75%**	**$576,140**

Tri-City Medical Center
Oceanside, California

Administrative Policy ~~Manual~~
Human Resources

ISSUE DATE: 05/86

SUBJECT: Alcohol and Drug Testing for Employees

REVISION DATE: 02/11, 04/12

POLICY NUMBER: 8610- 429

Department Approval:	**09/17**
Administrative Policies & Procedures Committee Approval:	**10/17**
Human Resources Committee Approval:	**~~04/15~~09/17**
Board of Directors Approval:	**04/15**

A. **PURPOSE:**

1. It is the goal of Tri-City Healthcare District (TCHD) to create a healthy and safe work environment in order to deliver the best and most cost-efficient service. It is the responsibility of TCHD employees to cooperate in efforts to protect the life, personal safety, and property of co-workers, patients, and members of the public. Substance abuse has been found to be a contributing factor to absenteeism, substandard performance, increased potential for accidents, poor morale, and impaired public relations. It is the goal of this policy to prevent substance abuse in the workplace. Employees must take all reasonable steps to abide by and cooperate in the implementation and enforcement of this policy.

B. **POLICY:**

1. Alcohol and/or drug abuse on the job will not be tolerated for any employee.
2. Alcohol or drug use off the job that negatively affects an employee's performance or negatively impacts ~~TCMC~~**TCHD**, its employees, staff, patients or its mission, in any way, will not be tolerated.
3. Violation of this Policy may result in disciplinary action, up to and including termination of employment.
4. This Policy sets forth the procedures to be followed where reasonable suspicion exists that an employee may be under the influence of drugs or alcohol.
   a. Reasonable Suspicion means a belief based upon objective facts sufficient to lead a reasonably prudent person to suspect that an employee is under the influence of drugs or alcohol so that the employee's ability to perform the functions of the job is impaired or so that the employee's ability to perform his/her job safely is reduced. For example, any of the following, alone or in combination, may constitute reasonable suspicion:
      i. Changes to employee's manner or disposition;
      ii. Changes to employee's appearance, including, but not limited to glassy eyes, eye dilation, shaking, or erratic movement;
      iii. Changes in an employee's behavior, including involvement in verbal or physical altercations;
      iv. Unsteady walking and movement;
      v. Slurred speech or alcohol odor on breath;
      vi. An accident involving the employee;
      ~~b.~~**vii.** An employee's possession of drugs or alcohol;
      ~~c.~~**viii.** Failure to follow TCHD's procedure for wastage of controlled drugs or an employee's abuse of TCHD's Pyxis Pharmacy override system; and/or
      ~~d.~~**ix.** Objective information obtained from another employee, law enforcement official, security service, or other person believed to be reliable.

C. **USE OF LEGAL/PRESCRIBED DRUGS:**

1. Using or being under the influence of any legally obtained drug while performing TCHD business or while in a TCHD facility is prohibited to the extent that such use or influence affects job safety or efficiency, or interferes with an employee's essential job functions.
2. No legal drug shall be possessed or used by any employee other than the employee for whom the drug was prescribed by a licensed medical practitioner. A legal drug shall be used only in the manner, combination and quantity prescribed.
3. If an employee is using a legal drug during work hours that could result in the employee being under the influence as defined above, it is the employee's responsibility to advise his/her supervisor of the use or influence of the prescription drug before beginning work and to advise his/her supervisor of the specific impairments that may result.
    a. The employee may work his/her assigned shift if his/her supervisor TCHD determines that the employee does not pose a safety threat and that job performance is not likely to be affected by use of the drug.
    b. The employee's supervisor will place the employee on paid Administrative Leave if the supervisor determines either:
        i. before the employee's shift starts, that the nature of the employee's position means that the risk that the employee may become under the influence while on duty is unacceptable; or
        ii. during the course of the shift, that the employee has come under the influence.
    c. Employees who are placed on paid Administrative Leave may be requested by TCHD to give their physician written authorization to provide information to TCHD regarding expected effects of prescribed medication.
        i. TCHD may consult with the prescribing physician to learn the expected effect of the drug and/or require a written statement from the physician that continued working will be safe and efficient.
        ii. Disclosures made to TCHD under an employee's written authorization will be confidential and will be disclosed to and used by TCHD staff only to the extent permitted by law.
    d. TCHD retains the right to direct an employee to submit to a fitness for duty examination by a physician selected by TCHD.
4. Marijuana is an illegal substance under federal law and will be treated as an illegal drug under this policy. California law does not prescribe that an employer must employ an individual who uses marijuana even for medicinal purposes. Accordingly, TCHD reserves the right to terminate the employment of any individual who reports to work under the influence of marijuana or who tests positive for marijuana

D. **DISCIPLINE:**

1. Employees who violate this policy shall be subject to disciplinary action up to and including termination. Discipline may be imposed regardless of whether an employee is charged with and/or convicted of a crime relating to any violation of this policy.
2. Conduct violating this policy includes, but is not limited to:
    a. Reporting for work or being at work under the influence of alcohol or drugs;
    b. The illegal use, possession, transfer, purchase or illegal sale, or the attempted illegal use, possession, transfer, purchase or illegal sale of drugs during work hours or while on TCHD premises;
    c. The use or attempted use of alcohol in any manner during work hours or while on TCHD premises;
    d. Using TCHD property or premises to manufacture alcohol or drugs;
    e. Criminal conviction for the use, possession, transportation, transfer, purchase, theft or sale of illegal drugs whether or not on TCHD premises;
    f. Failure to report in writing any conviction under D.2.e. within five days of such conviction;

g. Refusal to submit to a drug or alcohol test when requested to do so by a manager or lead Human Resources Officer; or his/her (designee).
h. Failure to provide, within 24 hours of a positive drug test, bona fide verification of a current valid prescription in the employee's name for any potentially impairing legal drug identified in the drug test.

3. Violations of this policy that may constitute criminal conduct will be reported to the appropriate law enforcement agency and State licensing agencies and the California Department of Public Health Services, as required by law.

E. PROCEDURES FOR ALCOHOL OR DRUG TESTING OF EMPLOYEES:

1. These procedures are to be used by Directors, managers, and supervisors for testing employees where they have a reasonable suspicion that the employee may be under the influence of alcohol and/or drugs.
   a. If a Director, manager, or supervisor has reasonable suspicion that an employee is under the influence of alcohol or drugs, or has otherwise violated this policy, the Director, manager or supervisor shall document the bases of suspicion. If possible, the Director/manager/supervisor shall ask another Director/manager/supervisor witness the behavior and independently document it.
   b. The Director/manager/supervisor shall then accompany the employee to a private office, room, or other area and advise the employee that his/her behavior or performance warrants a medical examination and alcohol and drug test.
   c. The examination and test will be conducted in the employee health department by the Employee Health Nurse, administrative coordinator or an emergency department physician. The Administrative Coordinator is to be contacted when Employee Health
2. If the employee agrees to an alcohol and drug test, the following procedures should be carried out.
   a. The employee shall be asked to read and sign an Authorization for Testing form and an Authorization for Release and Use of Testing Information (both forms are maintained by Employee Health); and
   b. If the results of the test(s) administered are negative or inconclusive no further action will be taken by TCHD with regard to the violation of this policy.
3. If the employee refuses to consent to a medical examination, alcohol and drug test, the following procedures should be carried out:
   a. The Director/manager/supervisor shall explain to the employee that the requested medical examination, alcohol and drug test is used to establish the employee's compliance with this policy and/or fitness to perform his/her job;
   b. The Director/manager/supervisor shall inform the employee that his/her refusal to consent to a medical examination, alcohol and drug test will be interpreted as a deliberate failure to comply with a reasonable request and the employee will be subject to discipline up to and including termination. The employee should also be advised that he/she will not be allowed to use evidence of alcohol or drug abuse as a mitigating factor regarding any discipline imposed for misconduct or unsatisfactory job performance; and
   c. The employee will be immediately placed on administrative leave if he/she refuses to consent to a medical examination and alcohol and drug test. If an employee refuses to submit to a medical exam and/or alcohol and drug test this refusal will not serve to reduce the discipline for misconduct or unsatisfactory job performance resulting from a positive test.
4. If the employee refuses to cooperate in the testing process in such a way that prevents completion of the test, or interferes with a test by adulterating or diluting the specimen, substituting the specimen with that from another person or sending an impostor to be tested, the employee will be subject to the same consequences as if he or she had been tested and the result had been positive.
5. If the drug or alcohol screen is positive, the employee will be placed immediately on administrative leave and arrangements will be made to transport the employee home.

a. If a positive drug screen identifies a legal drug, the employee may be requested to provide within 24 hours a bona fide verification of a valid current prescription in the employee's name for the drug identified in the drug screen.
b. A positive alcohol and/or drug test result will be confirmed.
c. A chain of custody of the tested blood, urine or other sample will be established and maintained by the testing clinic or laboratory.
d. Laboratory reports and/or test results shall not be placed in an employee's personnel file. Laboratory reports and/or the results shall be maintained in a separate confidential medical records file in the Employee Health Department. Laboratory reports and/or test results shall be disclosed only to individuals on a need to know basis and to the employee upon request.
e. Upon request the employee may have the original sample retested at an approved forensic accredited laboratory of their choice. This retest will be at the employee's expense.

F. **PROCEDURES FOR ALCOHOL AND DRUG TESTING OF APPLICANTS:**

1. As part of TCHD's employment screening process, applicants must pass a test for controlled substances, under the procedures described in Section E.2. of this Policy. The offer of employment is conditioned on a negative test result. Job announcements will contain notice of TCHD's drug testing policy and identify the positions subject to pre-employment testing.
2. A positive result for a drug and/or alcohol analysis may result in the applicant not being hired.
   a. If a drug screen is positive at a pre-employment physical, the applicant may be requested to provide within 24 hours a bona fide verification of a valid current prescription in the employee's name for the drug identified in the drug screen.
   b. If the applicant does not provide acceptable verification, or the drug may impair the applicant's ability to perform essential job functions, the applicant may not be hired.

G. **RELATION TO DISABILITIES:**

1. Nothing in this Policy shall affect TCHD's obligation to not discriminate and to reasonably accommodate those individuals with alcohol or drug dependencies, who have completed a rehabilitation program in accordance with applicable state and federal laws. Employees and applicants should be aware that none of these laws prohibit TCHD from taking disciplinary action against employees who are currently using illegal drugs, misusing legal drugs or abusing alcohol.
2. Employees who believe they have a drug or substance abuse problem should be aware of the counseling services that are available through TCHD's Employee Assistance Program ("EAP"). Information about EAP services is available in the Employee Handbook and from Employee Health.

H. **INSPECTION BASED ON REASONABLE SUSPICION OF POSSESSION OF ILLEGAL DRUGS:**

1. To promote an alcohol and drug free, safe, productive and efficient workplace, TCHD reserves the right to search or inspect all property which it owns or controls to determine the presence of alcohol or drugs.
   a. TCHD expressly reserves the right to inspect TCHD owned or controlled property including, but not limited to, buildings, break areas, lunch rooms, restrooms, loading docks, lockers, desks, filing cabinets, tool boxes, vehicles, packages, containers and other articles within the work area.
   b. TCHD shall neither physically search the person of an employee nor search the personal possessions of employees without freely given consent by the employee that is witnessed by the lead Human Resources official or his/her designee.
2. If the lead Human Resources Officer or his/her designee has reason to believe that an employee may have illegal drugs in his/her possession in an area not jointly or fully controlled by TCHD he/she shall notify the appropriate law enforcement agency.

PROCEDURES:

1. Employee Health Procedures provide detailed guidelines for testing listed in this policy and can be found in ~~the Health and Safety Manual, available in~~ Employee Health **& Wellness: Alcohol and Drug Testing Guidelines**. ~~(see 4.1.7)~~

J. **FORM(S):**

1. **Authorization for Testing Form**
2. **Authorization for Release and Use of Testing Information**

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

~~J.~~1. **Employee Health & Wellness: Alcohol and Drug Testing Guidelines**

Authorization for Testing Form

AUTHORIZATION FOR TESTING

Agreement to Submit to Drug and Alcohol Screen by Blood and Urine Tests

I have been informed that Tri-City Healthcare District (TCHD), based on my behavior and appearance, is concerned that I may be under the influence of drugs or alcohol, or may otherwise have violated TCHD's rules against drug and alcohol use, and that my ability to perform my job duties, is therefore, in question; and as a result, I have been requested to submit to a drug and alcohol screen.

I have been informed and I understand, that my agreement to submit to the requested alcohol and drug screens by blood and urine tests is completely voluntary on my part, and that I have the right to refuse to submit to the tests. I am aware and have been told, that my refusal to submit to the drug and alcohol screen by blood and urine tests may be grounds for disciplinary action against me, up to and including termination.

I have also been informed and am aware that the results of this drug and alcohol screen by blood and urine tests may be released to other TCHD officials, including but not limited to my supervisor as applicable, and that the results of such test(s) may form the basis for disciplinary action against me, up to and including termination.

With full knowledge of the above information, I have decided to voluntarily submit to the requested drug and alcohol screen by blood and urine tests, in recognition of this agreement, do sign this consent form.

Date:_____ Employee:_____

Date:_____ Witness:_____

Authorization for Release and Use of Testing Information

Tri-City Medical Center
4002 Vista Way, Oceanside, California 92056 (760) 724-8411

AUTHORIZATION FOR RELEASE AND USE OF TESTING INFORMATION

I have voluntarily agreed to submit to a drug and alcohol screen by blood and urine tests to be administered by Tri-City Healthcare District (TCHD). I hereby authorize the release of the results of the above-mentioned drug and alcohol screen by blood and urine tests to the Director for Human Resources, and such other TCHD officials and employees as the Director for Human Resources may determine it is necessary to disclose such information.

I understand the information so released to TCHD will be used to determine whether I was fit to perform my job duties, and/or whether I had violated TCHD's work rules concerning drug and alcohol use. TCHD Emergency Department and Laboratory Services, as applicable, only is authorized to disclose the results of my drug and alcohol screen, as described above, for 120 days after the date I executed this Authorization. I understand that I have a right to receive a copy of this authorization, and that one will be provided upon request.

Date:_____ Employee:_____

Date:_____ Witness:_____

Tri-City Medical Center
Oceanside, California

Administrative Policy
Human Resources

ISSUE DATE: 06/87 **SUBJECT:** Paid Time-Off Program

REVISION DATE: 04/12, 02/13, 01/16 **POLICY NUMBER:** 8610- 433

Department Approval:	**10/17**
Administrative Policies & Procedures Committee Approval:	**~~01/16~~10/17**
Human Resources Committee Approval:	**~~01/16~~10/17**
Board of Directors Approval:	**01/16**

A. **PURPOSE:**

1. The Paid Time-Off Program is designed to provide eligible Tri-City Healthcare District (TCHD) employees with compensated time away from their regular assignment in order to ensure their physical and mental well-being. It is also designed to encourage advance scheduling of time off in order to provide for optimum staffing.

B. **POLICY:**

1. The Paid Time-Off Program provides for the utilization and compensation of accrued time off.
2. Paid Time Off is to be used for absences to cover vacations, holidays, illnesses or injuries of employees or their immediate family members, and personal reasons.

C. **PAID TIME-OFF (PTO) ELIGIBILITY, ACCRUAL AND USE:**

1. All benefitted full-time, part-time and weekend professional employees are eligible to accrue Paid Time Off (PTO)hours each pay period in accordance with the **following** accrual schedule below:

FULL TIME **EMPLOYEE** ACCRUAL RATE			80% TIME **EMPLOYEE** (64-79 hrs/week) ACCRUAL RATE			60% TIME **EMPLOYEE** (48-63 hrs/week) ACCRUAL RATE		
Years of Tenure***	Pay Period Accrual	Maximum Hours	Years of Tenure***	Pay Period Accrual	Maximum Hours	Years of Tenure***	Pay Period Accrual	Maximum Accrual
0-3	7.38	384	0-3	5.91	307.2	0-3	4.43	230.4
4-9	8.92	464	4-9	7.14	371.2	4-9	5.35	278.4
10-14	10.46	544	10-14	8.37	435.2	10-14	6.28	326.4
15-19	10.77	560	15-19	8.62	448	15-19	6.46	336.0
20+	11.08	575	20+	8.86	460.8	20+	6.65	345.6

2. Per Diem Week-End Professionals accrue PTO at a rate of 1.23 hours/pay period.
3. Tenure is defined as the number of years worked since the most recent benefit eligibility date.
4. Eligible employees begin to accrue PTO on the first of the month following **thirty (**30**)** days of employment in a benefited status and are eligible to use PTO upon its accrual. In compliance with the CA Paid Sick Leave Law (PSL), benefited employees are eligible to utilize up to three days of their accrued PTO for PSL. (See **Administrative Policy: Leave of Absence~~Paid Sick Leave policy~~ 435**).
5. PTO is used for the first sixteen **(16)** consecutive hours of any absence.
6. PTO is used to compensate employees for both scheduled and unscheduled absences.
   a. Scheduled PTO – In order to provide for optimum staffing, absences must be planned and scheduled in advance. An employee must have his/her Department Director/Manager/designee's prior approval to schedule PTO. Vacations, holidays,

personal business, doctors' appointments, or other similar absences, will be paid through PTO provided appropriate, prior approval has been obtained. The amount of advance notice required is two weeks prior to the affected schedule.

b. Unscheduled PTO – Absences due to illness or emergencies are not possible to predict but may be compensated through unscheduled PTO. An employee who will be unable to report to work must notify his/her immediate supervisor, **two (2)** hours prior to the scheduled starting time of his/her workday, in accordance with **Administrative** Policy: **Absences and Tardiness** ~~#408, Absences and Tardiness~~.

c. For absences related to the employee's own illness, see the **Administrative Policy: Annual and Extended Leave Bank Policy 489.**

d. An employee who misses work due to an illness or injury may be required to obtain a physician's statement.

e. Employee Health Services is available to assist with situations involving illness or injury, fitness for duty, and reasonable accommodations.

f. Requests for PTO may be denied based upon departmental operational requirements.

7. TCHD requires the use of PTO to supplement other payments such as State Disability Insurance (SDI) and Family Temporary Disability Insurance (FTDI). PTO may be used to supplement workers compensation payments, if the employee chooses.

8. The maximum amount that an employee can accrue in his or her PTO account is two (2) times the employee's annual accrual rate as determined by designated FTE (see Table in Section C.1. above). When an employee's PTO account reaches this cap, accrual will stop until such time as the employee reduces his or her PTO balance.

9. The payment of accrued PTO hours is automatic for scheduled and unscheduled except in flex/float activity occurrences and is intended to compensate the employee at the level of his or her regularly scheduled hours.

10. In accordance with **Administrative** Policy: **Absences and Tardiness** #408~~, Absences and Tardiness~~, an employee may not use PTO for a "No Call, No Show" absence.

D. **PTO BUY-BACK:**

1. Employees are given the opportunity to be paid for a portion of their PTO once each year under conditions designed to comply with Internal Revenue Service requirements regarding constructive receipt:

a. The employee must complete an irrevocable election form during the designated election period, indicating the number of PTO hours to be paid. The employee may elect to be paid a minimum of **twenty (20)** hours and a maximum of **eighty (80)** hours. To be eligible to be paid PTO, the employee must maintain a minimum balance of **forty (40)** PTO hours following subtraction of the designated hours from his/her accrued PTO.

b. Once an employee has elected to be paid PTO hours, the designated hours are subtracted from his/her PTO balance and cannot be used for scheduled/unscheduled absences. The designated hours will be paid at the employee's base hourly pay rate in effect at the time of the payment.

c. **Generally, irrevocable elections will be made during the last calendar quarter of the year for payout during the last quarter of the following year.**

E. **CHANGE IN STATUS:**

1. When changing from benefited to non-benefited status, an employee will be paid all eligible accrued PTO hours at his/her benefited base rate of pay.

2. When changing from full time to part time status, an employee will be paid the number of eligible accrued PTO hours required to reduce his/her PTO balance relative to the part time maximum accrual.

F. **TERMINATION:**

1. Upon termination of employment, an employee will be paid all eligible accrued PTO hours at his/her base rate of pay.

G. **ADMINISTRATION:**

1. The Chief Human Resources Officer (CHRO), with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices and procedures to support the administration of this policy will be developed by the CHRO. Exceptions to this policy must be approved by the CHRO and Chief Executive Officer.

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

~~2.~~1. **Administrative Policy: Absences and Tardiness 408**
2. **Administrative Policy: Annual and Extended Leave Bank Policy 489**
3. **Administrative Policy: Leave of Absence 435**

I. **REFERENCE(S):**

1. **Paid Sick Leave Law, Cal. AB-1522 (2014).**

Department Approval:	**10/17**
Administrative Policies & Procedures Committee Approval:	**01/16**
Human Resources Committee Approval:	**10/17**
Board of Directors Approval:	**01/16**

Tri-City Medical Center
Oceanside, California

Administrative Policy
Human Resources

ISSUE DATE: NEW **SUBJECT:** Annual and Extended Leave Bank

REVISION DATE: **POLICY NUMBER:** 8610- 489

Department Approval:	10/17
Administrative Policies & Procedures Committee Approval:	10/17
Human Resources Committee Approval:	10/17
Board of Directors Approval:	

A. **PURPOSE:**

1. The Annual and Extended Leave Bank program is designed to provide eligible Tri-City Healthcare District (TCHD) employees with compensated time away from their regular assignment in coordination with the Paid Time Off Program, in order to ensure their physical and mental well-being.

B. **POLICY:**

1. The Annual Leave Bank (ALB) and Extended Leave Bank (ELB) program provides for the accrual and utilization of leave pay. ALB and ELB may be used to supplement other payments such as State Disability Insurance (SDI) and Family Temporary Disability Insurance (FTDI), as well as workers' compensation payments, if the employee chooses.

C. **ANNUAL LEAVE BANK AND EXTENDED LEAVE BANK, ACCRUAL AND USE:**

1. All full-time and part-time benefited and weekend professional employees are eligible to accrue ALB hours each pay period in accordance with the accrual schedule below:

FULL TIME EMPLOYEES ACCRUAL RATE			80% TIME EMPLOYEES ACCRUAL RATE			60% TIME EMPLOYEES ACCRUAL RATE		
Years of Tenure***	Pay Period Accrual	Maximum Hours	Years of Tenure***	Pay Period Accrual	Maximum Hours	Years of Tenure***	Pay Period Accrual	Maximum Accrual
All	1.85	n/a	All	1.48	n/a	all	1.11	

~~1. Eligible employees begin to accrue ALB on the first of the month following 30 days ofemployment in a benefited status and are eligible to use ALB upon its accrual.~~

2. Employees ~~in PTO Plan 1~~ accrue and may use ALB as follows:
   a. Upon completion of 90 days employment in a benefit status, employees accrue ALB each pay period in accordance with the schedule above.
   b. PTO is used for the first 16 consecutive hours of any absence. Beginning on the third consecutive day of an absence due to the employee's own illness or injury, ALB hours will be used until exhausted.
   c. Once ALB hours are exhausted, ELB hours will be used until exhausted. Once ELB hours are exhausted, remaining PTO hours will be used until exhausted.
   d. On the employee's anniversary date each year, employees with less than 120 hours in ELB will have all ALB hours automatically transferred from ALB to ELB.
   e. On the employee's anniversary date each year, employees with a minimum of 120 hours in ELB who have used less than 48 hours of ALB in the preceding 12 months may choose to transfer up to 50% of ALB to PTO. The remaining 50% of ALB is forfeited.
   f. An employee who misses work due to an illness or injury may be required to obtain a physician's statement.

g. Employee Health Services is available to assist with situations involving illness or injury, fitness for duty, and reasonable accommodations.

h. Employees whose PTO/ALB/ELB banks are exhausted should contact the Human Resources department Benefits section for assistance with continuation of benefits if applicable.

D. Annual Leave and Extended Leave Banks are not vested and are not paid out when the employee terminates employment.

E. **ADMINISTRATION:**

1. The Chief Human Resources Officer (CHRO), with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices and procedures to support the administration of this policy will be developed by the CHRO. Exceptions to this policy must be approved by the CHRO and Chief Executive Officer.

F. RELATED DOCUMENT(S):

~~2.~~**1. Administrative Policy: Paid Time Off Program 433**

Department Approval: **10/17**
Administrative Policies & Procedures Committee Approval:
Human Resources Committee Approval: **10/17**
Board of Directors Approval:

Employee Fiduciary Subcommittee
(No meeting held in October, 2017)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 19, 2017

MEMBERS PRESENT: Director Jim Dagostino, Director Larry Schallock; Dr. Victor Souza, MD; Bret Schanzenbach, Carol Herrera, Dung Ngo, Gigi Gleason, Linda Ledesma, Mary Donovan, Rick Robinson, Roma Ferriter, Rosemary Eshelman, Sandy Tucker, Ted Owen, Susan Bond.

MEMBERS ABSENT: CHAC Chair Julie Nygaard (on vacation), Barbara Perez, Danielle Pearson, Guy Roney, Jack Nelson, Mary Lou Clift Marilou de la Rosa Hruby, Mary Murphy, Scott Ashton, Xiomara Arroyo.

NON-VOTING MEMBERS PRESENT: David Bennett, Chief Marketing Officer, Fernando Sanudo

NON-VOTING MEMBERS ABSENT: Steve Dietlin, CEO; Kapua Conley, COO; Audrey Lopez

OTHERS PRESENT: Gwen Sanders, Brian Greenwald

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The October 19, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:37pm by Director Jim Dagostino, sitting in for Chair Julie Nygaard who is on vacation.		
Approval Of Meeting Agenda	Larry Schallock motioned to approve the October 19, 2017 meeting agenda. The motion was seconded by Sandy Tucker and unanimously approved.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

October 19, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Gigi Gleason motioned to approve the September 21, 2017 CHAC meeting minutes. The motion was seconded by Carol Herrera and unanimously approved.		
Presentation: Ted Owen CEO – Carlsbad Chamber of Commerce	CEO Bret Schanzenbach, presented information about the Vista Chamber of Commerce as follows: • The Vista Chamber was established in 1923. • Currently there are apx. 565 members made up of smaller businesses with <85 employees. • The Vista Chamber helped start the Vista Irrigation District. • Vista was at one time the Avocado capital of the world. • Vista became a major grower and exporter of strawberries in the 1960's & 1970's. • In the 1980's Vista became the *City of Industry* and today maintains a large industrial area with 7 microbreweries and other industries. • Vista is home to the 5th largest school district in the county. The Vista School District has received multiple awards, recognitions, and accolades. • Vista is home to a thriving arts community, including the Moonlight Theater (owned by the City of Vista). • Vista proudly displays wall murals, sculpture, "Alley Art", and themed kites throughout the city.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COMMITTEE STRUCTURE AND MEMBERSHIP MEETING FREQUENCY	Jim Dagostino approached the committee members to discuss the current efficiency and meeting frequency structure of CHAC. The purpose was to review the committee's functioning and determine if changes are needed. Several ideas presented included: • CHAC publication for committee member distribution • Building a culture of health through partnership and reflection (Director Schallock provided a handout titled "Building a Culture of Health" by Cynthia Hedges Greising) • Solicitation of membership partners within the district's communities After discussion by the group, the following recommendations will be brought to the Board of Directors for adoption: • CHAC meetings will go dark in the months of November and December In addition, the following suggestions will also be implemented: • Monthly updates will be provided by Dr. Souza (and other doctors as Dr. Souza recommends). • The Committee will work to arrange a tour of the hospital for members of CHAC (provided it is in compliance with the hospital's privacy policies).		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (Director Jim Dagostino)	CEO Steve Dietlin was not available to update the committee, but provided information to Director Dagostino who relayed the following: TCMC received its 2nd clean audit in 2017. The hospital will need three clean audits in a row to assist future financing talks with HUD. Wait time in the ED continues to improve, including EMT wall time. Dr. Souza noted that the ED received an award recently from Team Health for "Best Improvements." Bulldozers are expected on-site in Dec/Jan to break ground for the new parking structure. Redistricting Public Hearings have been set. Maps and public meeting information is currently on TCMC's website for viewing. There will 5 public meetings, one meeting in each community (Vista, Carlsbad and Oceanside), and 2 at the Board of Director's meetings held on the last Thursday of the month. A BOD decision will be reached by March 2018.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update Kapua Conley	Kapua Conley on PTO.		
CMO Update David Bennett	David Bennett updated the committee as follows: • The recent AHA walk in Oceanside exceeded expectations, with over 3,300 present, including 1,200 employees from TCMC. David noted that the combined network airtime coverage for this event exceeded 15 minutes and provided great exposure for TCMC and the event. • San Diego Magazine ran a "Top Doctors" edition in October which included 7 TCMC Physicians, including 5 ED Doctors. • The Marketing department will be managing 15 upcoming events through the remainder of October. • Social media is being updated regularly.		
Committee Vacancies	Jim Dagostino noted there are still two vacancies on the Committee - the Vista District Resident and the Oceanside District Resident positions. Linda Ledesma asked if members should solicit volunteers for this position. A criteria page will be created to distribute to interested parties.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Public Communications	None.		
Committee Communications	Rosemary Eschelman thanked David Bennett for his help in providing the *Healthy Choices* red ribbon reminders to Carlsbad students. Sandy Tucker requested an update on the office building on Vista Way. Jim Dagostino and Larry Schallock noted that is is still in litigation, on appeal, and may take up to two years for resolution. Sandy also extended an invite to attend the "Cookie Extravaganza" on December 14th in the AR. Proceeds benefit the Jr. Scholarship program. Mary Donovan spoke of the Lifeline Awards presentation noting that TCHD was a finalist. David Bennett thanked Mary for nominating TCHD for the award. Saturday is the Festival of the Arts in downtown Vista Dr. Souza updated the group on the Hep A outbreak in San Diego, noting over 500 cases have been reported and 19 deaths have resulted. Rosemary Eschelman stated that Vape Pens have become a problem in the school district and was wondering if TCMC has experienced an increase in health related issues due to Vape Pens. Rosemary also noted that they Carlsbad School District would like to see Biomedical Internships at TCMC.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 19, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Communications (con't)	Jim Dagostino reminded the group of the upcoming Diamond Ball on November 18th. Celia Garcia reminded everyone of the upcoming Turkey Trot on Thanksgiving morning. Linda Ledesma noted that the Carlsbad Village Fair is soon. Fernando Sanudo noted that the Medically Assisted Treatment (MAT) program has received some money to assist those in need of opioid treatment.		
Next Meeting	No meetings in November or December 2017. Next meeting date is January 18, 2018.		
Adjournment	The October 19, 2017 CHAC meeting was adjourned at 2:07pm.		

Tri-City M cal Center
Finance, Operations and Planning Committee Minutes
October 17, 2017

Members Present	Director Laura Mitchell, Director Cyril Kellett, Dr. Marcus Contardo, Dr. Mark Yamanaka, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Kapua Conley, COO, Carlos Cruz, CCO, Susan Bond, Director, Legal Services
Others:	Susan Webster, Jeremy Kneebusch, Brent Wiest, Lisa Murphy, Kathy Topp, David Bennett, Maria Carapia, Eva England, Jeremy Raimo, Charlene Carty, Sharon Schultz, Steve Young, Sherry Miller, Mark Albright, Priya Joshi, Norma Braun, Chris Miechowski, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Director Julie Nygaard, Dr. Gene Ma

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Mitchell called the meeting to order at 12:31 p.m.		
2. Approval of Agenda		**MOTION** **It was moved by Director Kellett, Dr. Yamanaka seconded, and it was unanimously approved to accept the agenda of October 17, 2017.**	
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
4. Ratification of minutes of September 19, 2017	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Yamanaka, Mr. Harrington seconded, that the minutes of September 19, 2017 are to be approved, with Dr. Kellett abstaining.**	
5. Old Business			

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	on(s) Responsible
6. New Business			
a. Reminder: • No FOP meeting to be held in November • December meeting scheduled on Thursday, 12/7/17	Director Mitchell announced that there would be no FOP meeting held in November, and that the meeting for December would be held on Thursday, 12/7/17.		Chair
b. Policy Review • Accounts Payable Check Processing, #8610-214 • Business Expense Reimbursement, Employees, #8610-270	Charlene Carty explained that the revisions made to both policies were minor changes primarily verbiage edits, to fine tune each policy.	**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 approve policies, Accounts Payable Check Processing, #8610-214 and Business Expense Reimbursement, Employees, #8610-270.**	Charlene Carty
c. Physician Agreement for ED On-Call Coverage – Cardiology-General • Ashish Kabra, M.D. • Ryan A. Smith, D.O.	Sherry Miller conveyed that this write-up is to add Drs. Ashish Kabra and Ryan A. Smith as new physicians to the existing panel for ED On-Call coverage for General Cardiology, with no increase in expense.	**MOTION** **It was moved by Dr. Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Ashish Kabra, M.D. and Ryan A. Smith, D.O. to the currently existing ED On-Call Coverage Panel for Cardiology, General for a term of 12 months, beginning November 1, 2017 – ending October 31, 2018.**	Sherry Miller
d. Physician Agreement for ED On-Call Coverage – Ophthalmology • Logan M. Haak, M.D.	Sherry Miller conveyed that this write-up is to add Dr. Logan M. Haak as new physician to the existing panel for ED On-Call coverage for Ophthalmology, with	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning**	Sherry Miller

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	on(s) Responsible
	no increase in expense.	**Committee recommend that the TCHD Board of Directors add Logan M. Haak, M.D. to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months, beginning November 1, 2017 and ending October 31, 2018.**	
e. ICU Patient Monitor Replacement Proposal • Philips Healthcare	Sharon Schultz explained that this proposal was for the purchase of 26 replacement patient monitors from Philips Healthcare for the Intensive Care Unit. The agreement also includes 96 hours of professional mapping service from Cerner for these replacement monitors.	**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 purchase of MX800 Patient Monitors with X2 Companion Transport Monitors to replace the current patient monitors in the ICU, for a total expected cost of $520,745.**	Merebeth Richins
f. Replacement Roche Histology Tissue Processing Instruments (4), Consumables & Cerner Interface Proposal • Roche Tissue Diagnostics	Steve Young conveyed that this agreement would replace the current tissue processing system, which is nearing its end of life. The proposed system includes instrumentation and a new specimen tracking system, as well as consumables and reagents.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Roche Diagnostics Corporation for Instruments and Consumables for a term of 7 years, beginning November 1, 2017 and ending October 31, 2024 for an annual cost not to exceed $782,064, and a total cost for the term not to exceed $5,483,978.**	Steve Young
g. Fresenius Dialysis & Apheresis Services Proposal	Kathy Topp detailed that this is a renewal agreement for increased rates, with Fresenius to provide	**MOTION** **It was moved by Dr. Contardo, Director Kellett seconded, and it was**	Kathy Topp

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	on(s) Responsible
	hemodialysis, advanced renal replacement options and peritoneal dialysis treatments, as well as apheresis treatments and therapeutic whole blood phlebotomy for TCMC patients.	**unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Fresenius Medical Care North America for dialysis and apheresis services for an average of $86,377 per month, for a term of 36 months, beginning November 1, 2017 and ending October 31, 2020 for a total cost not to exceed $3,109,568.**	
h. Physician Recruitment Proposal – Pulmonary / Critical Care • Malaygiri Aparnath, M.D.	Jeremy Raimo gave a brief PowerPoint presentation detailing the proposed recruitment of pulmonary / critical care physician Malaygiri Aparnath, M.D.	**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 find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $760,000 in order to facilitate this Pulmonary/Critical Care physician practicing medicine in the communities served by the District. This will be accomplished through an Independent Physician Recruitment Agreement (not to exceed a two-year income guarantee with a two-year forgiveness period) with Dr. Malaygiri Aparnath.**	Jeremy Raimo
i. Co-Medical Directorship for Hospitalist Services & Coverage • Dr. Mark O'Brien • Dr. R. Bart Day	Kapua Conley conveyed that this agreement is for the co-medical directorship for hospitalist services and coverage. The amount of this agreement was previously included in the total hospitalist coverage	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD**	Kapua Conley

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	P on(s) Responsible
	stipend approved by the Committee in September 2017, and does not increase the financial commitment of the District.	**Board of Directors authorize Drs. O'Brien, D.O. and R. Bart Day, M.D. as Co-Medical Directors for the Hospitalist program for a term of 22 months, beginning September 1, 2017 and ending June 30, 2019, for an average of 35 hours per month or 420 hours annually, at an hourly rate of $285 for an annual cost of $120,000 and a total cost for the term not to exceed $220,000.**	
j. Financials	Ray Rivas presented the financials ending September 30, 2017 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 90,053 Operating Expense $ 92,374 EBITDA $ 2,853 EROE $ (1,048) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 172 Adjusted Patient Days 28,232 Surgery Cases 1,644 Deliveries 626 ED Visits 15,990 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 29,551 Operating Expense $ 30,184 EBITDA $ 1,091 EROE $ (224) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 163		Ray Rivas

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Adjusted Patient Days 8,886 Surgery Cases 565 Deliveries 194 ED Visits 5,104 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 44.9 Days in Net A/R Avg. 48.1 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay		
k. Work Plan – Information Only • Wellness Center	Ray Rivas gave a two slide P&L presentation for FY2018 on both the Wellness Center (cost center 7760), as well as the combined Wellness Center complex. David Bennet introduced Eva England, Priya Joshi and Susan Webster, who collectively gave a PowerPoint presentation pertaining to their collaboration on the currently established medically integrated programs at the Wellness Center and the additional programs they project implementing in the future. Susan also shared some testimonials and introduced the new Wellness Center general manager, Brent Wiest, and trainer		David Bennett

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	on(s) Responsible
• Construction Report	Jeremy Kneebusch.		Chris Miechowski
• Infusion Center	No discussion		Sharon Schultz
• Medical Director, Surgery	No discussion Sharon Schultz gave a short PowerPoint presentation on Mary Diamond's behalf, reflecting the outcome performance metrics for Monthly First Case-On Time Starts, Total Block Utilization Percentage by Month and the Monthly Average Turnover & Close to Cut Intervals. Sharon noted that there had been a modification made to one of the metrics. Instead of measuring when the patient arrives in the room, it has now been modified to measure when the physician actually begins the procedure.		Mary Diamond
• Dashboard	No Discussion		Ray Rivas
7. Comments by committee members			
8. Date of next meeting	Thursday, December 7, 2017		Chair
9. Community Openings (3)			
10. Adjournment	Meeting adjourned 1:54 p.m.		

Tri-City Medical Center
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 07/87

SUBJECT: Accounts Payable Check Processing

REVISION DATE: 07/93, 11/00, 01/06, 01/09

POLICY NUMBER: 8610-214

Department Review:	**08/17**
Administrative Policies & Procedures Committee Approval:	**~~02/09~~08/17**
Finance, Operations ~~Team~~ and Planning Committee Approval:	**~~02/09~~10/17**
~~**Professional Affairs Committee Approval:**~~	~~**03/09**~~
Board of Directors Approval:	**03/09**

A. **PURPOSE:**

1. To set forth guidelines for the issuance of checks from Accounts Payable.

B. **POLICY:**

1. All expenditures will be in accordance with approved purchasing policies and procedures necessary for the financial viability of the District.

C. **PROCESS:**

1. Invoices and expense reimbursements to be processed for payment, must be accompanied by a purchase order, **Business** Expense Approval Request Form or Check Request Form.
   - ~~2.~~**a.** **Business** Expense Approval Request Forms are to be used for education, travel and mileage expense only. Reimbursement of actual expenses, as well as travel advances, will be paid in accordance with Administrative Policy: #270 **Business Expense Reimbursement, Employees**.
   - ~~3.~~**b.** Purchase orders are encouraged for all expenditures. Certain non-routine items may be processed with a check request; however, a purchase order is preferred and will expedite processing.
   - ~~4.~~**c.** Purchase orders are required for all purchases not referenced above. Vendors are to be instructed to send invoices to the attention of Accounts Payable only. All invoices that do not reference a valid purchase order number will be returned to the vendor unpaid. There are three departments authorized to issue purchase orders as listed below:
     - ~~a.~~**i.** Materials Management – all items not specified below
     - ~~b.~~**ii.** Pharmacy –Pharmaceuticals
     - ~~c.~~**iii.** Food ~~&~~ **and** Nutrition – Food products
2. ~~5.~~**2.** Accounts Payable processes checks. Any check requests needing special attention processing outside of the normal check processing schedule require the approval of the appropriate **C-Suite Member**~~Vice President~~ and the Chief Financial Officer or designee.
3. ~~6.~~**3.** All checks will be mailed to the payee unless otherwise indicated in writing.

D. **FORM(S):**

1. **Check Request Form - Sample**
2. **Business Expense Approval Request Form – Sample**

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

1. ~~7.~~**Administrative Policy: 270 Business Expense Reimbursement, Employees**

Check Request Form - Sample

TRI-CITY HOSPITAL DISTRICT
CHECK REQUEST FORM

PAYABLE TO		DATE
Address		
DESCRIPTION OF EXPENDITURE	**GL#**	**AMOUNT**

Supervisor signature _____

Director Signature _____ **All checks will be mailed directly to Payee**

Circle STAT or NEXT CHECK RUN
IF STAT Date required_____

If this is a stat request, VP signature authorization is required. Otherwise it will be included with next scheduled check run.

_____
ADMINISTRATIVE SIGNATURE

Business Expense Approval Request Form - Sample

Reset Print

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

Business Expense Approval Request

Date 08/07/2017

Employee Name	Employee #	Phone No	Dept Name	Dept #

Seminar, Meeting, Institute to be attended	Location
Purpose	From / To Dates
Date to return to work	Total number of scheduled work days

Estimated Expenditure

Total Expense	Estimated / Actual Cost (Column A)	Pre-payment Required (Column B)	Remaining Cost (Column A minus B)
Registration			$0.00
Hotel # of days			$0.00
Transportation			$0.00
Meals / Gratuity			$0.00
Other:			$0.00
Total	$0.00	$0.00	$0.00

Employee Signature	Date	Dept Director Signature	Date
Vice President Signature	Date	Approved	Disapproved

Required Pre-Payment (Attach all completed documentation to support payment)

Payee #1		Payee #2	
Address:		Address:	
City / State:		City / State:	
GL Acct #	Amt	GL Acct #	Amt

Summary of actual expenses after attendance (Attach all supporting documentation)

Date								TOTAL
Registration								$0.00
Airfare/Rail								$0.00
Hotel								$0.00
Car Rental								$0.00
Taxi/Shuttle								$0.00
Parking/Toll								$0.00
Mileage								$0.00
Meals								$0.00
Misc.								$0.00
Totals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Employee Signature	Date	Less Pre Payments by TCMC	
Authorization Signature	Date	Amount Due Employee	
Accounts Payable Usage		Amount Due TCMC	

8650-1006
(Rev 4/09)

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 10/99

SUBJECT: **Business Expense Reimbursement, Employees**

REVISION DATE: 05/03, 02/06, 02/09, 08/13

POLICY NUMBER: 8610-270

Department Review:	**08/17**
Administrative Policies and Procedures Committee Approval:	**~~08/13~~08/17**
Finance, Operations and Planning Committee Approval:	**~~02/14~~10/17**
Board of Directors Approval:	**02/14**

A. **PURPOSE:**

1. To provide consistent guidelines addressing the approval and documentation requirements for the reimbursement of ordinary, reasonable and necessary business expenses to **Tri-City Healthcare District** (TCHD) employees.

B. **POLICY:**

1. It is the policy of ~~Tri-City Healthcare District (~~TCHD~~)~~ to reimburse all employees for ordinary, reasonable, and necessary Business Expenses. Each employee is accountable for expenses incurred when conducting business on behalf of TCHD and will adhere to the policies and procedures adopted by the Board.

C. **SCOPE:**

1. TCHD will use the following guidelines to determine ordinary reasonable and necessary expenses for reimbursement:
2. Airfare
   a. Coach or economy class airline tickets are considered ordinary business expenses; first class tickets are not reimbursable under the policy. Each employee is expected to assist ~~TCMC~~ **TCHD** in acquiring the best rate and greatest discount on airline tickets. Reimbursement will be the ordinary, reasonable and necessary airline fare, or equal to the prevailing mileage rate published by the **Internal Revenue Service** (IRS) by private automobile, assuming a direct route whichever is least expensive unless extenuating circumstances exist and prior approval is received by the appropriate person as defined in ~~section~~ **the approval section below**~~D.1.g~~.
3. Lodging
   a. Choice of lodging shall be determined by convenience to the business location within reasonable economic limits. Association or governmental discounts should be requested based on whichever provides a lower cost. If the employees wish to take a guest, they must pay any rate differential over the single room rate.
   b. If it is not practical to drive 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.
4. Car Rental
   a. 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 based on minimizing the cost.
5. Car Rental Insurance
   a. TCHD is insured for collision and comprehensive coverage when renting vehicles. Directors/Employees shall decline coverage when renting vehicles.
6. Parking Expense

a. Ordinary, reasonable, and necessary parking expenses while on Company business will be reimbursed.

7. Mileage
   a. The reimbursement rate for use of personal vehicles is equal to the prevailing mileage rate published by the IRS. Mileage will be calculated as the actual mileage incurred assuming a reasonable and direct route between origin and destination point is taken. However, mileage will be paid only for those miles in excess of employee's normal home to work distance. **Business Expense Approval** Request form ~~reimbursement or~~ **Mileage Log** should be submitted ~~or the TCHD mileage log attached as Exhibit C~~.
8. Other Transportation
   a. Ordinary, reasonable and necessary expenses for taxi, bus, shuttle and tolls are reimbursable. Employees are expected to use hotel courtesy cars or shuttles where practical before using taxis or rental car services.
9. Meals and Gratuities
   a. Employees will receive reimbursement for reasonable actual meal related expenses for each day of authorized travel. Alcoholic beverages are considered a personal expense. Employees are expected to eat at scheduled group meal functions whenever possible.
10. Telephone/Fax
    a. Ordinary, reasonable, and necessary business related calls while traveling will be reimbursed at cost. Business calls from home, car phones or cellular phones will be reimbursed at cost as identified on the appropriate monthly statement. All telephone calls shall be of a reasonable frequency and duration.
11. Dues and Professional Organizations
    a. TCHD will reimburse professional exempt employees, managers' and above, for membership in a professional organization pertinent to their work and mutually beneficial to TCHD and the employee unless otherwise required by employment contract. TCHD may pay for these dues directly to the vendor on behalf of the employee, or reimburse the employee via the expense report process.
12. Certifications and Licenses
    a. Individual certifications and licenses are considered the responsibility of the employee and are not reimbursed whether or not the certification or license is required for the job. (See ~~Human Resources Manual,~~ Pay Practice**:** 474.01 Compensation for Mandatory Education **Policy**)
13. Dues to Civic Organizations
    a. As approved by the TCHD ~~President~~**Chief Executive Officer (CEO)**, dues may be paid directly to civic organizations for memberships if required by the organization, to be in the name of an employee. Such organization memberships would be to promote TCHD within the community and to demonstrate our organizations support of the community and would include such memberships as Rotary Club, Chamber of Commerce, Economic Development Council, etc.
14. Continuing Education
    a. As approved by the appropriate director or vice president, continuing education pertinent to the employee's work in the form of seminar, workshop fees, etc. (and within the department budget) is eligible for reimbursement to the employee or may be paid directly to the vendor on behalf of the employee. This includes any seminar, conference, workshop, etc. and registration fees.
15. Other Business-Related Expenses
    a. Ordinary, reasonable, 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.
    b. Directors/Employees will be reimbursed for the ordinary, reasonable and necessary cost of luncheons and dinners during the course of TCHD meetings if meals are not provided by TCHD.
    c. TCHD promotes health and wellness and will reimburse Directors/Employees for use of

hotel health/wellness facilities when traveling. A maximum reimbursement of $10.00 per day shall be applied.

16. Non-Reimbursable Expenses
    a. When traveling, charges for honor bars, dry cleaning, movies and other personnel items whether charged to a hotel room or not, are not reimbursable

D. **PROVISIONS:**

1. TCHD will reimburse employees for ordinary, reasonable and necessary business expenses within the following guidelines:
    a. Reimbursement will be ~~directly,~~**made** by check for ordinary, reasonable and necessary business expenses upon receipt of a properly documented expense report approved by the appropriate authorized person. One over one approval is necessary whereby no one is allowed to approve their own expenses and must receive approval from their supervisor. In the case of the TCHD CEO, the TCHD Board ~~President~~ **Chair** approves.
    b. TCHD follows the general rules of the IRS and California Governmental Code, which require that receipts support expenses and that the persons involved and the business purpose of each expenditure be identified. Receipts are required for all expenditures in excess of $10.00.
    c. Travel/Education/Seminar Expense Approval
        i. Prior to incurring any travel or educational expenses a Business Expense Approval Request Form ~~(Exhibit A)~~ must be completed and approved by the appropriate director or vice president. This form estimates total expenses to be incurred, and documents appropriate approval has been granted prior to committing TCHD to any expense. Travel expense reimbursement or advances cannot be paid by Accounts Payable without approval documented on this form.
    d. Direct Billing/Travel Advances
        i. Administrative approval (VP or above) for employees is required for airfare, registration fees and travel expenses to be direct billed to TCHD or for any advances to be granted. Advances or pre-payments are to be listed on the Expense Approval Request Form.
    e. Supporting Documentation
        i. Upon return from the business trip, expenses are to be summarized on the Business Expense Approval Form. Receipts shall be attached in the order in which they appear on the expense report. This procedure will facilitate the auditing of the report and provide for more efficient and timely processing. TCHD identifies the following as the necessary supporting documentation:
            1) Purpose/Reason for business expenses and identification of persons involved, where applicable
            2) Airfare- original ticket voucher
            3) Car Rental- original car rental invoice
            4) Lodging- original detailed hotel invoice
            5) Parking- original receipt from parking garage/service
            6) Mileage- mileage report documenting miles traveled, origin and destination points and business purpose
            7) Meals- original payment receipts, persons included and business purpose
            8) Business Telephone/Fax copy of detailed telephone bill identifying business calls, to whom call was placed and the business purpose
            9) All other expenses- receipts shall be included whenever possible but in all cases are required for expenditures in excess of $10.00
            ~~10) Educational programs-in order to share in the benefits of educational programs, each individual who attends an educational program (e.g. seminar, workshop, conference) at TCHD expense may be asked to complete a Seminar Evaluation Form (see Exhibit B). The completed form should be returned to the appropriate supervisory person at the time expenses are submitted for reimbursement.~~

f. Timely Submission of Expenses
   i. All requests for reimbursement should be submitted within 30 days of incurring the expense. 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 is not submitted within 60 days of incurring the expense.

g. Approvals
   i. All appropriate approvals must be documented before submitting a request to accounts payable for reimbursement. One over one approval is always necessary since no one in the organization is allowed to approve their own expenses as summarized:
      1) Staff and Supervisory employees are approved by **the** appropriate Department Director
      2) Department Directors are approved by the appropriate Vice President **or C-Suite member**
      3) Vice Presidents **and C-Suite members, except the CEO,** are approved by the TCHD ~~President and~~ CEO
      4) TCHD ~~President~~ **CEO** is approved by the TCHD Board Chair
      ~~4~~**5)** ~~**Business Expense Reimbursement must have C-Suite member approval**~~**In addition, all Business Expense Reimbursements must have C-Suite member approval in accordance with Administrative Policy: Signature Authority ~~Policy~~ #232.**

2. All requests for reimbursement must be submitted on the Business Expense Report form with all required documentation and receipts attached in the order they were incurred. If reimbursement is for travel related expenses, a copy of the Expense Approval Request Form must be submitted.
3. If there are any anticipated reimbursements from outside organizations, documentation of such should be noted on the Business Expense Report Form.

E. FORM(S):

1. Business Expense Approval Request Form - Sample
2. Mileage Log - Sample
~~4. Seminar Evaluation Form - Sample~~

F. RELATED DOCUMENT(S):

~~5.~~**1. Administrative Policy: Signature Authority Policy #232**
~~6.~~**2. Pay Practice: 474.01 Compensation for Mandatory Education Policy**

Business Expense Approval Request Form - Sample

Reset Print

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

Business Expense Approval Request

Date 08/09/2017

Employee Name	Employee #	Phone No	Dept Name	Dept #

Seminar, Meeting, Institute to be attended	Location
Purpose	From / To Dates
Date to return to work	Total number of scheduled work days

Estimated Expenditure

Total Expense	Estimated / Actual Cost (Column A)	Pre-payment Required (Column B)	Remaining Cost (Column A minus B)
Registration			$0.00
Hotel # of days			$0.00
Transportation:			$0.00
Meals / Gratuity			$0.00
Other:			$0.00
Total	$0.00	$0.00	$0.00

Employee Signature	Date	Dept Director Signature	Date

Vice President Signature	Date	Approved	Disapproved

Required Pre-Payment (Attach all completed documentation to support payment)

Payee #1	Payee #2
Address:	Address:
City / State:	City / State:

GL. Acct #	Amt	GL. Acct #	Amt

Summary of actual expenses after attendance (Attach all supporting documentation)

Date								TOTAL
Registration								$0.00
Airfare/Rail								$0.00
Hotel								$0.00
Car Rental								$0.00
Taxi/Shuttle								$0.00
Parking/Toll								$0.00
Mileage								$0.00
Meals								$0.00
Misc:								$0.00
Totals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Employee Signature	Date		Less Pre Payments by TCMC	
Authorization Signature	Date		Amount Due Employee	
Accounts Payable Usage			Amount Due TCMC	

8650-1006
(Rev 4/09)

Mileage Log – Sample

Mileage Log (Exhibit C)

Employee Name		Employee #	Phone No.	Dept #	Department Name	
Date	Description	Start Odometer	End Odometer	Business Miles	Rate	Amount
					Total	

I certify the above expenses were incurred on behalf of Tri City Medical Center:
Employee Signature____Date____________

Authorization Signature_________________________________ Date____________

~~Seminar Evaluation Form – Sample~~

SEMINAR EVALUATION FORM
Exhibit B

SEMINAR TITLE_____

LOCATION_____DATES_____

1. Identify reason for attending seminar:_____

2. List three major topics of the seminar. Rate them as to your evaluation of priorities. Provide a brief explanation of key information covered under each topic.

   a. _____

   b. _____

   c. _____

3. What was the most important topic covered in the seminar?_____

4. Who was/were the main speakers/s/and their topics?_____

5. Evaluate the seminar as a whole: _____

DELETE

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, General

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

Physician's Names: Ashish Kabra, M.D.; Ryan A. Smith, D.O.

Area of Service: Emergency Department On-Call: Cardiology, General

Term of Agreement: 12 months, Beginning, November 1, 2017 – Ending, October 31, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Cardiology, General

Rate/Day	Panel Days per Year	Panel Annual Cost
$200	365	$73,000

Position Responsibilities:

- Provide 24/7 patient coverage for all Cardiology-General specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Ashish Kabra, M.D. and Ryan S. Smith, D.O. to the currently existing ED On-Call Coverage Panel for Cardiology, General for a term of 12 months, beginning November 1, 2017 – ending October 31, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Logan M. Haak, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, November 1, 2017 – Ending, October 31, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Ophthalmology
New physician to existing panel, no increase in expense

Rate/Day	Panel Days per Year	Total Term Cost
$300	365	$109,500

Position Responsibilities:

- Provide 24/7 patient coverage for all Ophthalmology specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used*

Person responsible for oversight of agreement: 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 Logan M. Haak, M.D. to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months, beginning November 1, 2017 and ending October 31, 2018

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
ICU PATIENT MONITOR REPLACEMENT PROPOSAL

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

Vendor's Name: Philips Healthcare

Area of Service: Intensive Care Unit (ICU)

Term of Agreement: One-Time Purchase

Maximum Totals:

Item:	**Amount:**
• Purchase of 26 Philips MX800 Patient Monitors with X2 Companion Transport Monitors and Connectivity to Cerner	$932,171
• Cerner - 96 hours of professional service for mapping new monitor	$14,000
• 8% Tax, Shipping & Handling	$74,574
• Credit from Massimo	($500,000)
Total Expected Cost:	**$520,745**

Description of Services/Supplies:

- Replacement of patient monitors in the Intensive Care Unit.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Merebeth Richins, Director ICU & Peri-Anesthesia Nursing / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the purchase of MX800 Patient Monitors with X2 Companion Transport Monitors to replace the current patient monitors in the ICU, for a total expected cost of $520,745.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
Replacement Roche Histology Tissue Processing Instruments (4), Consumables & Cerner Interface Proposal

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

Vendor's Name: Roche Tissue Diagnostics

Area of Service: Laboratory – Histology & Pathology

Term of Agreement: 7 years, Beginning, November 1, 2017 – Ending, October 31, 2024

Maximum Totals:

	Average Monthly Cost Over Term	Average Annual Cost Over Term	Expected Term Cost
Roche Diagnostics Corp.	$65,172	$782,064	$5,474,448
Cerner Interface Costs			$9,530
Total			**$5,483,978**

Description of Services/Supplies:

- Service Support is now included in the proposal at no additional cost, reagent fees remain flat, and the proposed contract is consistent with Roche's current annual API increase of 3%.
- The Roche Tissue Diagnostic system is an essential tool needed in a laboratory that stains pathology specimens with selected protein markers so a pathologist can appropriately diagnose patient cases.
- The current system is nearing "end of life." The proposed system includes instrumentation, a new specimen tracking system and consumables/reagents.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Steve Young, Sr. Director, Ancillary Services /Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Roche Diagnostics Corporation for Instruments and Consumables for a term of 7 years, beginning November 1, 2017 and ending October 31, 2024 for an annual cost not to exceed $782,064, and a total cost for the term not to exceed $5,483,978.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
Fresenius Dialysis and Apheresis Services Proposal

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

Vendor Name: San Diego Dialysis Services, Inc.
dba Fresenius Medical Care North America

Area of Service: Dialysis and Apheresis Services

Term of Agreement: 36 months, Beginning, November 1, 2017- Ending, October 31, 2020

Maximum Totals:

Average Monthly Cost	Annual Cost	Total Term Cost
$86,377	$1,036,523	$3,109,568

Description of Services/Supplies:

- Provide hemodialysis, advanced renal replacement options, and peritoneal dialysis treatments for TCMC patients.
- Provide apheresis treatments and therapeutic whole blood phlebotomy treatments for TCMC patients.
- Projected cost based on actual utilization data May 2016 through April 2017, cost: $815,756.
- Fresenius proposed a three-year contract with an aggregate rate increase of 27%.

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Kathy Topp, Director, Education, Clinical Informatics & Staffing / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee Recommend that TCHD Board of Directors authorize the agreement with Fresenius Medical Care North America for dialysis and apheresis services for an average of $86,377 per month, for a term of 36 months, beginning November 1, 2017 and ending October 31, 2020 for a total cost not to exceed $3,109,568.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 17, 2017
Co-Medical Directorship for Hospitalist Services & Coverage

Type of Agreement	X	Co-Medical Director		Panel		Other:
Status of Agreement	X	New Agreement		New Rates		Extension – Same Rates

Physicians Name: Mark O'Brien D.O. and R. Bart Day M.D.

Area of Service: Co-Medical Directorship - Coastal Hospitalists Medical Associates, Inc.

New Agreement Term: 22 Months – Beginning, September 1, 2017 – Ending, June 30, 2019

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	Total NTE for 22 Month Term Not to Exceed
$285*	35	420	$10,000*	$120,000	$220,000

The amount was included in the total hospitalist coverage stipend in September's FOP Committee and does not increase the already approved financial commitment of the District.

Position Responsibilities/Scope: Physicians will serve as Co-Medical Directors and shall be responsible for the medical direction of the Hospitalist prgram and perform administrative services as outlined in the Hospitalist Services Coverage Agreement. Duties inlcude

- Establishing and evaluating policies, procedures and protocols for patient care
- Assure adequate coverage and supervision is provided for clinical services activities performed within Department during hours of operation
- Developing, implementing and evaluating a utilization review program, a quality assurance program and a risk management program
- Providing education to physicians regarding changes in medical standards of care and exceeding patient expectations
- Recommending, developing and implementing new services

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

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer / Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. O'Brien D.O. and R. Bart Day M.D. as the Co-Medical Directors for Hospitalist program for a term of 22 months, beginning September 1, 2017 and ending June 30, 2019, for an average of 35 hours per month or 420 hours annually, at an hourly rate of $285 for an annual cost of $120,000 and a total cost for the term of $220,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
October 12, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Director Leigh Anne Grass, Dr. Contardo, Dr. Souza, and Dr. Ma.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, Carlos Cruz, Chief Compliance Officer, Scott Livingstone, Interim Chief Compliance Officer, Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director of Quality and Regulatory and Susan Bond, Director of Legal Services.

Others Present: Joy Melhado, Tara Eagle, Lynette Diamond, Diane Sikora, Oska Lawrence, Sarah Jayyousi, Sherry Miller, Lisa Mattia, Rowena Okumura, Lisa Stroud, Lori Roach, Patricia Guerra and Karren Hertz.

Members Absent: Dr. Johnson.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:00 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass.	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 September 2017.	Director Mitchell called for a motion to approve the minutes from September 14, 2017 meeting.	The minutes were ratified and was approved by the group. Director Dagostino moved and Dr. Souza seconded the motion to approve the minutes from September 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Admission of Psychiatric Patients (LPS) Policy	There was a brief discussion on this policy under section A – there was a recommendation to add the CSU as one of the ways that a person can be admitted to BHU.	**ACTION:** The Patient Care policies and procedures were approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Admission to the Crisis Stabilization Unit (CSU)	It was further clarified that a discharge from the ED and admission to CSU for the same patient requires a separate and a whole nursing assessment to be done as this is a discharge from the ED and admission/transfer to CSU. Also, the term "wanded" should be taken out and replaced by scanned by a metal detector.		
3. Central Venous Access Devices Procedure	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Collection of Blood Specimen by Skin Puncture	There was no discussion on this policy.		
5. Critical Results & Critical Tests- Diagnostic Procedures	Director Mitchell posed a question if critical values apply to cord blood—but it was noted that arterial or capillary blood is used for ABGs only.		
6. Epilepsy Monitored Unit (EMU) Procedure	The term ACT (Advanced Care Technician) should be spelled out on this procedure for clarification purposes when patient is having a seizure.		
7. 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy	Director Mitchell made a recommendation to use the Institutional Codes (per Welfare Code) as a reference to this policy.		
8. Medical Examiner Notification Policy	The word facsimile needs to be corrected on the reference part of this policy.		
9. Medications Brought In by the Patient Policy	There was no discussion on this policy.		
10. Off Unit Transfer Process Policy	There was no discussion on this policy.		
11. Quality and Operations Committee Structure	There was no discussion on this policy.		
12. Skin and Wound Care	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Policy			
13. Specimen Labelling, Nurse Collectibles Procedure	There was no discussion on this policy.		
14. Standards of Care Adult	There was no discussion on this policy.		
15. Venipuncture for Specimen Collection Procedure	Director Mitchell made a suggestion to have a picture of all blood draw specimen tubes and then use it as a reference so people would know what to look for.		
Unit Specific **Acute Care**			
1. Scope of Practice	The term "admitting children 1 to 13" should be stricken since the hospital does not have that population. This policy is in place because it is a Joint Commission requirement. Neurological services will be added in the Acute Rehab scope of services and term "emphasized' should be taken out.	**ACTION:** The Acute Care policy was approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Behavioral Health Services			
1. 14 day Certification Review Hearings 2. 5250- 14 day Involuntary Hold 3. 5270- 30 days of Additional Intensive Treatment	Director Leigh Ann Grass made a recommendation to reference in the patient handbook "Jewish Family Service" (San Diego County Patient Advocates Office) *Policies 1,2, 3 and 5 were recommended to be placed in the Patient care Services as the content can be applied to all patient care areas.	**ACTION:** The Behavioral Health Services policies and procedures were approved as moved by Dagostino and seconded by Director Grass. These policies were approved for the BHU Manual and will then be resubmitted to undergo the PCS (Patient Care Services) approval	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Administration of Zyprexa Relprevv	This drug has proven to be very effective and it also helped a lot with the compliance rate. It was noted that the named external pharmacy should be taken out and made as a generic community pharmacy in its place.	process.	
5. Advisement of Legal Status 72 Hour Hold	This policy should be assigned in the Patient Care policies and procedures section.		
Infection Control			
1. Bloodborne Pathogen Exposure Control Plan	The decision table for medical waste will be deleted and the TCMC waste disposal guideline will be adapted. The grid was and moved from Forms to be linked as a related document.	**ACTION:** The Infection Control policy was approved. Dr. Ma moved and Dr. Souza seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Medical Staff			
1. Medical Staff Funds	This policy was pulled out for further review by the MSO.	**ACTION:** One of the policies and procedures for Medical Staff was approved as moved by Dr. Souza and seconded by Director Grass.	Patricia Guerra
2. Physician Format Approval Process	There was no discussion on this policy.		
Outpatient Behavioral Health			
1. Confidentiality 2. Informed Consent 3. Medical Record 4. Medications 5. Patient Neglect and Abuse 6. Patient Rights 7. Utilization Management	There were no discussions on these policies as they are all deletions.	**ACTION:** The Outpatient Behavioral Health Services policies and procedures were approved as moved by Dr. Souza and seconded by Director Dagostino.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Outpatient Infusion Center 1. Outpatient Specimen Transport to TCMC Main Hospital Laboratory	There was no discussion on this policy.	**ACTION:** The Outpatient Infusion Center policies and procedures were approved. Dr. Souza moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
6. Clinical Contracts	There were no clinical contracts that will be reviewed for this month.	**ACTION:** None.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:05 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:00PM.		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 2:05 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
October 12, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Admission of Psychiatric Patients (LPS) Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
2. Admission to Crisis Stabilization Unit (CSU)	NEW	Forward to BOD for Approval with Revisions
3. Central Venous Access Devices Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
4. Collection of a Blood Specimen by Skin Puncture Procedure	Practice Change	Forward to BOD for Approval
5. Critical Results & Critical Tests-Diagnostic Procedures	Practice Change	Forward to BOD for Approval
6. Epilepsy Monitored Unit (EMU) Procedure	NEW	Forward to BOD for Approval with Revisions
7. Hold 72 Hours, Evaluation and Treatment of the Involuntary Patient Policy	3 Year Review, Practice Change	Pulled for Further Review
8. Medical Examiner Notification policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
9. Medications Brought in By the Patient Policy	3 Year Review, Practice Change	Forward to BOD for Approval
10. Off Unit Transfer Process Policy	NEW	Forward to BOD for Approval
11. Quality and Operations Committee Structure	DELETE	Forward to BOD for Approval
12. Skin and Wound Care Policy	3 Year Review, Practice Change	Forward to BOD for Approval
13. Specimen Labeling, Nurse Collectibles Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
14. Standards of Care Adult – **Tracked Changes** Standards of Care Adult – **Clean Copy**	3 Year Review, Practice Change	Forward to BOD for Approval
15. Venipuncture for Specimen Collection Procedure – **Tracked Changes** Venipuncture for Specimen Collection Procedure – **Clean Copy**	3 Year Review, Practice Change	Pulled for Further Review
Unit Specific		
Acute Care		
1. Scope of Practice	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
Behavioral Health Services		
1. 14 Day Certification Review Hearings	3 Year Review, Practice Change	Forward to BOD for Approval
2. 14 Day Involuntary Holds 5250	3 Year Review	Forward to BOD for Approval
3. 5270 - 30 Days of Additional Intensive Treatment	3 Year Review	Forward to BOD for Approval with Revisions

PROFESSIONAL AFFAIRS COMMITTEE
October 12, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
4.	Administration of Zyprexa Relprevv	NEW	Forward to BOD for Approval with Revisions
5.	Advisement of Legal Status 72 hr hold	3 Year Review	Forward to BOD for Approval with Revisions
	Infection Control		
1.	Bloodborne Pathogen Exposure Control Plan	Annual Review, Practice Change	Forward to BOD for Approval with Revisions
	Medical Staff		
1.	Medical Staff Funds 8710-572	NEW	Pulled for Further Review
2.	Physician Formats Approval Process 8710-557	DELETE	Forward to BOD for Approval
	Outpatient Behavioral Health		
1.	Confidentiality	DELETE	Forward to BOD for Approval
2.	Informed Consent	DELETE	Forward to BOD for Approval
3.	Medical Record	DELETE	Forward to BOD for Approval
4.	Medications	DELETE	Forward to BOD for Approval
5.	Patient Neglect and Abuse	DELETE	Forward to BOD for Approval
6.	Patient Rights	DELETE	Forward to BOD for Approval
7.	Utilization Management	DELETE	Forward to BOD for Approval
	Outpatient Infusion Center		
1.	Specimen Transport	3 Year Review, Practice Change	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**08/01**	**SUBJECT:**	**Admission of Psychiatric Patients**
REVISION DATE:	**11/02, 02/03, 02/05, 09/06, 12/07, 05/11**	**POLICY NUMBER:**	**II.A**

Department Approval:	**12/15**
Clinical Policies & Procedures Committee Approval:	**~~01/11~~01/16**
Nursing Executive Council Approval:	**~~03/11~~01/16**
Division of Psychiatry Approval:	**06/17**
Medical Executive Committee Approval:	**~~04/11~~07/17**
Professional Affairs Committee Approval:	**~~05/11~~10/17**
Board of Directors Approval:	**05/11**

A. **POLICY:**

1. The Behavioral Health Unit develops, implements, and evaluates a plan of psychiatric nursing care to adults 18 years and older who are significantly impaired as a result of primary psychiatric disorders.

~~1. The Inpatient Behavioral Health Service consists of a 29-bed Lanterman-Petris-Short (L.P.S) adult facility providing 24 hours per day, 7 days per week intensive mental health services to adult patients who meet severity of illness criteria in two separate but adjoining units.~~

~~a. The Psychiatric Intensive Care Unit (PICU) consists of nine (9) locked beds. Criteria for admission to the PICU include the following:~~

~~i. Adult patients (age 18 years and older) who require 24 hour psychiatric intervention secondary to symptoms from a DSM-4R psychiatric disorder including but not limited to:~~

~~1) Schizophrenia~~
~~2) Schizo-affective disorder~~
~~3) Bi-polar disorder~~
~~4) Major depressive disorders~~

~~ii. Individuals who are considered to be at immediate risk for harm to self, harm to others or are gravely disabled and require at least every 15-minute monitoring.~~

~~iii. Individuals who are considered high risk for elopement.~~

~~iv. Individuals who consent to voluntary admission and meet risk and severity of illness criteria.~~

~~v. Individuals who are being held on involuntary status because they meet risk and severity of illness criteria.~~

~~1) 72 hour holds (5152)~~
~~2) 14 day holds (5250)~~

~~vi. Individuals who are assessed to be able to actually or potentially benefit from the therapies and services offered.~~

~~b. The Behavioral Health Main Unit consists of 20 beds. Criteria for admission to this unit include the following:~~

~~i. Adult patients (age 18 years and older) who require 24 hour psychiatric intervention secondary to symptoms from a DSM-4R psychiatric disorder including but not limited to:~~

~~1) Schizophrenia~~
~~2) Schizo-affective disorder~~
~~3) Bi-polar disorder~~

~~4) Major depressive disorders~~

~~ii. Individuals at high risk for harm to self or others or gravely disabled, but whose danger to self or others is not assessed to be immediate risk, and require at least every 30-minute monitoring on day shift (0730 – 1900) and at least every 15 minute monitoring on night shift (1915 – 0715).~~

~~iii. Individuals who consent to voluntary admission and meet severity of illness and risk criteria.~~

~~iv. On occasion a patient on a 72-hour hold will be admitted to the open unit (gravely disabled criteria only) at the discretion of the admitting psychiatrist. The patient can be transferred to the PICU if clinically necessary when a bed is available.~~

~~v. Individuals with DSM-4R diagnoses who are participating in research studies under the direction of a principal investigator who is an attending physician on the Tri-City Medical Center staff.~~

~~vi. Individuals who, upon assessment, are determined to be able to substantially benefit from the therapies and programs offered.~~

~~2. Transfers between the PICU and Open unit of the service are implemented when changes occur in the patient's condition indicating a need for either increased or decreased monitoring as follow:~~

~~a. When a patient on the PICU remains acutely ill but no longer requires 15--minute checks and/or is no longer considered at risk or immediate danger to self or others, and/or is no longer considered high risk for elopement, the patient may be moved to the open unit.~~

~~i. The move is treated as a transfer and the patient's record from the PICU accompanies the patient to the open unit.~~

~~ii. The physician writes an order to transfer the patient and indicates the reason for the transfer in a clinical note.~~

~~iii. The RN documents in the medical record the transfer has occurred.~~

~~b. When a patient on the open unit experiences an increase in symptoms or risk, or a change occurs in legal status from voluntary to involuntary, that patient will move to the PICU to ensure his or her safety and the safety of others in the environment.~~

~~i. The move is treated as a transfer, the patient's record from the open unit accompanies the patient to the PICU, and all legal actions that were initiated are entered into a logbook and followed up on by the RN.~~

~~ii. The physician writes an order to transfer the patient and indicates the reason for the transfer in a clinical note.~~

~~iii. The RN documents in the medical record the transfer has occurred.~~

~~3.~~**2.** Patients may be admitted to the Behavioral Health Service in ~~three~~ **the following** ways:

a. Following triage, assessment, and medical stabilization in the Emergency Department.

b. Following crisis stabilization in the Crisis Stabilization Unit (CSU).

~~b.~~**c.** Direct Admissions:

~~i. Following assessment of an established patient by one of the attending psychiatrists/~~**Allied Health Professionals (AHP)** ~~on staff without Emergency Department clearance facilitated by the BHU Assistant Nurse Manager (ANM), Charge RN, or Psychiatric Liaison.~~

~~ii.~~**i.** Following a physician-to-physician consultation between one of the attending psychiatrists on staff and a psychiatrist from a community program facilitated by the BHU Assistant Nurse Manager (ANM), Charge RN, or Psychiatric Liaison.

~~iii. As part of an established and approved research protocol.~~

~~c.~~**d.** Following medical stabilization on one of Tri-City Medical Center's ~~medical or surgical~~**inpatient** units.

i. The Psychiatrist/**AHP**, and/or Psychiatric Liaison, BHU ANM, and BHU Charge RN will serve as resources in the evaluation of patients who have psychiatric and medical, surgical, or obstetrical co-morbid conditions.

ii. The Psychiatrist/**AHP**, Psychiatric Liaison, and/or BHU ANM will assist in assuring that all requirements for 72 hour and 14 day holds are met during patients' stays on these other units.

iii. Processes will be in place for consultation and ~~transfer between other units and~~ **admission to** the Behavioral Health Service; patients with psychiatric illnesses who meet severity of illness criteria will be ~~transferred~~ **discharged from inpatient encounter and admitted** to the behavioral health service when they are considered medically stable in accordance with hospital in-house ~~transfer~~ policy.

~~iii.~~3. **See Inpatient Behavioral Health Unit Policy: Inpatient Admission Criteria for appropriate admissions for inpatient psychiatric treatment.**

4. **See Behavioral Health Unit Policy:** Exclusi**onary**~~ion~~ Criteria **for categories of patients who will not be admitted to the Inpatient Behavioral Health programs.**~~: Individuals in the following categories will not be admitted to the Inpatient behavioral health programs. When admission is denied, the physician, Psychiatric Liaison, and/or unit based Social Worker/Case Manager will be responsible for finding an appropriate disposition that meets the individual's treatment needs.~~

~~a. Individuals who do not meet severity of illness criteria related to danger to self, danger to others, or grave disability.~~

~~b. Individuals less than 18 years of age.~~

~~c. Individuals with a primary Axis 2 diagnosis in accordance with DSM-4R criteria, including those with chemical dependency diagnoses if those diagnoses are primary at the time of assessment.~~

~~d. Individuals with an established diagnosis of dementia whose primary need is for custodial care.~~

~~e. Individuals who are developmentally disabled whose primary need is for custodial care.~~

~~f. Individuals who for whatever reason are not able to participate in or benefit from the therapies and programs offered.~~

~~g.~~**a.** ~~Individuals whose co-morbid medical condition(s) require stabilization.~~

B. RELATED DOCUMENTS:

1. **Behavioral Health Unit Policy: Inpatient Admission Criteria**
2. **Behavioral Health Unit Policy: Exclusionary Criteria**
~~B.~~3. **Patient Care Services: Plan for Nursing Care**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW~~9/23/16~~ **SUBJECT:** **Admission to the Crisis Stabilization Unit (CSU)**

REVISION DATE(S): NEW

Department Approval:	**10/16**
Clinical Policies & Procedures Committee Approval:	**12/16**
Nurse Executive Council Approval:	**01/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define appropriate methods for admitting a patient to the Crisis Stabilization Unit (CSU)
2. To ensure patient rights are respected for those patients receiving behavioral health services at **Tri-City Healthcare District (**TC~~MC~~**HD)**.

B. **POLICY:**

1. Every patient must present to the Emergency Department **(ED)** and receive medical screening examination (MSE), prior to acceptance of the patient to the CSU.
2. All clinical interventions are aimed at rapid stabilization of the patient's condition, and focused on improved coping skills and increased motivation to change in order to re-establish the patient's psycho-social level of functioning and overall homeostasis.
3. **Patients being admitted to the CSU must be discharged from the ED and admitted to the CSU with a new visit number (financial number [FIN])**.

C. **PROCEDURE FOR CRISIS STABILIZATION UNIT (CSU):**

1. **If a patient is medically cleared and meets the CSU admission criteria, the ED physician(MD) collaborates with the psychiatrist or Allied Health Professional (AHP) for acceptance to CSU**~~After the MSE, Every patient must present to the Emergency Department and receive a MSE medical screening examination, prior to acceptance of the patient to the Crisis Stabilization Unit by the nurse practitioner, assistant nurse manager, or RN~~
2. **Once accepted for admission, a member of the ED staff (MD, Charge nurse, or RN) contacts the CSU charge nurse to make admission arrangements.**
3. Transfer the patient to the CSU via wheelchair, dressed in a hospital gown and escorted by an EMT or nurse.
4. On arrival to CSU, the patient and the patient's belongings will be ~~wanded~~ **scanned by metal detector** and locked up in the appropriate, assigned patient locker.
5. Use all available information to complete a comprehensive evaluation and perform a brief mental status examination:
    a. The clinical assessment will include the following:
        i. General patient information
        ii. A presenting problem and precipitating factors
        iii. The legal status of the patient
        iv. Psychiatric history (including past psychiatric hospitalizations)
        v. Whether the patient has any co-occuring substance use disorder (S-BIRT)

vi. A screening for acute and/or past trauma (LES)
vii. An inventory of the patient's strength, resilience factors, and current level of functioning
viii. A history of coping strategies and crisis resolution tools that have worked in the past
ix. A risk for self-harm/suicidal risk evaluation (C-SSRS)
x. A risk for Violence/danger to others evaluation (BROSET)
xi. Clinical impressions and recommendations
xii. An inquiry whether or not the patient has an advance directive
xiii. An inquiry whether or not the patient has a conservator

b. The assessment will result in the following:
   i. A DSM 5 diagnosis
   ii. A treatment plan developed by the CSU treatment team with input from the patient
   iii. A discharge plan appropriate to the clinical presentation and recommendations from the CSU treatment team.

~~5.~~**6.** Document available treatment information, including names, disciplines, and contact information, current and past medications prescribed, reported medication compliance, and consult with outpatient providers and or patient support with verbal and or written permission. The CSU nursing staff will focus on the medication history and medication reconciliation.

~~6.~~**7.** In the event a patient denies permission to contact family, friends, or other care providers, and the patient is in an emergent crisis situation, gather collateral information, without the patient's consent, from providers and patient support if vital for crisis stabilization treatment, clinical intervention, treatment goals and discharge planning.

a. Collateral information will be collected by CSU staff, but patient care information will not be disclosed unless consent is obtained by the patient.

~~7.~~**8.** In case the patient is not admitted to an acute inpatient setting, CSU staff will make sure the following steps are adhered to:

a. Make sure the patient understands and agrees with the discharge plan
b. Assure the patient has sufficient medications and/or prescriptions for medication to fill at local pharmacy (sufficient to bridge the gap until the patient is able to be seen by the outpatient provider)
c. Coordinate for pick up and or transportation needs
d. Review the appropriate outpatient resources and referrals with the patient and family or friend, as indicated. All minors will have discharge plans reviewed with legal parent or guardian
e. Develop a safety plan, if indicated, and document in medical record
f. Encourage patient to ask for help from support and professional providers when in crisis immediately
g. All patients will be provided the San Diego County Access and Crisis Line phone number 1-888-724-7240

~~8.~~**9.** Provide the patient with the referral site and the time and date for the appropriate outpatient follow up services and document the information in the patient's medical record.

a. During regular office hours, staff will assist patients with making contact with the appropriate referral source and make follow up appointment.

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

1. **Behavioral Health Services:** 72-Hour Hold~~,~~ Evaluation and Treatment of Involuntary Patient
2. Behavioral Health **Services:**~~Unit (BHU) Inpatient Policy:~~ Exclusionary Criteria

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CENTRAL VENOUS ACCESS DEVICES, ADULTS**
Purpose:	To outline the nursing responsibility in: A. Insertion B. Assessment C. Maintenance D. Documentation E. Flushing F. Blood draws G. Dressing changes H. Accessing or de-accessing implantable venous access ports I. Removal of non-tunneled central lines (Peripherally Inserted Central Venous Catheter (PICCs), Short-Term Multi Lumen Catheters, Vas Catheters)
Supportive Data:	See Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10).
Equipment:	Refer to ~~Appendix A~~**Central Line Supply List** for details.

A. **POLICY:**

1. Only Registered Nurses (RNs) may access central lines.
2. Insertion:
   a. Assemble supplies (See ~~Attachment A~~ **Central Line Supply List** for procedure lists).
   b. Assist physician/**Allied Health Professionals (AHP)** with selection of optimal catheter site.
   c. Ensure the physician/~~designated healthcare procedure (HCP~~**AHP**~~)~~ has performed chlorhexidine skin antisepsis.
   d. Provide maximal barrier precautions for **the** inserting ~~the~~ physician/**AHP** and assisting personnel (i.e. cap, mask, sterile gown, sterile gloves and full body sterile drape)
   e. Ensure "time out" is performed per Patient Care Services: ~~(PCS)~~ Universal Protocol Procedure.
   f. Ensure the physician/~~healthcare provider (HCP)~~**AHP** maintains sterility of the field throughout the procedure.
   g. Verify a **chest** X-ray is ordered and completed after placement ~~on~~**of a** newly inserted central venous catheters **that was not inserted using fluoroscopy**.
   h. Ensure Central Line Insertion Procedural Checklist **(CLIP)** is completed in Cerner.
   i. **Measure external length, if any, of catheter on insertion or upon admission if catheter placed at another facility.**
3. Assessment:
   a. **Verify chest x-ray results that central line placement is accurate before accessing central lines that were placed without using fluoroscopy.**
   b. **Measure external length, if any, of catheter on insertion or upon admission if catheter placed at another facility.**
   c. Monitor **central venous catheter**~~intravenous~~ sites **appropriately** every 2 hours and PRN.
   ~~b.~~**d.** Document each shift on the **Lines and Devices section in IView**~~Assessment Ongoing PowerForm Central IV section~~.
   ~~c.~~**e.** **Assess** ~~C~~central venous catheters ~~are assessed~~ daily to determine continued need and are removed when no longer needed.
      i. Does not apply to long term catheters (i.e. groshong, tunneled catheter, medi-port, and vas cath).

B. **MAINTENANCE:**

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/94, 12/09, 07/10, 03/13, 04/14, **05/17**	07/10, 03/13, 04/14, **02/17, 06/17**	08/10, 03/13, 04/14, 02/17, **07/17**	04/14, **03/17, 09/17**	08/10, 05/13, 07/14, **04/17, 09/17**	06/13, 08/14, **1017**	06/13, 08/14

1. **All patients with a central line will have a chlorhexidine (CHG) bath every 24 hours (except in the Women and Newborn Services departments).**
   a. **Do not use CHG wipes on:**
      i. **Patients allergic to CHG**
      ii. **Breast feeding mothers**
      iii. **Pregnant Patients**
      iv. **Non-intact skin, head, face, or genitalia (clean these areas with soap and water)**
   b. **CHG wipes should be used on buttocks and inner thigh after any episodes of fecal incontinence.**
   c. **Patient must be moisturized after CHG bath completed and skin is dry.**
2. **All central line patients will have high touch areas cleaned with a Sani wipe every 24 hours.**
   a. **High Touch areas include but are not limited to:**
      i. **Side rails of the patient's bed**
      ii. **Patient's call light/phone/TV remote**
      iii. **Patient's bedside table**
      iv. **Door knobs to room and bathroom**
3. **When possible, a patient specific vital signs machine is to remain at the patient's bedside for neutropenic patients during their entire length of stay.**

~~1.~~4. Use all new **intravenous (IV)** tubing after new ~~PICC/~~central line placement. **Never disconnect IV tubing or attached devices from an old intravenous site and reconnect into the new central line.**

~~2.~~5. Label IV tubing **per Patient Care Services: ~~(PCS)~~ Standards of Care, Adult**~~with change date sticker indicating date tubing is to be changed using numerical day and month~~.

6. Change tubing and any attached devices (e.g. extension tubing~~, neutral displacement connector~~) **per Patient Care Services: Standards of Care, Adult**~~every 4 days~~.

~~3.~~7. **Central line dressings will be changed every Saturday before midnight.**
   a. **Assess catheter to determine if migration has occurred. If migration has occurred, notify MD.**
      i. **Sutured central lines – ensure sutures are intact and the catheter has not become dislodged.**
         ~~i.~~1) **If sutures are no longer intact, measure external length and assess if migration has occurred.**
      ii. **Suture-less central lines – measure external length of catheter.**
         1) **Measure the external portion of the catheter from the insertion site to the hub of the access cap (neutral displacement connector) using a measurement tape.**
         2) **Compare measurement to length previously documented to determine if catheter migration has occurred.**

~~4.~~8. **Neutral displacement connectors (for example Microclave) are changed every Saturday with dressing change and every Wednesday (Green caps on Saturday, Yellow caps on Wednesday).**

~~5.~~9. Use an infusion pump for all infusions.
   a. Do not allow infusions to run dry.

~~6.~~10. Clamp tubing distally if air enters infusion tubing, aspirate fluid and air with a syringe from Y port. Never purge infusion line into patient.

~~7.~~11. Maintain **and** keep open rates at 20 mL per hour.

~~8.~~12. May connect continuous infusions **IV tubing directly to lumen** (hub to hub). **Neutral displacement connectors (for example** Microclave)~~ device is~~**are** only required for intermittent access.

~~9.~~13. ~~SwabCap~~**Port protector** – Unused central line ports will have a ~~SwabCap~~**Port protector** placed on the end of the neutral displacement connector (Microclave).

a. Apply the ~~SwabCap~~**Port protector** to the end of the neutral displacement connector (Microclave) by opening the packaging of the ~~SwabCap~~**Port protector** and twist into the end of the neutral displacement connector (Microclave).
b. To access a central line that has a ~~SwabCap~~**Port protector**, remove the ~~SwabCap~~**Port protector** from the neutral displacement connector (Microclave) and access central line port. No initial cleaning of the neutral displacement connector (Microclave) is needed after ~~SwabCap~~**Port protector** is removed.
c. Do not reuse the ~~SwabCap~~**Port protector**, a new one should be used each time it is removed, every 8 hours with routine IV flushing, when tubing is changed and PRN.
d. ~~SwabCap~~**Port protector** shall be placed only on the lowest IV port of the mainline (maintenance) infusion tubing.
   i. **Port protectors**~~Swab Caps~~ are not required on ports above the lowest port on a mainline.
e. If additional cleaning required between flushes **or if a port protector was not used**, cleanse port thoroughly using 3 alcohol wipes.

C. **DOCUMENTATION / EDUCATION:**

1. Document **care provided in the electronic health record (EHR).**~~and complete all appropriate fields in the "Lines and Devices" sections in IView.~~
   ~~2.~~**a.** Document flush~~ing~~ ~~o~~in the Medication Administration Record (MAR).
   b. **Document**~~Record~~ **patient** teaching ~~o~~in the **Central Line Topics section**~~Patient Education~~ **– All Topics Adhoc Form** ~~PowerForm~~.
   c. **Ensure the CHG bath and High Touch Area clean on the ADL section in Cerner.**
   ~~3.~~**d.** **Initiate the "Adult Lines Central" IPOC in Cerner.**

D. **FLUSHING:**

1. Obtain a physician's**/AHP's** order prior to accessing any central venous catheter if the patient is admitted with a pre-existing line and a diagnosis of sepsis or suspicion of line sepsis.
2. Always flush and check patency **(draw back for a positive blood return)** with a 10 mL size syringe due to the greater amount of pressure per square inch exerted with smaller syringes.
   ~~2.~~**a.** Once patency (blood return flash when you aspirate from the central line with a 10 mL syringe) has been established with a 10 mL normal saline flush, the use of a smaller syringe to administer medications is acceptable.
3. Flush with minimum of 10 mL normal saline:
   a. Before and after medication administration,
   b. After IV fluids or TPN discontinued
   c. For maintenance
   d. Before and after blood draws
   e. After blood backs up in the tubing
4. Flush unused ports with each use and as indicated in Catheter Specific Flushes Table ~~(see Attachment B)~~.
5. Heparin flushes require a physician's**/AHP's** order. ~~(See the CPOE Central Venous Access Powerplan).~~
6. Flush ports with heparin for patients discharged with a central line, to ensure patency for home care or other facility use (see **Catheter Specific Flushes Table**~~Attachment B~~).
7. **Procedure:**
   a. Identify type of catheter.
   b. Check for chlorhexidine gluconate, heparin, povidone-iodine, and alcohol allergies.
   c. Assemble supplies (see **Central Line Supply List**~~Attachment A for procedure lists~~).
   d. Explain procedure to patient.
   e. Perform hand hygiene and don clean non-sterile gloves.
   f. Remove ~~SwabCap~~**Port protector** from the neutral displacement connector (Microclave) if used.

i. If a ~~SwabCap~~**Port protector** is not present on injection port, cleanse neutral displacement connector thoroughly using 3 alcohol wipes or chlorhexidine swab.

g. Connect a 10 mL luer lock syringe to the neutral displacement connector.

h. Check for patency by pulling back to get a positive blood return.

i. Catheters with Heparin: Remove 5-7 mL of blood from lumen and waste.

~~g.~~**i.** Briskly flush catheter with10 mL **of** normal saline ~~after patency has been established~~.

~~h.~~**j.** Always wipe the neutral displacement connector with an alcohol wipe immediately before and after each syringe insertion to remove bacteria and prevent blood from accumulating.

~~i.~~**k.** Heparinize catheter lumen(s) if applicable (see **Catheter Specific Flushes Table**~~Attachment B~~).

l. Repeat flush procedure for each catheter lumen.

~~j.~~**m. If catheter does not aspirate easily with a brisk free flowing blood return when checking patency or if catheter does not flush easily and some resistance is met when flushing, refer to the Patient Care Services~~**(PCS) Procedure: Catheter Clearance with Alteplase (Cathflo Activase) Procedure.**

E. **BLOOD SPECIMEN COLLECTION FROM VENOUS ACCESS DEVICES:**

1. Peripheral blood is preferable for coagulation studies. A physician's**/AHP's** order is required if a line will be used to obtain blood for coagulation studies when the line has heparin infusing or if heparin was used as a routine flush.
2. Maintain a closed system by drawing blood directly from the neutral displacement connector when possible; except when drawing blood cultures.
   a. If the neutral displacement connector is removed for a blood draw, **sterile**~~aseptic~~ technique (with sterile gloves, mask and sterile field) must be used **per Patient Care Services ~~Policy~~: Sterile Technique Policy**.
3. On Acute Care Services (ACS) and Telemetry, a phlebotomist shall place plastic bags labeled with the patient's identifiers in the "Pending Labs" box on each unit prior to the morning blood draws.
4. Nursing shall review their orders for morning draws and complete the blood draws.
5. **Label specimen per Patient Care Services ~~Policy~~: Specimen Labeling, Nurse Collectibles Procedure**~~Once the blood draws are completed, nursing shall return the labeled specimen collection tubes to the patient's plastic specimen bag and place the specimen bag in the "Lab Test Pick-Up" box for phlebotomy to pick up~~.

~~6. Phlebotomy shall contact nursing on ACS and Telemetry if additional blood draws are required after the morning draw.~~

~~a. Nursing may complete the blood draws without a phlebotomist being present.~~

6. A phlebotomist must be present for blood cultures and blood bank draws in all clinical areas.
   a. Ensure correct process and labeling for blood cultures.
   b. **Ensure labeling of correct blood products.**
7. **Procedure:**
   a. Remove patient identified plastic bag with specimen collection supplies from the Pending Lab box on Acute Care Services and Telemetry.
      i. Do not take plastic specimen bag into isolation rooms.
   b. Verify patient by ensuring two patient identifiers match the specimen collection labels
   c. Perform hand hygiene.
   d. Assemble supplies (see **Central Line Supply List**~~Attachment A for procedure lists~~).
   e. Explain procedure to patient.
   f. Position patient, supine is the preferred position.
   g. Turn off any continuous infusions and disconnect as needed.
   h. Ensure all clamps are open **(if not going hub to hub for collection)**.
   i. Perform hand hygiene and don clean non-sterile gloves.
   j. Remove ~~SwabCap~~**Port protector** from the neutral displacement connector (Microclave) if used.

i. If a ~~SwabCap~~**Port protector** is not present **or cap has been on port for longer than 7 day** on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.

~~j.~~**k.** **Check patency.**

l. Flush with 10 mL normal saline after patency has been established~~;~~**.**

~~k.~~**m.** Wait 2 minutes.

~~l.~~**n.** Draw off and discard 5 mL of blood. If drawing specimens for blood cultures, ~~or~~ coagulation studies are to be obtained or the line has TPN infusing, draw off and discard 10 mL of blood.

i. Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect the blood to be discarded.

ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Flush with 10 mL of Normal Saline and clamp tubing before disconnecting syringe. Reconnect tubing or replace with a new neutral displacement connector being careful not to contaminate the end of the hub.

~~m.~~**o.** Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating.

i. Allow to dry, do not fan or blow on site to speed drying.

~~n.~~**p.** **For Direct Transfer Method:**

i. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion.

ii. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube.

1) Insert blood specimen collection tube in the appropriate numbered draw order (i.e. 1, 2, etc.).

iii. Remove and insert new vacuum tubes as needed.

~~o.~~**q.** **For Indirect Transfer Method:**

i. Attach new 10 mL luer lock syringe(s) to collect blood as needed.

1) A safety transfer device must be used to fill the vacuum tube from a syringe.

~~p.~~**r.** Remove device or syringe and wipe away blood residual.

~~q.~~**s.** Flush as indicated in Catheter Specific Flushes Table ~~(see Attachment C)~~ and reconnect to infusions.

~~r.~~**t.** Re-clamp lines as appropriate.

~~s.~~**u.** Remove gloves and perform hand hygiene.

~~t.~~**v.** Don clean gloves.

~~u.~~**w.** Document your Cerner logon, date and time of lab draw on the specimen label(s)

~~v.~~**x.** **Label specimen per Patient Care Services ~~Policy~~: Specimen Labeling Policy**~~Place label(s) on specimen collection tube(s) at patient's bedside~~.

i. On ACS and telemetry, ensure the color written on the patient label(s) matches the color of the specimen collection tube(s).

~~w.~~**y.** Place labeled specimen collection tube(s) in the patient's specimen collection bag on ACS and Telemetry units.

~~x.~~**z.** Place specimen collection bag in the "Lab ~~Test~~ Pick Up" box.

~~i. A phlebotomist will transport the specimen(s) to the lab.~~

F. **DRESSING CHANGES:**

1. All central lines shall have a Biopatch disk at the insertion site and be covered with a transparent dressing.
2. All central line dressings shall be changed every **Saturday before midnight**~~7 days from insertion or last dressing change~~.

a. **Central lines used for dialysis will be changed with dialysis treatment or as needed.**

~~b.~~**3.** Gauze dressing **(including transparent dressings with gauze underneath)** will only be used for bleeding or leaking at insertion site (edematous patient).

~~c. Gauze dressing~~

~~i.~~**a.** For newly inserted PICCs with a gauze dressing, the original dressing must be changed one day after insertion **then every two (2) days after**.

~~ii. Gauze dressings (including transparent dressings with gauze underneath) shall be changed every second days from last dressing change.~~

~~3. Implanted Ports~~

4. **Non-coring safety**~~Dressing and access~~ needles **devices** for implanted ports **will**~~shall~~ be changed every **Saturday before midnight**~~7 days from last~~ **with** dressing change~~ or as needed~~.
5. All dressings shall be changed as needed if they become loose, soiled, or moist.
6. Patients admitted with a pre-existing central line, will have the dressing changed within 24 hours after admission unless dressing is not dry and intact, then the dressing will be changed **as soon as possible**~~ASAP~~.
7. **Procedure:**
   a. Obtain central line dressing change kit and sterile gloves from supply Pyxis.
   b. Explain procedure to patient.
   c. Use Standard Precautions during dressing change (refer to Infection Control: ~~Policy IC.5~~ Standard and Transmission Based Precautions **Policy IC.5**).
   d. Perform hand hygiene, apply surgical hat and mask to self and apply mask to patient. Complete hand hygiene once again, apply clean non-sterile gloves remove the dressing and discard.
   e. Inspect and palpate the site for:
      i. Signs of infection **(**i.e. redness, or purulent drainage**)**.
      ii. Ensure the securement device and/or sutures are intact.
      iii. Ensure the catheter is not kinked, leaking, or otherwise compromised.
   f. Remove non-sterile gloves and perform hand hygiene.
   g. Open sterile supplies and don sterile gloves.
   h. Apply Chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site **and allow site to air-dry for at least 30 seconds (Use Betadine if patient is allergic to Chlorhexadine)**.
   i. Cleanse catheter tubing from exit site to end of catheter tubing.
   j. Allow antiseptic on skin and tubing to air dry (do not blow on or fan site) before redressing.
   ~~k. Replace securement device if needed per manufacturer's guidelines.~~
   k. Position tubing in a loop away from the insertion site.
   l. **Transparent Dressing with Biopatch:**
      i. Place Biopatch disk around catheter (not on top) with blue side up and white foam side next to skin at exit site.
      ii. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy.
      iii. Center transparent dressing over exit site and the Biopatch disk.
      iv. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.
   m. **Special Consideration: Implanted Venous Access Devices/Vita Ports/Medi-Ports:**
      i. Place folded 2x2 gauze under ~~huber~~**non-coring safety** needle **device** only if the **base of the device** ~~huber needle~~ is not flush with skin after insertion.
      ii. Gauze should be placed under the ~~huber~~**non-coring safety** needle **device** in such a way as to allow visibility of insertion point.
      iii. Secure the **tubing from the** ~~huber~~**non-coring safety** needle **device**~~tubing~~ with sterile steri-strips if needed.

~~iii.~~**iv. Pinch to remove the small plastic guide piece from the top of non-coring safety needle device before applying transparent dressing.**

v. Center ~~Continue with~~**transparent** dressing **to cover the safety non-coring needle device and site**~~application as outlined above~~.

~~iv.~~**vi. Write date of dressing change and initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.**

G. **ACCESSING OR DE-ACCESSING IMPLANTED VENOUS PORTS:**

1. Accessing procedure:
   a. Obtain physician's/**AHP's** order to use implanted device.
   b. Assemble supplies (see **Central Line Supply List**~~Attachment A for procedure lists~~) and use **non-coring** safety needle~~s~~ **device**.
   c. Explain procedure to patient.
   d. Check for Chloraprep, Heparin, Betadine, and alcohol allergies.
   e. Use standard precautions while accessing implanted venous ports (refer to Infection Control: ~~Policy IC.5~~ Standard and Transmission Based Precautions **Policy IC.5**)
   f. Wear a mask and surgical hat during procedure.
   g. Assemble equipment on sterile field.
   h. Perform hand hygiene and don sterile gloves and using aseptic technique waste 5mL normal saline from 10mL pre-filled syringe then prime the ~~huber~~**non-coring safety** needle and extension tubing (with neutral displacement connector attached). Leave the syringe attached.
   i. Using Chloraprep, cleanse area over implanted port thoroughly with a gentle back-and-forth motion for 30 seconds. Allow to air-dry for 30 seconds. Do not fan or blow on site to speed drying. Use Betadine if patient is allergic to Chloraprep or alcohol.
      i. Locate port septum by palpation and triangulate port between the thumb and first two fingers of non-dominant hand.
      ii. Aim for the center of the port and insert the needle, perpendicular to port septum. Advance needle through skin and septum until it reaches the bottom of the reservoir.
   j. Do not begin injection or infusion until proper needle placement is confirmed by aspirating blood. Confirm placement by:
      i. Aspirating 5 mL of blood using the 10 mL syringe attached to the extension tubing.
      ii. Waste 5mL aspirant.
      iii. Flush with 10mL normal saline.
      iv. Apply dressing per "Dressing Change" (section G) procedure.
         1) Date and initial dressing.
   k. After procedure, flush with 10 mL normal saline and follow with catheter specific flush (see **Catheter Specific Flushes Table**~~Attachment B~~) or connect to IV infusion as ordered.
      i. If implanted port must be accessed multiple times for PRN or intermittent medication regime, obtain a physician's/**AHP's** order for KVO solution.
      ii. If KVO order is unobtainable and port must be accessed multiple times perform the following:
         1) Withdraw 5 mL from accessed implanted port and discard (removes heparin).
         2) Flush port with 10 mL of normal saline after heparin has been removed.
         3) Administer medication or IV via port.
            a) When port is no longer needed, flush with 10 mL of normal saline and heparinize port per flush table (**Catheter Specific Flushes Table**~~Attachment B~~).
   l. Access needle for implanted ports shall be changed every 7 days.

2. De-accessing procedure:
   a. If port is heparinized**,** no flush is needed **and** ~~(~~skip to e. of this section~~)~~.
   b. Check for blood return prior to flushing port with a 10 mL pre-filled normal saline syringe.
   c. Flush port with 10 mL normal saline
   d. Always flush port with specific flush prior to de-accessing (see **Catheter Specific Flushes Table**~~Attachment B~~).
   e. Perform hand hygiene, apply mask and don clean non-sterile gloves to remove transparent dressing. Lift from the edge and stretch film laterally for easier removal. Remove securement device if applicable.
   f. Inspect the site for signs of infection (redness, pain, swelling and/or purulent drainage**)**.
   g. Cleanse exit site using Chloraprep, the preferred antiseptic, or Betadine if patient is allergic to Chloraprep or alcohol. Let dry for 30 seconds.
   h. To remove the **non-coring** safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed. A click will be heard indicating the tip of the needle is fully encased.
      i. If removing a~~n huber~~**non-coring** needle **device** that does not have a safety feature to prevent a needle stick, use two tongue depressors to stabilize in between the patient's skin and underneath the ~~huber~~**non-coring** needle **device** to prevent a rebound of the needle **when removing**.
   ~~j.~~**i. If access had a central line dressing and ~~it~~ was not an in and out access, cleanse site using alcohol wipe or chlorhexidine before applying band-aid. Allow to dry for 30 seconds.**
   ~~k.~~**j.** Apply small band-aid.
   ~~l.~~**k.** Discard needle in a sharps container.

H. **REMOVAL OF NON-TUNNELED CENTRAL LINES (PICCs, Multi-Lumen, Vas Cath):**

1. **Procedure:**
   a. Verify physician/**AHP** order to discontinue line.
   b. Assemble supplies (see **Central Line Supply List**~~Attachment A for procedure lists~~).
   c. Explain procedure to patient.
   d. Place absorbent pad under catheter site.
   e. Have patient lay flat or have head of bed no more than 30 degrees if possible.
   f. Use standard precautions for removal of non-tunneled central lines (refer to Infection Control: ~~Policy IC.5~~ Standard and Transmission Based Precautions **Policy IC.5**)
   g. Open the suture removal kit.
   h. Perform hand hygiene, apply mask and don clean non-sterile gloves to remove the dressing and discard.
   i. Check site for signs of infection.
      i. If there are signs of infection, send the catheter tip to the laboratory for culture and sensitivity testing, per physician's/**AHP's** order.
   j. Remove securement device if applicable.
   k. Cleanse exit site with Chloraprep with a back and forth motion for 30 seconds. Use Betadine if patient is allergic to Chloraprep or alcohol.
   l. Carefully remove sutures by grasping one-at-a-time with forceps held by the non-dominant hand. Use the dominant hand to clip suture at a spot close the skin. Take care so as not to cut catheter or patient's skin.
   m. Instruct patient to perform Valsalva maneuver during removal. If patient is unable to hold his/her breath and bear down, place the bed as flat as possible.
      i. For PICCs, have patient keep her/his arm straight.
   n. With 4x4 pad in non-dominant hand, grasp catheter with dominant hand and gently pull the catheter to remove. As catheter is coming out, place 4x4 over insertion site.
   o. Once removed, apply pressure with sterile 4x4 gauze to the insertion site for 5-10 minutes or until bleeding has ceased.

~~o.~~**i. If patient is taking anticoagulation medication, you may need to hold pressure for 10-20 minutes. Call MD if there is excessive bleeding or site continues to bleed after 20 minutes of applying pressure to the site.**

p. Apply new sterile folded 4x4, secure with large transparent dressing, and instruct patient to leave dressing on for 24 hours. Place date and initials with a permanent black marker on dressing.

q. Instruct patient to report shortness of breath, hematoma, or bleeding.

I. **ACCESSING THE DOUBLE LUMEN SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH:**

1. These Catheters Contain Large Doses of Heparin. Heparin must be aspirated before use.
2. Accessing procedure:
   a. Obtain a physician's**/AHP's** order to access only the venous port (blue port).
   b. Explain procedure to patient.
   c. Assemble supplies (see **Central Line Supply List**~~Attachment AB for procedure lists~~).
   d. Use standard precautions while accessing the double lumen subclavian/internal jugular vascath/permcath (refer to Infection Control: ~~Policy IC.5~~ Standard and Transmission Based Precautions **Policy IC.5**).
   e. Expose the vas cath/permacath in a way to prevent the patient from contaminating the ports with linens or gown.
   f. Place a sterile chux or drape under the access area to protect clothing and linen.
   g. Perform hand hygiene, apply mask and don sterile gloves.
   h. Ensure venous line is clamped before accessing.
   i. Saturate venous port thoroughly with Betadine and let stand for 5 minutes.
   j. Remove access cap and place sterile displacement connector (Microclave) on the end of port.
   k. Attach 10 mL syringe using aseptic technique.
   l. Unclamp and aspirate 5 mL (7 mL if drawing a PT or PTT).
   m. Clamp line and discard syringe.
   n. Attach 10 mL syringe containing 10 mL of normal saline.
   o. Unclamp venous port and instill 10 mL of normal saline.
   p. Clamp venous port and remove syringe.
      i. Venous line may now be accessed for IV fluids/IV medication administration.
         1) If a blood draw is needed, **refer to Patient Care Services:** ~~follow item E of this procedure "~~ **Collection of a** Blood Specimen **by Skin Puncture Procedure** ~~Collection from Venous Access Devices."~~
3. De-accessing:
   a. Flush venous port with 10 mL of normal saline after medication administration, after discontinuing IV fluids or after completion of blood draw.
   b. Heparinize Port (see **Catheter Specific Flushes Table**~~Attachment BC~~ for dosage) and label with a "Caution – High Dose Heparin" sticker.

J. **RELA~~LED~~TED DOCUMENT(S):**

1. Central Line Catheter Specific Flushes **- Sample**
2. Central Line Supply List **- Sample**
3. **Infection Control: Standard and Transmission Based Precautions Policy IC.5**
4. **Patient Care Services ~~Policy~~: Specimen Labeling, Nurse Collectibles Procedure**
5. **Patient Care Services ~~Policy~~: Sterile Technique Policy**
6. **Patient Care Services: Catheter Clearance with Alteplase (Cathflo Activase) Procedure**
7. **Patient Care Services: Collection of a Blood Specimen by Skin Puncture Procedure**
8. **Patient Care Services: Standards of Care, Adult**
9. **Patient Care Services: Universal Protocol Procedure**

K. **REFERENCE(S):**

1. Bard,~~.~~ **Hickman, Leornard, Broviac, Intro-Eze, & Surecuff** (~~n.d.~~**2007**). **Hemodialysis/apheresis** long term ~~polyurethane hemodialysis/apheresis~~ **central venous** catheters. *Bard* ***Access Systems, Inc.***~~nursing procedure manual~~
~~1.~~**2. Infusion Nurses Society (2016).** Infusion nursing standards of practice. ~~(2016~~11~~).~~ ***Infusion Nursing Society (INS).***
~~2.~~**3. Infusion Nurses Society (2016). Policies and procedures for infusion therapy. ~~5th edition (2016)~~*Infusion Nursing Society (INS).* 5th edition.**
~~3.~~**4.** San Diego Dialysis Center. (201~~4~~04). FMC hemodialysis procedure manual.

Central Line Supply List~~Attachment A~~

Central Line Supply Lists ~~Attachment A~~	
	1. Central Line insertion kit 2. Caps for assistant and physician/**AHP** 3. Full face shield for assistant 4. Mask with face shield for physician/**AHP** 5. Sterile gloves for assistant and physician/**AHP** 6. Sterile gown for physician/**AHP** 7. Full body sterile drape 8. Alcohol gel hand hygiene solution
Flushes	1. Non-sterile gloves. Mask if flushing a vas cath/permacath. 2. Alcohol wipes 3. Sterile field (may use 4x4 sterile gauze) 4. Sterile flush solution (see Catheter Specific Flushes - Attachment B) 5. 10mL Sterile normal saline filled syringe 6. 1 neutral displacement connector for each lumen.
Blood Specimen Collection	1. Non-sterile gloves (sterile gloves and sterile field for blood cultures) 2. Mask and goggles or full face shield 3. Alcohol wipes (3) or chlorhexidine swab 4. One 10 mL luer lock syringe for blood waste 5. Luer lock syringe(s) for blood specimen collection as provided by phlebotomist or safety vacutainer blood collection device 6. Patient lab identification labels 7. Vacuum blood specimen tubes as provided by phlebotomist 8. Plastic bag with patient labels for ACS and Telemetry morning blood draws 9. 10mL luer lock syringe with 10mL sterile normal saline 10. Sterile flush solution as appropriate (see Catheter Specific Flushes - Attachment B) 11. Neutral displacement connector
Dressing Changes	**1.** ~~Obtain c~~central line dressing change kit~~ and~~ **2.** ~~s~~**S**terile gloves~~ from supply Pyxis.~~ ~~1.~~**3. Neutral Displacement Connector (color specific for that day)**
Accessing or De-accessing Implantable Venous Ports	1. Central Line Dressing Kit ~~2.~~**a.** Non-sterile gloves **b.** Mask ~~and goggles or full face shield~~ **c. Cap** **d. 2 x 2 gauze** ~~and 4x4 or 2x2 sterile gauze~~ **e. Chloraprep (use Betadine if patient has allergy)** **f. Transparent Dressing** ~~3.~~**g. Biopatch (Mediport kit does not have Biopatch)** ~~4. Alcohol wipes~~ ~~5. Sterile drape~~ ~~1.~~**2. Neutral Displacement Connector** **3.** Sterile gloves ~~2.~~**4.** 10mL syringe filled with sterile normal saline ~~3.~~**5. Steri Strips (optional)** ~~4.~~**6.** Use only **non-coring** safety~~, non-coring~~ needles **device** to access implanted port, ~~5.~~**7.** Extension tubing per patient needs for length and gauge. ~~6.~~**8.** Neutral displacement connector attached to extension tubing ~~7.~~**9.** Tape **10. Additional supplies if De-Accessing** **a.** Flush solution as appropriate(See **Central Line** Catheter Specific

	Flushes ~~Attachment B~~) **b. Bandaid** **~~8.~~c. Tongue Depressors x2 if access needle is not a safety needle**
Removal Of Non-Tunneled Central Lines (PICCs, Multi-Lumen, Vas Cath)	1. Non-sterile gloves/ Mask and goggles or full face shield 2. Suture Removal Kit 3. Barrier-proof absorbent pad 4. Regular plastic bag for packaging and dressing disposal 5. 2x2 gauze, two 4x4 gauze 6. Large transparent dressing 7. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol

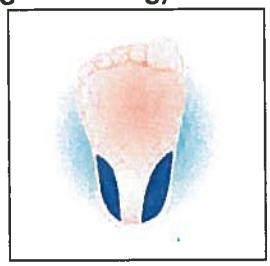
Central Line Catheter Specific Flushes

CENTRAL LINE CATHETER SPECIFIC FLUSHES ~~Attachment B~~			
TYPE	FLUSH SOLUTION	FREQUENCY	COMMENTS
Central Lines	Normal saline10mL	Q 8 hrs	1. Use proximal port as 1st choice for drawing blood, routine IV administration, and medication. 2. Use Medial port for TPN and may use for medications only if TPN not being given and not anticipated. 3. Distal port as alternative site for blood draw, administration of viscous fluids (i.e. blood products, colloids, albumin), CVP monitoring, and continuous fluid administration.
PICC/Midline	Normal saline 10mL	Q 8 hrs	
Patients going home with Central line or PICC	Heparin 200 units per lumen • 2mL of Heparin (100units /mL)	Q 12 hrs	Home Care: Q 24 hrs
Groshong	Normal saline 10mL	Once a week	
Implanted Port (VAD)			
Groshong	Normal saline 10mL	Once a month	
Vita-Port	Heparin 300 units • 300 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician/**AHP** order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Medi-Port	Heparin 500 units • 500 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician/**AHP** order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Vas Cath	Heparin Concentration 1000 units/mL • Check number on venous port • Instill that exact number in mL of heparin using the 1000 units/mL concentration (i.e. 1.6=1.6mL, 1.7=1.7mL, 1.8=1.8mL).	Once a week If not being accessed for dialysis	1. Only the Venous (blue port) port may be accessed and a Physician's/**AHP's** order is required before use. 2. Venous port must be clamped before syringes are connected or withdrawn. 3. Accessing – MUST ASPIRATE HEPARIN BEFORE USE. Using a 10mL syringe, remove 5mL of blood from the venous port and discard (7mL if drawing PT and/or PTT). Then port can be accessed. 4. De-accessing – Each Vas Cath/Permacath have a number located on the venous port that is the number of mL of heparin to be instilled when heparinizing the port (i.e. 1.6,1.7, 1.8)

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**COLLECTION OF BLOOD SPECIMEN BY SKIN PUNCTURE**
Purpose:	To outline the procedure for collection of blood specimen by skin puncture.
Supportive Data:	Skin puncture is applicable for: 1. Severely burned patients 2. Extremely obese patients 3. Patients with thrombotic tendencies 4. Patients with malignancies for whom venipuncture is reserved for therapeutic purposes 5. Geriatric patients or patients in whom superficial veins are not accessible or fragile 6. Patients performing tests at home (e.g. blood glucose) 7. Newborn/pediatric patients
Equipment:	1. Tenderfoot (NSY) and Preemie Tenderfoot (NICU) 2. Automatic lancet device 3. Heel warmer 4. Alcohol prep pad **or Chlorhexidine Gluconate prep pad and Saline wipe** 5. Capillary blood collection tubes ~~6. Microhematocrit tubes and clay – no longer in use; remove~~ **6. Gauze Pads** **~~6.~~7. Spot Bandages**

A. **PROCEDURE:**

1. Verify order for blood sampling.
2. Identify the patient per Patient Care Services Policy: ~~IV.A~~ Identification, Patient.
3. Ensure the blood specimen is collected from the individual designated on the specimen labels or requisition slip.
4. Choose the Puncture Site:
   a. Each patient should be assessed individually to choose the optimal blood-sampling method.
      i. **Venipuncture should be performed in the event finger stick cannot be obtained.**
   b. It is recommended greater than ~~1mL~~ **2mL** be drawn via venipuncture.
   c. Nonpharmacologic comfort measures ~~and/or sucrose~~ should be **considered for**~~provided to~~ patient**s** undergoing painful procedures such as skin puncture.
   d. Infant Heel Stick:
      i. Warm the infant's heel: Use a heel warmer according to manufacturer's instructions.
      ii. **Registered Nurse may** ~~P~~**p**rovide the patient with ~~a~~ **oral**~~pacifier dipped in~~ sucrose **and pacifier** ~~at least 2 minutes before beginning the procedure,~~ **per** ~~provider~~**physician/Allied Healthcare** ~~Provider~~**Professional (AHP) order.**
      iii. Provide developmental positioning **(for example swaddling or holding)**.
      iv. Site of Puncture: The blood must be obtained from the infant's heel using the most medial or lateral portion of the plantar surface of the heel, where "medial" is defined as closest to the midline of the body, "lateral" is defined as away from the midline of the body, and "plantar surface" as the walking surface of the foot.



      v. Assess the sampling site and select an area without excessive previous punctures, hematomas, or infection.
      vi. Contraindications to performing heel sticks are bruising or hematoma on the feet; feet that are edematous, injured, or infected; and feet with anomalies upon which pressures should be avoided.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/00; 05/12; 11/15; 03/17	06/12, 11/15, **05/17**	06/12, 12/15, **05/17**	03/16, **08/17**	n/a	10/12, 04/16, **09/17**	11/12, 05/16, **10/17**	12/12, 05/16

e. Children And Adult Finger Stick:
   i. The puncture shall be on the palmar surface (pad) of the distal phalanx and not at the side or tip of the finger.
   ii. Avoid puncturing the fifth finger if possible.
   iii. The skin puncture site must be warm and not swollen (edematous).

5. Clean the Puncture Site:
   a. Disinfect the site for sample collection **with alcohol pad** and allow it to dry. Betadine **or iodine** shall not be used to clean and disinfect skin-puncture sites.
   ~~b.~~**i. For NICU infants: disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU). Wipe away all disinfectant with saline wipe after procedure is complete. Alcohol should not be utilized for NICU infants.**

6. ~~Puncture the Skin~~**Select Puncture Device**:
   ~~a. Depth: The depth may be not more than 2.4 mm beneath the plantar heel skin surface and half this distance at the posterior curvature of the heel.~~
   ~~i.~~**a.** Infants: Use an automated heel lancing device that is appropriate size for the patient to perform the heel stick to ensure the proper depth.
   ~~ii.~~**b.** Finger Sticks: Use the **appropriate** automatic lancet device to ensure the proper depth.

7. **Order of Draw: If multiple specimens are to be collected, including preservative (EDTA – Lavender Cap) specimens, the EDTA specimen is drawn first to assure adequate volume (at least to the bottom 250 uL~~l~~ line but not more than the 500 uL~~l~~ line) and accurate hematology test results. Recap and mix IMMEDIATELY. Other additive specimens (Green top) are collected next and clotted specimens (Red top) last~~.~~.**

~~7.~~**8.** Perform the puncture:
   a. Puncture the chosen site that has been prepared.
   b. Wipe the first drop of blood with dry ~~sterile~~ gauze pad since it is most likely to contain excess tissue fluid.
   c. A second drop of blood will form over the puncture site. When a micro collection device touches this drop, blood will flow into the tubes by capillary action.
   d. During specimen collection, allow capillaries to refill (apply gentle pressure and then release) Avoid excessive squeezing of the heel). Fill specimen containers to the specified volume.
   e. Allow blood drops to fall freely into the tube (avoid scooping or scraping blood from the heel or finger).
   f. Fill specimen containers to the specified volume. Cap the tube when it is filled.
   g. Each additive tube must be mixed by gentle inversion 8-10 times immediately after collection.

~~8. Order of Draw: If multiple specimens are to be collected, including preservative (EDTA – Lavender Cap) specimens, the EDTA specimen is drawn first to assure adequate volume (at least to the bottom 250 ul line but not more than the 500 ul line) and accur~~
~~hematology test results. Other additive specimens (Green top) are collected next and clotted specimens (Red top) last..~~

9. Post Puncture Bleeding:
   a. Infant's Heel: Hold a ~~sterile~~ gauze pad pressed against the puncture site until the bleeding stops.
   b. Finger Stick: Apply pressure with a clean gauze pad until bleeding stops. Place a bandage on the site, if necessary.

~~10. Disposal of Automated lancing Device:~~
~~a.~~**10.** Dispose the automated lancing device in a sharps container.
11. Labeling Policy:

a. **Refer to Patient Care Services Specimen Labeling Procedure**~~Each sample must be accurately labeled. Sample labeled with the wrong patient or specimens without labels cannot be used. These samples have to be recollected~~.

b. ~~Each tube of blood must be labeled with the patient's full name, medical record number, time and date the specimen was collected, and the Compass log-on ID (Example: The Cerner log-on ID for Jane Doe is "doejan". DO NOT use initials.)~~

B. **REFERENCE(S):**

1. MacDonald, MG, and J Ramasethu. Folk LA. Capillary heel stick blood sampling. 4th ed. Philadelphia: Lippincott Williams and Wilkins, 2007. 93. Print.
2. Ohlsson, Shah VS A. "Venipuncture versus heel lance for blood sampling in term neonates." Cochrane Database System. 19 Apr. 2010. Web 24 May 2012. www.2.cochrane.org/reviews/en/ab001452.html.
3. Robbins, Meyers R. Pediatric Nutrition Practice Group. 2nd ed. Chicago: American Dietetic Association, 2011. Print.
4. Walton, DM, MG MacDonald, and J Ramasethu. Atlas of procedures in neonatology. 4th ed. Philadelphia: Lippincott Williams and Wilkins, 2007. 84. Print.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CRITICAL RESULTS AND CRITICAL TESTS - DIAGNOSTIC PROCEDURES**
Purpose:	1. A critical result is a test result at such variance with normal as to represent a pathophysiological condition that is potentially LIFE THREATENING unless action is taken in a short time. 2. A critical test/diagnostic procedure is defined as one that requires immediate action to be collected, transported, tested and results communicated to meet defined turnaround times. There is a limited menu of tests/diagnostic procedures considered critical tests. All critical tests are performed STAT, but not all STAT orders are critical tests.

A. **CRITICAL RESULTS PROCEDURE:**

1. It is the testing department's responsibility to immediately communicate critical results to the responsible nurse or physician/**Allied Health Professional (AHP)** and to maintain documentation of the communication. Critical results are the same for inpatients and outpatients.

B. **TURNAROUND TIME:**

1. The turnaround time for a critical result is defined as the difference between the time the result is obtained and communicated to the licensed healthcare **member**~~provider~~ responsible for the patient (RN) to the time of receipt of the result by the physician/**AHP**. Because the reporting process involved two steps (lab to RN and RN to physician/**AHP** in some cases requiring a call back of orders from the physician/**AHP**) the target turnaround time is less than 90 minutes.
2. The turnaround time for a critical diagnostic procedure is defined as the difference between the time the procedure resulted and the time communicated by the radiologist to the ordering physician/**AHP** shall be completed in less than 60 minutes.

C. **COMMUNICATION:**

1. The laboratory shall call the critical result to the licensed healthcare **member**~~provider~~ responsible for the patient who in turn shall notify the patient's physician/**AHP**.
   a. When the responsible licensed healthcare **member**~~provider~~ is not available to notify the physician/**AHP**, the notification task shall be delegated to another responsible licensed healthcare **member**~~provider~~.
   b. An exception to the above is when a standardized procedure or a physician/**AHP** order addresses a critical result.
   c. When an inpatient is discharged prior to the reporting of a critical lab result, the communication of the critical value will be as follows:
      i. Lab responsibilities:
      ii. Call the critical value to the Call Center extension 5719 Monday – Friday 0900 – 1700 or the Administrative Supervisor (AS) at 760-644-6968 after hours and weekends.
         1) All other critical values will be called by the lab as per the lab procedure for outpatients.
         2) All documentation of lab communication will be according to the Laboratory Procedure for Documenting Phoned or Verbal Communication
      iii. Call Center/AS responsibilities:
         1) Notify the physician's office of critical value
         2) Document the physician notification in the electronic health record (EHR)
2. Critical results from outpatients shall be phoned to the ordering physician's office. After office hours the critical result shall be phoned to the on-call physician/**AHP**.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy and Therapeutics	Department of Pathology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
08/05, 01/09, 07/09, 06/10, 05/13, 07/14	06/10,11/13, 08/14, **07/15**	08/09, 07/10, 11/13, 10/14, 07/15	09/14, **12/15**	**08/17**	08/09, 07/10, 11/14, **09/17**	09/09, 08/10, 01/15, **10/17**	09/09, 08/10, 01/15

a. If, after 60 minutes, the on-call physician/**AHP** does not return a call or if the on-call physician/**AHP** refuses to take the critical result, contact the on-call pathologist. Have the patient's phone number available.

3. Diagnostic procedure critical results are reported by the radiologist directly to the ordering physician or on-call physician.
4. Cardiology critical test results: All results of critical test results are communicated by the cardiologist to the ordering physician.

D. **DOCUMENTATION:**

1. Laboratory documentation shall be as a Result of Order comment.
2. RN documentation shall be completed in the patient's electronic medical record. Refer to Patient Care Services policy Documentation in the Medical Record, IX.I.
   a. Critical result including physician notification and plan of action (Physician Notification Power Form).
3. Diagnostic procedure documentation shall be completed by the radiologist in the patient's electronic medical record.

E. **CRITICAL VALUE LIST:**

1. Diagnostic Procedure Critical Results
   a. Hemorrhage: Intracerebral, intrabdominal/Retroperitoneal, and Intrathoracic
   b. Cerebral herniation
   c. New pneumothorax
   d. Bowel perforation
   e. Ectopic pregnancy
   f. Acute spinal cord compression
   g. Aortic dissection
   h. Leaking abdominal aortic aneurysm
   i. Spinal fractures
   j. Volvulus
   k. High probability VQ Scan or pulmonary embolus
   l. Testicular/ovarian torsion
   m. Fractures compatible with non-accidental child abuse
   n. Acute cervical fracture/hematoma
2. ABG Lab – Critical Values
   a. Adults:
      i. PaO2 mmHg less than 56
      ii. PaCO2 mmHg more than 55 **and** a pH less than 7.36
      iii. pH less than 7.32 or more than 7.52
      iv. MetHb more than 3.0
      v. Carboxy Hgb more than 14.0%
   b. Neonatal/Peds:
      i. PaO2 mmHg less than 50 or greater than 100, arterial only
      ii. PCO2 mmHg less than 25 or greater than 60, arterial or capillary
      iii. pH less than 7.28 or greater than 7.50, arterial or capillary
3. Laboratory Quantitative Critical Results:

CHEMISTRY	UNITS	LOW	HIGH	HEMATOLOGY [6]	UNITS	LOW	HIGH
Bilirubin, Total [1]	mg/dL	--	18.0	Fibrinogen	mg/dL	100	--
Calcium [2]	mg/dL	6.0	13.0	Hematocrit [7]	%	20	60
Calcium, Ionized	mg/dL	3.0	6.3	Hemoglobin [7]	g/dL	7.0	20.0
CO2	mmol/L	15	45	Platelet [8]	$x10^3/\mu L$	20	1000
Glucose	mg/dL	40	450	Protime INR	INR	--	4.5
Glucose, CSF	mg/dL	25	450	PTT on Heparin	sec.	--	200

CHEMISTRY	UNITS	LOW	HIGH	HEMATOLOGY [6]	UNITS	LOW	HIGH
Lactic Acid	mEq/L	--	4.0	PTT no Heparin	sec.	--	80
Magnesium [3]	mg/dL	1.0	4.5	Thrombin Time	sec.	--	90
O2 SAT Venous	%	70	--	WBC	$x10^3/\mu L$	2.0	30.0
Osmolarity, Serum	mOsm/kg	250	323				
Phosphate	mg/dL	1.0	10.0				
Potassium [4]	mEq/L	2.8	6.2				
Sodium	mEq/L	120	165				
Troponin [5]	ng/mL	--	0.06				

~~Notes:~~

1. Bilirubin, Total critical value applies to newborns and infants only.
2. For newborns less than 30 days old the low critical value for calcium is less than 8.0 mg/dL.
3. For OB patients receiving magnesium sulfate therapy call results greater than or equal to 7.0 mg/dL.
4. For patients undergoing dialysis the critical value for potassium is greater than 6.9 mEq/L.
5. For ~~patients in location ED,~~ critical value troponins ~~do not require phoned communication and documentation. For all other locations,~~ the critical value applies for the first positive result during the previous 48 hours and must be phoned and documented.
6. Hematology critical results will not be called if reoccurring within the same encounter and pass the delta check.
7. For infants 0-4 days the critical value for Hgb (g/dL) is less than 7.0 or greater than 24.0. For Hct (%) the critical value is less than 20 or greater than 63.
8. Platelet counts less than 10 ($x10^3/\mu L$), i.e. less than 10,000/µL, will always be phoned and documented.

4. Therapeutic Drugs:

DRUG	UNITS	CRITICAL VALUE
Acetaminophen	mcg/mL	greater than 100.0
Amikacin, trough	mcg/mL	greater than 10.0
Amikacin, peak	mcg/mL	greater than 35.0
Amikacin, random	mcg/mL	greater than 35.0
Carbamazepine	mcg/mL	greater than 12.0
Digoxin	mcg/mL	greater than 2.0
Disopyramide	mcg/mL	greater than 7.0
Gentamicin, trough	mcg/mL	greater than 2.0
Gentamicin, peak	mcg/mL	greater than 10.0
Gentamicin, random	mcg/mL	greater than 10.0
Lithium	mcg/mL	greater than 1.2
Lidocaine	mcg/mL	greater than 5.0
Magnesium Sulfate	mcg/mL	greater than 7.0
NAPA	mcg/mL	greater than 30.0
Phenytoin	mcg/mL	greater than 20.0
Phenobarbital	mcgmL	greater than 45.0
Primidone	mcg/mL	greater than 12.0
Procainamide	mcg/mL	greater than **12**~~16~~.0
Procn+NAPA	mcg/mL	greater than ~~4~~**635**.0
Quinidine	mcg/mL	greater than 7.0
Salicylate	mcg/dL	greater than 50.0
Theophylline	mcg/mL	greater than 20.0
Tobramycin, trough	mcg/mL	greater than 2.0
Tobramycin, peak	mcg/mL	greater than 10.0

DRUG	UNITS	CRITICAL VALUE
Tobramycin, random	mcg/mL	greater than 10.0
Valproic acid	mcg/mL	greater than 120.0
Vancomycin, trough	mcg/mL	greater than 20.0

5. Qualitative Critical Values:
   a. Blood Bank:
      i. Positive antibody screen
         1) Incompatible cross match
      ii. Newborn positive direct antiglobulin test (DAT) with positive antibody screen from mother
      iii. Transfusion reaction
   b. Hematology:
      i. Presence of blasts on blood smear
      ii. Presence of sickle cells
      iii. Presence of malaria parasites or other blood protozoans.
   c. Microbiology:
      i. Positive gram stain or culture results on CSF, # blood or any sterile body fluid or tissue
      ii. Positive India Ink prep
      iii. Positive bacterial or fungal antigen detection
         1) Serum or CSF Cryptococcal antigen
         2) Serum or CSF bacterial antigen (Haemophilus influenzae, Neisseria meningitides. Strep Group B, Streptococcus pneumoniae)\
      iv. Positive Acid fast stain or culture
      v. Stool positive for Salmonella, Shigella, E. coli 0157:H7 or Campylobacter
      vi. Culture positive for Neisseria Gonorrhoeae, Streptococcus Group A, Streptococcus Group B isolated from women of child bearing age, pregnant women and OB-GYN patients
      vii. Positive Malaria smear
      viii. Positive RSV, Rotavirus, Chlamydia Legionella
      ix. Positive amoebae from CSF direct wet mount
      x. Positive Clostridium difficile PCR.
      xi. Presence of organisms that would require the patient to be in isolation or under certain precautions; i.e. Salmonella spp., Shigella spp., Vancomycin-resistant Enterococcus faecalis or Enterococcus faecium, methicillin-resistant Staphylococcus aureus. For all other organisms, only the nursing unit is notified.
   d. Infectious Diseases:

HIV 1,2 Antibody	Confirmed Positive
Hepatitis B Surface Ag	Confirmed Positive
Hepatitis B Core Ab IgM	Positive
Hepatitis A Ab, IgM	Positive
Hepatitis C Ab	Positive

   e. Clinical Microscopy:
      i. Pediatric patient (less than 2 years of age) with Negative Urine Glucose and a Positive Urine Reducing Substance.
         1) Note: This could indicate the patient has galactosuria.
      ii. Presence of pathogenic crystals (cysteine, leucine or tyrosine) in urine

F. **CRITICAL TEST/DIAGNOSTIC TEST – PROCEDURE:**

1. A critical test is one that requires immediate action to be collected, transported, tested and results communicated, regardless of the value, within the defined turnaround time to the responsible licensed caregiver so that further care or treatment can be determined for an unstable patient.

2. Critical Tests And Turnaround Time:
   a. The turnaround time for a critical test is defined as the difference between the time the test is ordered and the time the result is received by the responsible licensed caregiver. In most cases the call will be made to surgery or to the Emergency Department and does not require a call back from a physician.
   b. The following are the critical tests in use and the expected turnaround times:

Critical Tests – Laboratory	Turnaround Time (Order to receipt of result)
Code Blue Panel	15 minutes
Blood Gas Panel (CVS)	15 minutes
Frozen Section	20 minutes
Pro Time/INR and PTT (Stroke Code)	45 minutes
Creatinine (Stroke Code)	20 minutes
Critical Tests – Radiology/Cardiology	
CT (Stroke Code)	30 minutes
ECG (Stemi Code)	~~15~~ **10** minutes

G. **COMMUNICATION:**
1. Laboratory results of critical tests shall be communicated by phone to a licensed healthcare **member**~~professional~~ within the turnaround times listed. A read back of results is required for any critical test results that are critical values as per the Procedure for Confirmation and Communication of Critical Results.
2. Diagnostic procedure critical test results are reported directly to the ordering physician within the turnaround times listed.

H. **DOCUMENTATION:**
1. Laboratory critical test result communication shall be documented in Cerner as a result comment by using the template code "RPCT." The required elements are the test(s) called, the name of the licensed healthcare provider to whom the results were given, their credential e.g. RN, LVN, MD, etc., the date and time of the call (F5 key) and the Cerner logon identification of the caller.
2. Diagnostic procedure critical test documentation is defined under Section D.3.

I. **RELATED DOCUMENT(S):**
1. Lab Gen Lab QA Manual: Procedure for Confirmation and Communication of Critical Results
2. Lab Gen Lab QA Manual: Laboratory Procedure for Documenting Phoned or Verbal Communication

J. **REFERENCE(S):**
1. College of American Pathologists. (2009). Laboratory general checklist. Commission on Laboratory Accreditation.
2. Clevenger, R.R. (1995). A protocol for verifying critical values. Medical Laboratory Observer 17, p. 73-76.
3. Joint Commission.2010. National patient safety goals.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**EPILEPSY MONITORED UNIT (EMU)**
Purpose:	To outline the EMU's responsibility when caring for a patient admitted to the EMU.
Supportive Data:	Neurologist Preference /VA EMU
Equipment:	EMU video screen, EMU alarm, EMU seizure alarm call button, seizure pads

A. **DEFINITION(S):**

1. Epilepsy- at least 2 discrete seizures which occur 24 hours apart, one seizure with greater than (>) 60% chance of having another seizure.
2. Epileptic seizures- abnormal electrical discharges.
3. Non-epileptic spells- normal brain activity (i.e., pseudoseizures or other behavior/movement disorder).
4. Partial Seizures-
   a. Simple Partial Seizure- Awareness preserved, symptoms depend on origin of seizure, twitching of face, jerking of arm or leg and or emotions, fear, déjà vu, panic.
   b. Complex Partial Seizure- Most difficult to control with treatment, impairment of consciousness, may have an "aura", typically last less than 3 minutes, may appear awake but are unaware, does not respond appropriately, repetitive behavior (chewing, picking, lip-smacking), postictal fatigue or aggression and are sometimes amnestic for these events.
5. Generalized Seizures- (Primary or Secondary)- Often proceeded by a cry, tonic-clonic, sudden falling to the ground, typical convulsive movements, eyes usually rolled back during convulsion.
6. Seizure Types:
   a. Absence- sudden onset of staring
   b. Myoclonic- brief muscle contractions
   c. Clonic- rhythmic muscle contractions
   d. Tonic- sudden stiffening
   e. Atonic- sudden loss of muscle tone causing drop attacks
7. **Video-Electroencephalography** (VEEG)- Video/Audio/EEG continuous monitoring- Allows seizures to occur naturally in a safe and controlled environment, helps physician understand seizure type, where it is coming from and how it spreads, and if in fact it is epileptic or not. This is also used for a surgical workup.

B. **POLICY:**

1. EMU Assistant~~ee~~ Nurse Manager (ANM), EMU secretaries and Monitor Technician will check the EMU alarm system every shift for adequate audibility.
2. All staff members on the EMU will promptly respond to alarm.

C. **ADMISSION:**

1. Patient Admission and Preparation:
   a. Admitting or EEG technologist will notify the EMU ANM/~~-or~~ relief charge **nurse** of the patient's pending admission.
   b. The admitting physician or ~~NP/~~**Allied Health Professional (AHP)**~~PA~~ provides orders (such as EMU power plan).
   c. ~~When patient arrives they will go to admitting to check in.~~**Patients shall check in at registration upon arrival.**
      i. After checking in, **registration** ~~admitting~~ will send patient to the EEG lab.~~ where the~~
      ~~c.~~**ii.** EEG tech will begin the preparation for the EMU unit.
   d. EEG Techs will complete the following:

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/17	07/17	07/17	n/a	08/17	10/17	

i. Have patient sign consent
ii. Routine EEG with activation procedures
iii. HV-Hyperventilate if ordered
iv. PS-Photic Stimulation if ordered

2. Patient will then be transferred to the EMU.
3. The primary nurse shall:
   a. Initiate the EMU Powerplan orders on patient when they arrive to the unit.
      i. **Automated External Defibrillator**~~Antiepileptic Drugs~~ (AEDs) may be lowered on admission and throughout hospital stay.
      ii. Sleep deprived, 2AM-6AM-only if ordered.
   b. Notify Monitor Technician (MT) of the patient's admission.
   ~~b.~~**c.** Ensure the following:
      i. Padded bed rails/chair arms
      ii. Call light and alarm button in reach
      iii. Suction and Oxygen connected and ready
      iv. Peripheral IV for emergency medication**, as ordered**
      v. EMU laminated instructional guidelines, nursing checklist and Pocket Guide will be placed above the patients bed
      vi. Camera will be on patient at all times (except in the Bathroom)
         1) View of Camera should ~~be on~~**include** the patient's entire body
      vii. EEG electrodes **are** effectively glued
      viii. Games, radios, computers, etct. are permitted, **but** must be battery operated to reduce EEG artifact
   ~~c.~~**d.** Ensure the patient is accompanied by a companion/sitter (family, friend or hospital-appointed) upon admission and is ~~oriented~~**educated on the following**:
      i. How to push the button during an event
      ii. Identifying signs and symptoms of seizures
      iii. Notifying nursing staff if need **to** leave the bedside
      iv. Accompanying patient during ambulation and toileting at all times
   ~~d.~~**a.** ~~Notify Monitor Technician (MT) of the patient's admission.~~
   e. Verify with MT, EMU ANM and/or EMU secretary the cameras, monitor volume and EEG button to ensure all equipment is working properly.

D. **ONGOING MONITORING:**

1. Primary Nurse Responsibilit**ies**~~y~~:
   a. ~~Will~~ Complete the "Epilepsy Monitoring Unit Checklist" at bedside at the beginning of every shift.
   b. Educate~~s~~ patient/sitter or companion on all safety measures and document~~s~~ the education in the electronic ~~medical~~**health** record **(EHR)**.
   c. Complete~~s~~ the initial and postictal assessment on the EMU patient
   d. Document~~s~~ a detailed description **of all seizure episodes** in the ~~electronic medical record~~**EHR** ~~of all seizure episodes~~.
   e. ~~Will make every~~ Attempt to remain in the EMU room with the patient ~~to do daily charting~~**when documenting,** if possible**,** to ~~make themselves more available to patient /sitter or companion when seizure occurs~~**monitor for seizure activity and offer support**.

2. Monitor Technician~~s~~ Responsibilit**ies**~~y~~:
   ~~2.~~**a. Ensure patient is visible on monitor during monitoring.**
   ~~a.~~**b.** Monitor the video screen for patient having any of the following visible seizure activity(s):
      i. Twitching body movements (extremities, face and/or eyes)
      ii. Jerking body movements
      iii. Stiffening of body or extremities
      iv. Staring
      v. Sudden falling to floor
      ~~vi. Loss of consciousness~~

~~vii. Verbal screaming, inappropriate outburst yelling or crying~~

~~b.~~**c.** If any of the above are observed the monitor tech will sound the alarm and contact the nurse's station to notify the nursing staff.

3. EMU ANM/~~-or~~ relief charge responsibilities:
   a. ~~Will~~ Respond to all EMU alarms on the unit to ensure patient safety and video recording is running
   b. ~~Will~~ Ensure there is adequate staffing to cover the EMU ~~unit~~ (**patient**/nurse ratio 4:1 with sitter or patient support person)
   c. ~~Will~~ Assign a primary nurse and a backup buddy nurse for the entire shift for the EMU patient
   d. ~~Will~~ Check the EMU video and alarm every shift to ensure volume of alarm, alarm functionality and video system is working properly.
   e. Assign~~s only~~ staff members to these patients that have met the training requirements to be considered competent to care for EMU patients.
4. Backup Buddy Nurse:
   a. ~~Will~~ Respond to the EMU alarm and ~~will~~ perform the initial assessment and safety measures for the EMU patient if the primary **nurse** is not available.

E. **WHEN PATIENT IS HAVING A SEIZURE:**

1. RN, ANM or **Advanced Care Technician (**ACT**)** ~~needs to~~ **shall** push alarm button at patient's bedside if patient or companion did not activate.
2. Primary RN, Backup Buddy nurse and/or ANM need to promptly respond to alarm.
3. ANM, relief charge or secretary need to check camera when alarm is activated. Patient's entire body needs to be in view of camera.
4. Turn on lights in room and close curtain for optimal video recording.
5. Make sure patient is safe.
6. Move bedside table away from patient.
7. Uncover bedding or covers from patient so all extremities are in view of camera.
8. Turn off any background noise (TV, radio etc.).
9. Stay clear of the camera (patient should be in total view).
10. If patient experiences generalized tonic-clonic seizure initiate emergency precautions:
    a. Goal: patient safety and supportive therapy
    b. Stay calm, stay with the patient and call for help
    c. Activate the rapid response team for standby
    d. Clear bed, uncover patient, on camera
    e. Turn patient to side (**to** avoid aspiration)
    f. **Utilize** suction apparatus **as necessary to clear airway**
    g. **Apply** O2 via **simple** face mask
    h. **Administer lorazepam (**Ativan**)** 1mg **IV Push** ~~may be given~~ per physician order
    i. Notify neurologist on-call if:
       i. Prolonged seizure greater than (>) 5 min~~in~~utes or recurrent/cluster seizures
    j. Postictally assess for fatigue/somnolent, wandering, aggression
11. Patient Assessment:
    a. **During the episode,** perform seizure assessment and verbally describe finding**s** in a loud**,** clear voice for the video, ~~during the episode and~~ repeat**ing** what the patient says if they cannot speak clearly**:**
       i. Level of consciousness
       ii. Orientation
       iii. Body movements
          1) Rhythmic action of face or limbs, progression of movements
          2) Is one side more involved
       iv. How are pupils oriented?
          1) Staring, deviation, left, right, etc.
       v. Is patient able to speak?
          1) Lips smacking , drooling, chewing, vocalization

vi. Is patient fidgety, picking, searching?
vii. Ask patient to remember a word, example "pink"
viii. Ask ~~them~~ **patient** to squeeze fingers and point to ceiling
ix. If very brief seizure or subjective sensation, ask patient companion to describe it. Patient saying "I just had a seizure' is not sufficient.

12. After Seizure Assessment (Postictal):
    a. Neurological Checks:
        i. Check for drift – have patient hold palms up
        ii. Tapping – have patient tap fingers on left and right hand
        iii. Facial droop – have patient smile
        iv. Counting - have patient count from 1-10
        v. Movement – have patient move his**/her** hands, legs and wiggle toes
        vi. Fear, agitation or mood changes. Patient may attempt to disrobe, get out of bed or "flee"
    b. Language:
        i. Comprehension – hold up two fingers on your right hand
        ii. Repetition – have patient repeat the phrase, "I sat in the front of the room"
        iii. Naming – Show an object such as a pen and ask the patient "what is this?"
        iv. Orientation- What is your name**?**~~,~~ Where are you**?**~~,~~ What is the name of this place**?**
        v. Recall – what word did I tell you to remember?

F. **DOCUMENTATION:**
1. Document patient and companion/sitter education in the ~~electronic health record (~~EHR~~)~~.
2. Document seizure assessment findings in the ~~electronic health record (~~EHR~~)~~.

G. **REFERENCES:**
1. VA Epilepsy Center of excellence web link:http://www.epilepsy.va.gov/nursing/
2. Epilepsy foundation:http://www.epilepsy.com/
3. National Association of Epilepsy Centers:http://www.naec-epilepsy.org/

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/64**	**SUBJECT:**	**Medical Examiner Notification**
REVISION DATE:	**06/64, 09/91, 07/97, 09/00, 04/02, 06/03, 08/05, 06/06, 08/08, 01/11, 06/11, 02/15**	**POLICY NUMBER:**	**IV.Z**

Department Review:	**07/17**
Clinical Policies & Procedures Committee Approval:	**~~11/14~~08/17**
Nursing Executive Council Approval:	**~~11/14~~08/17**
Medical Executive Committee Approval:	**~~01/15~~09/17**
Professional Affairs Committee Approval:	**~~02/15~~10/17**
Board of Directors Approval:	**02/15**

A. **PURPOSE**

1. To identify cases that must be reported to the Medical Examiner pursuant to California Health and Safety Code (Section 102850) as well as to Government Code, State of California (Section 27491).

B. **POLICY**

1. Only the mortuary needs to report the death to the Medical Examiner's Office in cases where it has been more than 20 days since the doctor who is signing the death certificate has seen the decedent and which is otherwise not reportable to the Medical Examiner.
2. In accordance with California State Law, TCMC must notify the Medical Examiner (858-694-2895) regarding all patients whose death meets the following criteria:
   a. Known or suspected homicide. (This would include any delayed (days to years) death resulting from any non-accidental trauma. Example: quadriplegic from a gunshot wound 10 years ago, remote head injury, or suspected elder abuse.)
   b. Known or suspected suicide. (This would include any delayed (days to years) death resulting from any accidental injury. Example: person with organ failure due to an intentional medication overdose.)
   c. A result of an accident, injury, trauma, or mishap either old or recent. (This would include any delayed (days to years) death resulting from any accidental injury. Example: person with a brain injury from a fall or motor vehicle accident, burns or drowning, pulmonary embolism or other complication following trauma, medication, or surgical error.)
   d. Grounds to suspect that the death occurred in any degree from a criminal act.
   e. No physician in attendance (No medical history).
   f. Wherein the deceased has not been attended by a physician in twenty (20) days prior to death.
   g. Wherein the deceased has not been attended by a registered nurse who is a member of a hospice care interdisciplinary team in the twenty (20) days to death.
   h. Wherein the physician is unable to state the cause of death. (Must be genuinely unable and not merely unwilling).
   i. Without medical attendance.
   ~~c.~~j. During the continued absence of the attending physician and surgeon.
   ~~d.~~k. Indications the death is the result of an acute alcohol and/or prescription or illegal drug overdose.
   ~~e.~~l. An infectious process, such as AIDS or hepatitis, which may pose a threat to public health.
   ~~f.~~m. A sudden unexpected infant/child death.

~~g.~~**n.** A death resulting from a complication during a recently performed surgical procedure.
o. Death of an inmate/prisoner or in-custody patient.
p. **All deaths of patients in state mental hospitals.**
~~h.~~**q.** **All deaths where there is no known next-of-kin.**
~~i.~~**r.** Fatal events occurring at decedent's place of employment.
~~j.~~**s.** Dead on arrival (DOA) to determine whether the cause of death is known, whether or not it is due to non-natural causes.
~~k.~~**t.** Emergency Room deaths before a diagnosis can be established.
~~l.~~**u.** Operating Room (OR) or Postoperative deaths where negligence or accident is suspected.
~~m.~~**v.** Anesthetic deaths whether it occurs in the OR, recovery room or elsewhere.
w. Unidentified persons regardless of circumstance of death
~~n.~~**x.** **All deaths where the suspected cause of death is Sudden Infant Death Syndrome (SIDS).**
~~o.~~**y.** Food poisoning / accidental poisoning
~~p.~~**z.** Maternal deaths during childbirth
~~q.~~**aa.** Any death without an underlying etiologic specific underlying cause (sepsis, shock, cardiac arrest, multi-organ failure, etc.)
~~r.~~**bb.** Coma – all deaths in which the patient is comatose
~~s.~~**cc.** All violent, sudden or unusual deaths

3. An investigator from the Medical Examiner's Office will review the decedent's demographic information, medical history, and circumstances surrounding the death to determine whether to accept the case for an investigation or issue a waive number.
   a. Waive numbers have the following format: WV## - #####.
4. Note: Death involving the above criteria must be reported even if a physician is willing to sign the death certificate. The State requires all death certificates to record both an actual and underlying cause of death.

C. **REFERENCES:**

~~4.~~1. **County of San Diego (2016) Deaths Reportable to the Medical Examiner's Office [~~Fascicle~~Facsimile to Tri-City Medical Center]. San Diego, CA.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**12/81**	**SUBJECT:**	**Medications Brought In By the Patient**
REVISION DATE:	**09/97; 12/00; 03/01; 02/05; 04/05; 03/07; 10/09; 06/11; 07/13**	**POLICY NUMBER:**	**IV.DD**

Department Approval:	**03/17**
Clinical Policies and Procedures Approval:	**~~07/13~~05/17**
Nurse Executive Committee Approval:	**~~07/13~~05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**05/17**
Medical Executive Committee Approval:	**~~07/13~~06/17**
Professional Affairs Committee Approval:	**~~08/13~~10/17**
Board of Directors Approval:	**08/13**

A. **POLICY:**

1. As part of the "Conditions of Admission," the patient understands and agrees personal medications (including non-prescription, prescription, and herbal) will not be consumed by patient during ~~patients~~ **their** hospital stay. This applies to both inpatient and outpatient services. The hospital pharmacy department may request a patient provide their personal medications for administration if the medication is unobtainable by the hospital pharmacy department. During the admission process, patients are asked to provide all medications (including non-prescription, prescription, and herbal) that he/she is currently taking. After review of the patient's personal medications by admitting staff, medications will be returned to the patient's family or patient's representative for storage at patients' residence. If the patient does not have family members or a representative present upon admission, the hospital pharmacy department will store the medications in the pharmacy department.
2. If it is deemed necessary to administer a patient's own medication while the patient is in the hospital (inpatient or outpatient) the following conditions must be met before the medication is administered to the patient:
   a. The patient's physician has ordered the drugs and the order has been entered in the patient's medical record. The order shall contain the name of the drug, strength, route, frequency, and the time the order was written.
   b. The medication containers are clearly and properly labeled.
   c. The contents of the containers have been examined and positively identified after arrival at the hospital, by the patient's physician or the hospital pharmacist. The pharmacist or physician will initial the vial, attach the medication checked by label, and affix the label to the medication container.
   d. The integrity of the medication has been visually evaluated by the pharmacist or the physician.
   e. If the pharmacist or physician cannot positively identify or assure the medications' integrity, administration of the medication is not allowed.
3. All medications are administered by the nurse and recorded on the patients' medication administration record.
4. If the medication is a non-controlled medication, it shall be stored in a secure area at the nursing station (locked medication room). If the medication is a controlled medication, it shall be stored in the Pyxis Medstation. The pharmacist shall inventory and add the controlled drugs to the Pyxis Medstation under patient's own medications (POM's). If a Pyxis Medstation is not available, the controlled medication will be stored in a locked, secure area at the nursing station

and the medication counted and remaining drug noted after every dispensation to the patient to maintain accountability.

5. Parenteral medications may not be administered to patients unless prepared by or acquired by the Pharmacy Department at Tri-City Medical Center.
6. When the patient's own medications are brought into the hospital **including Crisis Stabilization Unit (CSU)**, a family member shall take the medications home.
7. When patient's own medication(s) cannot be taken home, the nurse shall:
   a. Place a patient label on all 3 pages of the Patient's Own Medication Record form.
   b. List medications by name on the form:
      i. Any controlled substances need to be verified and counted by a nurse and pharmacist or pharmacy technician. Pharmacy personnel will provide a counting tray.
         1) **CSU: two nurses shall verify the medication(s)**
      ii. Non-controlled drugs do <u>not</u> need to be counted.
      iii. Indicate if any bottles are empty upon receipt.
   c. Call pharmacy to pick up patient's own medications and the attached form. When the pharmacy technician or the pharmacist arrives to pick up the medications, the nurse and pharmacy personnel shall verify that the non-controlled drugs listed on the form are present and will verify and count any controlled drugs that may be listed on the form. The quantity of the controlled drug counted shall be listed on the form attached to the bag. The nurse and pharmacy personnel shall each sign and date the form.
      i. CSU: does not call the pharmacy and two nurses shall verify the medication(s) and each sign and date the form.
   ~~c.~~**d.** Patients own medications are to be stored inside of security bags using unique numbered locks. The lock number shall be transcribed onto the form after verification of the medications is complete. Then the pharmacy personnel and nurse shall label the bag with a patient sticker and place the patient's own medications inside of the security bag which will be locked in the presence of both parties.
      i. **CSU: stores medications on the unit**
   e. Document that patient's meds have been stored in Pharmacy in the medical record. Give pink copy to patient, and place yellow copy in chart.
      i. CSU: document in patient's record that patient's medications have been stored on unit.
8. When patient is discharged:
   a. The nurse shall **ensure the pharmacy is notified** ~~write the patient's discharge location on the chart copy send of "Patient's Own Medication Record form and then scan the form" to the Pharmacy~~ to retrieve patient's medications **upon discharge**.
      ~~a.~~**i. CSU: stores medications on the unit**
   ~~a.~~**b.** If patient's own medications are ordered as discharge medications, the nurse shall instruct the patient accordingly.
   ~~b.~~**c.** ~~If the patient's own medications are NOT to be taken after discharge the nurse shall label the envelope "DO NOT TAKE UNLESS PHYSICIAN ORDERS THESE."~~
   ~~c.~~**d.** Pharmacy personnel will deliver the bag of patient's own meds to the nursing unit. Pharmacy personnel with the discharging nurse shall verify the lock number and that no tampering of the bag has occurred.
      i. **CSU: two nurses shall perform the verification**
   ~~d.~~**e. The patient's own medications shall be returned to the patient with their other belongings.**
   f. The patient's own medications that are not retrieved **will be disposed of per Pharmacy Policy: Unusable Medications** ~~within 1 week following the date of discharge shall be destroyed by the Pharmacy Department~~.

B. <u>RELATED DOCUMENT(S):</u>

~~e.~~**1. Pharmacy Policy: Unusable Medications**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT:** Off Unit Transfer Process

REVISION DATE(S):

Department Approval:	09/17
Clinical Policies and Procedures Approval:	09/17
Nurse Executive Committee Approval:	09/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

A. **DEFINITION(S):**
   1. Safety Hand-Off: Providing safety information including, but not limited to:
      a. Patient name, diagnosis
      b. Orientation (for example alert, confused, forgetful)
      c. Code status
      d. Isolation status
      e. Communication barriers (hard of hearing, legally blind, non-English speaking)
      f. Patient safety concerns, for example fall risk, **equipment,** conditions affecting ability to transfer safely

B. **POLICY:**
   1. When a patient is transferred from their current location to another department:
      a. The sending department will document the date/time patient leaves department and location patient being transferred to in the electronic health record (EHR).
      b. The receiving department will document the date/time patient arrives in department in the EHR.
      c. The hard copy of the patient's chart will be sent with the patient**, if applicable**.
   2. If the patient is assigned a primary nurse:
      a. The primary nurse will provide a safety hand-off to transporter if the patient is transferred unaccompanied by a licensed nurse.
      b. Assess the patient on return to unit and document any changes in the patient's status in the EHR.
   3. Telemetry and Acute Care Services (ACS) Monitored units nursing staff shall ~~ensure~~ **notify** the Monitor Technician **by telephone or the monitory system off unit function**~~is notified per Patient Care Services Policy: Monitor Technicians (MTs): Communication Process~~.

C. **RELATED DOCUMENT(S):**
   1. Patient Care Services: Hand-Off, Communication
   2. Patient Care Services: Monitor Technicians (MTs): Communication Process

Tri-City Medical Center
Oceanside, California

DELETE – Incorporated into the Plan for Nursing Care

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**8/01**	**SUBJECT:**	**Quality and Operations Committee Structure**
REVISION DATE:	**6/03, 4/05, 5/09, 4/11**	**POLICY NUMBER:**	**I.L**

Clinical Policies & Procedures Committee Approval:	**~~02/11~~09/16**
Nursing Executive Committee Approval:	**~~03/11~~09/16**
Medical Executive Committee Approval:	**~~10/16~~10/16**
Professional Affairs Committee Approval:	**~~04/11~~10/17**
Board of Directors Approval:	**04/11**

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

~~1. Patient Care Services (PCS) is managed through application of Interdisciplinary Shared Leadership.~~
~~2. All PCS departments have a PCS plan that describes their scope of service.~~
~~3. The councils of the PCS areas operate under Shared Leadership. A staff and management representative of the unit-based committees may participate in the councils as follows:~~
   ~~a. Clinical Policies and Procedures (CPP)~~
      ~~i. Nursing Professional Practice Council (NPPC)Nursing Quality~~
      ~~ii. Wound~~
      ~~iii. Falls~~
   ~~b. Managers' Council~~
   ~~c. Clinical Informatics Council~~
~~4. Patient Care Services Councils communicate with medical staff committees in the following way:~~
   ~~a. Quality reports to Medical Executive Committee (MEC)~~
   ~~b. CNE reports to Medical Executive Committee (MEC)~~
   ~~c. Medical Executive Committee reports to the Board of Directors (BOD)~~
~~5. Task forces, teams, committees and councils with staff participation as appropriate, shall be utilized to address issues identified through the Performance Improvement process.~~
~~6. The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/Manager. Each Director/Manager is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.~~
~~7. The CNE assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.~~
~~8. The CNE is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and Executive Council.~~
~~9. The Inpatient Nursing Departments shall have representation on appropriate interdisciplinary councils/committees and shall communicate pertinent nursing practice issues with the medical staff.~~
~~10. The CNE attends Medical Executive as the representative for the Department of Nursing.~~
~~11. Directors/ /Managers may attend the Medical Staff Division Meetings when appropriate.~~
~~12. Staff members/Assistant Nurse Managers (ANM) shall participate in committees/councils as assigned and shall be provided time for attendance when on duty.~~
~~13. Staff meetings shall be conducted by the Director/Clinical Manager or designee with a mechanism established for all staff members' participation.~~
~~14. The Manager/ANM shall meet with their assigned Director/CNE at least monthly.~~
~~15. Directors/Managers shall ensure staff communication meetings are held at least monthly.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/06	**SUBJECT: Skin & Wound Care Policy**
REVISION DATE: 09/06, 12/08, 07/09, 12/09, 06/10, 10/13	**POLICY NUMBER: IV.D**

Department Approval:	**04/17**
Clinical Policies and Procedures Approval:	**~~02/14~~05/17**
Nurse Executive Committee Approval:	**~~02/14~~05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/14~~09/17**
Professional Affairs Committee Approval:	**~~04/15~~10/17**
Board of Directors Approval:	**04/15**

A. **PURPOSE:**

1. The purpose of this policy is to define healthy maintenance of skin integrity, alteration in skin integrity and the process for assessment, treatment and documentation. For the purpose of this policy surgical wounds are considered acute wounds which proceed through an orderly and timely healing process not requiring interventions to heal. The surgeon provides orders for the care of the acute wound.
2. To ~~P~~prevent ~~P~~pressure ~~Ulcers~~ **injuries** a comprehensive visual and tactile skin inspection upon admission, regularly, and as needed. Identify risk factors of pressure ~~ulcer~~ **injury** development utilizing the Braden Risk Assessment identify alterations in skin integrity and implement pressure ~~ulcer~~**injury** prevention and nursing interventions to protect patient.
   a. Remove all garments, protectors, dressings (including wound vac dressings), and removable devices, as medically stable, to assess the skin.
   b. Assess splints, casts, tubes and other devices as potential sites for pressure ~~ulcer~~**injury** development.
   c. Maintenance of healthy skin integrity through clean and dry skin using non friction bathing standards with slightly warm non-irritating, non-sensitizing, ph- balanced every day and after each incontinence episode. Keep skin well hydrated and moisturized.

B. **DEFINITION(S):**

1. Arterial Ulcer – a wound which fails to heal secondary to insufficient arterial perfusion, commonly located on areas exposed to repetitive trauma (i.e. lateral malleolus, phalangeal heads, between the toes, or on tips of toes) and typically has a "punched" out appearance.
2. Diabetic Ulcer – a wound which fails to heal as a result of elevated glucose levels resulting in altered nerve function in the lower extremities. Commonly located on pressure points of the feet such as the plantar surface and the metatarsal heads.
3. Eschar – black or brown necrotic devitalized tissue (scab-like covering).
4. Friction – sanding away of surface layer of skin occurring with repetitive rubbing, often seen under restraints or on elbows/heels, or where skin is fragile and macerated.
5. Maceration – erythematous or "water-logged" skin secondary to diaphoresis or ~~incontinence,~~**incontinence** may also be seen around a percutaneous tube that is leaking.
6. Full Thickness – tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly muscle excluding pressure ~~ulcers~~**injuries**.

7. Partial Thickness – tissue damage to the epidermis and part of the dermis excluding pressure ~~ulcer~~**injuries**. Abrasions, skin tears, blisters and shallow craters are examples of partial thickness wounds.
8. Pressure ~~Ulcer~~**injury** – localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
   a. Suspected Deep Tissue Injury (DTI) Depth Unknown- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or *shear.* The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.
   b. Category/Stage I: Non-blanchable erythema -- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.
   c. Category/Stage II: Partial thickness – Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
      *Bruising indicates deep tissue injury.
   d. Category/Stage III: Full thickness skin loss – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle ~~are~~ **is** *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a Category/Stage III pressure ~~ulcer~~**injury** varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ~~ulcers~~**injuries**. Bone/tendon is not visible or directly palpable
   e. Category/Stage IV: Full thickness tissue loss – Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ~~ulcer~~**injury** varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable
   f. Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown -- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.
9. Shear – the mechanical force that is parallel to the skin which can damage deep tissue such as muscle. Tissues attached to the bone are pulled in one direction, whereas surface tissues remain stationary. Shearing occurs when the head of the bed (HOB) is elevated and the patient slides downward in bed.

10. Sinus Tract – may also be referred to as tunneling; course or path of tissue destruction occurring in any direction from the surface or edge of wound resulting in dead space with potential for abscess formation.
11. Skin Tear – a traumatic wound resulting from separation of the epidermis from the dermis. Skin tears without tissue loss may be linear type or flap type. Skin tears with tissue loss may be partial or complete.
12. Slough – loose, stringy, non-viable tissue, may be white, tan, or yellow.
13. Undermining – area of tissue destruction extending under intact skin along the periphery of a wound, commonly seen in shear injuries.
14. Venous Ulcer – a wound that has failed to heal secondary to venous insufficiency, commonly located on the medial aspect of lower leg and ankle or superior to the medial malleolus, will typically appear with irregular margins and surrounding skin will have brown/black discoloration, there may be evidence of healed ulcer.
15. Wound – a disruption of normal structure and function of the integumentary system. Wounds are classified as acute, chronic, or refractory.
    a. Acute – a wound which occurs suddenly (i.e. trauma or surgery) and heals in an orderly and predictable cascade of events.
    b. Chronic – an acute wound which fails to heal normally (i.e. dehisced surgical wound) or a wound that is not healing secondary to a loss of perfusion or some other breakdown in tissue integrity (i.e. nutritional status, infections, or elevated glucose levels).
    c. Refractory – a wound which shows no measurable progress for two consecutive weeks despite appropriate management.

C. **POLICY:**

1. Skin (Integumentary) Assessment:
    a. Braden Risk Assessment shall be completed with all hospital department nursing assessments, upon orders for inpatient admission, and admission. Reassessments will be upon unit specific standards and PRN.
    b. Skin condition shall be assessed with all hospital department nursing assessments, upon orders for inpatient admission, and admission. Reassessments will be upon unit specific standards and PRN.
        i. Outpatient Areas: (Emergency Department and Procedural Areas)
            1) Should assess high risk patient populations for the skin integrity at pressure points which will be affected by patient positioning during the procedure. Application of prophylactic Composite dressing**,** ~~ie~~**i.e.**~~:~~ sacral dressing, heel dressing should be considered.
        ii. For any area that has dressing (including wound vac) upon admission, the dressing should be removed, area assessed, skin condition documented and appropriate dressing applied.
            1) VAC dressings should be removed and a saline dressing can be used until the ~~Wound Team~~**Wound Team** can be consulted to replace.
    c. Skin Assessment shall be comprehensive (visual and tactile) including but is not limited to:
        i. Skin Turgor
        ii. Mucous Membranes Color and Description
        iii. Skin Color
        iv. Skin Temperature
        v. Skin Moisture
        vi. Presence of :
            1) Any skin abnormality including partial or full thickness wounds
            2) Pressure **Injuries**~~Ulcer~~ (DTI / Stage I / 2 / 3 / 4 or Unstageable)
            3) Skin Tear
            4) Surgical Incision

vii. Location of all any skin abnormality including partial or full thickness wounds, pressure ~~ulcer~~**injuries**, skin tears or surgical incisions and description of skin abnormality and surrounding tissue, description and drainage.

~~D.~~**d.** Assess skin abnormality for signs and symptoms of infection. If any new infection is identified, notify physician.

~~E.~~**e.** Photograph all skin **injuries**~~abnormality~~ including partial or full thickness wounds, pressure ~~ulcer~~**injuries**, skin tears or non-surgical wounds on admission, at least once every 7 days, with changes and new discovery. Photos shall include:

~~a.~~**i.** Measuring guide with the following information: **patient initials and location**~~length, width, depth, and location~~ of wound.

~~b. Date of photograph~~

~~i. Patients initials~~

~~ii. iv. Medical record number~~

2. Documentation:
   a. Braden Risk Assessment and nursing interventions to protect patient.
   b. Integumentary skin assessment including any skin **injuries.**~~abnormalities~~
   c. Dressing changes:
      i. Write date, time, initials, and stage on the dressing prior to application.
   d. **Skin Care treatment plans.** ~~Skin Care Treatments~~
3. Identify patients at risk for skin breakdown:
   a. Braden Risk Assessment Score ≤18
      i. Implement interventions in areas of deficit
   b. Immobility
   c. Dry Chapped Skin
   d. Over Hydrated Skin
   e. Renal / Hepatic Impairment
   f. Low Albumin Levels
   g. Surgery Lasting 4 Or More Hours
   h. Diabetic
   i. Sepsis / Infection
   j. Patients With Really Low a BMI (for example less than 19)
   k. Spinal Cord Injury
4. Skin protection / wound prevention guidelines and intervention options:
   a. Maintain healthy skin moisture (strengthen skin integrity):
      i. Clean incontinent episodes quickly to keep skin dry.
      ii. Use Shield pads to clean perineum after stool & urine.
      iii. Use protective barrier moisture lotion to prevent chaffing.
      iv. Keep irritating substances off the skin i.e. acidic stool.
      v. Use a single underpad for incontinent patients to absorb moisture.
      ~~v.~~**vi.** **Use female external containment device for ~~incontinence~~incontinent females, as appropriate.**
      ~~vi.~~**vii.** Avoid adult diapers except on incontinent patients except during transport or during ambulation.
      ~~vii.~~**viii.** Use pH balanced non-rinse cleanser (Sage Comfort wipes).
5. Reduce friction and shearing:
   a. Use ~~drawsheet~~**draw sheet** when repositioning patient in bed.
   b. Lift patients off bed when repositioning (to reduce drag).
   ~~b.~~**c.** Evaluate for appropriate assist devices (trapeze bar).
   ~~F.~~**d.** Consider use of specialty mattresses for patients at high risk, in addition to turning, position and offloading patient every 2 hours.
      ~~1)~~**i.** **Pressure redistribution standard mattress (Isoflex or Sizewise).**~~Isoflex~~

~~2.~~ii. **Pressure redistribution mattress with a blower** ~~Air II~~ – for patients with moisture problems, incontinence and only 2 intact turning surfaces. **(Pulsate Mattress).**

~~3.~~iii. **Pressure Relieving Mattress** ~~Dolphin~~ – for patients with flaps/grafts or with only 1 intact turning surface. **Paraplegic and Quadriplegic patient shall be place on a pressure relieving surface (Immerse Mattress and Evolution bed). Unstable spine patients should not be placed on this surface.**

~~4.~~iv. Bari Bed – for patients greater than 350 pounds or difficulty turning and positioning.

~~2.~~**6.** Reduce pressure and shearing:

a. Maintain proper alignment / body position.

b. HOB less than 30 degrees if not contraindicated for patient.

~~b.~~**c.** ~~iii. GL~~Latch knee of bed to prevent sliding down in bed.

~~c.~~**d.** Consider floating/elevating heels with pillow or heel protectors under ankles.

~~d.~~**e.** Off load pressure areas.

~~e.~~**f.** Avoid foam rings or donuts.

~~f.~~**g.** When side lying, avoid positioning on trochanter and turn off the back at 30 degree angle.

~~g.~~**h.** Consider applying preventative silicone composite dressing to high risk areas.

~~3.~~**7.** Maintain mobility to reduce pressure areas on patient:

~~i.~~**a.** Reposition immobile patients at least every 2 hours.

b. Encourage/assist ambulatory patients to change positions in bed.

~~b.~~**c.** Reposition patients in chair every 30 minutes.

d. Do not place patient on reddened areas until redness has completely resolved.

~~i.~~**8.** ~~e.~~ Care for incontinent patients:

~~c.~~**a.** Offer frequent toileting, cued voiding or timed ~~voiding~~ **voiding.**

~~d.~~**b.** Every 1 hour observation of incontinent episodes and immediate cleansing of area after each episode.

c. Cleanse with comfort shield perineal care.

~~e.~~**d.** Avoid diapering except when ambulating and during transport.

~~f.~~**e.** Use one incontinent pad (avoid chux) on top of draw sheet.

f. Use incontinence skin barriers / creams / ointments and skin protectants to protect and maintain intact skin.

g. Consider using containment device to contain urine/stool.

~~4.~~**9.** Nutrition:

a. Initiate nutrition consult for patients at high risk.

b. Consider nutrition supplement per physician's order if at high risk.

~~b.~~**c.** Offer fluids with each turn unless contraindicated.

~~c.~~**d.** Multi-vitamins per physician's order.

D. PROCEDURE TREATMENT:

1. Apply Prophylactic foam composite dressings to identified high risk pressure injury areas with low moisture.

a. Apply silicone composite dressing ~~iei~~.e.: sacral dressing, heel dressing to low moisture high risk areas.

b. Reassess high risk skin areas by peeling back Prophylactic silicone composite dressing every shift, ~~iei~~.e.: sacral dressing, heel dressing with assessments per standards of care.

c. Change prophylactic foam composite dressings every 3 days and prn if soiled.

d. Mark prophylactic prevention dressing with a "P" and the date and time

e. Frequent positioning and off-loading every 1-2 hours will assist in the prevention of pressure injuries.

~~5.~~**2.** Stage 1, Stage 2, and Suspect Deep Tissue Injury:

a. Apply silicone composite dressing, ~~ie~~**i.e.:** sacral dressing, heel dressing to Low moisture Stage 1 area.
b. Reassess Stage 1, Stage2, or Suspect Deep Tissue Injury Area by peeling back silicone composite dressing, ~~ie~~**i.e.:** sacral dressing, heel dressing with assessments per standards of care.
c. For Pressure **Injuries**~~Ulcers~~ in high moisture areas **utilize an external urinary containment device and** apply **a protective** barrier ~~paste~~ and leave open to air.
d. Position patients off area of Pressure ~~Ulcer~~**injury.**

~~6.~~**3.** Stage 3**:**
a. Cleanse wound with normal saline.
b. Assess for tunnels, tracts, or undermining.
c. Culture wound after cleansing if ordered.
d. If clean and shallow, fill visible wound bed with calcium alginate.
e. If infected, cleanse , culture and fill cavity with silver impregnated calcium alginate (silver) vs (calcium alginate).
f. If tracts, tunnels or undermining moisten kerlix roll with anasept gel and fill cavity, tracts, tunnels, or undermining with kerlix.
g. Cover wound with silicone composite dressing.
h. Change daily and if dressing becomes saturated with drainage.
i. Enter a referral to the Wound Team via Cerner.

~~7.~~**4.** Stage 4**:**
a. Cleanse wound with normal saline.
b. Assess for tunnels, tracts, or undermining and supporting structures: muscle, bone, tendon, or joint capsule.
c. Culture wound after cleansing.
d. If clean and shallow, fill visible wound bed with calcium alginate. If infected, cleanse, culture and fill cavity with silver impregnated calcium alginate (silver) vs (calcium alginate).
e. If tracts, tunnels, undermining, or ~~non visible~~**non-visible** wound bed moisten kerlix roll with anasept gel and fill cavity, tracts, tunnels, or undermining with kerlix.
f. Cover wound with silicone composite dressing.
g. Change every 12 ~~hrs~~ **hours** and if dressing becomes saturated with drainage.
h. Order **pressure relieving mattress, i.e.**~~Dolphin~~ air fluidized bed~~.~~**, immerse, or low air-loss.**
i. ~~i. i.~~ **Enter a referral to the Wound Team via Cerner.**

~~8.~~**5.** Unstageable – unable to determine staging of pressure ~~ulcer~~**injury:**
a. Relieve excessive moisture, pressure and/or shear.
b. Enter a referral to the **Wound Team**~~WOCN~~ via Cerner.
c. If only necrotic tissue (eschar) is present, cover the wound with dry gauze dressing until specific orders are given, or consult is obtained from ~~WOCN~~**Wound Team.**
d. For wound with a draining necrotic tissue (eschar/slough), follow Stage IV treatment options, silver or calcium alginate changing every 12 hours and if dressing becomes saturated with drainage, until specific orders are given, or consult is obtained from ~~WOCN~~**Wound Team.**

~~9.~~**6.** Skin Tear**:**
a. Cleanse wound area gently with normal saline.
b. ~~Approxiamate~~**Approximate** skin edges.
c. Apply ~~silcon~~**silicon** contact layer.
i. Change ~~silcon~~**silicon** contact layer every **seven** ~~five~~ days.
d. If bleeding, consider calcium ~~alignate~~alginate or calcium ~~alignate~~alginate with silver on top of silicone ~~contct~~contact layer.
~~d.~~**e.** Wrap area with kerlix and secure with tape. Avoid tape to skin.
i. Change kerlix every twenty-four (24) and as needed for saturation.
~~e.~~**f.** If unable to use kerlix, apply silicone composite dressing.

i. Change silicone composite dressing every twenty-four (24) and as needed saturation.

~~10.~~**7.** Partial Thickness Wound:
a. Cleanse wound area gently with normal saline.
b. Apply silicone composite dressing:
i. Change dressing every three (3) days and prn saturation.
c. If dressing does not adhere or requires replacement more than every three (3) days, consult ~~wound team~~**Wound Team**. May apply silicone composite foam and kerlix until ~~wound team~~**Wound Team** consult obtained. Change silicone composite foam daily.

~~11.~~**8.** Full Thickness:
a. Cleanse wound area gently with normal saline.
b. Apply silver to wound void.
c. Apply silicone composite dressing.
i. Change silicone composite dressing every three (3) days and as needed saturation.
1) Home Care patients change dressing every 3-5 days.
d. If wound appears infected, obtain order from physician to culture wound prior to silver application.

~~12.~~**9.** Medical Device Related ~~Pressure Ulcer~~**Pressure injury** Prevention:~~s~~
a. Apply Prophylactic foam composite dressing with Medical device initiation ~~Assess skin under medical device every shift when medical device is removable or adjustable~~**.**
~~a.~~**b.** Choose the correct size of medical device(s) to fit the individual.
~~b.~~**c.** Cushion and protect the skin with **foam composite** dressings in high risk area (i.e. nasal bridge).
i. Prophylactic silicone composite dressing application**,** ~~ie~~**i.e.**~~:~~ sacral dressing, heel dressing to high risk area.
1) Peel back every shift and assess skin:
a) If skin is not intact consult W**ound Team via Cerner.**~~OCN~~
2) Change silicone composite dressing every five (5) days and as needed if saturated.
~~c.~~**d.** Avoid placement of device(s) over sites of prior or existing pressure ~~ulcer~~**injury**~~ation~~**.**
~~d.~~**e.** Ensure staff know**s** the correct use of device(s) and prevention of skin breakdown.
~~e.~~**f.** Be aware of edema under device(s) and potential for skin breakdown.
~~f.~~**g.** Confirm that device(s) are not placed directly under an individual who is bedridden or immobile.

~~G.~~E. INCONTINENCE SKIN CARE:

1. Urinary:
a. Preventive:
i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application **of external containment device for incontinent females and**~~of~~ moisture barrier cream/ointment.
ii. Use of an absorptive wicking pad or containment device (i.e. external catheter) may be necessary.
b. Dermatitis/irritated red skin:
i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by **initiation of external urine containment device and** application of moisture barrier cream/ointment.
ii. Containment device may be indicated.
iii. Optimal to avoid use of absorptive brief/diaper.
iv. Consult ~~WOCN~~**Wound Team** if no positive response to treatment in forty-eight (48) to ~~seventytwo~~**seventy-two** (72) hours.
c. Fungal infection:

~~d.~~**i.** Assess for presence of fungal infection. Signs and symptoms include erythema, maceration and satellite lesions; at times the infection presents as solid plaques of moist, read areas. The chief symptom is pruritus at the site.

ii. Apply anti-fungal product.

~~e.~~**iii.** Containment device may be indicated.

iv. Optimal to avoid use of absorptive brief/diaper.

~~f.~~**v.** **Pulsate Mattress to dry out perineal microclimate~~.~~**

~~H.~~**vi.** Consult **Wound Team**~~WOCN~~ if no positive response to treatment in forty-eight (48) to seventy-two (72) hours.

~~1.~~**2.** Fecal:

a. Preventive:

i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream/ointment.

1) For frequent loose stooling and enzymatic drainage, **obtain order for** use of a containment device ~~(i.e.Dignicare Stool Management System / pouch) is indicated~~ to protect skin **(**~~[~~see P**atient Care Services Procedure:** Stool Management ~~(~~Rectal Tube**]**~~)~~ Dignacare Stool Management **System** ~~Procedure~~**).**~~]~~

b. Denuded/Excoriated Skin:

i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream/ointment every 1 – 2 hours.

ii. If skin is not broken, **obtain order for** use of a containment device ~~i.e.Dignicare Stool Management System / pouch) is indicated~~ to protect skin **(**~~[~~see P**atient Care Services Procedure:** Stool Management **[**~~(~~Rectal Tube~~)~~ **]** Dignacare Stool Management **System** ~~Procedure~~**])**

iii. If skin is broken, apply thick layer of Barrier paste 1/8 inch thick. Reapply paste every 1 -2 hours and PRN stooling

iv. Consult ~~WOCN~~**Wound Team** if no positive response to treatment in forty-eight (48) to seventy-two (72) hours.

~~2.~~**3.** Consultation and referral to ~~wound team~~**Wound Team:**

a. Consult when the condition necessitates:

i. Chronic pressure ~~ulcer~~**injury** history longer than 2 weeks, hospital acquired pressure ~~ulcer~~**injury**, any stage 3, stage 4, suspect deep tissue injury, or any full thickness wounds.

~~3.~~**4.** Pressure redistribution surface/Specialty bed selection:

a. Assure the appropriate selection of pressure redistribution support surface. All mattresses require scheduled turning and positioning to prevent pressure ~~ulcer~~**injuries**.

b. **Pressure redistribution** ~~Isoflex~~ mattresses are indicated for high risk patients, stage 1-**3. (isoflex and Sizewise).**~~4 and DTI~~

c. **Blower** ~~Air II~~ Mattress (rental) are indicated for moisture related issues with pressure ~~ulcer~~**injuries** and high need of pressure re-distribution. Avoid linens and padding on bed. **(Pulsate)**

d. Bari Air (rental) are indicated for patients greater than 350 pounds, low air loss.

e. **Pressure Relieving: Low Air Loss, Immerse and** ~~Dolphin~~ Air Fluidized Mattress (rental) are indicated for patients with stage 3 and 4 pressure ~~ulcer~~**injuries**, paraplegic and quadriplegic patients spinal cord injury patients, and patients after a surgical flap pressure ~~ulcer~~**injury** repair.

~~4.~~**5.** Education:

a. Educate family and patient on pressure ~~ulcer~~**injury** prevention and treatment per hospital policies; Educational Handout "How to Help Prevent and Manage Pressure Ulcers" and "It's Time To Take The Pressure Off!"

~~5.~~**6.** Call provider:

a. With discovery of a pressure **injury.**~~ulcer~~

b. Immediately if the patient exhibit signs or symptoms of super infection related to pressure ~~ulcer~~**injury** or the following symptoms in the wound present.
c. Wound appears to be deteriorating.
d. Increased necrosis of tissue in or around the wound.
e. Increased drainage or odor.
f. Progressive or noted peri-wound erythemia.

~~6.~~**7.** Evaluate for possible referral to the TCMC Center for Wound Healing and Hyperbaric Medicine upon discharge.

~~I.~~F. FORM(S):

1. Mattress Selection Guide (Bed Guide)
2. Pressure Ulcer Wound Dressing Selection (Includes Staging and Products)

G. RELATED DOCUMENTS:

1. Patient Care Services Procedure: PureWick Female Urinary Incontinence Management
~~3.~~2. Patient Care Services Procedure: Stool Management (Rectal Tube) Dignacare Stool Management System Procedure

~~J.~~H. REFERENCES:

1. Hiser, B., et. al.,. (2006, February). *WOCN clinical practice guidelines: prevention and management of pressure ulcers*, 52 (2).
2. Baranoski, S. & Ayello, E.A. (2004). *Wound care essentials: practice principles*. Philadelphia, PA: Lippincott Williams & Wilkins.
3. Magnan, M.A. and Makelebust, J. (2009). Braden scale risk assessments and pressure ulcer prevention planning. *Journal of Wound, Ostomy and Continence Nursing, 36* (6), 622-634. 4. 3M Skin Health Program
4. www.npuap.org 2008.
5. www.ihi.org 2010.

	Braden 15-18 Mild Risk	Braden 13-14 Moderate Risk	Braden 10-12 High Risk	Braden 1-9 Severe Risk
No Pressure Injury	➢ **Iso flex or NPT3** ➢ *If pain on Isoflex or moisture issues:* **Pulsate**	➢ **Iso flex or NPT3** ➢ *If pain on Isoflex or moisture issues:* **Pulsate**	➢ **Iso flex or NPT3** ➢ *If pain on Isoflex or moisture issues:* **Pulsate**	➢ **Pulsate** **Moisture Issues* **Pain on Isoflex* **Cachetic*
Pressure Injury Stage I More than 1 positioning option	➢ **Isoflex or NPT3**	➢ **Isoflex or NPT3**	➢ **Isoflex or NPT3**	➢ **Pulsate Mattress**
Pressure injury Stage II More than 1 positioning option	➢ **Isoflex or NPT3**	➢ **Isoflex or NPT3**	➢ **Isoflex or NPT3**	➢ **Pulsate Mattress**
Pressure Injury Stage III More than 1 positioning option	➢ **Isoflex or NPT3** ➢ **Pulsate Mattress**	➢ **Isoflex or NPT3** ➢ **Pulsate Mattress**	➢ **Isoflex or NPT3** ➢ **Pulsate Mattress**	➢ **Pulsate Mattress** ➢ **Pulsate Mattress**
Pressure Injury Stage III, IV, and Unstageable Fungal Rash / Moisture	➢ **Pulsate Mattress**	➢ **Pulsate Mattress**	➢ **Pulsate Mattress**	➢ **Pulsate Mattress**
Deep Tissue Injury Flaps / Grafts/ Spine	➢ **Pulsate Mattress** ➢ **Immerse**	➢ **Pulsate Mattress** ➢ **Immerse**	➢ **Pulsate Mattress** ➢ **Immerse**	➢ **Pulsate Mattress** ➢ **Immerse**
Para or Quads Or Limited turning options	➢ **Immerse**	➢ **Immerse**	➢ **Immerse**	➢ **Immerse**

MATTRESS SELECTION GUIDE

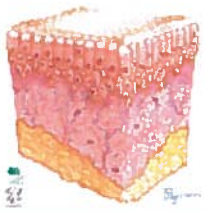
* All mattress require patient turning and positioning at least q 1-2 hrs to prevent Injury. If noted redness move up to Pulsate Mattress*
To Prevent Pressure Injury: Implement Braden Interventions and float heels
*** The immerse Mattress is not indicated for unstable spine patients***

PRESSURE INJURY AND STAGES

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense pressure, prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

NATIONAL PRESSURE ULCER ADVISORY PANEL

DEFINITION	SCHEMATIC DRAWING	EXAMPLE
STAGE 1 PRESSURE INJURY **Non-blanchable erythema of intact skin** Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.		
STAGE 2 PRESSURE INJURY **Partial-thickness skin loss with exposed dermis** Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).		
STAGE 3 PRESSURE INJURY **Full-thickness skin loss** Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.		
STAGE 4 PRESSURE INJURY **Full-thickness loss of skin and tissue** Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.		

DEFINITION	SCHEMATIC DRAWING	EXAMPLE
UNSTAGEABLE PRESSURE INJURY **Obscured full-thickness skin and tissue loss** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.		
DEEP TISSUE PRESSURE INJURY **Persistent non-blanchable deep red, maroon or purple discoloration** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.		
MUCOSAL MEMBRANE PRESSURE INJURY *Mucosal* membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. These ulcers cannot be staged.		

Tri-City Hospital Pressure Ulcer Wound Dressing Selection Guide

B/Y/R								
Description	Pressure Ulcer Prevention†	Stage I	Stage II	Stage III	Stage IV	Suspected Deep Tissue Injury (sDTI)	Unstageable	Eschar on heels (Colors may vary)
Wound Appearance								
Important!	Ensure that all anatomic sites at risk are protected from pressure: offload by repositioning at intervals appropriate for the patient¹							
Exudate Level (= indication of exudate level)	None		Low → to Heavy			None → to Heavy		
Depth	Closed		Shallow	Shallow/ Deep		Closed to Shallow	Closed	
Treatment Objective	Protect		Protect, Absorb, and fill dead space			Protect	Protect/Absorb	
Suggested Products and Change Rates (To the right are management options for each condition)	For Braden 18 or less or if otherwise at high risk: Mepilex® Border Sacrum® or Mepilex® Border or Mepilex® for device related (up to 3 days/ as needed) Peel Back Dressing Each Shift: Assess & Document Skin Condition	Cover choices Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)		Heavy to Moderate Exudate Fill with: Calcium Alginate-Melgisorb® (Up to 3 days/ as needed) Cover choices Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed) If Infection Suspected Fill with: Silver Calcium Alginate-Silvercel® (Up to 3 days/as needed) Cover choices Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days /as needed)		Cover choices Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)	Cover choices Mepilex® Border or Mepilex® Border Sacrum† (Up to 3 days / as needed)	Dry or Draining Heel Eschar° FLOAT HEELS Paint with Betadine® apply dry gauze dressing
				Consult Wound Team				
Notations	❶ Depending on Location: Use multilayered Mepilex® Border if possible. Choose product depending on location. ❷ Dressings with Safetac® technology DO NOT require use of skin barrier products				† As part of a comprehensive pressure ulcer prevention program individualized for the patient's condition, per hospital protocol ❸ DO NOT debride dry stable eschar - Consult Wound Team.			

Dressings available in multiple sizes

Mepilex®

Mepilex® Border

Mepilex® Border Sacrum

Melgisorb®

Use appropriate size for area to protect

The suggested topical management options and change rates are the treatment choice of Tri-City Hospital and may not reflect the opinions of Mölnlycke Health Care or in the case of products manufactured by a company other than Mölnlycke Health Care, the manufacturer's recommended usage guidelines.

MÖLNLYCKE® HEALTH CARE

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~MANUAL~~

ISSUE DATE: 04/09	**SUBJECT:** Specimen Labeling~~, Nurse Collectibles~~
REVISION DATE: 04/12	**POLICY NUMBER:** IV.RR

Department Approval:	10/16
Clinical Policies & Procedures Committee Approval:	~~04/12~~11/16
Nurse Executive Council Approval:	~~04/12~~01/17
Department of Pathology Approval:	08/17
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/12~~09/17
Professional Affairs Committee Approval:	~~06/12~~10/17
Board of Directors Approval:	06/12

A. **PURPOSE:**

1. To ensure all specimens collected from patients are properly identified and labeled in the presence of the patient.~~ Specimen containers may not be pre-labeled prior to collection.~~

B. **DEFINITIONS:**

1. Specimen: Any sample taken from a patient from which diagnostic tests can be performed.
2. Cerner log-on ID: The six letter code or user name consisting of the first three letters of the last name followed by the first three letters of the first name.
3. **Specimen Type: The type of specimen that will be analyzed in the laboratory (i.e. blood, urine, stool, sweat, saliva, CSF, synovial, amniotic, serous fluid, swab, products of conception (POC), tissue, etc).**
~~2.~~4. **Specimen Source: The source of the specimen type collected (i.e. urine source (clean catch, catheter, random, first morning, supra-pubic aspiration), swab source (nasopharyngeal, wound (i.e. right posterior hand~~)~~), serous fluid source (i.e. peritoneal, pericardial, pleural), solid tissue (i.e. right ovary).**

C. **POLICY:**

1. **Refer to specific specimen collection procedure prior to obtaining specimen.**
~~1. Specimens must be labeled in the presence of the patient.~~
~~a. If using a handwritten label, ensure the label is handwritten directly on the specimen container at the bed side after collection.~~
2. All labels must be legible and contain the **following:**
   a. **Patient's** full name~~,~~
   b. **M**~~m~~edical record number~~,~~
   c. **T**~~t~~ime and date of the collection~~, and the~~
   d. **Source and type of specimen**
   ~~2.~~e. Cerner log-on ID of the collector.
~~a.~~3. The type of label used may be one of the following:
   ~~i.~~a. Cerner generated label **(preferred)**
   ~~ii.~~b. Handwritten label
~~3. Specimen source is required on the specimen label for Histology and Cytology specimens.~~

D. **PROCEDURE:**

1. **Verify the physician/Allied Health Professional's order for specimen type.**

~~4.~~**2.** Match the collection label**(s)** information to the patient identification ~~prior to collection.Patient identification must be confirmed~~ using two patient identifiers **prior to collection** (Refer to Patient Care Services **(PCS) Policy:** Identification, Patient ~~Policy IV.A~~).

~~5. Collect the specimen and place the confirmed label on the side of the container (not on the lid) in the presence of the patient, i.e. an unlabeled container may not leave the patient's room or location.~~

- **a.** If multiple specimens are collected confirm each label with the **using two** patient~~'s~~ identifi**erscation**.
- **b. Do not collect specimen if there are any discrepancies between labels and patient identity.**

3. Labeling:

- **a. Only specimens collected by a patient may be pre-labeled (i.e. voided urine, sputum).**
- **b. Specimens collected by a healthcare provider must be labeled after the specimen collection in the presence of the patient.**
- **c. Place label on the side of container. Never on the lid of a specimen collection container.**
- **d. Never cover the patient's name on a preexisting specimen label with a Cerner label.**
- **e. Perform the Final Check:**
  - **i. Recheck that the specimen collected from the patient matches the label ID before leaving the patient's room.**
    - **1) "Say Out Loud" the last three digits of the patient's identification number (Refer to PCS Identification, Patient) from each label and compare it to the patient's arm band (White board in the operating room). Confirm they match.**

4. Place the collected specimen in the designated lab pick up receptacle for your specific unit.

~~6.~~5. Notify lab for pick-up of the specimen.

~~D. For surgical specimen handling, see Patient Care Services Specimen Handling Procedure.~~

E. RELATED DOCUMENT(S):

1. PCS Procedure: Specimen Handling
2. PCS Policy: Identification, Patient
~~1.~~3. General Laboratory QA Manual : Procedure for Assuring Correct Specimen Labeling

F. REFERENCE(S):

1. South Carolina Hospital Association. (2011). The ~~F~~final c~~C~~heck, A t~~T~~oolkit for the p~~P~~revention of m~~M~~islabeled b~~B~~lood s~~S~~pecimens ~~(2011). South Carolina Hospital Association~~ Retrieved from http://www.thefinalcheck.org.toolkit.

~~E.~~2. College of American Pathologists. (2016). All ~~C~~common ~~L~~laboratory ~~A~~accreditation ~~C~~checklist ~~R~~requirement COM.06100 – Primary Specimen Container Labeling.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

TRACKED CHANGES

STANDARDS OF CARE ADULT

I. **PREAMBLE:**

A. Health care providers at Tri-City Medical Center (TCMC) shall ensure that each adult patient and their family are treated equally, with dignity, and respect. Cultural, racial, language, life-style customs, and ethnic diversity of each patient shall be considered when providing care. Adult patients shall receive care based on disease, injury prevention, health promotion, health restoration and/or health maintenance. The nursing process shall be used to implement all patient care. Health care providers shall use TCMC Administrative Policy Manual, Patient Care Services Policies (PCS), PCS Procedures, Mosby's Online Procedures, and unit specific Standards of Care, policies and procedures to provide patient care.

II. **DEFINITION(S):**

A. Scope and Standards of Practice: "Describe what nursing is, what nurse do, responsibilities for which nurses are accountable, and the outcomes of that practice (American Nurses Association (ANA))".

~~A.~~**B.** Standards of Care: "Authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p.77)". "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p. 78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.

~~B.~~**C.** Nursing Process: **"The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care.** ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to clients and their caregivers, maintaining a patient safe environment, and patient health care promotion and the planning for continuity of care~~. The nursing process **as outlined by the ANA (2016)** includes the following:

1. Assessment: **"**A systematic, dynamic ~~process~~**way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors".** ~~by which the registered nurse, through interaction with the patient, significant others, and health care providers, collects comprehensive data pertinent to the patient's health and/or the situation.~~
   - **a. An assessment includes subjective and objective data**
     - **i. Subjective – what the patient says**
     - **ii. Objective – observation based on assessment findings**
   - ~~a. Registered Nurses (RN) performs assessments.~~

~~2. Licensed Vocational Nurses (LVNs) collect patient data.~~

~~3.~~**2.** ~~Only RNs perform admission, transfer, and/ or discharge assessments.~~Diagnosis: A **nurses'** clinical judgment about the client's response to actual or potential health conditions or needs.

~~4.~~**3.** Outcomes/**Planning**: **"Based on the assessment and diagnosis. Outcomes are m**easurable **and achievable short – and long-range goals".** ~~expected, client-focused goals~~

~~2.~~**a.** Planning: **Care Plan i.e.,** ~~(~~Plan of Care~~)~~: A comprehensive outline of care to be delivered to attain expected outcomes

Department Review	Clinical Policies and Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
02/16	11/16	01/17	n/a	03/17	10/17	03/13

~~5.~~**4.** Implementation: **"Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".** ~~Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~

~~6.~~**5.** ~~TCMC's, Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropria~~Evaluation: The process of determining both the **"patient's status and the effectiveness of nursing care. It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care".** ~~client's progress toward the attainment of expected outcomes and the effectiveness of nursing car~~

~~C.~~**D.** Patient: Recipient of nursing care.

~~D.~~**E.** Health Care Providers: Individuals with special expertise who provide health care services or assistance to clients

~~E.~~**F.** Significant Others: Family members and/or those significant to the client

G. Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.

~~F.~~III. POLICY:

~~III.~~**A.** "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patients to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)".

IV. GENERAL NURSING ASSESSMENT:

~~V.~~**A.** Standards **o**f Care: Vital Signs:

~~A.~~**1.** Vital signs shall include:

~~1.~~**a.** Temperature, documented in Celsius

~~2.~~**b.** Blood Pressure (BP)

~~3.~~**c.** Heart Rate (HR)

~~4.~~**d.** Respiratory Rate (RR)

~~5.~~**e.** Oxygen Saturation (SpO2)

~~6.~~**f.** Pain Level

~~B.~~**2.** Vitals signs shall be obtained on admission, transfer to a unit, at discharge, per physician's orders and as follows:

~~1.~~**a.** Intensive Care Unit (ICU): every 2 hours and as needed **(PRN)**

~~2.~~**b.** Telemetry: every 4 hours while patient is awake and **PRN**~~as needed~~

~~3.~~**c.** Acute Care Services (ACS): every 8 hours and **PRN** ~~as needed~~

~~4.~~**d.** Behavioral Health Unit (BHU): daily or as ordered by physician

e. Emergency Department: per unit specific policy

~~5.~~**f.** **Progressive Care Unit (PCU): Obtain vital signs based on the ordered Patient Admission Status i.e., ACS, Telemetry, Postpartum, and Rehabilitation**

~~C.~~**3.** Document values in the medical record

~~VI.~~**B.** Standards **o**f Care: Pain Assessment:

~~A.~~**1.** Assessment: Pain - A general pain assessment shall **be performed as outlined in the Pain Management Policy** consist of the following:

~~1. Target pain intensity~~

~~2. Pain scale~~

~~3. Current pain intensity~~

~~4. If patient complains of pain, assess the following:~~

~~a. Location, intensity, and duration/onset~~

~~b. Quality/type~~

~~c. Aggravating factors~~

~~d. Alleviating factors~~

~~B. Assess for presence of pain/discomfort on admission, initial shift assessment and PRN~~

~~C. Perform a pain assessment with each patient report of new or different pain.~~

~~D. Perform a pain reassessment as follows:~~

~~1. Thirty (30)~~ **~~to sixty (60)~~** ~~minutes after intravenous medications, intramuscular, or subcutaneous intervention~~

~~2. One (1) hour after PO intervention~~

~~E. Document patient's response in the medical record~~

~~VII.~~**C.** Standards **o**f Care: Intake **a**nd Output**:**

~~A.~~**1.** Intake and output shall be monitored as ordered and as follows:

~~1.~~**a.** ICU: **at least** every hour and **PRN** ~~as needed~~

~~2.~~**b.** Telemetry: **at least** every four hours and **PRN**~~as needed~~

~~3.~~**c.** ACS: **at least** every 8 hours and **PRN**~~as needed~~

~~a.~~**i.** Oncology: **at least** every 6 hours **and PRN**~~as needed~~

d. PCU: Obtain intake and output based on the ordered Patient Admission Status i.e., ACS, Telemetry, Postpartum, and Rehabilitation

~~4.~~**e.** BHU:

~~a.~~**i.** Monitor food intake every shift and PRN

~~b.~~**ii.** Monitor intake volume and output as ordered by physician

~~c.~~**iii.** Night shift shall assess bowel movements every morning with daily vital signs

~~B.~~**2.** Intake and output shall be documented in the medical record **after collecting and as follows**:

~~1.~~**a.** Prior to transfer to another level of care

~~2.~~**b.** Prior to the end of the shift

~~3.~~**c.** As ordered by a physician

~~4.~~**d.** Zero/clear infusion pumps every shift and prior to transferring to another level of care

~~5.~~**e.** BHU: document intake and output every shift

~~C.~~**3.** Review patient's intake and output for baseline urine output

~~1.~~**a.** Patients 14 years and older assess a minimum of 0.5 mL per kilogram per hour (example if the patient weighs 70 kg multiply 70 x (times) 0.5 equals 35 mL per hour or per physician order. Notify physician for abnormal findings.

~~VIII.~~**D.** Standards **o**f Care: Height **a**nd Weight

~~A.~~**1.** All patients shall be weighed on admission if not contraindicated and every seven days thereafter until discharge. Exceptions are as follows.

~~1.~~**a.** All ICU patients shall be weighed daily in the AM

~~2.~~**b.** Patients with the following diagnoses shall be weighed daily in the AM **at or prior to 0600 after voiding, if indicated**

~~a.~~**i. Acute and chronic kidney failure e.g., r**enal failure, ~~or~~ renal insufficiency**, acute renal injury**

~~b.~~**ii.** Heart Failure **this includes patients with cardiomyopathy receiving diuretics**

~~c.~~**iii.** Post cardiovascular surgery patients

~~3.~~**c.** Patients receiving nutrition support - i.e., enteral or parenteral feedings shall be weighed every 3 days after admission.

~~4.~~**d.** Medications shall be calculated using the patient's admission weight unless ordered otherwise by a physician.

~~5.~~**e.** Patient's weight shall be documented in the medical record in kilograms.

~~6.~~**f.** Patient's height shall be documented in the medical record in centimeters.

~~a.~~**i.** Height shall be obtained on admission; stated, estimated or measured.

~~B.~~**E.** Standards **o**f Care: Aspiration Assessment**:**

1. Assess on admission, initial shift assessment, and PRN **as outlined in Mosby's: Aspiration Precautions Procedure**

a. Perform a swallow screening PRN based on assessment findings as outlined in the Swallow Screening in the Adult Patient Procedure

~~F. Maintain aspiration precautions for patients identified at risk~~

b. Maintain head of bed (HOB) at 30 to 45 degrees and as ordered, unless contraindicated

~~Keep patient as near to 90 degrees (upright) as possible for eating or drinking~~
~~Maintain head of bed (HOB) at 30 degrees at all times~~

~~a. Discontinue tube feeding 30 minutes prior to procedures or when placing patient's HOB below 30 degrees~~

~~b. Offer small amounts of food, slowly~~

~~c. Offer thick liquids and avoid straws~~

~~a.~~**c. Ensure suction equipment is readily available at the bedside at all times.**

~~Maintain suction equipment at bedside at all times~~

~~C.~~**F.** Standards **o**f Care: Patient Safety**:**

~~D.~~**1.** The health care team shall provide measures to ensure patient safety.

~~E.~~**2.** Patient safety shall be assessed per the following:

~~1.~~**a.** The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after transport to procedures and as needed.

~~2.~~**b.** Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.

~~3.~~**c.** Orders shall be obtained, reviewed, and implemented per PCS: Physician Orders Policy.

~~4.~~**d.** Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.

~~5.~~**e.** Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.

~~6.~~**f.** Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.

~~a.~~**i.** Respiratory Care Practitioner shall be responsible for setting up home CPAP equipment.

~~7.~~**g.** Patients shall be assessed for falls per PCS: Falls Risk Procedure.

~~1. Aspiration precautions shall be implemented for high-risk patients per the following policies and/or procedures:~~

~~a. PCS: Swallow Screening in the Adult Patient~~

~~b. Mosby's: Aspiration Precautions~~

~~c. Mosby's: Swallowing, Food, Nutrition Considerations for Patients with~~

~~i. Oro-pharygeal Dysphagia~~

~~8.~~**h.** Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.

~~9.~~**i.** Medication shall be reconciled per PCS: Medication Reconciliation Policy.

~~10.~~**j.** Line connectors for IVs, epidurals, or enteral feedings cannot be used for a type other than the type intended.

~~11.~~**k.** All alarms shall be reviewed for appropriateness **as outlined in the Clinical Alarm Management policy.**~~based on patient's status and maintained in the ON position with the volume at an audible level~~.

~~IX.~~V. SYSTEM REVIEW:

~~X.~~**A.** ~~Mosby's assessment procedures may be used as a reference for performing system reviews~~All adult patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition **as outlined in this document**.

~~A.~~**B.** Standards ~~O~~**o**f Care I: Assessment**:**

~~A. All patients admitted to ACS and/or Critical Care Services nursing units shall be assessed by a Registered Nurse per the following:~~

~~B.~~**1. All patients admitted to inpatient nursing areas shall be assessed by a RN as outlined in this document.**

~~C.~~**2.** Admission and/or Transfer ~~**Biophysical :**~~ Assessment

~~1.~~**a.** All patients admitted or transferred to a higher level of care shall have a **brief** ~~biophysical~~ assessment **to identify patients' safety considerations, general well-being and immediate needs** initiated within the following time frames~~. A detailed or disease specific assessment shall document as needed.~~

~~a.~~**i.** ICU **Patients**: **approximately** 15 minutes upon arrival to unit

~~b.~~**ii.** Telemetry **Patients**: **approximately** 30 minutes upon arrival to unit

~~c.~~**iii.** ACS **Patients**: **approximately** 1 hour upon arrival to unit

~~d.~~**iv.** BHU **Patients**: within 1 hour of admission to the unit

v. Emergency department per unit specific policy

~~e.~~**vi. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)**

~~1. The biophysical assessment shall be completed in a timely manner.~~

3. Admission Head to Toe Assessment:

a. The RN shall perform a head to toe assessment as follows:

i. ICU Patients: approximately 1 hour after the patient's arrival to the unit

ii. Telemetry Patients: approximately 2 hours after the patient's arrival to the unit

iii. ACS Patients: approximately 3 hours after the patient's arrival to the unit

iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)

~~D.~~**4.** Admission Assessment- Patient History

a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.

~~E.~~**5.** Medication Patient History ~~Form~~

~~1.~~**a.** All patients shall have a Medication Patient History completed as soon as possible upon arrival to the unit per the Medication Reconciliation Policy.

~~F.~~**6.** Initial Shift Assessment **(including upon Transfer to the unit)**

~~1.~~**a. The** ~~A~~ RN shall perform a ~~n ongoing~~ head to toe assessment as follows:

~~a.~~**i.** ICU **Patients**: **approximately** ~~within~~ 1 hour of the start of the shift

~~b.~~**ii.** Telemetry **Patients**: **approximately** ~~within~~ 2 hours of the start of the shift

iii. ACS **Patients**: **approximately** ~~within~~ 3 hours of the start of the shift

~~c.~~**iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)**

~~G.~~**7.** Reassessment:

~~1.~~**a.** After completion **and documentation** of an admission~~, or an~~ initial shift **or transfer head to toe** assessment, all patients **will be reassessed as follows**~~shall have a head to toe reassessment performed and documented~~. **Document only the reassessment changes in the electronic health record**

~~2. Guidelines for reassessment are as follows:~~

~~a.~~**i.** ICU: **approximately**~~every~~ 4 hours **after completion of the initial assessment and every 4 hours thereafter**

~~a.~~**ii.** Telemetry: **approximately**~~every~~ 6 hours **after completing the initial shift assessment**

iii. ACS: **approximately**~~every~~ 8 hours **after completing the initial shift assessment**

~~b.~~**iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)**

~~c.~~**v.** BHU:

~~i.~~**1)** Not required every shift

~~ii.~~**2)** Shall be performed and documented when clinically indicated

8. Night Shift Reassessments

~~3.~~**a.** During the night shift, the reassessment shall be performed during the shift and no later than with the AM vital signs.

~~d.~~**b.** If the patient refuses a reassessment, document their refusal in the medical record.

~~2.~~**9.** ~~System Specific Assessment (~~**PRN** Focus assessment~~)~~ **(i.e., system specific assessment)** shall be completed as follows:

a. Change in patient's condition from the initial shift assessment or reassessment
b. Response to treatment provided to a patient
c. BHU: when clinically indicated

~~H.~~**C.** Standards ~~O~~**o**f Care I.1: Assessment Neurological System Review

~~I.~~**1.** Neurological: System Review

a. Assess the following:

i. Orientation Assessment
ii. Level of consciousness
iii. Affect/Behavior
iv. Characteristics of Speech
v. Characteristics of Communication
vi. Extremity movement and strength right and left upper and lower
vii. Facial symmetry
viii. Hearing
ix. Pupil checks (pupil description, size, reaction to light, and accommodation)

1) Pupil Checks
2) Pupil checks shall be performed as follows to establish a baseline:

a) **On admission, initial shift assessments, and PRN**
b) **As ordered by physician** ~~2. Orientation 3. Motor response.Verbal response 5 Extremity movement and strength right and left upper and lower 6. Facial symmetry 7.Ability to swallow 8. Speech9Hearing responses and facial expression appropriate to spoken wor~~

2. Neurological: Detailed System Review

a. The National Institute of Health Stroke Scale (NIHSS) will be performed by RNs who have met TCMC's criteria.

b. A NIHSS assessment is required for:

i. Patients admitted with signs and symptoms of a ~~Neurological: Possible or Confirmed~~ **Cerebral Vascular Accident (CVA) or** Transient Ischemic Attack (TIA) ~~and/or~~

~~1.~~**ii. Inpatients admitted or inpatient presenting with new signs and symptoms of a CVA or TIA**

~~i. Cerebral Vascular Accident (CVA). The National Institute of Health Stroke Scale (NIHSS) Assessment~~ **will be** ~~may only be performed by RNs who have met the TCMC criteria to perform the assessment~~ **for these patients**~~.~~

iii. A NIHSS assessment will be completed as follows:

~~b. It is recommended that all patients admitted to TCMC with a diagnosis of possible or confirmed TIA or CVA have an NIHSS assessment completed as follows:~~

1) Emergency Department (ED)
   a) On arrival to the department; complete a NIHSS assessment
   b) Complete items 1,5, and 6 per unit policy or as ordered
   ~~a) Assess the patients pupils with initial NIHSS assessment and PRN~~

2) ICU
   a) Admission and transfer ~~from Telemetry or Acute Care perform a complete NIHSS assessment~~
   b) Initial shift assessment perform a complete NIHSS assessment
   c) **Reassessments perform NIHSS** ~~and then complete~~ ~~i~~items 1, 5, and 6 every four hours for 72 ~~hours~~
      ~~ii.~~**i) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight**
      ~~Assess the patients pupils with initial NIHSS assessmentComplete a Rankin Assessment on admission~~

3) Telemetry**, ACS and PCU**
   a) Perform a NIHSS on admission, initial shift assessment and transfer. Assess items 1, 5, 6 at 0400, 1200, 1600 and midnight for 72 hours
   ~~a) Admission or transfer from Acute Care perform a complete NIHSS assessment~~
   ~~b) Perform a Rankin Assessment on admission~~
   ~~iii. Initial shift assessment perform a complete NIHSS assessment and then items 1, 5, and 6 every four hours for 72 hours~~
   b) Assess the patients pupils **and** ~~with initial NIHSS~~ **when:**
      ~~iv.~~**i)** ~~Transfer from ICU perform a complete NIHSS assessment on arrival and once every shift then complete items 1, 5, and 6 for the duration of the 72 hours initiated in ICU~~
      ~~i) On discharge perform a complete NIHSS and Rankin assessment~~

4) Stroke Unit
   a) Admission, discharge or transfer from other Acute Care units perform a complete NIHSS assessment
   b) Initial shift assessment perform a complete NIHSS assessment and then complete items 1, 5, and 6 every four hours for 72 hours
      ~~v.~~**i) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight**
   ~~a) Assess the patients pupils with initial NIHSS assessment~~
   ~~b) Perform a Rankin Assessment on admission and discharge~~
   ~~b)~~**c)** Transfer from ICU or Telemetry perform a complete NIHSS assessment and then complete 1, 5, and 6 for the duration of the 72 hours initiated in ICU or Telemetry

~~b. Pupil Checks~~
   ~~c) Pupil checks shall be performed as follows:~~
      ~~i) With admission and initial shift NIHSS assessment~~
      ~~ii) When a detailed neurological assessment is not completed~~
      ~~iii) As ordered by physician and PRN~~

c. **Modified** Rankin Assessment:
   i. A **Modified** Rankin Assessment shall be completed on admission ~~and discharge~~.

~~e. Neurological System Review:~~
~~i. The off-going and on-coming RN shall complete a neurological systems review together on ICU, Telemetry, and 4PAV.~~

d. Neurological: **Assessment:** Spinal Cord Injury

i. All patients with a spinal cord injury shall have the following assessed every four (4) hours.
ii. Neurological: System Assessment
iii. Neurological: Detailed Assessment
iv. Assess motor and sensory function from level of spinal cord injury using dermatomes.

e. Neurological: Spinal Cord Injury Nursing Interventions
i. To decrease worsening of neurological deficits, the following interventions shall remain in place unless otherwise ordered by a Physician:
1) Immobilization **(stabilization)** of the injury as soon as possible
2) Reposition patient as follows:
a) Changing position in bed: full log roll with a second nurse to stabilize the patient's neck
3) Assist patient out of bed as ordered or as follows:
a) Full log roll with assistance
b) Dangle patient's legs
c) Ask patient to use arms to push up to a sitting position
d) Assist patient to chair or with ambulation as ordered
4) Mattress to remain flat at all times (reverse Trendelenburg with physician order); do not place a pillow, rolled blanket or towel under the patient's head
5) Bed rest only (transport off unit in bed or stretcher, do not use a wheelchair)
6) Use slide board when transferring and stabilize neck with second nurse
7) Observe autonomic dysreflexia precautions
8) Avoid bowel and bladder distention
9) Apply supportive devices as ordered prior to getting patient out of bed

f. Neurological: Intracranial Pressure (ICP) Monitoring: ICU
i. Neurological assessment per physician order or every hour and PRN

g. Neurological: ICP Nursing Interventions
i. Post an intracranial pressure tracing every shift and PRN with changes in patient status in the patient's chart.
ii. Shut device off to drain when recording ICP value and obtaining tracing
iii. Document ICP and Cerebral Perfusion Pressure (CPP) every hour and PRN
iv. Fluid may be removed but never instilled
v. All fluid filled ICP monitoring devices shall have the transducer air/fluid interface leveled at the Foramen of Monroe (2 fingers breadths above the ear)
vi. Do not attach flush devices to the ICP monitoring system
vii. All ICP monitoring devices shall have sterile, occlusive dressing at insertion site

h. Neurological: Comatose Patients in the ICU
i. Comatose and pharmaceutically paralyzed patients shall have their eyes taped shut with non-allergic tape to prevent corneal abrasion or injury unless otherwise ordered. Obtain an order to administer lubricating eye ointment to both eyes.

i. Neurological: Neuromuscular Blockade (NMB): ICU
i. Assess patient per Mosby's Peripheral Nerve Stimulator.

~~J.~~**D.** Standards of Care I.2: Assessment Cardiovascular System Review:
1. Cardiovascular System Review
a. Cardiovascular symptoms
b. Assess **the following:**

~~4.~~**i.** heart sounds in all auscultatory areas; note regular or irregular
ii. Nail Bed color
~~2.~~**iii.** Check capillary refill
~~3.~~**iv.** Check edema location and grade
~~4.~~**v.** Palpate bilateral peripheral pulses: radial and dorsalis pedis
~~5.~~**vi.** ~~Assess~~ **skin temperature** ~~peripheral perfusion; skin warm and dry~~
~~6.~~**vii.** ~~Assess~~ presence of **cardiovascular implantable electronic devices i.e.,** permanent pacemaker **or defibrillator**
~~i. Assess presence of arteriovenous (AV) fistula or graft~~

2. Cardiovascular: Detailed System Review
   a. All patients admitted to ~~a Cardiovascular Monitored Units (~~ED, ICU, and Telemetry~~)~~ shall have the following assessed on admission~~, transfer, and as part of the~~ initial shift**, and reassessment** ~~assessment~~.
      i. Heart sounds ~~in all auscultatory areas,~~ note S1,S2 or presence of abnormal sounds
      ii. Cardiac rhythm
      ~~ii.~~**iii. Jugular venous distension**
   b. Pacemaker Temporary
      i. Check temporary transvenous/epicardial pacer stimulation and sensitivity thresholds every shift. Check thresholds with physician for patients with underlying complete heart block or extreme bradyarrhythmias. Assess the following:
         1) Type
         2) Function
         3) Percent paced
         4) Connection status **i.e., on or off**
         5) **Presence of atrial, ventricular or both wires** ~~Number of wires~~
         6) Mode
         7) Rate ~~Settings~~
         ~~7)~~**8) Output settings**
         9) Site**, dressing**
         10) Side effects i.e., coughing of hiccups, or muscle twitching
         ~~8)~~**11) Distal pulses for transvensous femoral site**
   c. Lead Placement and Rhythm interpretation for ED, ICU, and Telemetry **this includes PCU patients with Telemetry orders**
      i. Standard lead selection shall be leads II and V1. V1 shall be used to assess Supraventricular Tachycardia's, ~~and~~ Bundle Branch Blocks~~.~~**, and wide QRS complexes**
      ii. Cardiac rhythm ECG shall be monitored continuously unless otherwise ordered.
      iii. A six (6) second **ECG** strip shall be recorded, interpreted and posted in the patient's chart on:
         1) Admission
         2) Transfer
         3) At the beginning of the shift and per unit specific policies and procedures
         4) As needed with rhythm and rate changes
         5) Alarms shall be set **per the Clinical Alarm Management policy**~~at an audible level at all times~~
         6) Heart rate alarms shall be set 10-20 beats above or below the patient's baseline heart rate.
         7) The following shall be documented in the electronic health record (EHR), if present:
            a) Ventricular heart rate
            b) Lead interpreted

c) Wave form measurements of the following:
i) PR Interval
ii) QRS Interval
iii) QT Interval
d) Presence of ectopic beats
e) Documentation of the following is recommended but not required:
i) ST segment elevation or depression
ii) Morphology of P waves and T waves
iii) presence of U waves

iv. ED: Cardiac Monitoring
1) All patients requiring cardiac monitoring shall be placed on a cardiac monitor on arrival to the unit
2) All patient requiring cardiac monitoring shall be transported with an ECG monitor and RN

v. ICU: Cardiac Monitoring
1) All patients shall be placed on a cardiac monitor on arrival to the unit
2) All patients shall be transported with an ECG monitor and RN

vi. Telemetry: Cardiac Monitoring
1) All patients shall be placed on a cardiac monitor **as outlined in the Management of Telemetry Patients unit specific policy.**
~~1)~~**2)** **PCU patients with Telemetry admission orders shall follow the requirements outlined in Telemetry unit specific policy.** ~~on arrival to the unit~~
~~2)~~**3)** All patients shall be transported with an ECG monitor and ~~RN unless~~**RN unless** otherwise ordered. Review the following unit specific policies:
a) Management of Telemetry Patients
b) Admission and Discharge Criteria

vii. Medically Monitored Lead Placement and Rate Monitoring
1) Standard lead selection shall be leads II and V1
2) The monitor technician (MT) shall record **and**~~,~~ analyze ~~and post~~ a six (6) second strip ~~in the patient's chart on~~ **on**:
~~a)~~ ~~Admission,~~
a) At the beginning of the shift
b) As needed with rate changes **or new ectopic beats**
3) The MT shall communicate the analyzed strip to the primary RN **or designee**
~~3)~~**4)** **The Unit Secretary or designee identified by the Assistant Nurse Manager (ANM) or relief charge RN will post the strips in the appropriate patient chart.**

d. Invasive Pressure Monitoring Lines (Arterial, Pulmonary Artery, and Central Venous Pressure (CVP).)
i. Alarms
1) All invasive pressure lines must be monitored with alarms on.
2) All arterial line alarms shall be set according to the parameters and limits specified in the physician orders. If the physician orders do not address limits, alarms shall be set based on systolic pressure.
3) Pulmonary artery lines shall be set according to the diastolic parameter and shall be set 10 mm/Hg above and below the diastolic pressure.

4) CVP/RA alarms shall be set at "Mean" with limit set per physician order or 50% above and below baseline when port is not being used for infusions.

ii. Invasive Pressure Line Maintenance

1) Transducers shall be leveled to and maintained at the phlebostatic axis (supine or prone position), 4th intercostal space, ½ anterior-posterior diameter of the chest for all pressure measurements.

2) All pressurized transduced indwelling catheters shall be maintained with a 2 unit per mL concentration heparin flush bag pressurized at 300 mm/Hg **or normal saline based on the patient condition or physician heparin**~~unless otherwise ordered by a physician~~**.**

3) ~~Heparin~~**The** flush bag shall be elevated for adequate volume every shift and PRN. Change bag every 4 days and when empty.

4) Needleless system shall be used for drawing blood from all invasive lines.

5) A safety transfer device shall be used when filling blood tubes.

6) All arterial and pulmonary artery catheters shall be attached to a transducer.

7) All transduced lines shall have pressure waveforms continuously displayed on the bedside monitor.

8) All transduced lines shall have accuracy of the system checked by performing a square waveform test at the beginning of each shift and any time the system is disturbed (e.g. blood draw).

9) Patient shall be positioned supine, head of bed (HOB) between 0-60 degrees, lateral position 20, 30 or 90 degrees or supine for all pulmonary artery pressure (PAP), pulmonary artery occlusion pressure (PAOP) and central venous pressure (CVP) measurements. Patient shall be stabilized 5-15 minutes after a position change before readings are obtained.

10) Obtain PAP/PAOP/CVP measurements from a graphic tracing at end-expiration Q shift and PRN using a simultaneous ECG tracing to assist with proper waveform identification.

e. Pulmonary Artery Catheter Monitoring

i. Cardiac Output (CO) shall be measured every 4 hours and PRN

~~K.~~**E.** Standards of Care I.3: Assessment Pulmonary System Review

1. Pulmonary: System Review

a. Assess the following:

~~1.~~**i.** ~~Check~~ oxygen delivery devices

~~2.~~**ii.** ~~Check amount~~ oxygen flow/FiO2

iii. Respiratory Symptoms

iv. Respirations

v. Respiratory Pattern

vi. Chest Motion

~~3. Assess respiratory effort~~

~~a.~~**b.** Auscultate breath ~~sounds,all~~**sounds, all** lobes

c. Assess the following if present:

~~4.~~**i.** ~~Assess~~ sputum amount, color, and consistency

~~5.~~**ii.** ~~Assess for presence of~~ cough

~~6.~~**iii.** ~~Assess for presence of~~ artificial airway, tubes, and drains

2. ~~Assess chest expansion for symmetry~~Pulmonary: Detailed System Review

a. Pulmonary: Chest Tubes

i. Assess **the following:**

1) Insertion location

a) Palpate insertion site for crepitus, document if present

2) Dressing condition
3) Color and consistency of drainage
4) Amount of suction or gravity drain i.e., water seal
5) Suction chamber fluid level
6) Water seal chamber fluid level, presence of air leak, tidling
7) Complications i.e., air leaks, indications of bleeding etc.

b. ~~amount of suction; presence or absence of air leaks, condition of insertion site and dressing; and color and consistency of drainage~~Pulmonary: Chest Tube Nursing Interventions **as outlined in the following:**

i. Chest Tube Management Procedure

~~7.~~**ii. Mosby's Chest Tube: Closed Drainage Systems**

~~i. Patients with chest tubes shall be managed using TCMC Chest Tube~~
~~ii. Procedure and Mosby's Closed Chest Drainage Systems: Pleur Evac procedure~~
~~iii. Ensure Chest Tube Removal Kit is readily available in patient's room~~
~~1) On Telemetry and ACS, hang Chest Tube Removal Kit on IV pole~~
~~iv. Ensure chest drainage system is secured~~
~~1) On Telemetry and ACS, secure chest tube to IV pole using two-three zip ties.~~
~~v. Change chest tube insertion site dressing every other day~~

~~b.~~**c.** ~~Do not reinforce saturated chest tube insertion site dressing. Remove dressing, assess site, check connections, and redr~~Pulmonary: Bi-Level Positive Airway Pressure (BiPAP) Assessment

i. Patients receiving BIPAP shall have skin assessed as follows:
ii. Area under headgear
iii. Bridge of nose, around perimeter of mask and along course of headgear straps
1) Ensure mask has a tight seal
iv. Place patient in a room near the nurse's station when possible
v. Elevate head of bed 30 degrees unless contraindicated
vi. Remove BIPAP mask when patient is eating or drinking to prevent aspiration as tolerated
vii. Readjust mask as appropriate to maintain oxygenation parameters as ordered and for patient comfort
viii. Provide communication equipment, i.e. picture boards
ix. Monitor continuous pulse oximetry and respiratory rate per physician's order
1) Ensure continuous pulse oximetry is ordered for patients on Telemetry

~~c.~~**d.** Pulmonary: Artificial Airway

i. The RN is primarily responsible for ensuring the tracheostomy tube is secured.
ii. Patients with tracheostomy tubes shall have a tracheal change set and an extra tracheostomy tube of the same size readily available at their bedside.
iii. Manual self-inflating resuscitation bags shall be used in the adult patients with endotracheal tubes (ETT) or tracheostomy patients for temporary ventilation whenever patient cannot be effectively ventilated by his/her own efforts.
iv. Two licensed health care providers are required when taping, manipulating, or cutting an endotracheal tube.
v. Trach care shall be done every shift and PRN by a licensed nurse or Respiratory Care Practitioner (RCP).
1) Trach care shall include evaluation and cleaning of the site

a) rach holders shall be changed PRN by a licensed nurse or RCP with the assistance of a second healthcare provider
2) Disposable inner cannula shall be changed every shift and PRN by the RN or RCP
vi. The head of the bed will be elevated 30 degrees unless contraindicated
vii. Oral care will be provided every 2-4 hours

~~d.~~**e.** Artificial Airway Nursing/Mechanical Ventilation Interventions
i. Ensure ICU and Telemetry patients with mechanical ventilation have continuous pulse oximetry.
ii. Ensure continuous pulse oximetry is ordered and monitored on patients with tracheotomies on Telemetry.
iii. Verify mechanical ventilation settings every shift and PRN with changes
1) Assess tidal volume with routine vitals in ICU and PRN
2) Assess spontaneous tidal volume with routine vitals in ICU and PRN
iv. Collaborate with respiratory therapy to assess patient's readiness for extubation daily except for patients receiving paralytic agents, ICP monitoring, pressure control inverse ratio ventilation, and/or immediate post-op open heart surgery
1) Stop all sedation prior to 0800 between 0800 and 1000
2) Assess readiness to extubate
a) Patient is awake and calm with a Richmond Agitation Sedation Scale (RASS) of 3 to 4
b) Obtain rapid shallow breathing index (RSBI) as appropriate for RCP
c) Initiate spontaneous breathing trials as appropriate
i) Monitor patient for signs of fatigue
ii) Continue for up to 2 hours or as ordered
v. Collaborate with physician regarding patient's readiness to extubate
vi. Monitor patient for signs of weaning failure during all weaning trials
1) Notify the physician if patient is unable to reach or maintain physician set goals.
vii. Ensure ETT placement is confirmed with a chest x-ray.
viii. Documentation of oral endotracheal tube placement shall be in cm at the lip line. Make every adjustment to an ETT with the aid of an RCP or additional RN.
ix. Perform oropharyngeal suctioning prior to making adjustments to the ETT.
x. Standard oral endotracheal tube position shall be changed (from side to side) every 24 hours.
xi. Auscultate and document after any ETT repositioning or manipulation.
1) Never re-tape, move, or adjust an ETT without assistance.
xii. Perform oropharyngeal suctioning prior to making adjustments to the ETT.
xiii. Suction patient only when necessary and do NOT instill normal saline while suctioning unless necessary.

~~e.~~**f.** Pulmonary: Passy Muir Speaking Valve
i. Requires a physician order for application
ii. Initial application and evaluation shall be completed by Speech Therapy
iii. Tracheostomy cuff must be deflated prior to the application of the Passy Muir

~~f.~~**g.** Pulmonary: Respiratory Procedures
i. Nasotracheal/Orotracheal suctioning requires a physician order except in the ICU

ii. Nasal airway (trumpet) may be used per RN/RCP discretion for patient comfort or airway protection

~~L.~~**F.** Standards of Care1.4: Assessment Gastrointestinal (Gi) System Review

1. GI: System Review
   a. Assess contour of abdomen
   b. Assess for nausea and/or vomiting
   c. Auscultate for presence of bowel sounds in all four quadrants
   d. Assess bowel function including passing flatus or last stool
   e. Assess for the presence of tubes and drains. If present, assess type and location
      i. Confirmation of placement, and drainage description
      ii. Check tube placement for drainage and insertion site integrity
      iii. Assess type of formula, rate, residual amounts
      ~~iii.~~**iv. Assess condition of nares and mucosa (check for inflammation and excoriation)**
   f. Assess for the presence of ostomies. If present, assess condition of stoma and surrounding skin.
      ~~1.~~**i. Document nursing ostomy interventions in the medical record**

~~M.~~**G.** Standards of Care 1.5: Assessment Genitourinary (GU) System Review

1. GU: System Review
   a. Assess urine color and clarity, frequency, and voiding difficulties
   b. Assess for bladder distension
   c. Assess external anatomy/perineum as applicable
   d. Dialysis vascular access, if present
      i. Type
      ii. Location
      iii. Patency i.e., presence of thrill and bruit
      iv. Site
      ~~1.~~**v. Dressing**
   e. Assess for presence of tubes/drains/ostomies**, if present**
      ~~2.~~**i. Document nursing ostomy interventions in the medical record**
2. GU: Nursing Interventions
   a. Use bladder scanner to assess for urinary retention
   b. Urinary Catheter (foley)
      i. Insertion
         1) Pericare shall be performed prior to urinary catheter insertion
         ~~a.~~**2)** Urinary catheters should be inserted only when necessary and left in place only for as long as necessary.
         3) If urine analysis or urine culture is ordered, obtain the urine specimen at the time of catheter insertion
      ii. Preexisting urinary catheters
         1) If patient is admitted with a preexisting urinary catheter it should be removed and a new urinary catheter should be inserted.
      iii. Maintenance
         1) Assess and consult with a physician for the need, indwelling catheter daily.
            ~~b.~~**a)** Other methods of urinary drainage such as condom catheter drainage, suprapublic catheterization, and intermittent urethral catheterization **should be considered as** ~~can be useful~~ alternatives to indwelling urethral catheterization.
         2) Foley care should be ~~complete~~**performed every shift and PRN (i.e., after bowel movement)**
            a) Document care provided in the EHR

~~1.~~**3)** Ensure drainage tube is secured with hospital approved securement device, i.e. Statlock
~~2.~~**4)** Ensure the tamper evident seal is intact
~~3.~~**5)** Ensure the drainage system does not touch the floor and is without dependent loops
~~4.~~**6)** Ensure the drainage bag is not overfilled
~~c.~~**7)** **Urinary catheters should be changed every 28 days.**

c. **Discontinuation**
i. Review the patient's medical record for an order to discontinue the urinary catheter.
1) If a patient has discharge orders and there is no order to discontinue the Foley catheter, contact the discharging physician.
ii. Discontinue the urinary catheter per the Urinary Catheter: Indwelling Catheter Removal Procedure
iii. If patient is unable to void 2 hours after the urinary catheter is removed:
1) Verify the bladder volume using a bladder scanner, document the volume in the medical record
2) If patient has discharge orders, notify the discharging physician (do not discharge the patient)
a) Time urinary catheter removed
b) Bladder volume
iv. Document the following in the medical record after removing the urinary catheter:
1) Amount of urine in urinary drainage bag
2) Time catheter removed
3) Condition of the catheter
4) Patient's response to the procedure
5) Unexpected outcomes related to the removal of the urinary catheter
v. Document the time the patient voids after the removal of the urinary catheter, color and amount of urine and unexpected outcomes in the medical record.

3. Dialysis In-Patients **Nursing interventions**
~~3.~~**a.** Weigh all patients receiving peritoneal or hemodialysis daily prior to 0600
~~4.~~**b.** ~~ONLY~~ **Only** ~~the~~ dialysis staff shall access dialysis catheters except with a physician order, See TCMC Central Venous Access Devices Procedures.
~~5.~~**c.** Do not use the extremity in which a fistula or graft is placed for peripheral IV, blood pressure measurements, invasive monitoring or blood draws without a physician order.
~~a.~~**i.** Place an information sign above the head of the patient's bed to communicate the extremity with the dialysis access and the information listed in number 4 to other members of the health care team.
~~b.~~**ii.** Maintain bed rest for all patients with femoral dialysis access catheters. The head of the bed may be elevated per the patient's request or comfort.

~~6. Genitourinary- Continuous Ambulatory Peritoneal Dialysis (CAPD) Exchange and Continuous Cyclic Peritoneal Dialysis (CCPD) Exchange.~~
~~a. Patients receiving CAPD and CCPD shall be managed per PCS Policy Continuous Ambulatory Peritoneal Dialysis and Continuous Cyclic Peritoneal Dialysis Procedure.~~

~~7. Genitourinary- Continuous Renal Replacement Therapy (CRRT) ICU~~
~~a. ICU nurses shall manage patient receiving CRRT per the ICU unit specific procedure: Continuous Renal Replacement Therapy~~

~~N.~~**H.** Standards of Care 1.6: Assessment Musculoskeletal System Review

1. **Musculoskeletal System Review**
   a. **Assess the following:**
      i. **Extremity movement**
      ii. **Extremity strength**
      iii. **Gait/ mobility appropriate for age**
      iv. **Presence of joint or musculoskeletal abnormalities, if applicable**
      v. **Full range of motion against gravity, some to full resistance of all extremities, if applicable**
   ~~A.~~**b.** Musculoskeletal System **Abnormality Review**
      ~~1.~~**i.** Presence of assistive devices
      ~~2. Presence of joint or musculoskeletal abnormalities~~
      ~~3. Full range of motion against gravity, some to full resistance of all extremities~~
      ~~4. Mobility appropriate for age~~

~~O.~~**I.** Standards of Care 1.7: Assessment Integumentary System Review

1. Integumentary System Review **shall be performed as outlined in the Skin and Wound Care Policy**

~~1. Note mucous membranes and skin color; consistent with person's ethnicity~~
~~2. Palpate skin for temperature and moisture~~
~~3. Assess skin turgor~~
~~4. Assess skin integrity, temperature, and condition of any dressings~~
~~5. Complete Braden Risk Assessment Scale on admission, once a shift and PRN~~
~~6. Assess for presence of specialty mattress/bed or overlays~~
~~7. Assess for the presence of skin abnormalities~~
~~8. Assess for the presence of pressure ulcers~~
~~9. Integumentary; Nursing Interventions~~
~~a. Photograph all wounds, skin abnormalities, skin tears; reddened heels, and pressure ulcers on admission, once a week and with changes per TCMC Skin and Wound Care Policy~~
~~i. Change dressings on pressure ulcers and skin tears as outlined in the Skin and Wound Care Policy and/or per physician order~~
~~b. Obtain physician order for Wound Nurse evaluation and treatment for pressure ulcer as outlined in the Skin and Wound Care Policy~~

~~P.~~**J.** Standards of Care 1.8: Assessment Psychological/Social

1. Psychosocial assessment shall consist of the following:
   a. Coping
   b. Affect/Behavior
   c. Social Service (SS) Referral Reason
   d. Distress
   e. Stressors
   f. Support/Coping Interventions
2. Psychological/Social: Nursing Interventions
   a. In ordered to promote family centered care, the nurse shall:
      ~~1.~~**i.** Introduce bedside health care providers to the patient/family.
      ~~2.~~**ii.** Review visitation and unit policies with patient/family on admission and as needed.
      ~~3.~~**iii.** Assess and then verify with patient/family age appropriate needs.
      ~~4.~~**iv.** Assess and then verify patient/family ability to understand and participate in the plan of care.
   b. Promote patient/family centered care
      i. Discuss expectations and collaborate with patient/family
      ii. Encourage patient/family to ask questions
      iii. Encourage patient and/or their family to participate in their plan of care.
      ~~ii.~~**iv. Request the assistance of Case Managers and Social Services**

c. Promote patient independence in Activities of Daily Living (ADL)
d. Promote comfort measures by:
~~a. Pharmacological and nonpharmacological Music therapy~~
~~b. Photo therapy~~
~~c. Spiritual comfort~~
~~d. Guided imagery~~
~~e. Reminiscence therapy~~
~~f. Encourage family/friend to visit~~
e. ~~Arrange for a child's visitation~~
~~g. Arrange for pet therapy~~
f. Patients shall be informed of their responsibilities upon admission and as necessary thereafter. These responsibilities include: providing information, asking questions, following instructions, accepting consequences, following rules and regulations, showing respect and consideration, and meeting financial commitments. ~~See TCMC Patient Handbook~~.
~~h. Encourage patient and/or their family to participate in their plan of care.~~
~~i. Request social services as appropriate.~~

~~Q.~~**K.** Standards of Care: Infusion Therapy
1. Central venous lines shall be assessed **as outlined in the** ~~per~~ PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed:
a. On admission
b. Initial shift assessment~~**and reassessments,** ongoing, and~~
c. Maintenance or continuous infusion shall be assessed every 2 hours and PRN
~~p~~~~**Every hour**~~
d. ~~**Prior to** transfer~~**, upon transfer** ~~from other~~ **to** nursing unit ~~**and PRN**~~
~~a. As needed ().~~
~~b.~~**e.** The following shall be assessed:
i. IV insertion date **and time**
ii. IV access type
iii. IV site and condition
iv. Patency
v. Dressing type and condition
vi. Document drainage if present
vii. Infiltration score
~~v.~~**viii. Phlebitis score**
~~i. Date infusion changed~~
~~ii. Date central venous dressing changed~~

~~2. Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN.~~
~~3. Maintenance or continuous infusion shall be assessed every 2 hours and PRN~~
3. Infusion Therapy: Nursing Interventions
a. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
b. Document initials and date IV started directly on the dressing.
c. Pre-hospital IV starts shall be discontinued and restarted within 4~~8~~**24** hours of admission.
d. IV site shall be discontinued **immediately** and restarted with ~~complaint~~**patient's complaint** of persistent discomfort **or signs and symptoms of the following:**
~~not relieved by comfort measures,~~
~~**IV site will be discontinued and restarted with one or all of the following:**the:~~
i. ~~presence of an~~ Infiltration
1) Skin at site blanched, cool to touch with or without pain~~,~~
ii. Inflammation

iii. **P**allor
iv. **P**hlebitis
1) **Erythema at site with or without pain**
2) **Pain at site with erythema and/or edema**
3) **Streak formation, palpable, cord of any size**
v. **B**leeding at insertion site
vi. **L**eaking of IV solution at insertion site
~~4.~~**vii.** **Pain**

~~d.~~**e.** IV solutions and tubing shall be changed as follows:
i. Change every 4 days
1) All IV tubing
2) Add-on devices (neutral displacement connector (MicroClave), anti-reflux, extension set, etc) and with tubing change
3) Rotate IV insertion sites
4) Commercially prepared solutions, if the bag is spiked once with initial start
5) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback

~~e.~~**f.** Change every 24 hours
i. All IV solutions mixed by pharmacy or nursing, unless manufacturer's
1) **E**xpiration recommends less than 24 hours (examples: Lipids or lipid containing products, neutral displacement connector ~~MicroClave~~, anti-reflux, extension set, etc. and with tubing change).

4. Label IV tubing ~~and/or neutral displacement connector (MicroClave) with~~ change date sticker indicating date tubing is to be changed using numerical day and month.
5. Label IV solutions with date and time IV solution hung.
6. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct ~~V~~visualization of the site.
7. Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
8. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
9. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter-related infection is suspected or documented.
10. **Port Protector**~~SwabCap~~
a. Place a ~~SwabCap~~ **port protector** on all unused central venous and peripheral line injection port(s) **and at the lowest port of the IV tubing if used frequently for intravenous pushes (IVP) or intermittent infusions**
b. **Port protector** ~~SwabCap~~ shall be used on IV tubing ports for patients with central and peripheral lines receiving mainline infusion.
c. Apply a new **port protector** ~~SwabCap~~
i. Every time **a port protector** ~~the cap~~ is removed
ii. Every 8 hours with routine IV flushing
iii. PRN IV flushing

~~XI.~~VI. NURSING PROCESS:

A. Standard of Care: Assessment
1. The RN shall ensure all adult patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.

B. Standard of Care: Diagnosis
1. The RN shall review the data obtained from the patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) on admission, every shift, on transfer to another nursing unit, and PRN.

2. RNs shall review the data collected by LVNs to develop the patient's POC.

C. Standard of Care: Outcome Identification
1. The RN shall use the information obtained from Standard of Care: Assessment and Standard of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.

D. Standard of Care: Planning
1. The RN shall use the outcomes identified in Standard of Care: Outcome Identification and the physician orders to develop an individualized patient POC. The POC shall prescribe interventions that which may be implemented to attain expected outcomes.

E. Standard of Care: Implementation
1. A RN shall implement the interventions identified in the POC and~~/or~~ ensure **task delegated to** unlicensed assistant personnel are assigned ~~task~~ appropriately **and completed.**~~.~~

F. Standard of Care: Evaluation
1. A RN shall evaluate the patient's progress toward obtaining their outcomes in the POC every shift and PRN.
2. Emergent and urgent changes in the patient's assessment shall be communicated to physicians as soon as possible per TCMC policy.
3. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during physician rounds or as soon as possible within the shift the changes were identified.

G. Standard of Care: Documentation
1. ~~It is recommended that a~~**A**ll shift assessments~~,~~**, focus** reassessments, PRN assessments and/or care provided **will** be documented after completion of the care in a timely manner.
2. When it is not possible to document shift assessments, **focus** reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.
3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

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WOMEN'S AND CHILDREN'S SERVICES Addendum
For O~~B~~**bstetric** Patients Receiving ~~Health~~ Care on Non-Obstetric Nursing Units

I. **GENERAL NURSING ASSESSMENT**

A. Standards of Care: Vital Signs

~~a. Vital Signs shall be completed as defined in I.A, page 2 of 14 of the Standards of Care for Adults~~

1. Vital signs shall be obtained ~~on~~ **upon** admission, **upon** transfer to a unit, ~~at~~ **upon** discharge, per **provider's** ~~physician's~~ orders, **or** per unit standard**s of care** ~~and/or as follows~~:

a. Notify provider for the following for any antepartum or postpartum patient:
i. Temperature greater than or equal to 100.4° F or 38° C
ii. Blood Pressure:
1) Systolic Blood Pressure (SBP) greater than or equal to 140 and/or Diastolic Blood Pressure (DBP) greater than or equal to 90
2) For know Preeclampsia with severe features: SBP greater than or equal to 160 and/or DBP 110
iii. Heart Rate greater than or equal to 120 beats per minute (bpm)
~~A.~~iv. Respirations greater than 28 or less than 12 breaths per minute

~~a.~~**b.** Antepartum:
i. ~~At minimum every 6 hours, or a~~ **A**s ordered by ~~**provider**physician~~, or as clinically indicated per protocol, i.e., PCS procedure: Magnesium Sulfate Administration for Obstetric Patient
ii. Subjective assessment-ask patient if having any of the following: leaking of fluid, bleeding, contractions, fetal movement, headache or visual disturbances q shift
iii. Coordinate fetal assessment by Obstetric provider
~~1.~~**1) For ordered fetal monitoring contact Labor and Delivery**

~~2. Notify physician for:~~
~~a. Temperature greater than or equal to 38° C~~
~~i. Systolic Blood Pressure (SBP) greater than or equal to 140 and/or Diastolic Blood Pressure (DBP) greater than or equal to 90~~
~~3. For Known Preeclampsia~~
~~a. SBP greater than or equal to 160 and/or DBP110 diastolic~~
~~i. Heart Rate greater than or equal to 120 beats per minute (bpm)~~
~~ii. Respirations greater than 28 or less than 12 breaths per minute~~

~~B.~~**c.** Postpartum: Vaginal Delivery:
~~1.~~**i.** Vital signs including temperature shall be obtained ~~every 15 minutes x 4, and at 2 hours~~ upon admission ~~to couplet care~~, then every 6 hours for the first 24 hours post-delivery, then every shift until discharge, ~~and as~~ **prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients, and prn** ~~needed per as~~ clinically indicated **or per provider order**.

~~2. Notify physician for:~~
~~a. Temperature greater than or equal to 38° C~~

~~b. SBP greater than or equal to 140 and/or DBP greater than or equal to 90~~
~~3. For Known Preeclampsia~~
~~a. SBP greater than or equal to 160 and/or DBP110 diastolic~~
~~b. Heart rate greater than or equal to 120 bpm~~
~~c. Respirations greater than 28 or less than 12~~

~~C.~~**d.** Post-Operative: Cesarean Delivery: Post Anesthesia Care Unit (PACU)
i. Vital signs as ordered by anesthesiologist/~~physician~~**provider**
~~1.~~**1) See Anesthesia PowerPlan for vital signs in the first 24 hours after cesarean section (generally includes respiratory rate every 1 hour times 12 hours then every 2 hours times 12 hours).**

2. Vital sign shall include temperature, upon admission ~~to couplet care and at 2 hours,~~ then every 6 hours for first 48 hours post-delivery, then every shift **until discharge, prn as clinically indicated or ordered by provider and prior to discharge per PCS procedure Discharge of Patients**

~~2. and as needed as clinically indicated~~
~~3. Notify physician for:~~
~~a. Temperature greater than or equal to or 38° C~~
~~b. SBP greater than or equal to 140 and/or DBP greater than or equal to 90~~
~~c. For Known Preeclampsia~~
~~4. SBP greater than or equal to 160 and/or DBP greater than or equal to 110~~
~~a. Heart Rate greater than or equal to 120 bpm~~
~~b. Respirations greater than 28 or less than 12~~

~~b. STANDARDS OF CARE: PAIN ASSESSMENT~~
~~A. Maternal: Same as Adult Standards of Patient Care (SOC)~~

B. Standards of Care: Intake And Output
1. ~~Maternal:~~ **As outlined in this document and as follows:** ~~Same as Adult Standards of Patient Care (SOC)~~
~~B. Antepartum/Intrapartum Care on Non-Obstetric Nursing Units:~~
~~1. I&O totals every shift with 24 hour totals~~
~~2. Assess bladder every 2 hours while awake, every 4-6 hours when sleeping, or as ordered by physician~~
~~3. Notify physician if patient is not voiding and/or measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours~~

~~4.~~**2.** ~~Bleeding patients shall be screened for risk of obstetrical hemorrhage upon admission and as~~ **Assess for vaginal bleeding as** part of the shift reassessment throughout antepartum ~~and/or intrapartum~~ **and postpartum period.** ~~admission~~
a. Assess and document:
i. quantity (number) of pads/chux
ii. degree of saturation
iii. color ~~associated symptoms~~
iv. frequency of bleeding
b. **For concerns of hemorrhage** ~~W~~weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
i. Notify physician for active bleeding and report above findings
ii. ~~Cumulative blood loss greater than 500 mL~~ **.**
1) **Obtain order to** ~~S~~start IV infusion with Normal Saline or Lactated Ringers ~~per physician order~~
~~i. Cumulative blood loss greater than 1000 mL~~
~~1) Call Rapid Response Team (RRT)~~

~~2) Notify OB and primary unit Assistant Nurse Manager (ANM)/Relief Charge Nurse~~
~~3) Start IV infusion with Normal Saline or Lactated Ringers per physician order or RRT standardized procedure~~

~~ii. Cumulative blood loss greater than 1500 mL~~
~~1) Start IV infusion with Normal Saline or Lactated Ringers.~~
~~2) Call RRT to facilitate Code OB~~
~~3) Notify OB and primary unit ANM/Relief Charge RN~~
~~4) Assist with patient care as directed by RRT and/or Code OB team.~~

~~iii. Document blood loss in medical record, including physician notification, interventions, and blood replacement products.~~
~~1) Medications given during the Code OB shall be documented by an OB Code RN on the Code OB Report form.~~

~~iv. Reference the WCS Obstetrical Hemorrhage Procedure for the following:~~
~~1) Information on the definitions of:~~
~~a) General hemorrhage~~
~~b) Standard definition for safety and quality monitoring~~
~~c) Massive hemorrhage~~
~~d) Additional Clinical Triggers~~
~~e) Risk assessment~~
~~2) Stages of Obstetric Hemorrhage and Primary Treatment Goals~~

~~C. Postpartum, Vaginal Delivery:~~
~~Check patient for voiding without difficulty every 2 hours x 2 post-delivery, then every 6 hrs x 4After delivery or~~ **~~Monitor intake and output per unit practices outlined in this document and the following:~~**
~~1. If patient on I/O, notify physician if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours~~
~~2. Maintain IV access for 24 hrs post epidural anesthesia then per unit policy~~

~~D. Post-partum hemorrhage~~
~~1. Assess and review risk factors for obstetrical hemorrhage~~
~~a. Monitor patient's blood loss for baseline blood loss output~~
~~b. Monitor lochia for color, odor, amount, consistency, clots, steady stream or~~
~~i. trickle~~
~~ii. Assess number of pads and degree of saturation~~
~~c. Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss~~
~~2. Cumulative blood loss greater than 500 mL~~
~~a. Start IV infusion with Normal Saline or Lactated Ringers~~
~~b. Call RRT and notify OB and primary unit ANM/Relief Charge Nurse~~
~~3. Cumulative blood loss greater than 1000 mL~~
~~a. Start IV infusion with Normal Saline or Lactated Ringers~~
~~b. Call RRT and notify OB and primary unit AMN/Relief Charge Nurse~~
~~4. Cumulative blood loss greater than 1500 mL~~
~~a. Start IV infusion with Normal Saline or Lactated Ringers~~
~~b. Call RRT to facilitate Code OB~~
~~c. Notify OB and primary unit ANM/Relief Charge Nurse~~
~~d. Assist with patient care as directed by RRT and/or Code OB team~~

~~5. Document blood loss in medical record, including physician notification, interventions, and blood replacement products.~~
~~a. Medications given during the Code OB shall be documented by an OB Code RN on the Code OB Report form~~
~~6. Postoperative: Cesarean Delivery:~~
~~a. OB PACU, upon arrival from the OR and prior to transfer to Non-Obstetric Units~~
~~b. Assess and document the number of the IV fluid bag~~
~~**Cumulative Blood Loss**~~
~~**Cumulative blood loss greater than 500 mL**~~
~~**Start IV infusion with Normal Saline or Lactated Ringers**~~
~~**Call RRT and notify OB and primary unit ANM/Relief Charge Nurse**~~
~~**Cumulative blood loss greater than 1000 mL**~~
~~**Start IV infusion with Normal Saline or Lactated Ringers**~~
~~**Call RRT and notify OB and primary unit AMN/Relief Charge Nurse**~~
~~**Cumulative blood loss greater than 1500 mL**~~
~~**Start IV infusion with Normal Saline or Lactated Ringers**~~
~~**Call RRT to facilitate Code OB**~~
~~**Notify OB and primary unit ANM/Relief Charge Nurse**~~
~~**Assist with patient care as directed by RRT and/or Code OB team**~~
~~**Document blood loss in medical record, including physician notification, interventions, and blood replacement products.**~~
~~**Medications given during the Code OB shall be documented by an OB Code RN on the Code OB Report form**~~
~~**Reference the WCS Obstetrical Hemorrhage Procedure for the following:**~~
~~**Information**~~
~~**Information on the definitions of:**~~
~~**General hemorrhage**~~
~~**Standard definition for safety and quality monitoring**~~
~~**Massive hemorrhage**~~
~~**Additional Clinical Triggers**~~
~~**Risk assessment**~~
~~**Stages of Obstetric Hemorrhage and Primary Treatment Goals**~~
~~7. Assess and document patency of the foley catheter with urine~~
~~a. Collection bag for amount, color and clarity of urine~~
~~b. I&O totals every shift with 24 hour totals for day of delivery, and post-op day one (1)~~
~~c. Notify physician if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours~~
~~d. IV converted to saline lock or discontinued on post-op day one (1), or as ordered by physician or per unit policy~~
~~e. Foley catheter discontinued on post-op day one (1) or as ordered by physician~~
~~i. Assess bladder/voiding difficulties PRN~~
~~ii. Assess voiding every 2 hours x 2 post removal of foley catheter, the every 6 hrs x 4~~

3. ~~Post-operative Cesarean~~ **Postpartum** Hemorrhage **is defined as a cumulative blood loss greater than**:
   a. 500 mL for Vaginal Delivery

b. 1000 mL for Cesarean Section
~~E.~~**c. 1500 mL for massive hemorrhage for any birth mode**
~~c.~~**d.** Assess and review risk factors for obstetrical hemorrhage and monitor patient's blood loss for baseline blood loss output
~~d.~~**e.** Monitor lochia for color, odor, amount, consistency, clots, steady stream or trickle
i. Assess number of pads and degree of saturation
ii. Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
~~e.~~**f. When there is a ~~C~~cumulative blood loss considered to be a postpartum hemorrhage:** ~~greater than 1000 mL~~
i. Start IV infusion with Normal Saline or Lactated Ringers **per provider order**
ii. Call RRT ~~to facilitate~~ **and/or** Code ~~OB~~ **Maternity**
iii. Notify OB and primary unit ANM/Relief Charge Nurse
iv. Assist with patient care as directed by RRT and/or Code **Maternity** ~~OB~~ team
~~iv.~~**v. Consider uterotonic medications per provider order**
g. Documen**tation should include:**
i. ~~b~~**B**lood loss in medical record~~, including physician notification~~,
~~1.~~**ii. Provider notification**
iii. Interventions ~~and blood replacement products.~~
~~v.~~**iv. Blood replacement products**
v. Medications given during the Code **~~Maternity~~**~~OB shall~~**Maternity shall** be documented by a~~n OB Code~~ RN on the Code OB Report form
~~a.~~**h. Refer to Obstetrical Hemorrhage procedure**

~~c. STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENTS~~
~~A. Maternal: Same as Adult SOC~~

C. Standards of Care: Aspiration Assessment
1. Maintain aspiration precautions for <u>maternal</u> patients identified at risk.
a. Maintain head of bead (HOB) at 30 degrees at all times.
i. If eclamptic seizure **occurs:**~~,~~ lower head of bed, open airway, roll patient to side and suction secretions as necessary
ii. Avoid attempts to insert suctioning device when patient's teeth are clenched.
b. Maintain suction equipment at bedside at all times.

D. Standards of Care: Patient Safety
~~B.~~ Maternal: Same as Adult SOC and as indicated below ~~(includes infant security measures).~~
1. ~~The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet.~~
2. Patient safety shall be assessed per the following:
a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement, and/or other procedures and as needed.
b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
3. System Specific Assessment (Focus assessment/postpartum assessment) shall be completed as follows:
a. Change in patient's condition from the initial shift assessment or reassessment
b. Response to treatment provided to a patient
c. Postpartum assessment:
i. Uterine assessment (to include lochia assessment):
~~a.~~**1)** Fundal height/relationship to umbilicus (-3, -2, -1, 0, +1, +2, +3)

~~b.~~**2)** Location (midline (ML) **is the normal location**, right **or** left of ML **may means a** ~~,~~ displaced bladder **that needs to be emptied** ~~assessment~~)

~~1)~~**3)** Consistency (firm, boggy-firms with massage, boggy)

~~i.~~**ii.** Time intervals, beginning post-delivery:

~~C.~~**1)** ~~Birth – 2 hrs: every 15 minutes x 4, then at 2 hours~~

~~D.~~**2)** 2 hrs.-6 hrs.: upon admission ~~to MBU, then at 2 hours,~~ then at 6 hrs. post-delivery

3) **Vaginal Delivery:** 6 hrs. – 24 hrs.: every 6 hrs or sooner if clinically indicated**, then q shift until discharge**

~~E.~~**4)** **Cesarean Section: 6-48 hours every 6 hours or sooner if clinically indicated times 48 hours, then q shift until discharge**

~~F. 24 hrs – discharge: every shift if stable and at time of discharge~~

~~1.~~**5)** Evaluation of blood loss/lochia: include at the same time intervals for uterine assessment

~~a.~~**a)** Slight, Scant, Moderate, Heavy (with or without clots)

~~b.~~**b)** Rubra, serosa, **alba** or other

~~c.~~**c)** Note presence of foul odor

~~d. Risk assessment for OB Hemorrhage~~

~~i. Refer to III. Standards of Care – Intake and Output: 1.a.b.c. for OB hemorrhage definitions~~

d. Breast Assessment

i. Assess breasts per the postpartum documentation section

1) Assess for softness of the breast

2) Assess nipples

3) Document treatment to nipples

~~IV. STANDARDS OF CARE I.1: ASSESSMENT NEUROLOGICAL SYSTEM REVIEW~~

~~A. Neurological: System Review~~

4. Maternal

a. Assess the following:

i. Level of consciousness

ii. Orientation

iii. Presence of:

1) Headache

2) Visual disturbances, e.g. blurred vision or scotoma

iv. Deep Tendon Reflexes**-usually done in the presence of hypertension**

~~a.~~**1)** Patellar or brachial (0, 1+, 2+, 3+)

v. Clonus (absent or present)**-usually done in the presence of hypertension**

1) Effects of epidural/regional anesthesia on lower extremities

vi. Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs

vii. Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: WCS procedure: "Epidural Medication Administration")

~~e. STANDARDS OF CARE I.2: ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW~~

~~A. Cardiovascular System Review~~

~~1. Maternal: Same as Adult SOC~~

E. Standards of Care I.3: Assessment Pulmonary System Review

1. Pulmonary: System Review

a. Maternal: (in addition to the Adult SOC Patient Care Pulmonary System review)

b. Assess pulse oximetry

i. Continuous monitoring post-epidural placement

ii. Continuous monitoring for Magnesium Sulfate administration for preeclampsia/preterm labor. Reference: PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients

~~f. STANDARDS OF CARE1.4: ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW~~

~~A. GI: System Review (Maternal assessment same as Adult SOC)~~

F. Standards of Care 1.5: Assessment Genitoutinary System Review

1. Genitourinary (GU) System Review
   a. Assess urine color and clarity, frequency and voiding difficulties
   b. Assess for bladder distension
   c. Assess external anatomy/perineum as applicable
   d. Assess bladder every 4-6 hours or as ordered by provider
   e. Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
   f. Postpartum patient
      i. Check patient for voiding without difficulty every 2 hours x 2 voids post-delivery. After delivery or catheter removal goal is for patient to void spontaneously within 6 hours.
      ii. Assess and document patency of a ~~foley~~Foley catheter as well as collection bag for amount, color and clarity of urine

~~g. STANDARDS OF CARE 1.6: ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW~~

~~1. Musculoskeletal System Review: Maternal, Same as Adult SOC~~

~~h. STANDARDS OF CARE 1.7: ASSESSMENT INTEGUMENTARY SYSTEM REVIEW~~

~~A. Integumentary System Review, Maternal: Same as Adult SOC~~

G. Standards of Care 1.8: Assessment Psycho/Social

~~B. Psychosocial assessment shall consist of the following: Same as Adult Standard of Patient Care and as the follows:~~

~~1. Observe bonding behaviors:~~
~~2. Eye contact~~
~~3. Holding infant~~
~~4. Talking to infant~~
~~5. Participating in care of infant – feeding, diaper changes, comforting~~

1. Request social services as appropriate.
2. Initiate social services referrals for the following including, but not limited to:
   a. Adoptions
   b. Infants going to foster care
   c. Patients with no prenatal care
   d. Teen moms (less than 17 years old)
   e. Positive toxicology results
   f. Mothers of infants in Neonatal Intensive Care or in facility
   g. All mothers and families experiencing Perinatal loss

~~i. **STANDARDS OF CARE: INFUSION THERAPY**~~

~~A. Maternal: Same as Adult SOC~~

~~B. Newborn: Same as Neonatal Intensive Care Unit~~

~~j. **NURSING PROCESS:** Same as Adult SOC for Maternal and Newborn~~

Tri-City Medical Center
Oceanside, California

CLEAN COPY

PATIENT CARE SERVICES

STANDARDS OF CARE ADULT

I. **PREAMBLE:**

A. Health care providers at Tri-City Medical Center (TCMC) shall ensure that each adult patient and their family are treated equally, with dignity, and respect. Cultural, racial, language, life-style customs, and ethnic diversity of each patient shall be considered when providing care. Adult patients shall receive care based on disease, injury prevention, health promotion, health restoration and/or health maintenance. The nursing process shall be used to implement all patient care. Health care providers shall use TCMC Administrative Policy Manual, Patient Care Services Policies (PCS), PCS Procedures, Mosby's Online Procedures, and unit specific Standards of Care, policies and procedures to provide patient care.

II. **DEFINITION(S):**

A. Scope and Standards of Practice: "Describe what nursing is, what nurse do, responsibilities for which nurses are accountable, and the outcomes of that practice (American Nurses Association (ANA))".

B. Standards of Care: "Authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA, p.77)". "Standards of care describe a competent level of nursing care as demonstrated by the nursing process (ANA, p. 78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.

C. Nursing Process: "The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA (2016) includes the following:

1. Assessment: "A systematic, dynamic way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors".
    a. An assessment includes subjective and objective data
        i. Subjective – what the patient says
        ii. Objective – observation based on assessment findings
2. Diagnosis: A nurses' clinical judgment about the client's response to actual or potential health conditions or needs.
3. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measurable and achievable short – and long-range goals".
    a. Planning: Care Plan i.e., Plan of Care: A comprehensive outline of care to be delivered to attain expected outcomes
4. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".
5. Evaluation: The process of determining both the "patient's status and the effectiveness of nursing care. It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care".

D. Patient: Recipient of nursing care.

E. Health Care Providers: Individuals with special expertise who provide health care services or assistance to clients

F. Significant Others: Family members and/or those significant to the client

G. Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.

Department Review	Clinical Policies and Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
02/16	11/16	01/17	n/a	03/17	10/17	03/13

III. **POLICY:**

A. "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patients to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)".

IV. **GENERAL NURSING ASSESSMENT:**

A. Standards of Care: Vital Signs:
   1. Vital signs shall include:
      a. Temperature, documented in Celsius
      b. Blood Pressure (BP)
      c. Heart Rate (HR)
      d. Respiratory Rate (RR)
      e. Oxygen Saturation (SpO2)
      f. Pain Level
   2. Vitals signs shall be obtained on admission, transfer to a unit, at discharge, per physician's orders and as follows:
      a. Intensive Care Unit (ICU): every 2 hours and as needed (PRN)
      b. Telemetry: every 4 hours while patient is awake and PRN
      c. Acute Care Services (ACS): every 8 hours and PRN
      d. Behavioral Health Unit (BHU): daily or as ordered by physician
      e. Emergency Department: per unit specific policy
      f. Progressive Care Unit (PCU): Obtain vital signs based on the ordered Patient Admission Status i.e., ACS, Telemetry, Postpartum, and Rehabilitation
   3. Document values in the medical record

B. Standards of Care: Pain Assessment:
   1. Assessment: Pain - A general pain assessment shall be performed as outlined in the Pain Management Policy consist of the following:

C. Standards of Care: Intake and Output:
   1. Intake and output shall be monitored as ordered and as follows:
      a. ICU: at least every hour and PRN
      b. Telemetry: at least every four hours and PRN
      c. ACS: at least every 8 hours and PRN
         i. Oncology: at least every 6 hours and PRN
      d. PCU: Obtain intake and output based on the ordered Patient Admission Status i.e., ACS, Telemetry, Postpartum, and Rehabilitation
      e. BHU:
         i. Monitor food intake every shift and PRN
         ii. Monitor intake volume and output as ordered by physician
         iii. Night shift shall assess bowel movements every morning with daily vital signs
   2. Intake and output shall be documented in the medical record after collecting and as follows:
      a. Prior to transfer to another level of care
      b. Prior to the end of the shift
      c. As ordered by a physician
      d. Zero/clear infusion pumps every shift and prior to transferring to another level of care
      e. BHU: document intake and output every shift
   3. Review patient's intake and output for baseline urine output

a. Patients 14 years and older assess a minimum of 0.5 mL per kilogram per hour (example if the patient weighs 70 kg multiply 70 x (times) 0.5 equals 35 mL per hour or per physician order. Notify physician for abnormal findings.

D. Standards of Care: Height and Weight
1. All patients shall be weighed on admission if not contraindicated and every seven days thereafter until discharge. Exceptions are as follows.
   a. All ICU patients shall be weighed daily in the AM
   b. Patients with the following diagnoses shall be weighed daily in the AM at or prior to 0600 after voiding, if indicated
      i. Acute and chronic kidney failure e.g., renal failure, renal insufficiency, acute renal injury
      ii. Heart Failure this includes patients with cardiomyopathy receiving diuretics
      iii. Post cardiovascular surgery patients
   c. Patients receiving nutrition support - i.e., enteral or parenteral feedings shall be weighed every 3 days after admission.
   d. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a physician.
   e. Patient's weight shall be documented in the medical record in kilograms.
   f. Patient's height shall be documented in the medical record in centimeters.
      i. Height shall be obtained on admission; stated, estimated or measured.

E. Standards of Care: Aspiration Assessment:
1. Assess on admission, initial shift assessment, and PRN as outlined in Mosby's: Aspiration Precautions Procedure
   a. Perform a swallow screening PRN based on assessment findings as outlined in the Swallow Screening in the Adult Patient Procedure
   b. Maintain head of bed (HOB) at 30 to 45 degrees and as ordered, unless contraindicated
   c. Ensure suction equipment is readily available at the bedside at all times.

F. Standards of Care: Patient Safety:
1. The health care team shall provide measures to ensure patient safety.
2. Patient safety shall be assessed per the following:
   a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after transport to procedures and as needed.
   b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
   c. Orders shall be obtained, reviewed, and implemented per PCS: Physician Orders Policy.
   d. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
   e. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
   f. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.
      i. Respiratory Care Practitioner shall be responsible for setting up home CPAP equipment.
   g. Patients shall be assessed for falls per PCS: Falls Risk Procedure.
   h. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.
   i. Medication shall be reconciled per PCS: Medication Reconciliation Policy.
   j. Line connectors for IVs, epidurals, or enteral feedings cannot be used for a type other than the type intended.
   k. All alarms shall be reviewed for appropriateness as outlined in the Clinical Alarm Management policy.

V. **SYSTEM REVIEW:**

A. All adult patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition as outlined in this document.

B. Standards of Care I: Assessment:

1. All patients admitted to inpatient nursing areas shall be assessed by a RN as outlined in this document.
2. Admission and/or Transfer Assessment
   a. All patients admitted or transferred to a higher level of care shall have a brief assessment to identify patients' safety considerations, general well-being and immediate needs initiated within the following time frames
      i. ICU Patients: approximately 15 minutes upon arrival to unit
      ii. Telemetry Patients: approximately 30 minutes upon arrival to unit
      iii. ACS Patients: approximately 1 hour upon arrival to unit
      iv. BHU Patients: within 1 hour of admission to the unit
      v. Emergency department per unit specific policy
      vi. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
3. Admission Head to Toe Assessment:
   a. The RN shall perform a head to toe assessment as follows:
      i. ICU Patients: approximately 1 hour after the patient's arrival to the unit
      ii. Telemetry Patients: approximately 2 hours after the patient's arrival to the unit
      iii. ACS Patients: approximately 3 hours after the patient's arrival to the unit
      iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
4. Admission Assessment- Patient History
   a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
5. Medication Patient History
   a. All patients shall have a Medication Patient History completed as soon as possible upon arrival to the unit per the Medication Reconciliation Policy.
6. Initial Shift Assessment (including upon Transfer to the unit)
   a. The RN shall perform a head to toe assessment as follows:
      i. ICU Patients: approximately 1 hour of the start of the shift
      ii. Telemetry Patients: approximately 2 hours of the start of the shift
      iii. ACS Patients: approximately 3 hours of the start of the shift
      iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
7. Reassessment:
   a. After completion and documentation of an admission, initial shift or transfer head to toe assessment, all patients will be reassessed as follows. Document only the reassessment changes in the electronic health record
      i. ICU: approximately 4 hours after completion of the initial assessment and every 4 hours thereafter
      ii. Telemetry: approximately 6 hours after completing the initial shift assessment
      iii. ACS: approximately 8 hours after completing the initial shift assessment
      iv. PCU Patients: Based on the ordered level of care (i.e., Medical Surgical, Telemetry, Postpartum, and Rehabilitation)
      v. BHU:
         1) Not required every shift
         2) Shall be performed and documented when clinically indicated
8. Night Shift Reassessments

a. During the night shift, the reassessment shall be performed during the shift and no later than with the AM vital signs.
b. If the patient refuses a reassessment, document their refusal in the medical record.

9. PRN Focus assessment (i.e., system specific assessment) shall be completed as follows:
   a. Change in patient's condition from the initial shift assessment or reassessment
   b. Response to treatment provided to a patient
   c. BHU: when clinically indicated

C. Standards of Care I.1: Assessment Neurological System Review

1. Neurological: System Review
   a. Assess the following:
      i. Orientation Assessment
      ii. Level of consciousness
      iii. Affect/Behavior
      iv. Characteristics of Speech
      v. Characteristics of Communication
      vi. Extremity movement and strength right and left upper and lower
      vii. Facial symmetry
      viii. Hearing
      ix. Pupil checks (pupil description, size, reaction to light, and accommodation)
         1) Pupil Checks
         2) Pupil checks shall be performed as follows to establish a baseline:
            a) On admission, initial shift assessments, and PRN
            b) As ordered by physician

2. Neurological: Detailed System Review
   a. The National Institute of Health Stroke Scale (NIHSS) will be performed by RNs who have met TCMC's criteria.
   b. A NIHSS assessment is required for:
      i. Patients admitted with signs and symptoms of a Cerebral Vascular Accident (CVA) or Transient Ischemic Attack (TIA)
      ii. Inpatients admitted or inpatient presenting with new signs and symptoms of a CVA or TIA
      iii. A NIHSS assessment will be completed as follows:
         1) Emergency Department (ED)
            a) On arrival to the department; complete a NIHSS assessment
            b) Complete items 1,5, and 6 per unit policy or as ordered
         2) ICU
            a) Admission and transfer
            b) Initial shift assessment perform a complete NIHSS assessment
            c) Reassessments perform NIHSS items 1, 5, and 6 every four hours for 72
               i) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight
         3) Telemetry, ACS and PCU
            a) Perform a NIHSS on admission, initial shift assessment and transfer. Assess items 1, 5, 6 at 0400, 1200, 1600 and midnight for 72 hours
            b) Assess the patients pupils and when:
         4) Stroke Unit
            a) Admission, discharge or transfer from other Acute Care units perform a complete NIHSS assessment

b) Initial shift assessment perform a complete NIHSS assessment and then complete items 1, 5, and 6 every four hours for 72 hours
   i) Recommended times 0400, 0800, 1200, 1600, 2000, and midnight
c) Transfer from ICU or Telemetry perform a complete NIHSS assessment and then complete 1, 5, and 6 for the duration of the 72 hours initiated in ICU or Telemetry

c. Modified Rankin Assessment:
   i. A Modified Rankin Assessment shall be completed on admission.
d. Neurological: Assessment: Spinal Cord Injury
   i. All patients with a spinal cord injury shall have the following assessed every four (4) hours.
   ii. Neurological: System Assessment
   iii. Neurological: Detailed Assessment
   iv. Assess motor and sensory function from level of spinal cord injury using dermatomes.
e. Neurological: Spinal Cord Injury Nursing Interventions
   i. To decrease worsening of neurological deficits, the following interventions shall remain in place unless otherwise ordered by a Physician:
      1) Immobilization (stabilization) of the injury as soon as possible
      2) Reposition patient as follows:
         a) Changing position in bed: full log roll with a second nurse to stabilize the patient's neck
      3) Assist patient out of bed as ordered or as follows:
         a) Full log roll with assistance
         b) Dangle patient's legs
         c) Ask patient to use arms to push up to a sitting position
         d) Assist patient to chair or with ambulation as ordered
      4) Mattress to remain flat at all times (reverse Trendelenburg with physician order); do not place a pillow, rolled blanket or towel under the patient's head
      5) Bed rest only (transport off unit in bed or stretcher, do not use a wheelchair)
      6) Use slide board when transferring and stabilize neck with second nurse
      7) Observe autonomic dysreflexia precautions
      8) Avoid bowel and bladder distention
      9) Apply supportive devices as ordered prior to getting patient out of bed
f. Neurological: Intracranial Pressure (ICP) Monitoring: ICU
   i. Neurological assessment per physician order or every hour and PRN
g. Neurological: ICP Nursing Interventions
   i. Post an intracranial pressure tracing every shift and PRN with changes in patient status in the patient's chart.
   ii. Shut device off to drain when recording ICP value and obtaining tracing
   iii. Document ICP and Cerebral Perfusion Pressure (CPP) every hour and PRN
   iv. Fluid may be removed but never instilled
   v. All fluid filled ICP monitoring devices shall have the transducer air/fluid interface leveled at the Foramen of Monroe (2 fingers breadths above the ear)
   vi. Do not attach flush devices to the ICP monitoring system
   vii. All ICP monitoring devices shall have sterile, occlusive dressing at insertion site

h. Neurological: Comatose Patients in the ICU
   i. Comatose and pharmaceutically paralyzed patients shall have their eyes taped shut with non-allergic tape to prevent corneal abrasion or injury unless otherwise ordered. Obtain an order to administer lubricating eye ointment to both eyes.
i. Neurological: Neuromuscular Blockade (NMB): ICU
   i. Assess patient per Mosby's Peripheral Nerve Stimulator.

D. Standards of Care I.2: Assessment Cardiovascular System Review:
1. Cardiovascular System Review
   a. Cardiovascular symptoms
   b. Assess the following:
      i. heart sounds in all auscultatory areas; note regular or irregular
      ii. Nail Bed color
      iii. Check capillary refill
      iv. Check edema location and grade
      v. Palpate bilateral peripheral pulses: radial and dorsalis pedis
      vi. skin temperature
      vii. A presence of cardiovascular implantable electronic devices i.e., permanent pacemaker or defibrillator
2. Cardiovascular: Detailed System Review
   a. All patients admitted to ED, ICU, and Telemetry shall have the following assessed on admission initial shift, and reassessment.
      i. Heart sounds note S1,S2 or presence of abnormal sounds
      ii. Cardiac rhythm
      iii. Jugular venous distension
   b. Pacemaker Temporary
      i. Check temporary transvenous/epicardial pacer stimulation and sensitivity thresholds every shift. Check thresholds with physician for patients with underlying complete heart block or extreme bradyarrhythmias. Assess the following:
         1) Type
         2) Function
         3) Percent paced
         4) Connection status i.e., on or off
         5) Presence of atrial, ventricular or both wires
         6) Mode
         7) Rate
         8) Output settings
         9) Site, dressing
         10) Side effects i.e., coughing of hiccups, or muscle twitching
         11) Distal pulses for transvensous femoral site
   c. Lead Placement and Rhythm interpretation for ED, ICU, and Telemetry this includes PCU patients with Telemetry orders
      i. Standard lead selection shall be leads II and V1. V1 shall be used to assess Supraventricular Tachycardia's, Bundle Branch Blocks, and wide QRS complexes
      ii. Cardiac rhythm ECG shall be monitored continuously unless otherwise ordered.
      iii. A six (6) second ECG strip shall be recorded, interpreted and posted in the patient's chart on:
         1) Admission
         2) Transfer
         3) At the beginning of the shift and per unit specific policies and procedures
         4) As needed with rhythm and rate changes

5) Alarms shall be set per the Clinical Alarm Management policy
6) Heart rate alarms shall be set 10-20 beats above or below the patient's baseline heart rate.
7) The following shall be documented in the electronic health record (EHR), if present:
    a) Ventricular heart rate
    b) Lead interpreted
    c) Wave form measurements of the following:
        i) PR Interval
        ii) QRS Interval
        iii) QT Interval
    d) Presence of ectopic beats
    e) Documentation of the following is recommended but not required:
        i) ST segment elevation or depression
        ii) Morphology of P waves and T waves
        iii) presence of U waves

iv. ED: Cardiac Monitoring
1) All patients requiring cardiac monitoring shall be placed on a cardiac monitor on arrival to the unit
2) All patient requiring cardiac monitoring shall be transported with an ECG monitor and RN

v. ICU: Cardiac Monitoring
1) All patients shall be placed on a cardiac monitor on arrival to the unit
2) All patients shall be transported with an ECG monitor and RN

vi. Telemetry: Cardiac Monitoring
1) All patients shall be placed on a cardiac monitor as outlined in the Management of Telemetry Patients unit specific policy.
2) PCU patients with Telemetry admission orders shall follow the requirements outlined in Telemetry unit specific policy. t
3) All patients shall be transported with an ECG monitor and RN unless otherwise ordered. Review the following unit specific policies:
    a) Management of Telemetry Patients
    b) Admission and Discharge Criteria

vii. Medically Monitored Lead Placement and Rate Monitoring
1) Standard lead selection shall be leads II and V1
2) The monitor technician (MT) shall record and analyze a six (6) second strip on:
    a) Admission, At the beginning of the shift
    b) As needed with rate changes or new ectopic beats
3) The MT shall communicate the analyzed strip to the primary RN or designee
4) The Unit Secretary or designee identified by the Assistant Nurse Manager (ANM) or relief charge RN will post the strips in the appropriate patient chart.

d. Invasive Pressure Monitoring Lines (Arterial, Pulmonary Artery, and Central Venous Pressure (CVP).

i. Alarms
1) All invasive pressure lines must be monitored with alarms on.
2) All arterial line alarms shall be set according to the parameters and limits specified in the physician orders. If the physician orders do not address limits, alarms shall be set based on systolic pressure.

3) Pulmonary artery lines shall be set according to the diastolic parameter and shall be set 10 mm/Hg above and below the diastolic pressure.
4) CVP/RA alarms shall be set at "Mean" with limit set per physician order or 50% above and below baseline when port is not being used for infusions.

ii. Invasive Pressure Line Maintenance
1) Transducers shall be leveled to and maintained at the phlebostatic axis (supine or prone position), 4th intercostal space, ½ anterior-posterior diameter of the chest for all pressure measurements.
2) All pressurized transduced indwelling catheters shall be maintained with a 2 unit per mL concentration heparin flush bag pressurized at 300 mm/Hg or normal saline based on the patient condition or physician heparin.
3) The flush bag shall be elevated for adequate volume every shift and PRN. Change bag every 4 days and when empty.
4) Needleless system shall be used for drawing blood from all invasive lines.
5) A safety transfer device shall be used when filling blood tubes.
6) All arterial and pulmonary artery catheters shall be attached to a transducer.
7) All transduced lines shall have pressure waveforms continuously displayed on the bedside monitor.
8) All transduced lines shall have accuracy of the system checked by performing a square waveform test at the beginning of each shift and any time the system is disturbed (e.g. blood draw).
9) Patient shall be positioned supine, head of bed (HOB) between 0-60 degrees, lateral position 20, 30 or 90 degrees or supine for all pulmonary artery pressure (PAP), pulmonary artery occlusion pressure (PAOP) and central venous pressure (CVP) measurements. Patient shall be stabilized 5-15 minutes after a position change before readings are obtained.
10) Obtain PAP/PAOP/CVP measurements from a graphic tracing at end-expiration Q shift and PRN using a simultaneous ECG tracing to assist with proper waveform identification.

e. Pulmonary Artery Catheter Monitoring
i. Cardiac Output (CO) shall be measured every 4 hours and PRN

E. Standards of Care I.3: Assessment Pulmonary System Review
1. Pulmonary: System Review
a. Assess the following:
i. oxygen delivery devices
ii. oxygen flow/FiO2
iii. Respiratory Symptoms
iv. Respirations
v. Respiratory Pattern
vi. Chest Motion
b. Auscultate breath sounds, all lobes
c. Assess the following if present:
i. sputum amount, color, and consistency
ii. cough
iii. artificial airway, tubes, and drains
2. Pulmonary: Detailed System Review
a. Pulmonary: Chest Tubes
i. Assess the following:
1) Insertion location

a) Palpate insertion site for crepitus, document if present
2) Dressing condition
3) Color and consistency of drainage
4) Amount of suction or gravity drain i.e., water seal
5) Suction chamber fluid level
6) Water seal chamber fluid level, presence of air leak, tidling
7) Complications i.e., air leaks, indications of bleeding etc.

b. Pulmonary: Chest Tube Nursing Interventions as outlined in the following:
i. Chest Tube Management Procedure
ii. Mosby's Chest Tube: Closed Drainage Systems

c. Pulmonary: Bi-Level Positive Airway Pressure (BiPAP) Assessment
i. Patients receiving BIPAP shall have skin assessed as follows:
ii. Area under headgear
iii. Bridge of nose, around perimeter of mask and along course of headgear straps
1) Ensure mask has a tight seal
iv. Place patient in a room near the nurse's station when possible
v. Elevate head of bed 30 degrees unless contraindicated
vi. Remove BIPAP mask when patient is eating or drinking to prevent aspiration as tolerated
vii. Readjust mask as appropriate to maintain oxygenation parameters as ordered and for patient comfort
viii. Provide communication equipment, i.e. picture boards
ix. Monitor continuous pulse oximetry and respiratory rate per physician's order
1) Ensure continuous pulse oximetry is ordered for patients on Telemetry

d. Pulmonary: Artificial Airway
i. The RN is primarily responsible for ensuring the tracheostomy tube is secured.
ii. Patients with tracheostomy tubes shall have a tracheal change set and an extra tracheostomy tube of the same size readily available at their bedside.
iii. Manual self-inflating resuscitation bags shall be used in the adult patients with endotracheal tubes (ETT) or tracheostomy patients for temporary ventilation whenever patient cannot be effectively ventilated by his/her own efforts.
iv. Two licensed health care providers are required when taping, manipulating, or cutting an endotracheal tube.
v. Trach care shall be done every shift and PRN by a licensed nurse or Respiratory Care Practitioner (RCP).
1) Trach care shall include evaluation and cleaning of the site
a) rach holders shall be changed PRN by a licensed nurse or RCP with the assistance of a second healthcare provider
2) Disposable inner cannula shall be changed every shift and PRN by the RN or RCP
vi. The head of the bed will be elevated 30 degrees unless contraindicated
vii. Oral care will be provided every 2-4 hours

e. Artificial Airway Nursing/Mechanical Ventilation Interventions
i. Ensure ICU and Telemetry patients with mechanical ventilation have continuous pulse oximetry.
ii. Ensure continuous pulse oximetry is ordered and monitored on patients with tracheotomies on Telemetry.
iii. Verify mechanical ventilation settings every shift and PRN with changes
1) Assess tidal volume with routine vitals in ICU and PRN

2) Assess spontaneous tidal volume with routine vitals in ICU and PRN

iv. Collaborate with respiratory therapy to assess patient's readiness for extubation daily except for patients receiving paralytic agents, ICP monitoring, pressure control inverse ratio ventilation, and/or immediate post-op open heart surgery
1) Stop all sedation prior to 0800 between 0800 and 1000
2) Assess readiness to extubate
a) Patient is awake and calm with a Richmond Agitation Sedation Scale (RASS) of 3 to 4
b) Obtain rapid shallow breathing index (RSBI) as appropriate for RCP
c) Initiate spontaneous breathing trials as appropriate
i) Monitor patient for signs of fatigue
ii) Continue for up to 2 hours or as ordered

v. Collaborate with physician regarding patient's readiness to extubate
vi. Monitor patient for signs of weaning failure during all weaning trials
1) Notify the physician if patient is unable to reach or maintain physician set goals.
vii. Ensure ETT placement is confirmed with a chest x-ray.
viii. Documentation of oral endotracheal tube placement shall be in cm at the lip line. Make every adjustment to an ETT with the aid of an RCP or additional RN.
ix. Perform oropharyngeal suctioning prior to making adjustments to the ETT.
x. Standard oral endotracheal tube position shall be changed (from side to side) every 24 hours.
xi. Auscultate and document after any ETT repositioning or manipulation.
1) Never re-tape, move, or adjust an ETT without assistance.
xii. Perform oropharyngeal suctioning prior to making adjustments to the ETT.
xiii. Suction patient only when necessary and do NOT instill normal saline while suctioning unless necessary.

f. Pulmonary: Passy Muir Speaking Valve
i. Requires a physician order for application
ii. Initial application and evaluation shall be completed by Speech Therapy
iii. Tracheostomy cuff must be deflated prior to the application of the Passy Muir

g. Pulmonary: Respiratory Procedures
i. Nasotracheal/Orotracheal suctioning requires a physician order except in the ICU
ii. Nasal airway (trumpet) may be used per RN/RCP discretion for patient comfort or airway protection

F. Standards of Care1.4: Assessment Gastrointestinal (Gi) System Review
1. GI: System Review
a. Assess contour of abdomen
b. Assess for nausea and/or vomiting
c. Auscultate for presence of bowel sounds in all four quadrants
d. Assess bowel function including passing flatus or last stool
e. Assess for the presence of tubes and drains. If present, assess type and location
i. Confirmation of placement, and drainage description
ii. Check tube placement for drainage and insertion site integrity
iii. Assess type of formula, rate, residual amounts
iv. Assess condition of nares and mucosa (check for inflammation and excoriation)

f. Assess for the presence of ostomies. If present, assess condition of stoma and surrounding skin.
   i. Document nursing ostomy interventions in the medical record

G. Standards of Care 1.5: Assessment Genitourinary (GU) System Review
1. GU: System Review
   a. Assess urine color and clarity, frequency, and voiding difficulties
   b. Assess for bladder distension
   c. Assess external anatomy/perineum as applicable
   d. Dialysis vascular access, if present
      i. Type
      ii. Location
      iii. Patency i.e., presence of thrill and bruit
      iv. Site
      v. Dressing
   e. Assess for presence of tubes/drains/ostomies, if present
      i. Document nursing ostomy interventions in the medical record
2. GU: Nursing Interventions
   a. Use bladder scanner to assess for urinary retention
   b. Urinary Catheter (foley)
      i. Insertion
         1) Pericare shall be performed prior to urinary catheter insertion
         2) Urinary catheters should be inserted only when necessary and left in place only for as long as necessary.
         3) If urine analysis or urine culture is ordered, obtain the urine specimen at the time of catheter insertion
      ii. Preexisting urinary catheters
         1) If patient is admitted with a preexisting urinary catheter it should be removed and a new urinary catheter should be inserted.
      iii. Maintenance
         1) Assess and consult with a physician for the need, indwelling catheter daily.
            a) Other methods of urinary drainage such as condom catheter drainage, suprapublic catheterization, and intermittent urethral catheterization should be considered as alternatives to indwelling urethral catheterization.
         2) Foley care should be performed every shift and PRN (i.e., after bowel movement)
            a) Document care provided in the EHR
         3) Ensure drainage tube is secured with hospital approved securement device, i.e. Statlock
         4) Ensure the tamper evident seal is intact
         5) Ensure the drainage system does not touch the floor and is without dependent loops
         6) Ensure the drainage bag is not overfilled
         7) Urinary catheters should be changed every 28 days.
   c. Discontinuation
      i. Review the patient's medical record for an order to discontinue the urinary catheter.
         1) If a patient has discharge orders and there is no order to discontinue the Foley catheter, contact the discharging physician.
      ii. Discontinue the urinary catheter per the Urinary Catheter: Indwelling Catheter Removal Procedure
      iii. If patient is unable to void 2 hours after the urinary catheter is removed:
         1) Verify the bladder volume using a bladder scanner, document the volume in the medical record

2) If patient has discharge orders, notify the discharging physician (do not discharge the patient)
   a) Time urinary catheter removed
   b) Bladder volume

iv. Document the following in the medical record after removing the urinary catheter:
1) Amount of urine in urinary drainage bag
2) Time catheter removed
3) Condition of the catheter
4) Patient's response to the procedure
5) Unexpected outcomes related to the removal of the urinary catheter

v. Document the time the patient voids after the removal of the urinary catheter, color and amount of urine and unexpected outcomes in the medical record.

3. Dialysis In-Patients Nursing interventions
   a. Weigh all patients receiving peritoneal or hemodialysis daily prior to 0600
   b. Only dialysis staff shall access dialysis catheters except with a physician order, See TCMC Central Venous Access Devices Procedures.
   c. Do not use the extremity in which a fistula or graft is placed for peripheral IV, blood pressure measurements, invasive monitoring or blood draws without a physician order.
      i. Place an information sign above the head of the patient's bed to communicate the extremity with the dialysis access and the information listed in number 4 to other members of the health care team.
      ii. Maintain bed rest for all patients with femoral dialysis access catheters. The head of the bed may be elevated per the patient's request or comfort.

H. Standards of Care 1.6: Assessment Musculoskeletal System Review
   1. Musculoskeletal System Review
      a. Assess the following:
         i. Extremity movement
         ii. Extremity strength
         iii. Gait/ mobility appropriate for age
         iv. Presence of joint or musculoskeletal abnormalities, if applicable
         v. Full range of motion against gravity, some to full resistance of all extremities, if applicable
      b. Musculoskeletal System Abnormality Review
         i. Presence of assistive devices

I. Standards of Care 1.7: Assessment Integumentary System Review
   1. Integumentary System Review shall be performed as outlined in the Skin and Wound Care Policy

J. Standards of Care 1.8: Assessment Psychological/Social
   1. Psychosocial assessment shall consist of the following:
      a. Coping
      b. Affect/Behavior
      c. Social Service (SS) Referral Reason
      d. Distress
      e. Stressors
      f. Support/Coping Interventions
   2. Psychological/Social: Nursing Interventions
      a. In ordered to promote family centered care, the nurse shall:
         i. Introduce bedside health care providers to the patient/family.
         ii. Review visitation and unit policies with patient/family on admission and as needed.
         iii. Assess and then verify with patient/family age appropriate needs.

iv. Assess and then verify patient/family ability to understand and participate in the plan of care.

b. Promote patient/family centered care
   i. Discuss expectations and collaborate with patient/family
   ii. Encourage patient/family to ask questions
   iii. Encourage patient and/or their family to participate in their plan of care.
   iv. Request the assistance of Case Managers and Social Services

c. Promote patient independence in Activities of Daily Living (ADL)

d. Promote comfort measures by:
   e. Pharmacological and nonpharmacological

f. Patients shall be informed of their responsibilities upon admission and as necessary thereafter. These responsibilities include: providing information, asking questions, following instructions, accepting consequences, following rules and regulations, showing respect and consideration, and meeting financial commitments..

K. Standards of Care: Infusion Therapy

1. Central venous lines shall be assessed as outlined in the PCS Central Venous Access Devices Procedure

2. Peripheral IV site shall be assessed:
   a. On admission
   b. Initial shift assessment
   c. Maintenance or continuous infusion shall be assessed every 2 hours and PRN
   d. prior to transfer, upon transfer to nursing unit PRN
   e. The following shall be assessed:
      i. IV insertion date and time
      ii. IV access type
      iii. IV site and condition
      iv. Patency
      v. Dressing type and condition
      vi. Document drainage if present
      vii. Infiltration score
      viii. Phlebitis score

3. Infusion Therapy: Nursing Interventions
   a. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
   b. Document initials and date IV started directly on the dressing.
   c. Pre-hospital IV starts shall be discontinued and restarted within 24 hours of admission.
   d. IV site shall be discontinued immediately and restarted with patient's complaint of persistent discomfort or signs and symptoms of the following:
      i. Infiltration
         1) Skin at site blanched, cool to touch with or without pain
      ii. Inflammation
      iii. Pallor
      iv. Phlebitis
         1) Erythema at site with or without pain
         2) Pain at site with erythema and/or edema
         3) Streak formation, palpable, cord of any size
      v. Bleeding at insertion site
      vi. Leaking of IV solution at insertion site
      vii. Pain
   e. IV solutions and tubing shall be changed as follows:
      i. Change every 4 days
         1) All IV tubing
         2) Add-on devices (neutral displacement connector (MicroClave), anti-reflux, extension set, etc.) and with tubing change

3) Rotate IV insertion sites
4) Commercially prepared solutions, if the bag is spiked once with initial start
5) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback

f. Change every 24 hours
i. All IV solutions mixed by pharmacy or nursing, unless manufacturer's
1) Expiration recommends less than 24 hours (examples: Lipids or lipid containing products, neutral displacement connector, anti-reflux, extension set, etc. and with tubing change).

4. Label IV tubing change date sticker indicating date tubing is to be changed using numerical day and month.
5. Label IV solutions with date and time IV solution hung.
6. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site.
7. Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
8. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
9. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter-related infection is suspected or documented.
10. Port Protector
a. Place a port protector on all unused central venous and peripheral line injection port(s) and at the lowest port of the IV tubing if used frequently for intravenous pushes (IVP) or intermittent infusions
b. Port protector shall be used on IV tubing ports for patients with central and peripheral lines receiving mainline infusion.
c. Apply a new port protector
i. Every time a port protector is removed
ii. Every 8 hours with routine IV flushing
iii. PRN IV flushing

VI. NURSING PROCESS:

A. Standard of Care: Assessment
1. The RN shall ensure all adult patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.

B. Standard of Care: Diagnosis
1. The RN shall review the data obtained from the patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) on admission, every shift, on transfer to another nursing unit, and PRN.
2. RNs shall review the data collected by LVNs to develop the patient's POC.

C. Standard of Care: Outcome Identification
1. The RN shall use the information obtained from Standard of Care: Assessment and Standard of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.

D. Standard of Care: Planning
1. The RN shall use the outcomes identified in Standard of Care: Outcome Identification and the physician orders to develop an individualized patient POC. The POC shall prescribe interventions that which may be implemented to attain expected outcomes.

E. Standard of Care: Implementation
1. A RN shall implement the interventions identified in the POC and ensure task delegated to unlicensed assistant personnel are assigned appropriately and completed.

F. Standard of Care: Evaluation

1. A RN shall evaluate the patient's progress toward obtaining their outcomes in the POC every shift and PRN.
2. Emergent and urgent changes in the patient's assessment shall be communicated to physicians as soon as possible per TCMC policy.
3. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during physician rounds or as soon as possible within the shift the changes were identified.

G. Standard of Care: Documentation
1. All shift assessments, focus reassessments, PRN assessments and/or care provided will be documented after completion of the care in a timely manner.
2. When it is not possible to document shift assessments, focus reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.
3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

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WOMEN'S AND CHILDREN'S SERVICES Addendum
For Obstetric Patients Receiving Care on Non-Obstetric Nursing Units

I. GENERAL NURSING ASSESSMENT

A. Standards of Care: Vital Signs
1. Vital signs shall be obtained upon admission, upon transfer to a unit, upon discharge, per provider's orders, or per unit standards of care :
   a. Notify provider for the following for any antepartum or postpartum patient:
      i. Temperature greater than or equal to 100.4° F or 38° C
      ii. Blood Pressure:
         1) Systolic Blood Pressure (SBP) greater than or equal to 140 and/or Diastolic Blood Pressure (DBP) greater than or equal to 90
         2) For know Preeclampsia with severe features: SBP greater than or equal to 160 and/or DBP 110
      iii. Heart Rate greater than or equal to 120 beats per minute (bpm)
      iv. Respirations greater than 28 or less than 12 breaths per minute
   b. Antepartum:
      i. As ordered by provider, or as clinically indicated per protocol, i.e., PCS procedure: Magnesium Sulfate Administration for Obstetric Patient

ii. Subjective assessment-ask patient if having any of the following: leaking of fluid, bleeding, contractions, fetal movement, headache or visual disturbances q shift
iii. Coordinate fetal assessment by Obstetric provider
1) For ordered fetal monitoring contact Labor and Delivery

c. Postpartum: Vaginal Delivery:
i. Vital signs including temperature shall be obtained upon admission, then every 6 hours for the first 24 hours post-delivery, then every shift until discharge, prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients, and prn clinically indicated or per provider order.

d. Post-Operative: Cesarean Delivery: Post Anesthesia Care Unit (PACU)
i. Vital signs as ordered by anesthesiologist/provider
1) See Anesthesia PowerPlan for vital signs in the first 24 hours after cesarean section (generally includes respiratory rate every 1 hour times 12 hours then every 2 hours times 12 hours).

2. Vital sign shall include temperature, upon admission then every 6 hours for first 48 hours post-delivery, then every shift until discharge, prn as clinically indicated or ordered by provider and prior to discharge per PCS procedure Discharge of Patients

B. Standards of Care: Intake And Output
1. As outlined in this document and as follows:
2. Assess for vaginal bleeding as part of the shift reassessment throughout antepartum and postpartum period.
a. Assess and document:
i. quantity (number) of pads/chux
ii. degree of saturation
iii. color
iv. frequency of bleeding

b. For concerns of hemorrhage weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
i. Notify physician for active bleeding and report above findings
1) Obtain order to start IV infusion with Normal Saline or Lactated Ringers

3. Postpartum Hemorrhage is defined as a cumulative blood loss greater than:
a. 500 mL for Vaginal Delivery
b. 1000 mL for Cesarean Section
c. 1500 mL for massive hemorrhage for any birth mode
d. Assess and review risk factors for obstetrical hemorrhage and monitor patient's blood loss for baseline blood loss output
e. Monitor lochia for color, odor, amount, consistency, clots, steady stream or trickle
i. Assess number of pads and degree of saturation
ii. Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss

f. When there is a cumulative blood loss considered to be a postpartum hemorrhage:
i. Start IV infusion with Normal Saline or Lactated Ringers per provider order
ii. Call RRT and/or Code Maternity
iii. Notify OB and primary unit ANM/Relief Charge Nurse
iv. Assist with patient care as directed by RRT and/or Code Maternity team
v. Consider uterotonic medications per provider order

g. Documentation should include:
i. Blood loss in medical record,
ii. Provider notification
iii. Interventions
iv. Blood replacement products

v. Medications given during the Code Maternity shall be documented by a RN on the Code OB Report form

h. Refer to Obstetrical Hemorrhage procedure

C. Standards of Care: Aspiration Assessment

1. Maintain aspiration precautions for maternal patients identified at risk.
   a. Maintain head of bead (HOB) at 30 degrees at all times.
      i. If eclamptic seizure occurs: lower head of bed, open airway, roll patient to side and suction secretions as necessary
      ii. Avoid attempts to insert suctioning device when patient's teeth are clenched.
   b. Maintain suction equipment at bedside at all times.

D. Standards of Care: Patient Safety

1. Maternal: Same as Adult SOC and as indicated below
2. Patient safety shall be assessed per the following:
   a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement, and/or other procedures and as needed.
   b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
3. System Specific Assessment (Focus assessment/postpartum assessment) shall be completed as follows:
   a. Change in patient's condition from the initial shift assessment or reassessment
   b. Response to treatment provided to a patient
   c. Postpartum assessment:
      i. Uterine assessment (to include lochia assessment):
         1) Fundal height/relationship to umbilicus (-3, -2, -1, 0, +1, +2, +3)
         2) Location (midline (ML) is the normal location, right or left of ML may means a displaced bladder that needs to be emptied)
         3) Consistency (firm, boggy-firms with massage, boggy)
      ii. Time intervals, beginning post-delivery:
         1)
         2) 2 hrs.-6 hrs.: upon admission then at 6 hrs. post-delivery
         3) Vaginal Delivery: 6 hrs. – 24 hrs.: every 6 hrs or sooner if clinically indicated, then q shift until discharge
         4) Cesarean Section: 6-48 hours every 6 hours or sooner if clinically indicated times 48 hours, then q shift until discharge
         5) Evaluation of blood loss/lochia: include at the same time intervals for uterine assessment
            a) Slight, Scant, Moderate, Heavy (with or without clots)
            b) Rubra, serosa, alba or other
            c) Note presence of foul odor
   d. Breast Assessment
      i. Assess breasts per the postpartum documentation section
         1) Assess for softness of the breast
         2) Assess nipples
         3) Document treatment to nipples
4. Maternal
   a. Assess the following:
      i. Level of consciousness
      ii. Orientation
      iii. Presence of:
         1) Headache
         2) Visual disturbances, e.g. blurred vision or scotoma
      iv. Deep Tendon Reflexes-usually done in the presence of hypertension
         1) Patellar or brachial (0, 1+, 2+, 3+)

v. Clonus (absent or present)-usually done in the presence of hypertension
1) Effects of epidural/regional anesthesia on lower extremities
vi. Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
vii. Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: WCS procedure: "Epidural Medication Administration")

E. Standards of Care I.3: Assessment Pulmonary System Review
1. Pulmonary: System Review
a. Maternal: (in addition to the Adult SOC Patient Care Pulmonary System review)
b. Assess pulse oximetry
i. Continuous monitoring post-epidural placement
ii. Continuous monitoring for Magnesium Sulfate administration for preeclampsia/preterm labor. Reference: PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients

F. Standards of Care 1.5: Assessment Genitoutinary System Review
1. Genitourinary (GU) System Review
a. Assess urine color and clarity, frequency and voiding difficulties
b. Assess for bladder distension
c. Assess external anatomy/perineum as applicable
d. Assess bladder every 4-6 hours or as ordered by provider
e. Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
f. Postpartum patient
i. Check patient for voiding without difficulty every 2 hours x 2 voids post-delivery. After delivery or catheter removal goal is for patient to void spontaneously within 6 hours.
ii. Assess and document patency of a Foley catheter as well as collection bag for amount, color and clarity of urine

G. Standards of Care 1.8: Assessment Psycho/Social
1. Request social services as appropriate.
2. Initiate social services referrals for the following including, but not limited to:
a. Adoptions
b. Infants going to foster care
c. Patients with no prenatal care
d. Teen moms (less than 17 years old)
e. Positive toxicology results
f. Mothers of infants in Neonatal Intensive Care or in facility
g. All mothers and families experiencing Perinatal loss

Tri-City Medical Center
Oceanside, California

ACUTE CARE SERVICES

ISSUE DATE: 10/89 **SUBJECT: Scope of Services**

REVISION DATE(S): 09/04, 06/06, 08/06, 11/07, 02/09, 06/10, 08/11

Department Approval:	09/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	08/11

A. **GOALS:**
1. To provide individualized quality patient care in a safe environment.
2. To reduce complications and unexpected outcomes
3. To continuously evaluate and improve the service provided.
4. To participate in interdisciplinary care by working closely with other disciplines.

B. **BRIEF DESCRIPTION OF SERVICE:**
1. Acute Care Services (1North/Acute Rehabilitation, 2 Pavilion, ~~3 Pavilion~~ and 4 Pavilion) develop, implement and evaluate a plan of nursing care for adult (14 years and older), ~~and Pediatric (1 day-13 years) on 3 Pavilion only,~~ acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.

C. **METHODS USED TO ASSESS PATIENTS' NEEDS:**
1. Initial patient assessments are performed by the Registered Nurse upon arrival of the patient to the unit. Reassessments are performed post-operative, when a change in status occurs, when there is a change in the caregiver and at a minimum once every shift. Nurses utilize a variety of sources to gather pertinent information like physical assessment, data from the patient's chart, observations of team members, patient, families or significant others, and other disciplines.

D. **SCOPE AND COMPLEXITY OF SERVICES:**
1. Patient care at Tri-City Medical Center encompasses health promotion, disease prevention, and treatment activities in the community, home acute care, inpatient and outpatient arena. Health care providers with specialized knowledge, judgement, and skill provide the care collaboratively. Patient care is planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize physical, psychological, and spiritual needs of patients.
2. Services provided include a variety of conditions/presentations of a medical/surgical nature. Non-surgical patients may include patients with respiratory, cardiovascular, neurologic, kidney/urinary diseases, cancer, immuno-suppressed conditions, abdominal pain, orthopedic infection, and short stay diagnostic procedures. Surgical patients may include general surgical, orthopedic, vascular and urologic procedures.
3. The nursing services are coordinated with other disciplines and integrated in the interdisciplinary care and treatment of the patients. Areas in the nursing assessment, if appropriate, trigger screenings for other departments including Dietary, Social Service, Case Management, Respiratory, Occupational Therapy, Physical Therapy, and Speech Therapy. Physician aligned case management and biweekly clinical collaboration meetings reflect one form of information exchange between disciplines and interdisciplinary care.

4. 1N: Orthopedic diagnoses are emphasized with an emphasis on orthopedic surgeries including total joint replacement, spinal surgeries and hip replacements.
5. Acute Rehabilitation: Orthopedic **and neurological** diagnoses ~~are emphasized~~ as outlined in inpatient acute rehabilitation (ARU). The ARU provides restorative and maintenance programs for the adult (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services. The plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation unit.
6. 2 Pavilion: Oncological diagnoses are emphasized; along with women's surgeries and the DiVinci Robotic Surgery patients, in addition to general medical surgical diagnosis.
~~7. 3 Pavilion: Medical Surgical with an emphasis on diabetes and pulmonary diagnoses are emphasized unit specialties. Pediatric patients with varying diagnosis, non-tertiary.~~
~~8.~~**7.** 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis.

E. **STAFFING AND THE AVAILABILITY OF STAFF:**

1. Staffing plans for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Each department has a formalized staffing grid which is reviewed at least annually based on the following: Hours per patient day/hours per unit of service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized in the Staffing Office and are kept in unit/departmental documents.
2. The units are staffed with a Clinical Manager, Clinical Nurse Leader, Clinical Educators, Assistant Nurse Managers, Diabetes Educator, Stroke Coordinator, Registered Nurses, Monitor techs, Acute Care Technicians and Chief Nurse Executive. The Manager has 24-hour responsibility for patient care and unit management Staff work 12-hour shifts.
3. The Assistant Nurse Manager or Relief Charge Nurse will make staff assignments according to patient acuity, staff availability, individual staff competencies, and the amount of supervision needed by staff members in accordance with Title 22 regulations. Patient acuity and specific patient needs are determined for each patient by the nurse for each shift, and then used for staffing. The staffing matrix provides information about staff/staff mix requirements based on acuity and minimum staffing requirements. Minimum staffing requirements provide a nurse/patient ratio of 1 RN for every 5 patients. The manager will confer if additional staff is needed. Staffing is also adjusted during each shift should the requirements change (See classification policy).
4. Basic Life Support (BLS) is required on all acute care units, Advanced Cardiac Life Support (ACLS) and National Institues of Health Stroke Scale (NIHSS) is required for 4P~~, and PALS is required for pediatric nurses on 3P~~. Initial and bi-annual competency requirements for staff are defined and updated on a yearly basis.

F. **ASSESSING DEPARTMENT SERVICES:**

1. The unit is a 24-hour, 7-day-a-week service. If a patient needs a higher level of care, physicians, and nursing staff coordinate the transfer to an appropriate unit or facility with assistance of case management as appropriate.

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

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

H. **PERFORMANCE IMPROVEMENT**

1. In order to improve patient care, several indicators are monitored to measure care given and effect change (see PI plan). Data is reported quarterly to the Quality Council.

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

1. The nursing service abides by regulations by California Title XXII, JCAHO, HCFA, and BRN. The unit uses a CMS Clinical Practice Guideline for Community Acquired Simple Pneumonia, Congestive Heart Failure, and Alcohol Withdrawal.

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

1. Medications, general and narcotics, are dispensed via the Pyxis system. Daily patient doses are stored and dispensed from the locked profile machine. Antibiotics and IV bags are kept in a separate area. Medications requiring refrigeration are stored at the appropriate temperatures. Nurses assess and document the administration/effectiveness/side effects of medication.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: 14-Day Certification Review Hearings
POLICY NUMBER: 501

ISSUE DATE: 03/08
REVISION DATE: 08/09, 03/13, ~~06/16~~

Department Approval:	**03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the procedure to be followed when a patient is scheduled for a 14-day Certification Review Hearing.

B. **POLICY:**

1. Each patient who is certified for 14 days of involuntary treatment because he or she is a danger to self or others or is gravely disabled, has the right to a Certification Review Hearing ~~unless he or she has requested judicial review by a Writ of Habeas Corpus~~. The hearing is designed to assure ~~that~~ the commitment of all patients beyond 72 hours is reviewed to determine whether probable cause exists to continue the involuntary confinement.
2. The Certification Review Hearing will be conducted on the unit and attended by a Clinical Social Worker/Marriage and Family Therapist (Discharge Planner) and Registered Nurse, both whom will be prepared to provide information in support of continuation of involuntary treatment.

C. **PROCEDURE:**

1. Meeting between the patient and his or her representative:
   a. As soon after the certification as is practical, the Patient**'s Rights** Advocate will meet with the patient to discuss the commitment process, assist the patient in preparing for the hearing, and answer the patient's questions.
   b. ~~This individual~~**The Patient's Rights Advocate** will attend the hearing with the patient and will present information, on behalf of the patient, that supports the position that the patient does not meet criteria for continuation of the involuntary confinement.
   c. If a family member has information supporting the release of the patient from Tri-City Healthcare District (TCHD), they should give this information to the Patients' Rights Advocate who will present the information at the hearing.
      ~~b.~~**i. The offer by a family member or other person to provide food, clothing or shelter to a patient is required to be in writing. This requirement also may be satisfied by the Patients' Rights Advocate talking to the family member or other person and obtaining an Affidavit from that person over the telephone to present at the hearing.**
2. The Certification review hearing will be held within **four (4)** days of the date on which the person was certified unless the patient or **Patient's Rights** Advocate requests a postponement of the hearing.

~~2.~~**a.** Postponements may be requested for a maximum period of 48 hours.

3. The Hearing will be held in the patient dining room of the Inpatient Psychiatric unit.
   a. The patient will be afforded privacy for the hearing:~~.~~
      i. The blinds to the room will be closed.
      ii. Only those individuals directly involved in the hearing will be granted entry to the room during the hearing.
      iii. A sign will be placed on the door indicating that a hearing is occurring.
      iv. A member of the clinical staff will inform other patients that a hearing is occurring.
      v. The coffee and snack cart will be made accessible to other patients by moving it from the dining room to the hallway outside of the dining room for the duration of the hearing.
4. **The certification review hearing shall be conducted by a court-appointed commissioner, referee, or a hearing officer; who is either a state qualified administrative law hearing officer, a medical doctor, a licensed psychologist, a registered nurse, a lawyer, a certified law student, a licensed clinical social worker, or a licensed marriage, family and child counselor with a minimum of five (5) years' experience in mental health.**~~A court-appointed commissioner or referee or a "certification review hearing officer" must conduct the hearing.~~
   a. ~~This~~ **The** ~~individual~~ **officer** will be welcomed by the clinical staff upon his or **her** arrival to the unit.
   b. Clinical staff will direct the officer to the dining room at the time of the hearing.
   c. **A** security officer will be present during the hearing in the patient dining room, when clinically indicated.
5. The Clinical Social Worker/M.F.T. and Registered Nurse will present evidence in support of the certification decision at the hearing.
   a. The hearing is informal in nature.
   b. Judicial rules of procedure and evidence will not apply.
   c. The presenter will be an individual who is familiar with the patient's condition such that he or she is able to present information in support of the determination that the patient is either a danger to self or others or is gravely disabled (as is indicated on the Certification).
      i. The clinical staff will complete a questionnaire that directs him or her to the pertinent questions that will be asked prior to attending the hearing.
      ii. The medical record will be taken into the hearing and used to reference information or to answer questions posed by the hearing officer or advocate.
6. **During the Certification Review Hearing, the officer will:**
   a. Determine whether a person certified has filed a petition for habeas corpus relief.
      i. If so, the person is not entitled to a certification review hearing.
   b. Review the notice of certification and determine whether it has been signed by the person in charge of the evaluation facility or his or her designee, and a physician, psychologist, nurse, or licensed clinical social worker who participated in the evaluation.
   c. Determine whether the notice has been properly served on the person and sent to his or her attorney (often the public defender) or advocate or any other person designated by the certified person.
   d. Determine whether the hearing is being held within four (4) days of certification unless judicial review has been requested or the hearing has been postponed at the request of the person certified or his or her attorney or advocate.
   e. Ask the person certified whether he or she has met with an attorney or patient advocate and discussed the commitment process and any questions the person may have about the certification process and review hearing.
   f. Determine whether TCHD has made reasonable efforts to notify family members or others designated by the certified person of the date and place of the hearing, or in the alternative, that the certified person

g. Check to see has patient requested that this information not be provided to family members.

h. Inquire whether the certified person has recently taken any medication and, if so, what the probable effects are.

i. Consider evidence from the designee of the director of TCHD and the district attorney or county counsel, if appropriate.

j. Consider evidence presented from the certified person, including any written statements from family, friends, or others who indicate a willingness and ability to assist with the certified person's basic personal needs for food, clothing, or shelter.

i. Resistance to involuntary commitment alone does not indicate evidence of a mental disorder, danger to self or others, or grave disability.

~~6.~~**7.** Patient rights at the Certification Review Hearing will all be upheld:

a. The patient has the right to be present, with his or her representative unless he or she has specifically waived this right.

b. The patient has the right to be assisted by an attorney or patient advocate.

c. The patient has the right to present evidence on his or her own behalf.

d. The patient may question the clinical staffs who are presenting evidence to uphold the certification.

e. The patient may ask other members of the clinical staff who have knowledge of the patient or of the certification decision to be present at the hearing.

~~f. The patient has the right to have the persons conducting the hearing informed as to whether he or she has received medication within the past 24 hours and if so the probable effects of that medication.~~

~~7.~~**8. At the end of the hearing, the officer will determine whether there is probable cause to believe the person is gravely disabled or a danger to self or others.**~~The hearing officer will make a decision as to whether the patient should be detained.~~

a. ~~At the conclusion of the hearing~~ The ~~attorney or advocate~~**officer** will give the patient verbal notification of the decision.

b. The ~~hearing~~ officer will also give a written decision ~~that~~ identify**inges** the evidence relied upon and the reasons for the decision to the Patient's **Rights Advocate**~~attorney or advocate~~ and to ~~the hospital~~**TCHD**.

c. A copy of the decision and the 14-day certification will be submitted to superior court.

~~8.~~**9.** If the certification is not upheld **and no probable cause is found, the court must either order the person released from involuntary detention or, if the person consents, allow the person to remain voluntarily at TCHD.**~~the patient may not be detained for further treatment and will be discharged or may elect to remain for treatment on a Voluntary basis.~~

~~9.~~**10.** If the certification is upheld **and probable cause is found, order the person detained for involuntary treatment**:

a. The patient may be held for up to 14 additional days; he or she may be discharged **at** any time during that period of time if the psychiatrist determines ~~that~~ the patient no longer meets the criteria addressed in the certification.

b. The patient will be informed of his or her right to judicial review by Writ of Habeas Corpus.

~~10.~~**11.** ~~At the end of the 14 days~~ If the patient continues to meet the criteria **at the end of the 14 days** that justified the certification, he or she may be detained for additional involuntary treatment in accordance with procedures applicable to the certification for 14 additional days for danger to self, 30 days for grave disability, and 180 days for danger to others.

a. For patients who are gravely disabled, application for temporary or permanent conservatorship may also be initiated.

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

~~b.~~1. California Department of Health Care Services (2014). Rights for Individuals In Mental Health Facilities http://www.jfssd.org/site/DocServer/RightsHandbook_English.pdf?docID=2713

E. **REFERENCE(S):**

1. Certification for Intensive Treatment, CA Welfare and Institution Code § 5250-5256 (1982)
2. Judicial Review, CA Welfare and Institution Code § 5275-5276 (1968)

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: 5250: 14-Day Involuntary Holds
POLICY NUMBER: 502

ISSUE DATE: 03/08
REVISION DATE: 08/09, 03/13, ~~06/16~~

Department Approval:	**03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the procedure for issuing 14-day involuntary holds.

B. **POLICY:**
1. When it has been determined that a patient who has been evaluated for a minimum of 72 hours, while either on a 5152 hold or on Voluntary status, displays behavior that would indicate that the person is a danger to him/herself or others or is gravely disabled, the psychiatrist will initiate a 5250 hold that allows treatment to continue, on an involuntary basis, for a maximum of 14 additional treatment days.

C. **PROCEDURE:**
1. Conditions for detention:
   a. If a person has been hospitalized on a 72 hour hold, application may be made to request that the person be certified for not more than an 14 additional days of involuntary treatment under the following conditions:
      i. The professional staff has assessed the patient and found him or her to be a danger to self, others, or gravely disabled as a result of a mental disorder.
      ii. The person has been advised of the concern and has declined the opportunity to remain for treatment on a Voluntary status.
      iii. The facility is equipped and staffed to provide intensive treatment, is designated by the County to provide intensive treatment, and has agreed to treat the patient.
   b. If a person has been hospitalized on a Voluntary status for a minimum of 72 hours, application may be made for either a 72 hour hold or a 14 day hold under the same conditions, i.e. the patient has been assessed as meeting criteria for danger to self, danger to others, or grave disability and the person has declined the opportunity to remain for treatment on a Voluntary basis.
2. Completion of Notice of Certification:
   a. Two clinicians will sign the application for certification.
      i. The first person will be the professional, or designee, in charge of the facility that provides the services. This is the attending psychiatrist or his/her designee.
         1) The designee must be another psychiatrist or a psychologist who participated in the evaluation of the patient and made the determination that the patient met criteria for continued treatment.

2) If the designee is a psychologist, that individual must be licensed, have a doctoral degree in psychology, and have at least 5 years post-graduate experience in the diagnosis and treatment of emotional and mental disorders.

ii. The second person should be a physician or psychologist who participated in the evaluation.
1) If possible the physician should be a board-certified psychiatrist.
2) The psychologist must be licensed and have at least 5 years of experience in the diagnosis and treatment of emotional and mental disorders.
3) If the professional in charge or his/her designee is the physician who performed the medical evaluation, or a psychologist, the second person to sign may be another physician or psychologist unless one is not available.
a) In this case a licensed clinical social worker or a registered nurse who participated in the evaluation must sign the notice of certification.

iii. It is recommended that the State form "Notice of Certification for Intensive Treatment" (CHA Form 12-6) be used for these notification purposes.

3. Delivery of Copies of the Certification Notice:
a. A copy of the certification notice must be personally delivered to the patient who is being certified.
b. A copy must also be sent to the patient's attorney or advocate designated to represent the patient in the certification review hearing.
c. The person being certified must be given an opportunity to designate another person who he or she wishes to also receive a copy of the certification notice.
i. If he or she is not able to make such a designation at the time of certification, he or she must be asked to designate another person as soon as he or she is capable to do so.
d. A copy of the certification notice must be submitted to the superior court with a copy of the decision that results from the certification review hearing on the same day of notification.
e. The hospital may consult with legal counsel regarding the advisability of filing documents with the court under seal and/or obtaining a protective order.

4. Advisement of Rights to the Patient:
a. The person who delivers the copy of the Notice of Certification to the person being certified must, at the time of the delivery, inform the person of the right to have either a Certification Review Hearing within four (4) days or a review by a court pursuant to a Writ of Habeas Corpus, to determine whether probable cause exists to detain the person for continued intensive treatment. (Refer to Policy: Judicial Review Pursuant to a Writ of Habeas Corpus)
b. The person being certified must be informed of his or her rights with respect to the Certification Review Hearing including the right to the assistance of another person to prepare for the hearing and/or to answer other questions and concerns regarding the involuntary commitment.
c. The person must receive an explanation regarding what judicial review by Habeas Corpus entails and must be informed to his or her right to counsel at these hearings including counsel appointed by the court.
d. The person who delivers a copy of the Certification Notice and who advises the patient of his or her rights to review by a Certification Review Hearing of by a court pursuant to a Writ of Habeas Corpus must complete the form, "Advisement of Rights-Involuntary Patient" (CHA Form 12-7).

i. This form provides documentation that the requirements related to the delivery of copies of the Notice of Certification as well as advisement of the right to review have been met.
ii. The completed form will be placed in the medical record.

5. Maximum Period of Detention:
   a. After an involuntary commitment is initiated, the total period of detention, including intervening periods of voluntary treatment, must not exceed the total maximum period during which the person could have been detained on an involuntary basis from the time of the initial involuntary commitment.
   b. If a person is admitted as a Voluntary patient and is subsequently detained on an Involuntary basis, the maximum period of time is counted from the first date of any involuntary treatment.
   c. After the maximum period of Involuntary treatment has passed, the patient may receive further treatment:
      i. If he or she agrees to remain in the hospital on a Voluntary basis
      ii. If he or she is suicidal or is certified for additional intensive treatment **for suicide**
      iii. If he or she is a danger to others or is certified for a180 days post-certification treatment or
      iv. If he or she is gravely disabled and a conservatorship is initiated.
6. Termination of Certification:
   a. Certification may be for no more than 14 days and may terminate earlier only if the psychiatrist directly responsible for the person's treatment believes, as a result of his or her personal observations, that the person is no longer, as a result of a mental disorder or impairment by chronic alcoholism, a danger to self or others or is gravely disabled.
   b. If any other professional who is authorized to release the person believes the person should be released during the 14-day additional treatment period and the psychiatrist directly responsible for the person's treatment objects, the matter will be referred to the medical director for a final decision.
7. Notification of Release:
   a. The attending psychiatrist or his or her designee must notify the county mental health director or a designee, and the peace officer who made the original application for a 72-hour hold, or a person designated by the law enforcement agency that employs the peace officer when a patient admitted for involuntary treatment has been released unconditionally when:
      i. The peace officer requested notification at the time the application for the 72-hour was made and
      ii. The peace officer certified in writing that the person was referred to the facility under circumstances that would support the filing of criminal charges.
   b. The only information that may be released is the person's name, address, date of admission for the 72-hour, and the date of release.

D. RELATED DOCUMENT(S):

1. **5250 (14 Day) Probable Cause Notification Form - Sample**
2. **Advisement of Rights-Involuntary Patient- CHA 2017 Form 12-7 - Sample**
3. **Notice of Certification for Intensive Treatment- CHA 2017 Form 12-6 - Sample**

E. REFERENCE(S):

1. **Certification for Intensive Treatment, CA Welfare and Institution Code § 5250 (1982)**
~~D.~~2. **California Hospital Association. (2017). *Consent Manual.* Sacramento: California Hospital Association.**

5250 (14 Day) Probable Cause Notification Form – Sample

PROBABLE CAUSE NOTIFICATION FORM

California State Law requires that this facility attempt to contact the family of any person being detained on a 14-day certification (W&I 5250) to advise them of the place, date and time of the Probable Cause Hearing. You have the right to:

1. Identify any family member(s) or others you wish to be notified of this hearing so that they can attend the hearing, or
2. Refuse to have any family member(s) or others notified of this hearing.
3. A Patient Advocate will represent you at your hearing unless you wish to have your own private attorney represent you.

Your doctor placed you on a 14-day certification beginning on:

_____

5250 START DATE/END DATE

_____

PROBABLE CAUSE HEARING TIME/DATE

My Name is: _____

☐ You have informed me that you wish the following family member(s) or others to be notified of your Probable Cause Hearing:

FAMILY MEMBER'S NAME _____ TELEPHONE # _____

_____

_____

☐ You have informed me that you do not wish any family member(s) or others to be notified of your Probable Cause Hearing.

☐ The patient, as a result of their mental disorder, is unable to respond to inquiries regarding the notification of their family or others (and as a result, no one has been contacted).

☐ I (staff member) have contacted family member(s) or others.

☐ I have not been able to reach the family member(s) or others shown above.

_____	_____	___/___/___	___:___ AM/PM
Name: Patient/Representative	**Signature:** Patient/Representative	**Date**	**Time**

☐ Patient refuses to sign

If patient is unable to sign, state reason: _____

_____	_____	___/___/___	___:___ AM/PM
Witness – TCHD Representative **(print name)**	**Signature**	**Date**	**Time**

Affix Patient Label

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

6340-1026
(Rev. 02/17)

5250 (14 DAY) PROBABLE CAUSE NOTIFICATION FORM

White - Chart Yellow - Patient

Advisement of Rights-Involuntary Patient- CHA 2017 Form 12-7 – Sample

FORM 12-7

ADVISEMENT OF RIGHTS — INVOLUNTARY PATIENT

This is to certify that on *(date)* _____, the undersigned advised *(name of patient)* _____, a patient at *(name of hospital)* _____, of the following:

1. That the patient is being certified for not more than 14 days of involuntary intensive treatment for:
   - ☐ Mental health disorder
   - ☐ Impairment by chronic alcoholism
   - ☐ Use of narcotics or restricted dangerous drugs

   And I have personally delivered a copy of the certification notice to him/her.
2. His/her legal rights to designate any person whom he/she wishes informed regarding his/her certification or judicial review (the patient understands that he/she has the right to request that this information not be provided), and the patient has designated the following person(s): *(names, relationships and address)* _____;
3. His/her legal right to a certification review hearing or a habeas corpus hearing by the superior court to review this certification for involuntary treatment in order to determine whether he/she is a danger to others or to himself/herself or is gravely disabled; whether he/she has been advised of, but has not accepted voluntary treatment; and whether the facility providing intensive treatment is equipped and staffed to provide treatment, is designated by the county to provide intensive treatment, and has agreed to admit him/her; and
4. His/her legal right to assistance of an advocate at a certification review hearing or to counsel, including court-appointed counsel at no cost to him/her if he/she is unable to pay for such legal services, to prepare for and represent him/her at a writ of habeas corpus hearing.

I believe as a result of my own personal observation that *(name of patient)* _____ has the capacity to comprehend the nature of the notice of certification and of the right to counsel to a certification review hearing and habeas corpus hearing.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

Print name: _____
(patient/legal representative)

Capacity or relationship to patient: _____

Reference: Welfare and Institutions Code Sections 5253 and 5254.1

California Hospital Association

(03/15)
Page 1 of 1

Notice of Certification for Intensive Treatment- CHA 2017 Form 12-6 – Sample

FORM 12-6

NOTICE OF CERTIFICATION FOR INTENSIVE TREATMENT

PURSUANT TO: *(Check applicable box)*

- ☐ ***Welfare and Institutions Code 5250 (Additional 14 days of intensive treatment)***
- ☐ ***Welfare and Institutions Code 5270.15 (Additional 30 days of intensive treatment)***

The authorized agency providing evaluation services in the County of _____ has evaluated the condition of:

Name: _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____

_____

We, the undersigned, allege that the above-named person is, as a result of mental health disorder or impairment by chronic alcoholism *(check all applicable boxes)*:

- ☐ A danger to others
- ☐ A danger to himself/herself
- ☐ Gravely disabled as defined in Welfare and Institutions Code Section 5008(h)(1)

The specific facts which form the basis for our opinion that the above-named person meets one or more of the classifications indicated above are as follows *(certifying persons to detail facts)*: _____

_____

_____

The above-named person has been informed of this evaluation, and has been advised of the need for, but has not been able or willing to accept treatment on a voluntary basis, or to accept referral to, the following services: _____

_____

Therefore we certify the above-named person to receive intensive treatment related to the mental health disorder or impairment by chronic alcoholism beginning this ____ day of *(month)* _____, 20____, in the intensive treatment facility named: _____.

We hereby state that we delivered a copy of this notice this day to the above-named person. We informed him or her that unless judicial review is requested, a certification review hearing will be held within four days of the date on which the person is certified for a period of intensive treatment to determine whether or not probable cause exists to detain him or her for intensive treatment related to the mental health disorder or impairment by chronic alcoholism. We informed the above-named person that an attorney or advocate will visit him or her to provide assistance in preparing for the hearing or to answer questions regarding his or her commitment or to provide other assistance. The court has been notified of this certification on this day.

(over)

Form 12-6 Notice of Certification for Intensive Treatment

Also, on this day the above-named person has been informed of his/her legal right to a judicial review by habeas corpus, and the term "habeas corpus" has been explained to him/her, and that he/she has been informed of his/her right to counsel, including court-appointed counsel pursuant to Welfare and Institutions Code Section 5276.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician/staff member of facility)

Print name: _____
(physician/staff member of facility)

Date: _____ Time: _____ AM / PM

Signature: _____
(representing intensive treatment facility)

Print name: _____
(representing intensive treatment facility)

Date: _____ Time: _____ AM / PM

Signature: _____
(countersignature)

Print name: _____
(countersignature)

COPIES:

Patient: _____

Patient's attorney or representative: _____

Other person designated by patient: _____

Superior Court (to be submitted with the psychiatric certification review hearing decision)

Reference: Welfare and Institutions Code Section 5252 to 5254.1

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
~~**Crisis Stabilization Unit**~~

SUBJECT: **5270 30 Days of Additional Intensive Treatment**

ISSUE DATE: **NEW**
REVISION DATE(S):

Department Approval:	**03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide continued involuntary intensive treatment for a patient who is gravely disabled following the conclusion of a 14-day certification by initiating a 5270 (30-day hold) according to LPS and San Diego County Board of Supervisor requirements in a designated facility for treating involuntary patients.

B. **POLICY:**

1. Upon completion of a 5250 14-day period of intensive treatment a patient may be certified for an additional period of not greater than thirty (30) days of intensive treatment under both of the following conditions:
   a. The professional staff of ~~the~~**Tri-City Healthcare District** (TC~~MC~~**HD)** facility treating the patient has found that the patient remains gravely disabled as a result of a mental disorder or impairment by chronic alcoholism.
   b. The person has been advised of the need for continued treatment but is unwilling or unable to accept intensive treatment on a voluntary basis (5270.15).
   c. When a 5270 is initiated as a new hold, it must be signed by the professional person in charge of the ~~TCMC~~ **TCHD** facility providing the intensive treatment, and by (if possible) a board-qualified psychiatrist, or a licensed psychologist who has a doctoral degree in psychology and at least five years of post graduate experience in the diagnosis and treatment of emotional and mental disorders (5270.20). The physician or psychologist who signs must have participated in the evaluation. (5270.20).
   d. If the professional person in charge is the physician who performed the medical evaluation and finding, or a psychologist, the second person to sign may be another physician or psychologist, unless another one is not available, in which case a licensed clinical social worker or a registered nurse who participated in the evaluation and finding shall sign the notice of certification (5270.15.)
   e. Any person certified for an additional 30 days pursuant to this article shall be provided with a Certification Review Hearing unless the patient requested a Judicial Review per Article 5.
   f. The certification form contains the same elements as the form for the 5250 (but can only be used for grave disability).
   g. Copies of the second notice of certification as set forth in Section 5270.25, shall be filed with the court (sent to the confidential fax line at the Counselor in Mental Health [Superior Court]: 619-450-7799) and personally delivered to the person certified. A copy

is also be sent to the person's attorney, to County Counsel (confidential fax line: 619-531-6005), to the Public Defender (confidential fax line: 619-338-4847), if any, to the JFS Patient Advocacy (confidential fax line: 619-282-4885) and to the facility providing intensive treatment.

h. The person certified shall also be asked to designate any individual who is to be sent a copy of the certification notice. If the person certified is incapable of making the designation at the time of certification, that person shall be given another opportunity to designate when able to do so.

i. The professional staff of the ~~TCMC~~ **TCHD** facility providing intensive treatment must analyze the person's condition at an interval of not more than 10-days, and monitor the person's treatment plan and progress.

j. Termination of 5270 certification can occur prior to the 30th day per 5270.35, as long as the psychiatrist directly responsible for person's treatment believes the person no longer meets the criteria for certification and involuntary treatment.

k. Any individual who is knowingly and willfully responsible for detaining a person for more than 30 days in violation of the provisions of Section 5270.35 is liable to that person in civil damages.

l. Whenever a county designates two or more facilities to provide intensive treatment and the person to be treated, his or her family, conservator, or guardian expresses a preference for one facility, the professional person certifying the person to be treated shall attempt, if administratively possible, to comply with the preference.

C. **PROCEDURE:**

1. When a patient is placed on a 5270 30-day hold a new notice of certification is required. It must be signed by the attending Psychiatrist providing treatment. The patient being certified shall be provided a certification review hearing in accordance with Section 5256 unless a judicial review is requested by the person pursuant to Article 5 (commencing with Section 5275).

   a. For purposes of certifying an individual for a 5270, a notice of certification shall be signed by two people. The first person signing the certification shall be a Psychiatrist or a Psychologist with five or more years of experience and certified/designated to initiate a hold. The second person certifying and signing the 5270 30-day hold will be a Psychologist. In the absence of a second psychologist or psychiatrist, a designated Registered Nurse, or a Licensed Clinical Social Worker, will countersign the petition.

   b. The person delivering the copy of the notice of certification to the person shall, at the time of delivery, inform the patient being certified that he or she is entitled to a certification review hearing to be held within four (4) days of the date on which the certification is filed or they may request a judicial review.

   c. The patient being certified shall be informed of his or her rights with respect to the hearing, including the right to the assistance of another person to prepare for the hearing or to answer questions and concerns regarding her or her involuntary detention or both.

   d. Documentation on the 5270 must include either; "Patient Requests Writ" – followed by signature of licensed staff or "Patient Does Not Request Writ" – followed by signature of licensed staff. If a patient requests a writ, the patient must be provided with a Petition for Writ of Habeas Corpus, and facility staff must assist the patient with preparation of the form, if assistance is needed or requested. The completed form should be faxed to the Public Defender (confidential fax line: 619-338-4847).

   e. On the first day of the 30 day hold, the facility must call the Superior Court's Office of the Counselor in Mental Health at 619-450-7829, to provide the necessary information to schedule the certification review hearing, (similar to when calling in a request for a 14 day hold hearing). Please provide the following information: Name of caller, facility, phone number, patient's last name, first name, DOB, unit/room/medical floor, doctor's name, grave disability criteria, and request for interpreter/language if needed.

   f. A copy of the completed 5270 is given to the patient and JFS Patient Advocacy Office (confidential fax line: 619-282-4885).

g. A certification will be for no more than thirty (30) days of intensive treatment and shall terminate only as soon as the psychiatrist directly responsible for the patient's treatment believes, as a result of the psychiatrist's personal observations, that the patient no longer meets the criteria for the certification or is prepared to remain in treatment on a voluntary basis.

h. An original or copy of the 5270 remains with the patient upon transfer.

i. Once any involuntary detention has been initiated a patient may not be detained more than a maximum of 47 days pursuant to W&I Code Section 5150 (3 days), 5250 (14 days) and 5270 (30 days) regardless of the number of days the patient may have been on voluntary status between the initiation of the holds (W&I Code Section 5258).

j. Termination of the 5270 may only be determined by the attending Psychiatrist or the Psychiatric Medical Director of the Facility. As soon as the Psychiatrist who is directly responsible for the care of the patient believes, based on personal observation, that the patient no longer meets the criteria for the certification, or is prepared to accept voluntary treatment the attending Psychiatrist must release the patient from the 5270.

D. **DOCUMENTATION:**

1. The Psychiatrist or Psychologist shall enter their findings in the patient's medical record which will include their findings from their review for the continuation of the 5270 and the need for continuation of the certification will be documented by the treating psychiatrist in the patient's record at least every ten (10) days to establish that the patient continues to meet the criteria for certification as stated in Section 5270.15 of the W&I Code.
2. The Psychiatrist will monitor the patient's treatment plan daily and document progress or lack of progress in the patient's medical record.

E. **ADDITIONAL RIESE (CAPACITY HEARING:**

1. In order to administer antipsychotic medication involuntarily to a patient who is subject to 5270, a Riese (capacity) hearing must be held to determine whether the patient has the capacity to consent or refuse medication.
2. Only a patient who has been determined to lack capacity at a Riese hearing may be medicated involuntarily (absent a temporary emergent condition, in which the emergency has been clearly documented).
3. Even if a patient has already had a Riese hearing during a 5150 (72-hour hold) or a 5250 (14-day hold), a new Riese hearing must be held upon the initiation of the 5270, if the intention is to continue to medicate the patient involuntarily.

F. **LEGAL STATUS CHANGE TO TEMPORARY CONSERVATORSHIP:**

1. If it is determined that an involuntary patient who is on a 14-day hold (5250) is likely to qualify for the appointment of a conservator, the conservatorship referral shall be made to the Public Conservator's Office by close of business on the 9th (ninth) day of the 14-day hold to allow time to meet legal noticing requirements (confidential fax line: 858-495-5127).
2. If it is determined that an involuntary patient who is on a 30-day hold (5270) is likely to qualify for the appointment of a conservator, the conservatorship referral shall be made to the Public Conservator's Office by close of business on the 5th (fifth) day of the 30-day hold to allow time to meet legal noticing requirements (confidential fax line: 858-495-5127).
3. It is strongly encouraged that conservatorship referrals be made as early as possible during 14 day and 30 day holds to allow time for investigation and meeting legal noticing requirements.
4. If a 5270 is converted to a temporary conservatorship, the timelines run concurrently for the 30-day period. Any person held involuntarily using any combination of 5270 and temporary conservatorship shall not be held for more than a total of 30 days.

G. **FORM(S):**

1. ~~5270~~ Notice of Certification **of Up to 30 Days of Additional Intensive Treatment**
2. **Probably Cause Notification 5270 Form - Sample**

~~2. Probable Cause Notification Form – 30 Day Certification~~

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

1. http://www.jfssd.org ~~/site/PageServer~~

I. **REFERENCE(S) ~~LIST~~:**

1. Postcertification Procedures for Imminently Dangerous Persons, CA Welfare and Institution Code § 5300 (1967)

~~1.~~**2.** Phillips, M. (2014). 5270 Policies and Procedures Template for LPS Facilities. Retrieved August 1, 2014 from http://www.jfssd.org/site/PageServer

Notice of Certification of Up to 30 Days of Additional Intensive Treatment

County of San Diego, Health and Human Services Agency — Behavioral Health Services

NOTICE OF CERTIFICATION OF UP TO 30 DAYS OF ADDITIONAL INTENSIVE TREATMENT
(Rev. 06/14)

Confidential Patient Information per Welfare & Institutions Code Section 5328 and Penal Code 1174.2 — HIPAA Privacy Rule 45 C.F.R. § 164.508

The authorized agency providing evaluation services in the County of _____ has evaluated the condition of:

Name _____

Address _____

Marital Status _____ Date of Birth _____ Sex _____

We, the undersigned, allege that the above-named person is, as a result of a mental disorder or impairment by chronic alcoholism:

☐ Gravely disabled as defined in paragraph (1) of subdivision (h) or subdivision (1) of Section 5008 of the Welfare & Institutions Code

The specific facts which form the basis for our opinion that the above-named person meets the classification indicated above are as follows:

The above-named person has been informed of this evaluation, and has been advised of the need for, but has not been able or willing to accept treatment on a voluntary basis, or to accept referral to, the following services:

We, therefore, certify the above-named person to receive intensive treatment related to the mental disorder or impairment by chronic alcoholism beginning this _____ day of _____, 20____ (date 30-day hold begins), in the intensive treatment facility herein named _____

_____
Date of Assessment

Signature _____

Signature _____

I hereby state that I delivered a copy of this notice this day to the above-named person and that I informed him or her that unless judicial review is requested, a certification review hearing will be held within four days of the date on which the person is certified for a period of intensive treatment and that an attorney or advocate will visit him or her to provide assistance in preparing for the hearing or to answer questions regarding his or her commitment or to provide other assistance. The court has been notified of this certification on this day.

☐ Patient Requests Writ ☐ Patient Does Not Request Writ

Signature _____

Copies: Person Certified - Personally delivered
Person's Attorney
Patient Advocate
Superior Court, Counselor in Mental Health
County Counsel
Facility Providing Intensive Treatment
Public Defender, if any

Probably Cause Notification 5270 Form - Sample

PROBABLE CAUSE NOTIFICATION FORM

California State Law requires that this facility attempt to contact the family of any person being detained on a 30-day certification (W&I 5270) to advise them of the place, date and time of the Probable Cause Hearing. You have the right to:

1. Identify any family member(s) or others you wish to be notified of this hearing so that they can attend the hearing, or
2. Refuse to have any family member(s) or others notified of this hearing.
3. A Patient Advocate will represent you at your hearing unless you wish to have your own private attorney represent you.

Your doctor placed you on a 30-day certification beginning on:

_____

5270 START DATE/END DATE

_____

PROBABLE CAUSE HEARING TIME/DATE

My Name is: _____

☐ You have informed me that you wish the following family member(s) or others to be notified of your Probable Cause Hearing:

FAMILY MEMBER'S NAME _____ TELEPHONE # _____

FAMILY MEMBER'S NAME _____ TELEPHONE# _____

FAMILY MEMBER'S NAME _____ TELEPHONE# _____

☐ You have informed me that you do not wish any family member(s) or others to be notified of your Probable Cause Hearing.

☐ The patient, as a result of their mental disorder, is unable to respond to inquiries regarding the notification of their family or others (and as a result, no one has been contacted).

☐ I (staff member) have contacted family member(s) or others.

☐ I have not been able to reach the family member(s) or others shown above.

_____	_____	__/__/__	__:__ AM/PM
Name: Patient/Representative	**Signature:** Patient/Representative	**Date**	**Time**

☐ Patient refuses to sign

If patient is unable to sign, state reason: _____

_____	_____	__/__/__	__:__ AM/PM
Witness – TCHD Representative **(print name)**	**Signature**	**Date**	**Time**

Affix Patient Label

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

6340-1059
(Rev. 02/17)

PROBABLE CAUSE NOTIFICATION 5270 FORM

White - Chart Yellow - Patient

~~Probable Cause Notification Form – 30 Day Certification~~

PROBABLE CAUSE NOTIFICATION FORM **DELETE**

30-Day Certification

California State law requires that this facility attempt to contact the family of any person being detained on a 30-day certification (W&I 5270) to advise them of the place, date and time of the Probable Cause Hearing. You have the right to:

1. Identify any family member(s) or others you wish to be notified of this hearing so that they can attend the hearing, or
2. Refuse to have any family member(s) or others notified of this hearing.
3. A patient advocate will represent you at your hearing unless you wish to have your own private attorney represent you.

Your doctor placed you on a 30-day certification beginning on:

START DATE: _____ END DATE: _____

PROBABLE CAUSE HEARING DATE/TIME: _____

My Name is: _____

☐ You have informed me that you wish the following family member(s) or others to be notified of your Probable Cause Hearing:

FAMILY MEMBER'S NAME_____TELEPHONE #_____

FAMILY MEMBER'S NAME_____TELEPHONE #_____

FAMILY MEMBER'S NAME_____TELEPHONE #_____

☐ You have informed me that you **do not** wish any family member(s) or others to be notified of you Probable Cause Hearing.

☐ The patient, as a result of their mental disorder, is unable to respond to inquiries regarding the notification of their family or others, and as a result, no one has been contacted.

☐ I (staff member) have contacted family member(s) or others

☐ I have not been able to reach the family members(s) or others shown above.

Advising Staff's Signature_____Date:_____

TCMC
PROBABLE CAUSE NOTIFICATION 5270
9/2014
White-Chart
Yellow- Patient

ADDRESSOGRAPH

Tri-City Medical Center
Oceanside, California

Behavioral Health Unit
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Administration of Zyprexa Relprevv**

ISSUE DATE: **NEW**
REVISION DATE(S):

Department Approval:	**~~9/2015~~03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**09/17**
Medical Executive Committee Approval:	**09/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish specific procedures which must be followed to participate in the Patient Care Program of Zyprexa Relprevv. To ensure the safety of consumers prescribed Zyprexa Relprevv and to mitigate negative outcomes associated with Zyprexa Relprevv post-injection delirium/sedation syndrome (PDSS).

B. **DEFINITION(S):**

1. Zyprexa Relprevv: is a long-acting atypical antipsychotic for intramuscular gluteal injection which can be prescribed and administered every 2-4 weeks as indicated for the treatment of adults with Schizophrenia.
2. Zyprexa Relprevv Post-injection Delirium /Sedation Syndrome (PDSS): is a serious adverse reaction or event which can occur after the administration of a Zyprexa Relprevv injection if the medication enters the bloodstream too rapidly. Possible symptoms may encompass sedation (can range in severity from mild to coma), and delirium including confusion, disorientation, agitation, anxiety and other cognitive impairment. Other symptoms can include extrapyramidal symptoms, dysarthrias, ataxia, aggression, dizziness, weakness, hypertension, and convulsion. The potential for onset of this event is greatest within the first hour post-injection and the majority of cases have occurred within the first three hours after injection. If any of the above symptoms occur post-injection medical or emergency treatment **is needed** immediately.

C. **POLICY:**

1. It is the policy of **Tri-City Healthcare District (TCHD)**~~TCMCMHS~~ to ensure the safety of all patients who participate in the Zyprexa Relprevv Patient Care Program by training staff in protocols for use, safe administration, and monitoring for Post-Injection Delirium Sedation Syndrome.

D. **PROCEDURE:**

1. Enrollment:
   a. The prescribing physician must enroll in the Zyprexa Relprevv Patient Care Program after they review the available training educational materials **at www.zyprexarelprevvprogram.com**:
      i. The Zyprexa Relprevv Patient Care Program Instructions Brochure ~~(Attachment B),~~

ii. The Health Care Professional Training Slide Presentation with text notes ~~(Attachment C) and~~
iii. The Reconstitution and Administration Poster and complete Prescriber Registration Form ~~(Attachment D)~~ online or fax to 1-877-772-9391

b. After the decision has been made to prescribe Zyprexa Relprevv, the prescribing physician will be responsible for completing the Healthcare Facility Registration Form ~~(Attachment A)~~ and fax to 1-877-772-9391 or complete it online: www.zyprexarelprevvprogram.com.

c. All patients who, in consultation with their Attending Psychiatrists, elect to be treated with Zyprexa Relprevv must be enrolled in the Zyprexa Relprevv Care Program prior to receiving their first injections.

d. Fax completed Patient Registration Form to Zyprexa Relprevv Patient Care Program (Fax No. 1-877-772-9391) or can be filled out online @ www.ZyprexaRelprevvprgrogam.com

e. After enrollment is completed a unique Patient Identification Number (PIN) and the Healthcare facility unique identifier will be provider to the hospital.

f. The staff will provide these two numbers with the first prescription of this medication to ~~Rez Care~~ **the designated** Pharmacy ~~on C Street Downtown San Diego~~ for enrollment and medication dispensing.

g. The Enrollment process will be repeated every three years. Notification by fax or email will be given 60 days prior to the re-enrollment date by the Patient Care Program Coordinating Center. Non-compliance with program requirements may result in dis-enrollment from the Zyprexa Relprevv Patient Care Program.

2. Prescribing Zyprexa Relprevv:
   a. Prior to prescribing Zyprexa Relprevv for patient the prescribing physician will determine if patient will benefit from Zyprexa Relprevv or not.
      i. Tolerability with oral olanzapine should first be established prior to initiating treatment with Zyprexa Relprevv
3. Administration of the Injection:
   a. Provide the Medication Guide to the consumer. Answering any questions the consumer may have in order to ensure the patient's understanding of the information in the guide.
   b. The staff will prepare and administer the Zyprexa Relprevv injection per the steps outlined in the Poster entitled: Instructions to Reconstitute and Administer Zyprexa Relprevv (posted in the medication room)
   c. It is good practice to administer Zyprexa Relprevv between hours of 0900 – 1600 and must be administered in a registered healthcare facility with ready access to emergency response services
   d. All providers and nursing staff administering injections and involve in the continuous monitoring of patients at any time post-injection are required to be trained on the educational materials addressed **under enrollment** ~~in D. I.ii.~~ either online or via with an in-service from the program.
   e. It is important to note that the risk of a PDSS event is present with each injection of Zyprexa Relprevv. Although this risk cannot be eliminated, good injection technique is necessary to minimize the occurrence of these events.
   f. Zyprexa Relprevv is intended for deep intramuscular gluteal injection **ONLY**. Do not administer intravenously or subcutaneously. It is **not approved** for deltoid injections.
   g. Administrators must aspirate the syringe for several seconds prior to injection to ensure that no blood is visible in the syringe. If blood is visible, they must not proceed with the injection. They should discard the syringe and reconstitute a new vial for injection, then inject into the alternate side of the buttock, deep into the gluteal muscle.
4. Continuous Monitoring Post Injection:
   a. Directly after the injection, a healthcare professional must observe the patient for at least 3 hours. The patient should be located in an area where he or she can be seen and/or heard at all time.

b. After completion of the observation period, the administrators will complete and submit the Single or Multiple Patient Injection Form ~~(Attachment E)~~ for each consumer receiving an injection to the Zyprexa Relprevv Patient Care Program Coordinating Center within seven days of the date of the injection.
c. PDSS is suspected, close medical supervision and monitoring should be instituted in a facility capable of resuscitation and report event through the Zyprexa Relprevv Patient Care Program.
d. Complete and submit the Post –injection Delirium Sedation Syndrome (PDSS) Form ~~(Attachment F)~~ by fax: 1-877-772-9391 Online: www.zyprexarelprevvprogram.com
e. Healthcare professionals must confirm that the patient is alert, oriented, and absent of any signs and symptoms of post-injection delirium/sedation syndrome prior to being released.

5. Patients should be periodically reassessed to determine the need for continued treatment:
   a. Diazepam (Valium): May potentiate orthostatic hypotension
   b. Alcohol: May potentiate orthostatic hypotension
   c. Carbamazepine (Tegretol): Increased clearance of olanzapine
   d. Fluvoxamine (Luvox): May increase olanzapine levels
6. Process for receiving medication:
   a. Once received medication from **the designated**~~Rez Care~~ Pharmacy, healthcare professional must send medication along with the original prescription to TC**HD**~~MC~~ In-Patient pharmacy for medication review & labeling.

E. EXTERNAL LINKS~~FORMS~~:

1. **www.zyprexarelprevvprogram.com**
   - ~~1.~~**a.** ~~Attachment A:~~ Healthcare Facility Registration Form
   - ~~2.~~**b.** ~~Attachment B:~~ The Zyprexa Relprevv Patient Care Program Instructions Brochure
   - ~~3.~~**c.** ~~Attachment C:~~ The Health Care Professional Training Slide Presentation with text notes
   - ~~4.~~**d.** ~~Attachment D:~~ Prescriber Registration Form
   - ~~5.~~**e.** ~~Attachment E:~~ Single or Multiple Patient Injection Form
   - ~~6.~~**f.** ~~Attachment F:~~ Post–injection Delirium Sedation Syndrome (PDSS) Form

F. REFERENCE(S) ~~LIST~~:

1. Zyprexa Relprevv Patient Care Program
2. Zyprexa Relprevv Risk Evaluation and Mitigation Strategy (REMS) EliLilly and Company

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Advisement of Legal Status 72-Hour Hold
POLICY NUMBER: 504

ISSUE DATE: 03/08
REVISION DATE: 08/09, 03/13, ~~06/16~~

Department Approval:	**03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide guidelines for advising patients of their legal status when a patient has been hospitalized pursuant to a 72 hour hold for evaluation and treatment.

B. **POLICY:**
1. The responsible clinical staff will give each person who is admitted pursuant to a 72 hour hold specific information, both orally and in writing, in a language or modality that is accessible to that person.

C. **PROCEDURE:**
1. The language in which the information is given must be the patient's native language or the language that is the patient's principle means of communication.
2. The information given must include the following:
   a. Name and position of the person providing the information
   b. The date
   c. The reason the person is being detained
      i. Danger to self
      ii. Danger to others
      iii. Unable to provide his or her own food, clothing, or shelter
   d. The narrative reason it is believed that the patient meets one of the above criteria
   e. The fact that the person will be detained for 72 hours, with beginning and ending times
   f. Good cause for incomplete advisement
   g. A statement of what will occur if the clinical staff believes the patient requires further treatment after the 72 hours including the right to a lawyer, an interpreter, and a hearing before a judge.
   h. A statement that state law presumes competency irrespective of legal status
3. A record of the advisement will be kept in the patient's medical record that includes the above information.
4. If the advisement was not given or completed at admission, the advisement process will continue until it has been completed.

D. **REFERENCE(S):**
1. **Certification for Intensive Treatment, CA Welfare and Institution Code § 5250 (1982)**

2. **Detention of Mentally Disordered Persons for Evaluation and Treatment, CA Welfare and Institution Code § 5150**
~~5.~~3. **Lanterman–Petris–Short Act, CA Welfare and Institution Code § 5000 (1967)**

Tri-City Health Care District
Oceanside, California

Infection Control ~~Policy Manual~~

ISSUE DATE:	**09/01**	**SUBJECT:**	**Bloodborne Pathogen Exposure Control Plan**
REVISION DATE:	**09/02, 09/03, 09/04, 09/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/12, 10/15**		

Infection Control Department Approval:	**~~07/16~~06/17**
Infection Control Committee Approval:	**~~07/16~~07/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/16~~07/17**
Professional Affairs Committee Approval:	**~~08/16~~10/17**
Board of Directors Approval:	**08/16**

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect healthcare workers from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

C. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD)

D. **AVAILABILITY TO HEALTHCARE WORKERS:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to healthcare workers at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in orientation and during annual reviews.

E. **PROGRAM ADMINISTRATION:**

1. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program. In conjunction with the Infection Preventionist, she/he will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified tasks and procedures.
2. To assist the Director of Safety/ Environment of Care (EOC) in carrying out their duties, the Environmental Health and Safety (EHSC) Committee and following specific people will be contacted as needed.
   a. Infection Preventionist
   b. Employee Health
   c. Staff Educator

d. Engineering
e. Human Resources
f. Environmental Service Managers

3. Department Directors, Managers, and Supervisors are responsible for compliance in their respective areas. They work directly with the Director of Safety/EOC, the Infection Control Department, Education Department, Employee Health Nurse and our employees to ensure that proper exposure control procedures are followed.
   a. Managers will support activities that encourage the active involvement of employees in education and safety programs. Managers will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
   b. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
   c. Annually, managers will complete the template "Safer Work Practices" (see Safer Work Survey) with input from employees with respect to the procedures performed in their respective work areas or departments related to safe work practices, engineered safety devices and personal protective equipment (PPE).
   d. Managers will review quality review reports (RL Solutions) their employees complete to document why they did not use an available safety device.
      i. Managers will counsel employees who do not use safe practices, PPE, and/or safety devices.
4. The Director/Manager of Education and Training Services has been selected to be the facility's Education/Training Coordinator. He/she is responsible for providing information and training to all employees with potential for exposure to bloodborne pathogens including:
   a. Developing and scheduling suitable education/training programs.
   b. Periodically reviewing training programs with the Environment of Care Officer, Employee Health, Infection Control, and Department Managers/Supervisors to include appropriate new information.
   c. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
5. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
6. The Clinical Value Analysis Team has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See Clinical Value Analysis Team Product Evaluation and User Product Evaluation.
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environment of Care or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
   d. See Product List for a table of safety devices that have been adopted.
7. Employees who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.

a. Our employees are expected to complete initial bloodborne pathogens training and annual review.
b. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Safer Work Survey).
c. Licensed healthcare professionals are required to complete a quality review report (RL Solutions) when they do not use available Sharps safety devices during the care of a patient. The report will outline their determination of why using an engineering control would have jeopardized the patient's safety or the success of a medical, dental, or nursing procedure.
d. Employees will participate in the trial and selection of new safety devices.

8. The EHSC will compile and trend the information gathered above. August has been selected as the regular month for annual plan update.
   a. Safety rounds are conducted on an annual or **as needed** ~~biannual~~ (for patient care units or departments) schedule.
   b. Information from the annual "Safer Work Survey" is compiled by the Director of Safety/EOC or designee and reported to Environment of Care, Infection Control, and Products Standards Committees.
   c. Risk, Legal and Regulatory Services forwards information from incident and Quality Review Reports to the Director of Safety/EOC as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.

   ~~Area Safety Representatives will support safe work practices by participating in education efforts and reporting concerns.~~

9. Employee Health and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Employee Health identifies products involved in contaminated sharps injuries and reports this information to Material Management so that the number of those devices ordered in the previous year can be reported to the EHSC.
   e. Recommendations are made to the Product Standardization Committee- when a need for a safety device or alternative product is detected.
   f. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   g. Employee Health will present sharps Injury data specific to TCHD at the Infection Control Committee meeting annually (i.e. safety devices, work practice changes or engineering).

F. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are considered to be exposed even if they wear personal protective equipment).
2. See Potential Blood Exposure by Job Category for a list of the job classifications in our facility where all or some employees handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.
3. Since not all of the employees in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these employees to have occupational exposure are listed in Potential Blood Exposure by Job Category.

G. **ENGINEERING CONTROLS:**

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize employee exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying employees with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. TCHD is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   e. See the table on Product List for a review of the Sharps Safety Devices that have been adopted.
   f. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   g. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily

iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.
iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.

h. In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.
i. Hand washing facilities and waterless hand cleansers are readily accessible to employees with potential for exposure.
ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.
iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

H. WORK PRACTICE CONTROLS:

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize employee exposure to bloodborne pathogens.
a. Employees follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:
i. Semen
ii. Vaginal Secretions
iii. Peritoneal fluid
iv. Tissue and Organs
v. Amniotic fluid
vi. Synovial fluid
vii. Pleural fluid
viii. Saliva with visible blood
ix. Pericardial fluid
x. Cerebrospinal fluid
b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
i. Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.
c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.
d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.
e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.
i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
ii. Information regarding the contamination is conveyed to all affected employees, the equipment manufacturer, and the equipment service representative.

I. PERSONAL PROTECTIVE EQUIPMENT:

1. The employee's 'last line of defense' against bloodborne pathogens. Because of this, our facility

provides (at no cost to our employees) the Personal Protective Equipment that they need to protect themselves against such exposure. See Standard Precautions-Personal Protective Equipment Table for tasks/PPE suggested. This equipment includes, but is not limited to:

a. Gloves
b. Fluid resistant gowns
c. Glove liners
d. Laboratory coats
e. Face shield
f. Resuscitation bags
g. Masks
h. Hoods
i. Safety glasses/goggles
j. Shoe covers
k. Mouthpieces
l. Pocket masks

2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Standard Precautions-Personal Protective Equipment Table.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and Standard Precautions-Personal Protective Equipment Table.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to employees who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Standard Precautions-Personal Protective Equipment Table.

J. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All employees are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.
   c. All pails, bins, cans and other receptacles intended for use are routinely inspected,

cleaned and decontaminated as soon as possible if visibly contaminated.

d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.

4. All regulated waste is safely handled by staff according to TCHD policies and procedures. Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual **Section 6: Hazard Material Management: Waste Management Policy.** ~~(formerly Safety Manual) - Waste Management Plan section and Infection Control Policy Waste Management.~~
   a. See ~~the Decision Table for Medical Waste in Decision Table for Medical Waste~~**TCMC Waste Disposal Guidelines.**
5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides **should** hold the bags away from their bodies when removing **waste. During removal,** use heavy gloves to protect their hands from possible sharps injury**,** and do not push down on trash in garbage containers.
6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded ~~(see Labels to follow)~~ and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Employees who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

K. **FORM(S):**

1. Safer Work Survey
2. Clinical Value Analysis Team Product Evaluation
3. User Product Evaluation
4. Product List
5. Potential Blood Exposure by Job Category
6. Standard Precautions – Personal Protective Equipment
7. ~~Decision Table for Medical Waste~~

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

1. Employee Health and Wellness Policy: Injury and Illness Prevention Program
2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body Fluid Secretions
3. Environment of Care Manual: Hazardous Material and Waste Management and Communication Plan
4. Environment of Care Manual: Hazardous Waste Management
5. Infection Control Manual: Hand Hygiene
6. Infection Control Manual: Standard and Transmission Based Precautions
7. **TCMC Waste Disposal Guidelines**

M. **REFERENCES:**

1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry

Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998. **https://www.dir.ca.gov/title8/5193.html**

2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2000 www.cadhs.gov
3. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
4. Wenzel, RP & Nettleman, MD, Principles of Hospital Epidemiology in: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.
5. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

Safer Work Survey

TRI-CITY HEALTHCARE DISTRICT
SAFER WORK SURVEY

The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 sharps injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure. The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury, is used to puncture the vascular system, or causes deep injury.

1. Safety Devices

Do you have suggestions for sharp devices with built in protection that would make your job safer?
Comments: _____

_____

_____

_____

_____

_____

_____

2. Safe Work Practices

Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays)
Comments: _____

_____

_____

_____

_____

_____

_____

3. Personal Protective Equipment

Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection)
Comments: _____

_____

_____

_____

Clinical Value Analysis Team Product Evaluation

Clinical Value Analysis Team Product Evaluation

1. Manufacturer of Product_____
2. Name of Product_____
3. Distributed by_____Sales Rep_____
4. Description of Use_____
5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? ☐ Yes ☐ No
6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit _____
7. What items would this replace?_____
8. Cost _____Standard item cost_____
9. Has TCHD rejected the device in the past? ☐ Yes ☐ No _____
10. Does the device have a passive safety mechanism? ☐ Yes ☐ No
11. Can the safety mechanism be activated with one hand? ☐ Yes ☐ No
12. Can the user tell when the safety mechanism has been activated? ☐ Yes ☐ No
13. Are minimal changes in technique and use required? ☐ Yes ☐ No

_____

14. Is this product dependent on other products or items? ☐ Yes ☐ No
    Identify:_____
15. Is the device compatible with products currently in use? ☐ Yes ☐ No
16. Does the system/device require a minimal number of parts? ☐ Yes ☐ No
17. Is the product available in typical size ranges? ☐ Yes ☐ No
18. Is the product on contract ☐ Yes ☐ No
19. Product rep available for 24hrs/day in-service? ☐ Yes ☐ No
20. Does the manufacturer supply free trial products? ☐ Yes ☐ No
21. Does the manufacturer have adequate supply capability? ☐ Yes ☐ No

APPROPRIATE FOR TRIALS ☐ **REJECTED** ☐

COMMENTS_____

_____

_____

_____

User Product Evaluation

User Product Evaluation

Name_____Date_____

Dept/Unit_____

How would you rate this product compared to other similar products you have used?

CRITERIA	BETTER	SAME	WORSE
Easy to open package			
Ease of assembly			
Ease of use			
Comfortable feel for user			
Length of time required for use			
Activation of safety feature			
Safety feature can't be defeated			
Has minimum failure rate and functions as intended			
Good for use with different patients			
Safe for healthcare workers			
Safe for patients			
Patients complaints			
Doctors complaints			
Easy to dispose			
Compatible with other products			
Will reduce the risk of injury			
Reasonable number of parts			
Available in the sizes you need			

How many times did you use the product?_____

Would you recommend purchasing this device? ☐ Yes ☐ No

Is there another safety device you would rather use? ☐ Yes ☐ No

Specify:_____

Comments? _____

_____

_____

_____

Product List

PRODUCT LIST					
PRODUCT TYPE	**SPECIFIC DEVICE**	**M/M EVAL.**	**RECOMMENDATION**	**USER EVAL. DATES**	**IMPLEMENTATION & COMMENTS**
1. **Needleless IV**	All I.V. Tubing Alaris Needleless I.V. System	N/A	Alaris I.V. needleless system and tubing recommendation by Nursing Operations Managers Council.	2/2005	3/2005, Alaris Medley pumps w/ Guardrails introduced as standard. Contractual changes for pump and product changes. Minimum 5-year agreement.
2. **ABG Kits**	1-ml ABG Kit 3-ml ABG Kit	N/A	Pulmonary Department selection of Sims Portex products	5/2001	reviewed 10/2005
3. **Blood Lancet**	Heel stick, Tenderfoot Fingerstick, Glucolet	N/A	Products utilized hospital-wide.	< 1996 1/2001	< 1996 1/2001 1/2002 reviewed 10/2005
4. **IV Starts** • Angiocaths • Butterfly	Insyte Autoguards, various Gauges Saf-T E-Z Set, various	N/A N/A	Nursing Council selection to replace Johnson & Johnson I.V. Catheters with Becton Dickinson products Nursing Council selection to replace Becton Dickinson non-safety products w/ Becton Dickinson safety products	10/2000 10/2000	10/2000 reviewed 10/2005 10/2000. Catalog changes, 08/2001 reviewed 10/2005

PRODUCT LIST					
PRODUCT TYPE	**SPECIFIC DEVICE**	**M/M EVAL.**	**RECOMMENDATION**	**USER EVAL. DATES**	**IMPLEMENTATION & COMMENTS**
Pre-filled syringe	*Code Drugs* *Vit K* *Hepatitis B vaccine*	*Dec 2002*	Recommends/stocks Sims needles as alternative and Product Standards approved Safety standard approved	07/01	07/01 *8/31/2002* reviewed 10/2005
6. Blood Collection • Tubes • Vaccutainer • Butterfly needle • Needle/Syringe • Cord blood	Vaccutainer Tubes w/ Top	N/A	Laboratory selection of Becton Dickinson products to replace rubber stopper tops	< 1992	< 1992
	Vaccutainer Eclipse Blood Ion Needle	N/A	Laboratory selection of Becton Dickinson products to replace Bio-plexes puncture Guard	< 2000	2000
	Vaccutainer Safety-lok Blood Collection Set		Laboratory selection of Becton Dickinson products to Replace non-safety butterfly	< 1999	2000
	Safety-glide, various gauges		Nursing and Laboratory selection of Becton Dickinson products to replace Non-safety products. Safety standard approved	< 09/01 05/01 07/01 *8/02*	09/2001 05/01 07/01 reviewed 10/2005

PRODUCT LIST					
PRODUCT TYPE	**SPECIFIC DEVICE**	**M/M EVAL.**	**RECOMMENDATION**	**USER EVAL. DATES**	**IMPLEMENTATION & COMMENTS**
• blood culture • line sampling • transfer device	Bactec Media Bottles See Needleless System Diff-safe blood dispenser *BD- Blood transfer devices*	N/A N/A N/A	Laboratory selection of Becton Dickinson product BD Luer-Lok Access device/ BD SafetyLok Blood Collection Set; BD Luer-Lok Tip Syringes	< 1996 09/2001 < 1996	On going < 1996: Used in Phlebotomy to eliminate use of needles to make slides. Changed in 2001 Reviewed 11/9/05 LLT Changed to BD luer loc access devices for direct draw 4/1/08
7. IV injections Regular syringes Pre-filled syringes Contrast in Dx. Imag	Refer to Needleless System Safety-lok, various gauges	N/A	Nursing Council selection of Becton Dickinson products	< 9/01	09/2001
8. Scalpel	Personna Safety Scalpel Personna Safety Blades	N/A N/A	Safety blades in Microbiology & Cytology ER, SPD, ACCU recommended change to Persona safety scalpels	01/2001 09/2001	03/2002 Reviewed 11/2005 LLT 03/2002 Reviewed 8/08
9. Suture needle	Safe work practices adopted. Stapling devices used when possible.				

PRODUCT LIST					
PRODUCT TYPE	**SPECIFIC DEVICE**	**M/M EVAL.**	**RECOMMENDATION**	**USER EVAL. DATES**	**IMPLEMENTATION & COMMENTS**
10. Non coring needle for implanted vascular access	Bard Smith	N/A	Provide safety device only for non-coring needles	3/08	4/08

Potential Blood Exposure by Job Category

POTENTIAL BLOOD EXPOSURE BY JOB CATEGORY

'ALL' EMPLOYEES	'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK)
Administrative Coordinator Advanced Care Technician	Case Managers/ Clinical Social Worker (during patient interviews or family conferences)
Biomedical Tech Mechanic I & II	Chaplain (during patient or family ministrations)
Cardiac Rehabilitation Coordinator	Food Service Worker (during tray delivery, pick-up, or cleaning)
Certified Nursing Assistant	Clinical Dietician
EEG Tech and EEG coordinator	Security Officer
EKG Tech	
Environmental Service Aide and Supervisor	
Emergency Medical Technician	
Employee Health Nurse Occupational Health Nurses & Manager	
Infection Control Specialist	
Laboratory Assistant/Phlebotomist Operations Manager Clinical Laboratory Scientist Histology Lab Tech	
Licensed Vocational Nurse	
Lift Team	
Nurse Practitioner Physicians Assistant	
Occupational Therapist and Rehab Aid	
OR Tech/Sterile Processing Tech/Perioperative Aide/Surgical Instrument Aide	
Perfusionist	
Phlebotomist	
Physical Therapist	
Physicians	
Pulmonary Services Operations Manager	
Radiology Operations Manager & Tech	
Registered Nurse	
Rehabilitation Services Manager	
Respiratory Care Practitioner I, II & III	
Security Officer	
Wound Care Nurses	

Standard Precautions – Personal Protective Equipment

Standard Precautions
Personal Protective Equipment Table

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
REMOVING, OPENING AND MANIPULATING OR ASSISTING WITH THE REMOVAL OF HOLLOW CORE BLOOD OR BODY FLUID FILLED TUBES, NEEDLES OR CATHETERS															
• Abdominal paracentesis catheter • Angiograph catheter • Bronchoscope (as above & to clean) • Central venous catheter • Chest tube/vent • Endoscope (as above & to clean) • Intravascular catheters • Thoracentesis • Urine catheter	*			*				*			*			*	
ASSISTING WITH PROCEDURES															
Angiography	*			*					*	*				*	
Bone marrow asp/bx	*				*			*			*				*
Bronchoscopy	*			N95				*			*				*
Bronchoscopy (R/O TB)	*			PAPR				*			*				*
Central venous catheter insertion	*				*			*			*				*
Chest tube/vent placement	*				*			*			*				*
Childbirth	*			*					*	*				*	
Endoscopy	*			*			*				*				*
Intubation	*			*				*			*				*
L.P. (holding R/O meningitis)	*			*				*			*				*
Morgue Release	*					*			*						*
Proctosigmodoscopy	*				*			*			*				*
Suture or stapling (within 3 ft. of wound)	*			*				*			*			*	
Assisting with Surgery														*	
Thoracentesis ass.	*				*			*			*				*
SPECIMEN COLLECTION															
ABG	*				*			*			*				*
Blood glucose test	*				*			*			*				*
Clean catch urine specimen	*				*			*			*				*
Dipstick urine test	*				*			*			*				*
Gastric occult. blood test	*			*				*			*				*
Nose/throat (R/O infection)	*			*				*			*				*
Sputum for AFB or TB culture	*			N95				*			*				*
Stool	*				*			*			*				*
Stool occult blood test	*				*			*			*				*
Urine	*				*			*			*				*
Urine specific gravity	*				*			*			*				*
Vaginal or urethral	*				*			*			*				*
Venipuncture for blood	*				*			*			*				*
Wound or wound drainage	*				*			*			*				*
SPECIMEN PROCESSING	*			per S.O			Lab coat								

R = Required **A = Available** **N/A = Not Applicable**	**Exposed Body Parts**						**Contamination of Clothing**								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
CLINICAL TASKS															
Ambu bag: usage	*			*				*			*				*
Bladder irrigation	*			*				*			*				*
Blood or blood products administration	*				*			*			*				*
Blood warmer	*				*			*			*				*
Cleaning used instruments	*			*				*			*				*
Urine catheter: insert	*				*			*			*				*
Colostomy irrigation	*			*				*			*				*
Condom catheter application	*				*			*			*				*
Contact lense care	*				*				*			*			*
Dressing change	*				*			*			*				*
Emerson pump: use	*				*			*			*				*
Endoscope / Bronchoscopy cleaning	*			*			*				*				*
Enema administration	*			*				*			*				*
Enteral feeding tube (insert or manipulate)	*			*				*			*				*
Fecal disimpaction	*			*				*			*				*
Fecal or gastric occult blood test	*				*			*			*				*
Foley cath insertion	*				*			*			*				*
Gastric lavage	*			*					*	*					*
Hemovac drains-manipulate, empty / DC	*			*				*			*				*
Injections	*				*				*			*			*
Intravenous catheter insertion	*				*			*				*			*
J-P drain care	*				*			*			*				*
Nasogastric tube insertion and DC	*			*				*			*				*
Neonatal suck evaluations (latex-free)	*				*			*				*			*
1st. Newborn bath	*			*				*			*				*
Normal Saline or Heparin lock irrigation	*				*			*				*			*
O2 therapy w/ mucus membrane touch	*				*				*			*			*
Open suctioning of airway or airway tube	*			*				*			*				*
Oral care	*			*				*				*			*
Oral/nasal airway insertion or DC	*			*				*			*				*
Pleur-evac care	*				*			*			*				*
Postural drainage	*				*			*			*				*
Rectal tube insertion	*				*			*			*				*
Resp. Tx, cough inducing	*			*				*				*			*
Restraint placement		*			*			*				*			*
Seizing patient		*			*			*				*			*
Sputum Induction for AFB	*			N95				*				*			*
Sputum Induction for AFB R/O tuberculosis	*			PAPR				*				*			*
Total parenteral nutrition administration	*				*			*				*			*
Urine bag emptying	*			*				*				*			*
Vital signs and Weighing patients		*			*			*				*			*
Wound care (without irrigation)	*				*			*			*				*
Wound irrigation Pulsevac Tx	*			*				*			*				*

~~Decision Table for Medical Waste~~

~~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 dripping and/or saturated 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 and/or saturated.~~	X		
~~Surgical specimens.~~	X		
~~Wound dressings, bandages, and wrappings dripping and/or saturated 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	
~~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 and/or saturated items such as dressings, bandages, cotton balls, peripads, chux, cotton swabs.~~		X	
~~Suction Canisters, treated with solidifying agent.~~	X		
~~Used gloves, aprons, masks, goggles, and respirators.~~		X	
~~Broken glass, guide wires.~~			X
~~Uncapped Needle/syringe units, needles, scalpels, vials from live, or attenuated vaccines.~~			X

TCMC Waste Disposal Guidelines

						 
Regular Waste NO NEEDLES	**Biohazardous Waste** NO NEEDLES	**Sharps** NEEDLES OK	**Pharmaceuticals** NEEDLES OK	**Controlled Substances** NO NEEDLES	**RCRA Pharmaceuticals** NO NEEDLES	**Chemo/Hazardous Waste** NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	▫ **All sharps** *Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples* ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with pourable medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication ***Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)*** ▫ Inhalers with no propellants *Examples: Advair, Foradil* **NO PHI**	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	**EPA designated R.C.R.A. Pharmaceuticals only:** *Examples:* ▫ *Insulin/Insulin Pen* ***(needles removed)*** ▫ *Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort* ▫ *Warfarin /Coumadin* ▫ *Used & Unused nicotine gum or patches, (include empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** Return to pharmacy all unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf; County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

Tri-City Medical Center
Oceanside, California

DELETE: No longer needed per Sherry Miller.

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 11/09	**SUBJECT:** Physician Format Approval Process
REVISION DATE(S): 12/09	**POLICY NUMBER:** 8710-557

Department Approval:	03/17
Department of Medicine Approval:	~~11/09~~06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/09~~07/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	11/09

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

~~1. This statement outlines the steps taken to obtain approval by Chairs/Chiefs of new physician dictation formats with annual review of formats by the dictating physician.~~

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

~~1. It is the policy of Tri-City Medical Center to ensure that all physician formats are approved within 10 days of the physician's initial request with annually review to ensure outdated documents are inactivated.~~

~~C.~~ ~~**RESPONSIBILITIES**~~:

~~1. Medical Records Department will coordinate newly submitted physician dictation formats for review/approval by the respective Department Chair/Division Chief.~~

~~2. The Department Chair/Division Chief will review the requested format and indicate approval, recommended revisions, or denial of the submitted dictation format.~~

~~3. Physicians with dictation formats will be responsible to complete an annual review of formats and indicate those that are to be inactivated.~~

~~4. The Medical Records Committee will have oversight on the timely review and approval of dictation formats by the Department Chair/Division Chief and will enforce the annual review requirements for ongoing evaluation and maintenance of all formats.~~

~~D.~~ ~~**PROCEDURE**~~:

~~1. New Dictation Formats:~~

~~a. The physician requesting a dictation format will communicate his/her request in writing to Transcription and provide the information to be included in the format.~~

~~b. Transcription drafts the dictation format and forwards the document and request for approval to the respective Department Chair/Division Chief (Attachment A)~~

~~i Any format that includes a CPT code will be reviewed by the Medical Records department to verify that the body of the document supports the code that will become part of the requested format.~~

~~ii Language utilized in the format needs to reflect specific information relating to the individual patient~~

~~c. Upon receipt of the response from the Department Chair/Division Chief the Transcription Supervisor finalizes the document and communicates its availability to the physician.~~

~~i If full approval of the format is not obtained the response from the Department Chair/Division Chief will be forwarded to the dictating physician for revision of the dictation template.~~

~~2. Annual Review of Dictation Formats:~~

a. Once a year each physician with dictation formats will be sent a copy of his/her formats that are on file.
b. The physician is to review each format and identify:
   i. No Changes
   ii. Revisions to be made
   iii. Direct Transcription to Deactivate the format
c. The Medical Records/Transcription department will submit to the Medical Records Committee any issues with the approval of new formats and completion of the required annual review.

E. **RELATED DOCUMENT(S):**
1.

Approvals:
Medical Division Approval: 11/09
Medical Executive Committee Approval: 11/09
Board of Directors Approval: 12/09

Communication to the Department Chair/Division Chief (Initial Format)
Date:

Dear Doctor _____:

The content of our dictated reports is strictly governed by Federal, State and JCAHO regulations. To ensure that our dictated reports meet the various regulatory agency requirements, a policy has been issued to define the process through which physicians may seek approval to use a unique dictation report format.

As Department Chair/Division Chief you are asked to review the attached proposed format submitted by Dr. _____ for _____

Your leadership review is to verify that the information reflected in the report meets with the general standards for your practicing specialty.

We are asking that you review and respond by completing the section below and faxing the document to my attention within ten (10) days so we can follow-up with the dictating physician. He/she will not be permitted to utilize the format until you have responded to this request.

These processes have been implemented to better serve our Medical Staff in completing dictated reports that are fully compliant with the various governing regulations and we appreciate your assistance in this process.

Please call me, or stop by the office if you have any questions. My direct telephone number is 760-940-3033.

Thank you,

Terri Hartzell
Operations Manager
Medical Records/Health Information Management Department

Cc: Medical Staff Office

Please fax this document back to my attention at: 760-940-3414

☐ I approve the format as submitted

☐ I approve the format with the following recommendations: _____

_____

☐ I deny the approval of this format. Reason for Denial: _____

_____

Completed by: _____ **Date:** _____

Tri-City Medical Center
Oceanside, California

DELETE: Utilizing Administrative Hospital Policy: Notice of Privacy Practice 518

Outpatient Behavioral Health Services

SUBJECT: Confidentiality

ISSUE DATE: 08/96
REVISION DATE(S):04/00, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

~~A. **PURPOSE:**~~
~~1. To identify the importance of patient confidentiality.~~

~~B. **POLICY:**~~
~~1. The Outpatient Behavioral Health Services staff will keep all patient information confidential.~~

~~C. **PROCEDURE:**~~
~~1. Who May Perform/Responsible: OPBHS clinical and administrative staff~~
~~2. Both written and verbal information must remain confidential between the patient and the staff. It is the responsibility of the staff to emphasize the importance of maintaining patient confidentiality.~~
~~3. At admission, all patients are given a notice of Privacy Practices for Tri-City Medical Center in accordance with HIPAA.~~
~~4. Patients must sign a written Release of Information to allow staff to communicate with persons other than those on the OPBHS treatment team. This includes but is not limited to family members, Case Managers, Board and Care operators.~~
~~5. Confidentiality also applies to telephone conversations and inquiries from the family and the public. Unless disclosure is authorized there is no information given regarding clients' presence or treatment in the Behavioral Health Outpatient Services.~~
~~6. Violation of patient confidentiality constitutes a breach of the client's rights and can result in formal counseling, written warning, or termination.~~
~~7. Exceptions to this policy Include incidents when the patient is a danger to self or gravely disabled or is threatening to harm an identified person (at which time staff must comply with the Tarasoff responsibility of duty to warn; see Policy A-108**Duty to Warn Potential Victims Policy**). Other exceptions to confidentiality include reportable incidents, such as child abuse, dependent adult abuse, and domestic violence. Please refer to Policy A-109**Patient Neglect and Abuse Policy** regarding CPS and APS reports. Physicians must also comply with mandatory reporting of conditions with cognitive impairments or loss of consciousness to DMV, and mandatory reporting of certain communicable diseases to the Department of Health.~~

Tri-City Medical Center
Oceanside, California

DELETE: Duplicate of Conditions of Admission Form

Outpatient Behavioral Health Services

SUBJECT: Informed Consent

ISSUE DATE: 02/97
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To identify the importance of informed consent in decisions about patient care.~~

~~B. **POLICY**~~

~~1. Each patient has the right to clear, concise and understandable information concerning all treatment provided and any procedure performed. This includes the risks, complications and expected benefits.~~

~~C. **PROCEDURE**~~

~~1. Who may perform/responsible: OPBHS clinical or administrative staff~~
~~2. The OPBHS staff must provide the patient with information regarding any treatment or procedure, prior to obtaining written consent.~~
~~3. Medication consent must be obtained if the program physician prescribes psychotropic mediation.~~
~~4. The patient or conservator may revoke the consent at any time.~~
~~5. Staff are to be available to answer any questions or concerns and inform the physician of these concerns.~~
~~6. A clinician is responsible for checking to see that a signed consent is obtained prior to a procedure or treatment being performed.~~
~~7. All consents are part of the medical record.~~
~~8. Informed consent and other written consent forms will be obtained, from the patient or the conservator, for the following:~~
~~a. Admission to program;~~
~~b. Release of information;~~
~~c. Administration of psychotropic medications;~~
~~d. Appointment of Representative;~~
~~e. Consent to photograph;~~
~~f. Self-administration of medication release.~~

Tri-City Medical Center
Oceanside, California

DELETE: Utilizing Patient Care Services: Documentation in the Medical Record Policy

Outpatient Behavioral Health Services

SUBJECT: Medical Record

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify the purposes, content and guidelines for the medical record. The medical record's accuracy is critical to maintaining quality care and protecting the patient and the Tri-City Medical Center.

B. **POLICY:**

1. The Purposes of the Medical Record are:
   a. to provide a mechanism for communication among all members of the treatment team
   b. to provide data for planning patient care
   c. to provide a record of the care planned and treatment administered
   d. to provide a source of information for evaluation of care
   e. to provide a mechanism for assessing medical necessity and addressing denials or medical review by insurance companies
   f. to provide data regarding the efficacy of treatment and the rationale for changes to treatment plans
2. Content of the Medical Record includes:
   a. Admission Records
   b. MD Orders
   c. Assessments
   d. History and Physical
   e. Treatment Plan
   f. Physician Progress Notes
   g. Daily Progress Notes
   h. Medication/Vital Signs
   i. Legal Section
   j. Laboratory and
   k. Miscellaneous

C. **PROCEDURE:**

Who may perform/responsible: Clinical Staff and Physicians

1. Guidelines for Documenting in the Medical Record
   a. M.D. must sign, date and time all written orders.
   b. R.N. and M.D. must sign, date and time all telephone orders.
   c. When writing an M.D. telephone order, the RN must write and read back the order, and the M.D. must sign off, date and time each order within 48 hours.
   d. All staff entries are signed with full names, and dated.
   e. Write legibly using black ink.

f. Make no alterations in charted material. In case of error, **in a paper document**, draw one line through the mistake, write "error" over the mistake and initial it.
g. Use only approved abbreviations.
h. Chart all medications and treatments.
i. Chart all medications and treatments ordered but not given along with the reason they were not given
j. All laboratory reports, test results and consultations must be included in the chart.
k. Do not place incident reports in the medical record.
l. All observations, events or documents recorded in the medical record must be written or dictated and authenticated via signature by the individual who observed such event or document. (See "Release of Information" for copies of external, non-program records.)
m. The patient's medical record will be stored in a locked area.
n. Files will be kept in alphabetical order at the Program. Following discharge, the medical record is sent to Tri-City Medical Center Medical Records Department and scanned to the EMR.

2. Clinical Staff Documentation Requirements
   a. Per service notes must be recorded daily by program clinical staff.
   b. The per- service notes should reflect patient's observed behavior, staff interventions and patient responses.
   c. The Initial Treatment Plan must be established on the day of admission.
   d. Following completion of all clinical assessments, the Master Treatment Plan will be completed **finalized** no later than seven days following admission to OPBHS.
   e. The Treatment Plan Review will be completed monthly and should reflect a precise assessment of the patient's progress in accordance with the original or revised Treatment Plan and further recommendations for revisions, as indicated.
   f. The discharge summary must be completed by each patient's Therapist within 10 7 days of discharge.
3. Attending Psychiatrist
   a. The psychiatrist must provide a verbal **telephone** or written admission order prior to treatment.
   b. He/she is responsible to complete an Admission Psychiatric Assessment (psychiatric evaluation), within seven calendar days of the patient's admission to **Intensive Outpatient and within 24 hours for the Partial Hospitalization** Program.
   c. Psychiatrist progress notes - their frequency is determined by the condition of the patient, but should be recorded at least monthly. The notes should contain an assessment of the patient's progress in accordance with the identified problems and goals and the need for continued treatment. The status of the patient's discharge readiness or justification for continued treatment is evaluated and documented in each progress note.
   d. The psychiatric diagnoses contained in the final diagnoses are written in the terminology of the American Psychiatric Association's current DSM Manual.

Tri-City Medical Center
Oceanside, California

DELETE: Utilizing Patient Care Services: Medication Reconciliation Policy

Outpatient Behavioral Health Services

SUBJECT: **Medications**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**09/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	

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

~~1. To identify Patient, Physician and R.N. responsibilities regarding medication education, documentation and reconciliation.~~

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

~~1. Patients are responsible for providing their own medications needed during Program hours and, as outpatients, they, a responsible caregiver, or their licensed residential care facility assume the responsibility for administration of medications. Program physicians may prescribe medications for their patients or work in collaboration with a community physician who is the prescribing physician. Program RNs are responsible for taking medication orders, medication education, reconciliation and documentation.~~

~~C. **PROCEDURE:**~~

~~**WHO MAY PERFORM/RESPONSIBLE:** Physicians and R.N.~~

~~1. If medications are being managed by the attending Program physician they may write order for medications in the medical record, after obtaining informed consent by the patient. They may either give the prescription directly to the patient or ask~~**The** the RN **will** ~~to call the order in to the pharmacy and reconcile by notifying the licensed residential care facility or the caregiver of the medication or medication change.~~

~~2. When orders are called in to a pharmacy by the RN, the medications may be delivered to the patient's place of residence.~~

~~3. The RN is responsible for assessing the patient for competency to take medications independently and educating the patient about their medications.~~

~~4. The RN maintains a current list of each patient's medications. Medications must be reconciled upon admission, when medication changes occur or routinely on a quarterly basis, and upon discharge. Reconciliation will be completed with the patient, the patient's pharmacy, other physicians who may be treating the patient concurrently, the patient's caregiver, the Board and Care Manager and upon discharge with the clinician or agency that will be treating the patient in the community.~~

~~5. The RN is responsible for completing the Medication Reconciliation Checklist within the prescribed Program timelines.~~

~~6. If the patient is co-treated with another community physician, the medication list must be updated and reconciled when medication changes occur. If the Program physician is ordering the medication, the patient's log is updated as orders change.~~

~~7. Telephone and written orders are accepted only from TCMC physicians and written in the medical record by the Program RN.~~

~~8. The Program physician may authorize the RN to notify the pharmacy for medication refills.~~

~~Refills are noted on the Medication Log contained in the patient's medical record.~~

9. ~~Telephone orders are signed by the ordering physician within 48 hours.~~
10. ~~If a patient is ordered an injectable medication, a Program RN may perform this process. All injectable medications must be verified by the issuing pharmacy for accuracy prior to the injection. Injectable medications will be stored properly and according to manufacturer's directions.~~
11. ~~After opening multi dose vials, the RN will write in the expiration date on the vial (28 days from date of open unless shorter expiration date indicated on original vial)~~
12. ~~The use of psychopharmacological agents for patients will be monitored for drug interactions, appropriateness and safety.~~
13. ~~Physicians will be provided a list of FDA dosing guidelines by the pharmacist and will review for drug interaction and appropriateness of dose during each patient visit.~~
14. ~~In the event that patients receive more than seven scheduled psychotropic medications, more than two regularly scheduled psychopharmacological agents, within the hypnotics, or anxiolytic class, or more than three within the antipsychotics, mood stabilizers, and antidepressants class, then the patient is identified as receiving polypharmacy. An exception to this is an additional agent that is used only as a PRN, on an as needed basis, during periods of increased acuity of symptoms.~~
15. ~~When circumstances warrant larger doses than approved by the FDA label, or a higher number of medications within the same class, the physician will review for drug interactions and appropriateness of care and will document specific rationale in the medical record.~~
16. ~~It is the responsibility of the prescribing physician to order psychopharmacologic agents in an appropriate and safe manner. Appropriateness of dose and number of psychotropics will be determined at the discretion of the physician in order to address current patient condition and the severity of presenting symptoms.~~

~~D. REFERENCES~~

1. ~~Joint Commission Standards for Behavioral Health MM.01.01.05~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Incorporated in Administrative Policy: 236 Mandatory Reporting Requirements

SUBJECT: Patient Neglect and Abuse

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To protect the patient's rights, health and safety.~~

~~B. **DEFINITIONS**~~

~~1. Abuse and neglect is defined as physical, sexual, financial, mental suffering, neglect, self neglect, isolation, or abandonment, which has a potential of physical or emotional harm to a patient.~~

~~C. **POLICY**~~

~~1. Outpatient Behavioral Health Services staff are to report all incidents of possible patient neglect or abuse to the appropriate agency.~~

~~D. **PROCEDURE**~~

~~Who may perform/responsible: OPBHS clinical and administrative staff~~

~~1. The staff member contacts the Operations Manager or Clinical Coordinator if they suspect patient neglect or abuse.~~
~~2. If the incident is reportable a verbal report to the appropriate agency is made immediately. A written APS report or CPS report is completed and submitted to APS within 2 business days or to CPS within 36 hours, according to California law.~~
~~3. If a patient lives in a licensed care facility, and the abuse involves the facility staff or residents, then the incident must be reported to the local Ombudsmen Office. Community Care Licensing will also be contacted if we suspect abuse in a licensed care facility.~~
~~4. If there is immediate danger, consultation with the local police is indicated.~~
~~5. The incident is documented in the patient chart, but the APS/CPS report is not filed in the medical record.~~
~~6. The original report is sent to social services department.~~
~~7. Keep the treatment team and attending physician apprised of any pertinent information. Follow through, as needed, to ensure that the patient is not in an abusive/neglectful situation.~~

Tri-City Medical Center
Oceanside, California

DELETE: Utilizing Patient Care Services: Patient Rights and Responsibilities 302 Policy

Outpatient Behavioral Health Services

SUBJECT: Patient Rights

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 07/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

~~A. **PURPOSE**~~
~~1. To identify and respect each patient's rights while in the Program.~~

~~B. **POLICY**~~
~~1. Each patient has all rights given to all citizens unless relieved of these rights by court action. Specifically, staff needs to assist in maintaining the patient's rights to:~~
~~a. Confidentiality;~~
~~b. Privacy and dignity;~~
~~c. Individualized treatment that is appropriate to the patient's problems and needs;~~
~~d. Informed consent;~~
~~e. Consultation with an attorney; and~~
~~f. Release of information only with the patient's informed consent.~~

~~C. **PROCEDURE**~~
~~Who may perform/responsible: OPBHS Clinical and Administrative staff~~
~~1. If required by State Licensing, a copy of the Mental Health Patients' Rights **and Complaint Procedure** is posted in a visible place in the Outpatient Behavioral Health Services.~~
~~2. Upon admission, patients' rights will be reviewed and it is understood that these include:~~
~~a. Each patient having impartial access to treatment, regardless of race, religion, gender, ethnicity, age or handicap; and~~
~~b. Each patient's personal dignity being recognized and respected while receiving care and treatment in the Program.~~
~~3. Each patient is informed of his/her rights in a language the patient understands.~~
~~4. While in program, each patient receives individualized treatment that minimally includes:~~
~~a. Provision of adequate and humane services, regardless of the source(s) of financial support;~~
~~b. Provision of services within the least restrictive environment possible;~~
~~c. Provision of an individual treatment plan;~~
~~d. Periodic review of the patient's treatment plan;~~
~~e. Active participation of patients, relatives or guardians in planning for treatment; and~~
~~f. Provision of an adequate number of competent, qualified and experienced professional clinical and nursing staff to supervise, provide clinical care and implement the treatment plan.~~
~~5. Each patient has the right to request the opinion of a consultant at his/her expense or to request an in-house review of the individual treatment plan.~~
~~6. Full information is given on (see attached form):~~
~~a. The nature of care, procedures and treatment that the patient will receive;~~

~~b. The rules and regulations of the program applicable to the patient's conduct;~~
~~c. The right to initiate a complaint or grievance procedure and the appropriate means of requesting a hearing or review of the complaint;~~
~~d. The discharge plan; and~~
~~e. The plan for providing continuity of care following discharge.~~
~~7.~~

Tri-City Medical Center
Oceanside, California

DELETE: Department specific guideline, no need for policy.

Outpatient Behavioral Health Services

SUBJECT: ~~Utilization Management~~Chart Audits

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/17
Professional Affairs Committee Approval:	10/17
Board of Directors Approval:	

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

~~1. To insure efficient and effective utilization of Outpatient Behavioral Health Services. To insure that Tri-City Medical Center policies and procedures for quality documentation are upheld and that Outpatient Behavioral Health Services patients meet established and applicable standards and criteria for eligibility and the ability to actively participate in treatment.~~

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

~~1. Medical records are to be reviewed to ensure compliance with all regulatory standards as well as medical necessity for treatment and appropriate clinical documentation.~~

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

~~1. Who may perform/responsible: MDs, RNs, LCSWs, MSWs, MFTs, and MFTIs (Marriage Family Therapist Interns).~~
~~2. The Operations Manager or designee will oversee the Utilization Review process.~~
~~3. Ongoing~~ ~~**As part of Utilization Management, ongoing**~~ ~~clinical content audits are completed randomly by a designated staff member. A report of the findings is routinely given to the Operations Manager and responsible staff for supervision purposes.~~
~~4. A designated staff member audits at least one medical record~~~~**s**~~ ~~per~~ ~~**for each**~~ ~~clinician per month..~~
~~5. All out of compliance issues must be resolved~~ ~~**addressed**~~ ~~within ten days of the audit.~~
~~6. In addition, a complete audit of the medical record is performed at the time of the patient's discharge from Outpatient Behavioral health Services. This audit is specific to technical compliance as it pertains to documentation.~~
~~1. Medicare Additional Development Request (ADR) and a Medicare denial appeal process also fall under the umbrella of Utilization Management. Upon receipt of the ADR an entry is made in the ADR Tracking Log, the chart is copied and sent by certified mail to the Medicare Fiscal Intermediary. If payment is denied, the Operations Manager or designee is responsible for the appeal process.~~
~~2. Discharge Planning is included under the umbrella of utilization management and is initiated upon admission to facilitate a timely discharge and appropriate transition to a lower level of care. Discharge planning will be an organized, coordinated process, with interdisciplinary treatment team, patient, physician and family/significant other input. The process identifies the patient's needs before and after discharge, delineates plans to meet these needs and teaches the patient and family/significant other how to implement the plans.~~
~~3. Discharge criteria are tied to the long-term goals and will be established during the development of the Master Treatment (MTP). At each Treatment Plan Update the discharge criteria will be reviewed and modified as necessary, depending upon the rate of progress (or lack of progress)~~

~~in treatment. A rationale for each change will be documented.~~

4. ~~If a patient does not respond favorably to the Program(s) or does not seem to be benefiting from the prescribed course of treatment, the issue is taken to the treatment team meeting to determine appropriateness of the treatment and identify possible alternative referral. However, lack of progress in treatment does not automatically imply the necessity for discharge. Treatment goals need to be re-evaluated and every effort must be put forth to insure that identified problems and target dates are appropriate and reasonable, prior to considering discharge.~~
5. ~~The focus of discharge planning is to assist patients in achieving and maintaining their goals. This will be provided on an individual basis and will be related to the treatment plan. Assessing the potential of each individual, evaluating his/her progress in overcoming deficits and assisting in the development of appropriate skills to promote positive outcomes will be an on-going part of treatment. Planning for a smooth transition from the Program(s) will also be an ongoing part of treatment.~~

B. ~~**REFERENCES**~~

7. ~~Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services, LCD ID Number L27587, For services performed on or after 4/19/10, Center for Medicare and Medicaid Services.~~

ISSUE DATE: ~~2/13~~03/13

SUBJECT: **Outpatient Specimen Transport ~~To~~ to TCMC Main Hospital Laboratory**

REVISION DATE:

Department Approval	**11/16**
Clinical Policies and Procedures Approval:	**03/17**
Nurse Executive Committee Approval:	**03/17**
Department of Pathology Approval:	**08/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/13~~09/17**
Professional Affairs Committee Approval:	**10/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To protect the integrity of all laboratory specimens and to ensure accuracy of results, specimens collected at the Center must be transported in a timely manner as mandated by the hospital's laboratory policies.

B. **POLICY:**

1. All specimens will be delivered to the laboratory as prescribed by laboratory policy.
2. In the event that a specimen cannot be transported in the prescribed time period, the laboratory will be contacted for assistance to accomplish transport.

C. **PROCEDURE:**

1. When collecting specimens, clinic staff will wear, at a minimum, exam gloves. If soiling or splattering is likely, the proper personal protective equipment will be utilized during the specimen collection procedure.
2. All specimens are collected following specific laboratory procedures.
3. ~~The specimen container shall be properly labeled with:~~
   - ~~a. Patient name.~~
   - ~~b. Patient age.~~
   - ~~c. Medical record number.~~
   - ~~d. Physician name.~~
   - ~~e. Type of specimen.~~
3. **Labeling**
   - **a. Refer to the Patient Care Services Specimen Labeling Procedure**
4. Specimens will be placed in plastic sealed biohazard bags with an outside pouch to secure the appropriate request form.
5. Specimens will be brought to the laboratory within the timeframe designated by the hospital laboratory.
6. If the ~~Center~~ **outpatient facility** cannot deliver the specimen in a timely manner, the laboratory will be contacted for assistance.
7. The laboratory will notify the clinic when specimens are not acceptable.
   a. The clinician will notify the physician for further orders.

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Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
October 3, 2017

Members Present: James J. Dagostino, PT, DPT, Chairperson; Director Laura E. Mitchell; Director RoseMarie V. Reno; Robin Iveson, Community Member; Dr. Victor Souza, Chief of Staff

Non-Voting Members: Steve Dietlin, CEO; Kapua Conley, COO; Susan Bond, Director, Legal Services

Others Present: Teri Donnellan, Executive Assistant; Greg Moser, General Counsel; Scott Livingstone, VP/Transformation; David Bennett, CMO; Jane Dunmeyer, League of Women Voters

Absent: Dr. Cary Mells, Physician Member; Dr. Marcus Contardo, Physician Member; Dr. Paul Slowik, Community Member; Carlos Cruz, CCO

	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. Chairman Dagostino introduced Ms. Susan Bond, Director of Legal Services.		
2. Approval of Agenda	Director Reno questioned if there was going to be an update on the policies and procedures related to implied consent as discussed at last month's meeting. Ms. Bond stated she will provide an update at next month's meeting. **It was moved by Director Mitchell and seconded by Director Reno to approve the agenda as presented. The motion passed unanimously.**	Implied Consent update to be placed on next month's agenda. Agenda approved.	Ms. Donnellan/ Ms. Bond
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 Reno and seconded by Ms. Robin Iveson to ratify the minutes of the September 5, 2017 Governance & Legislative Committee. The motion passed unanimously.**	Minutes ratified.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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5. Old Business Review and discussion of Board Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms	In follow-up to discussion at last month's meeting, Mr. Conley stated Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms was revised to reflect the individuals responsible for scheduling of meeting rooms. He stated Janet Drury, Secretary in the Education Department is the individual responsible for the scheduling of Nursing and outside community events. Director Reno stated that in her opinion there should be a designated event coordinator who is cognizant of room costs, set up, food and general costs. She commented that as a Board member she is disappointed that we would eliminate this position. With regard to fair market value, Mr. Conley stated that the Chief Compliance Officer has determined the fees meets fair market value. Director Mitchell questioned if the policy applies to the Wellness Center. Mr. Moser stated the policy relates to all District facilities. Mr. Conley stated often times the rental room fee is waived for groups that are providing health related lectures. Chairman Dagostino questioned if the policy as written allows for Pet Therapy animals. Mr. Conley confirmed that service animals are allowed under the policy. Extensive discussion was held regarding the fact that rental room fees will not be returned for cancellations without a 48 hour notice of cancellation. Mr. Conley explained that in most cases the room is cancelled by the requestor not by Tri-City. Ms. Iveson questioned the rationale for not returning the rental room fee when a meeting has been cancelled. Mr. Conley explained we are moving resources to accommodate the meeting, i.e. room set up, catering, etc. and need 48 hours' notice to avoid unnecessary expenses on the part of the district.	Recommendation to be sent to the	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	It was moved by Ms. Iveson to recommend approval of Board Policy Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms. Director Mitchell seconded the motion. The motion passed with Director Reno voting no.	Board of Directors to approve Board Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms; item to be placed on agenda and included in agenda packet.	
6. New Business 1. Review and discussion of Committee Structure, Membership and Meeting Frequency	Chairman Dagostino stated that the Board has requested that each Board Committee discuss their committee membership and meeting frequency to determine if adjustments should be made for efficiency and time management. Chairman Dagostino requested that the committee consider amending the Charter to reflect community membership would consist of two (2) members and physician membership be reduced to two (2) members. He stated there has been difficulty in filling the Community openings with individuals who have the interest and knowledge base needed for the committee. Chairman Dagostino expressed concern that physician's time would be better spent attending to patients rather than attending committee meetings. Chairman Dagostino also expressed concern with the number of administrative members on the committee and their time. Ms. Iveson stated she prefers that the composition of the committee remain unchanged as it allows all parties an equal voice. Chairman Dagostino questioned what value community members add to the committee. Ms. Iveson stated community members bring their experience and expertise to the committee. Director Reno commented that community members feel their voice is unheard. She also expressed concern with the manner in which we solicit new community members. Chairman Dagostino disagreed with Director Reno's comments. Ms. Iveson stated in her opinion community		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	interest declined due to the nature of the work of the committee, i.e. "word smithing" policies and the like. Dr. Souza stated he is in support of reducing the physician membership from three to two. Chairman Dagostino suggested that Mr. Dietlin be free to determine which Administrative staff sits on the committee. Director Reno commented that in-house legal counsel and the Chief Compliance Officer are integral to the committee. Director Reno questioned if a third community member could be appointed as a subject matter expert. Mr. Moser stated the committee may appoint a subject matter expert who can serve longer than the prescribed community member terms. Chairman Dagostino also recommended that meeting frequency be changed to quarterly. Dr. Souza stated he is in favor of quarterly meetings versus monthly meetings. Mr. Moser stated the Charter as written allows for modification to the meeting schedule. It was noted the Committee also has the ability to schedule a special meeting if the need arises. Chairman Dagostino stated he will provide the Board with the Committee's comments for consideration that include a reduction in community and physician membership and quarterly rather than monthly meetings.	Recommendation to be sent to the Board of Directors for approval to include a reduction of two community members and one physician member; recommendation to be sent to the Board of Directors for approval to change meeting frequency to quarterly.	Chairman Dagostino
7. Discussion regarding Current Legislation a) Summary of AB 1728	Mr. Moser reported Assembly Bill 1728, effective January 1, 2018, is the result of an assembly oversight committee hearing in March 2017 on healthcare districts which largely focused on those which do not operate hospitals. Mr. Moser explained that the bill requires (1) adoption of an annual budget by September 1st of each year; (2) a website containing contact information and (3) annual adoption of policies for providing assistance		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	or grant funding, meeting certain criteria. In review of the bill, Mr. Moser believes that Tri-City District's current process of having the Board adopt a budget annually already complies with the requirements of the bill. Additionally, Tri-City maintains a website which currently complies with the law. Mr. Moser stated Tri-City's community grant program is currently suspended, however before the program is reinstated, Board policies conforming to AB 1728's requirements will need to be developed and adopted. Director Reno questioned if CHA has taken a position on the bill. Chairman Dagostino stated he will inquire next week at the CHA Governance Forum in Sacramento. Chairman Dagostino reported ACHD's legislative committee will be putting together an omnibus bill for February, 2018 and suggested Tri-City provide input with the help of General Counsel on changes we would like to see be made in Healthcare District law. He stated one change he would like to propose involved an adjustment to compensation for Board members.	Chairman Dagostino to work with General Counsel on proposed modifications to District Law.	Chairman Dagostino/General Counsel
8. Review of FY2018 Committee Work Plan	The FY2018 Committee Work Plan was included in the agenda packet for information.	None	
9. Committee Communications	Director Reno commented on the September 5, 2017 committee minutes related to Board Policy 14-001 – Budget for Medical Equipment or Medical Services for Tri-City Healthcare District. Mr. Moser stated the verbiage accurately reflects the changes recommended by the committee and suggested the policy be brought back to the next meeting if the language needed to be amended. Director Reno requested the policy be placed on the next agenda. Director Reno questioned what the Chief Compliance Officer's role is related to governance. She stated literature reflects the Chief Compliance Officer should be	Board Policy 14-001 – Budget for Medical Equipment or Medical Services for Tri-City Healthcare District to be placed on November agenda.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	involved with governance and the Board. Chairman Dagostino responded that the Chief Compliance Officer is very much involved with the Audit, Compliance & Ethics Committee and is also a member of the Governance Committee.		
10. Committee Openings – One	There is currently one opening on the committee.		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, November 7, 2017 at 12:30 p.m.	The next meeting of the Committee is November 7, 2017.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 1:53 p.m.		

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #15-043

POLICY TITLE: External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms

I. PURPOSE

To set forth limitations, requirements and guidelines for public rental/usage of Tri City Medical Center and other District facilities, including assembly rooms, classrooms, and conference rooms by those external and affiliated organizations, groups and persons which support the public purposes of the District.

II. POLICY

A. **Permitted Uses**. Tri City Medical Center assembly rooms, classrooms, and conference rooms shall be available to those public agencies, nonprofit organizations, associations and other groups, which further the health care needs of the public within the boundaries of the Tri-City Healthcare District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District, including meetings of the Medical Staff, and charitable organizations primarily engaged in providing financial or other support to the District.

Although it is a public agency, the use of hospital and other district facilities is dedicated to the provision of health care to the community. By enacting this policy, the District does not intend to create a public forum in its facilities, but only to promote community health and improve health care services delivery within the District.

B. **Compatible Uses**. Public use authorized by this policy shall be solely for meetings and activities which are compatible with the safe, quiet and secure conduct of hospital and health care facility operations, and with the District's status as a public agency of the State of California. For example, several laws prohibit the use of public resources, such as office equipment, staff time, etc., for campaign or personal purposes (e.g., Gov. Code sections 8314, 85300; Penal Code section 426.) Government Code section 54964 restricts an officer or employee of a local agency from expending or authorizing the expenditure of any local agency funds to support or oppose a ballot measure or a candidate. In addition, the following are prohibited:

1. Tobacco use

2. Alcoholic beverages

3. Political or religious activities

4. Amplified sound which can be heard outside of the room being used

5. Commercial uses

6. Personal use by district employees

7. Animals, other than those needed by disabled persons.

C. **Priority of District Use**. The medical, governance, operational, business and emergency needs of the District shall take precedence over other uses of District property in the scheduling and allocation of space under this policy. Scheduled public uses under this policy are subject to cancellation at the discretion of the District. The District will endeavor to provide as much notice as possible..

D. **Liability for Damages/Insurance Coverages**. Groups or persons using District facilities under this policy shall agree to be liable for any personal injury, property damage or liabilities arising out of the conduct of the activity or conduct of the participants. The District may charge the amount necessary to repair damages and/or clean the facility, and may deny the responsible group or person further use of District facilities. Groups engaged in activities posing significant risks to the District may be required to provide evidence of liability, property and professional liability insurance. The Chief Nurse Executive may establish such requirements on a case- by-case basis. Examples of activities which may require evidence of insurance include: professional liability insurance for groups offering free medical screening or other medical services; groups exceeding 100 persons. For activities involving more than 100 persons, the District may require evidence of liability and property insurance.

E. **Rules for Use**

1. No signage or placards will be allowed on District premises without the prior written approval of the District. The District provides standard signage to direct participants to the activity location.

2. Halls, entrances, elevators and stairways will not be obstructed or used for any purpose other than ingress/egress under any circumstances.

3. No furniture, freight or equipment shall be brought in without prior notice, and approval by District.

4. No self-provided food services will be permitted without prior notice and approval by District.

5. Unless otherwise specifically approved, hours of usage will be limited to the hours of 7 a.m. through to 8:30 p.m. Monday through Friday, excluding District holidays.

F. **Cause for Denial**. The Chief Nurse Executive (CNE) will review all requests by external and affiliated organizations for meeting room space under this policy. Request for space use may be denied for any of the following reasons:

1. The space requested is not available.

2. The applicant is not among those described in paragraph 1.

3. The applicant has not fully complied with this policy.

4. The use proposed will disrupt the provision of medical care or normal hospital or facility operations, or is otherwise incompatible or prohibited under this policy.

5. The applicant has not provided the evidence of insurance required.

6. The applicant has previously failed to comply with this policy.

III. PROCEDURE

A. Applications for usage of assembly rooms, classrooms, and conference rooms are processed via the applicable room scheduler as described in Exhibit B via e-mail or by telephone.

B. The room request form must be completed in full and submitted before applications will be reviewed for compliance with this policy.

C. The room request form will be forwarded to the CNE for review and approval/denial or approval with conditions.

D. The room applicable scheduler will communicate results of request with the applicant.

E. A deposit may be required for any food services or other special services, facilities, setup or equipment to be provided by the District.

F. The District shall be given 48 hours advance notice of cancellation by a successful applicant, or a cancellation fee will be charged.

G. If the District's needs require cancellation of the planned use by an applicant, advance notice shall be given promptly.

H. If an application is denied, an applicant may appeal to the Chief Executive Officer.

I. The Chief Financial Officer of the District shall establish a schedule of fees and charges, from time to time, based upon the District's reasonably estimated costs for providing services, including but not limited to: Custodial services; room setup; food services; equipment rental. Supplemental charges may also be

incurred to cover any unusual staff time or legal expenses which may be incurred in reviewing, processing or accommodating a request. The CNE may request supplemental charges, in addition to the payment of scheduled fees and charges. A copy of the Fee schedule and the Meeting Room Request Form shall be provided and appended to this policy as Exhibits A and B.

J. Other than the hourly room rental fee, groups not charging any fee for participation and those not requiring any special services shall not be charged a fee solely for room use.

K. Applicant shall be invoiced by the District on a monthly basis for room rental fees incurred.

IV. ATTACHMENT(S)

A. Exhibit A: Fee Schedule

B. Exhibit B: Meeting Room Request Form

Reviewed by the Gov/Leg Committee: 4/11
Approved by the Board of Directors: 4/11
Reviewed by the Gov/Leg Committee: 4/14
Approved by the Board of Directors: 4/14
Reviewed by the Gov/Leg Committee: 7/15
Approved by the Board of Directors: 7/15
Reviewed by the Gov/Leg Committee: 10/17
Approved by the Board of Directors:

EXHIBIT A

FEE SCHEDULE

Organizations/groups will not be charged room rental fees if they are 1) a non profit with proper proof of such status; and 2) a health-related program intended to further the healthcare needs of the community; and 3) a service fee of $25 per use to cover basic setup, utilities, custodial services, etc., is paid in advance. Any organizations/groups that do not meet all three of these criteria will be charged the below room rental rates in addition to catering, equipment, and any other fees for additional requests.

ROOM TYPE	*HOURLY RATE*
Classroom	*$30*
French Room	*$30*
Assembly Room	*$50*

These fees are for room rental only and are based on total time utilization for the hours reserved. Should the event exceed the hours requested, the user will be billed for the additional time used in hourly increments. Should an event end earlier than reserved, user will not be entitled to a refund of fees paid. Separate charges will be incurred for custom set-up and break-down, catering, equipment, etc. TCHD retains the right to adjust the rental charges when assessing fees for unusual situations or requests.

EXHIBIT B

Meeting Room Request Form

Date of Request: _____Requestor: _____

Name of Meeting: _____

Date(s) of Meeting(s): _____

Start Time: _____ End Time:_____

Number Attending: _____

Meeting Organizer/Contact Information: _____

Cost Center_____

Seating Style:

Conference___
U-Shaped___
Theater___
Classroom___
Chevron___
Other (attach schematic) _____

A/V Equipment Needed: _____

Additional Comments: _____

_____

Complete form and forward via email to the appropriate Administrator.

Karren Hertz – Board and Auxiliary room requests
Pamela Alm – Non-Nursing and Foundation room requests
Janet Drury – Nursing and Community room requests
Sarah Plant – Medical Staff room requests

Tri-City Medical Center
Audit, Compliance & Ethics Committee
October 19, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino; Director Leigh Anne Grass; Faith Devine, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, CFO; Carlos Cruz, CCO, Susan Bond, Director, Legal Services
Others Present:,	Jody Root, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp, Director of Education & Clinical Informatics
Absent:	Kapua Conley, COO; Scott Livingstone, Vice President/Transformation; Cary Mells, M.D.; Physician 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 Chairman Schallock.		
2. Approval of Agenda	**It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	
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 – September 21, 2017	**It was moved by Director Dagostino and seconded by Ms. Kathryn Fitzwilliam to approve the minutes as presented. The motion passed unanimously.**	**Minutes ratified**.	
5. Old Business	None		
6. New Business a) Administrative Policies & Procedures:			

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
1. Conflicts of Interest (DELETE)	Ms. Kathy Topp stated the Conflicts of Interest Policy is a duplication of Policy 8610-483. In addition, Conflicts of Interest Attestation is not required by law and is inconsistent with reporting obligations set forth by TCHD's Conflict of Interest Code.		
2. Compliance Education & Training	Ms. Topp stated the Compliance Education & Training Policy is brought forward for a routine three-year review. She noted revisions were made for clarity. Ms. Topp reviewed the orientation/training timeline for new employees and noted Net Learning modules are all required within 30 days of start date. Ms. Topp explained the training process for Covered Contractors. She stated Covered Contractors complete consolidated training modules followed by an abbreviated test. **It was moved by Director Grass and seconded by Director Dagostino to recommend deletion of the Conflicts of Interest Policy and approval of the Compliance Education & Training policy. The motion passed unanimously.** *Ms. Kathy Topp left the meeting at 8:37 a.m.*	**Recommendation to be sent to the Board of Directors to delete the Conflict of Interest Policy and approve the Compliance Education & Training policy; items to be placed on Board agenda and included in agenda packet.**	Ms. Donnellan
b) Consideration to appoint Leslie Schwartz to an additional two-year term on the Committee	**It was moved by Director Grass and seconded by Director Dagostino to recommend Mr. Leslie Schwartz be appointed to the committee for an additional two-year term. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to appoint Mr. Leslie Schwartz to an additional two-year term; item to be placed on Board agenda.**	Ms. Donnellan
c) Discussion regarding 2018 Financial Statement Audit	Chairman Schallock questioned if the committee is satisfied with Moss Adams or if they would prefer to do an RFP and look at other firms. Chairman Schallock stated he did have		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	some frustration with the change in auditors mid-cycle. Discussion was held regarding best practice. Ms. Fitzwilliam stated large facilities are obliged to bid periodically however many keep the same auditors for decades. She did comment that there should be a partner rotation every five years. Discussion was held regarding the advantages of continuing with the same firm including cost containment, continuity and local presence. Mr. Dietlin stated costs tend to be higher when a new firm is engaged as they have to start from scratch. We have been able to keep costs down as the audits have been less complicated and clean. Mr. Dietlin stated when a facility makes the decision to change auditors there can be a perception that there was a major difference in opinion. Ms. Fitzwilliam questioned if the partner change mid-cycle caused any difficulties for the district. Mr. Rivas stated Ms. Stelzeride had extensive experience in how the district operates and also had familiarity with HUD and the need for a single audit. **It was moved by Ms. Fitzwilliam to direct Administration to seek an audit proposal with Moss Adams to conduct the FY2018 Financial Statement audit with no increase in fees. Director Dagostino seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to seek an audit proposal with Moss Adams to conduct the FY2018 Financial Statement audit with no increase in fees; item to be placed on board agenda.**	Ms. Donnellan
d) Chief Compliance Officer Update	Mr. Carlos Cruz, Chief Compliance Officer provided a summary of his background and experience. Mr. Cruz presented a Chief Compliance Officer Report reviewing the following: 1) Effective Compliance Program Elements established by	**Information Only**	

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	the U.S. Federal Sentencing Commission and includes the following: a) Policies and Procedures b) Standards of Conduct c) Training and Education d) Open Lines of Communication e) Enforcement f) Internal Auditing and Monitoring g) Prompt Response 2) Program Effectiveness: Strategic Plan which includes the following Strategic Objectives: a) Refresh awareness of the organization's commitment to compliance b) Increase understanding of role of compliance program c) Review and develop tools that ensure effective program 3) Refresh Awareness: Marketing of Program that might include "meet and greets", program advertising and a Compliance Program "Road Show". 4) The Role of Compliance at TCMC that includes education of all levels of staff on compliance and the 5 "W"s of Compliance – What? When? Who? Why? Where? 5) Effectiveness Tools which might include the development of a formal enterprise-wide risk assessment to proactively identify organizational gaps/opportunities, review of each element of the program and update as needed and development of formal reporting. Mr. Cruz stated the Board is ultimately responsible for the compliance program and it is important to develop a dashboard that identifies what issues we are focusing on and what issues we are working on. Mr. Cruz presented a sample dashboard that mimics the seven areas of an		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	effective compliance program. Director Dagostino questioned what the OIG exclusion is. Mr. Cruz explained that the OIG has a list of vendors who are not allowed to do business with the federal government and the district cannot employ an individual or company that is on the exclusion list. Discussion was held on internal auditing that can often be time consuming. Mr. Cruz stated he is evaluating what expertise we have in place. Mr. Cruz stated he is confident we have the seven elements of an effective compliance program in place and we are ready to take it to the next level. Mr. Cruz stated in his short time here he has not identified any major issues of concern. Lastly, Mr. Cruz commented on the Timeline that was included in today's meeting packet. Mr. Cruz stated this is a very fluid document and he is looking at things we can do in the next couple of months. He stated he wants to get education done as soon as possible. Mr. Cruz stated the OIG Work Plan comes out in November and we will develop our Work Plan based on the OIGs. There was brief discussion on the various Compliance Committees including the Operational Committee for the manager level and Executive Compliance Committee where issued get reported up. Mr. Dietlin emphasized that the tone at the top matters.		
e) Review and discussion of Committee Structure, Membership and Meeting Frequency	Chairman Schallock stated a Board Workshop was held in September and the Board was charged with finding ways to be more efficient and cognizant of the utilization of staff on those committees. Chairman Schallock referred the committee to the Charter which was included in the agenda packet which indicates the committee should review and oversee the non-clinical		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	contracts at least twice annually. Discussion was held regarding the committee structure which includes three Board members, one physician and up to four community members, along with management as prescribed by the CEO. Discussion was held regarding the fact that it might not be wise for community members to outnumber Board members on the committee. It was suggested the Charter be amended to provide for up to three community members and a subject matter expert who would not be a voting member. Mr. Cruz suggested language be added to the membership section that provides that members also have an understanding of compliance. Mr. Cruz stated he would be happy to conduct 1:1 training with our community members. Mr. Schwartz questioned whether the word procedures should be included in section I. a. f. Mr. Dietlin explained that many of the policies currently include specific procedures. It was recommended the I. a. f stand as written.	**Recommendation to be sent to the Board of Directors to allow up to three community members and a subject matter expert; item to be placed on Board agenda.**	Ms. Donnellan
	With regard to the meeting schedule for 2018, Chairman Schallock suggested the committee meet in January, April, July and October for the compliance component and May and September for the audit component. Members concurred with this approach. With regard to education of community members, Director Dagostino suggested committee members attend the December 14th Regular Board Meeting in which a webinar will be presented by CHA related to healthcare reimbursement.	**Recommendation to be sent to the Board of Directors to modify meeting schedule to provide for six meetings as described; item to be placed on agenda.**	Ms. Donnellan
	It was recommended that the Charter be amended to reflect today's discussion and be placed on the January agenda for consideration.	**Charter to be amended to accurately reflect discussion and placed on January agenda for**	Ms. Donnellan/Mr. Cruz

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
		consideration.	
10. Motion to go into Closed Session	It was moved by Ms. Devine and seconded by Ms. Fitzwilliam to go into closed session at 9:52 a.m.		
11. Open Session	The committee returned to open session at 9:59 a.m. with attendance as previously noted.		
12. Report from Chairperson on an any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
13. Comments from Committee Members	There were no comments from members of the committee.		
14. Committee Openings	There are no committee openings.	**None**	
15. Date of Next Meeting	Chairman Schallock stated the next meeting will be held on January 18, 2018.	**The Committee's next meeting is scheduled for January 18, 2018.**	
16. Adjournment	Chairman Schallock adjourned the meeting at 9:59 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
October 19, 2017

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Conflicts of Interest	570	DELETE	Forward to BOD for Approval
2. Compliance Education and Training	549	3 Year Review, Practice Change	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE- Policy is unnecessary and is a duplication of Policy-8610-483. Conflicts of Interest Attestation is not required by law and inconsistent with reporting obligations set forth by TCHD's Conflict of interest code. Procopio recommends deleting policy.

ISSUE DATE: 05/12

SUBJECT: Conflicts of Interest

REVISION DATE(S):

POLICY NUMBER: 8750-570

Department Approval:	~~03/16~~07/17
Administrative Policies and Procedures Approval:	07/17
Organizational Compliance Committee Approval:	08/17
Medical Executive Committee Approval:	09/17
Audit and Compliance Committee Approval:	10/17
Board of Directors Approval:	02/13

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

~~1. Policy 8750-570 sets **To set** forth (1) a statement of Tri-City Healthcare District's **(TCHD's)** policy regarding the District's **TCHD's** avoidance of actual, potential and/or perceived conflicts of interest, and establishes procedures designed to ensure that conflicts are properly disclosed and resolved in the best interests of District **TCHD** and those whom it serves.~~

~~B. **GENERAL POLICIES:**~~

~~1. District **TCHD** is a public entity that utilizes public funds. Moreover, it is a public entity that furnishes high quality care to patients in its communities. In this capacity, **TCHD**District must earn and consistently maintain the trust and confidence of the families and patients that it serves, making it essential that **TCHD**District undertake all matters in the best interests of **TCHD**District without the presence or perceived presence of any conflicts of interest.~~

~~2. Consistent with **TCHD's**District's Code of Conduct, **TCHD**District's directors, officers and employees must perform their duties and obligations in the best interests of **TCHD**District, avoiding all transactions, arrangements and decisions that may give rise to conflicts of interest or personal gain.~~

~~C. **DEFINITIONS:**~~

~~1. Conflict of Interest: A conflict of interest occurs whenever an individual, whether or not the individual is a **TCHD**District employee, is in a position to control or influence a **TCHD**District business matter or decision has a personal, financial or otherwise competing interest in the outcome of the matter or decision.~~

~~a. A potential or perceived "personal, financial or otherwise competing interest" is considered a Conflict of Interest for purposes of this Policy 8750-570.~~

~~b. A personal, financial or otherwise competing interest" exists when an individual or an Immediate Family Member stands to gain or lose – directly or indirectly – as a result of the outcome of the matter or decision.~~

~~2. Immediate Family Member: This term means a spouse or civil union partner, natural 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 the spouse of a grandparent or grandchild.~~

~~D. **EXAMPLES:**~~

~~1. The following are examples of potential Conflicts of Interest, but is by no means an exhaustive list:~~

a. The son of a **TCHD**District employee spouse is the co-owner of a gardening company that submits a bid to perform lawn and gardening maintenance services for **TCHD**District.
b. A member of **TCHD's**District's Board of Directors is a partner in an entity seeking to do business with **TCHD**District.
c. The sales representative of one of the **TCHD's**District's equipment vendors offers one of **TCHD's**District's managers (who is important to the representative's account) a gift or other entertainment, such as a coupon for a dinner for two at a fine local restaurant.
d. A member of **TCHD's**District's senior management team owns stock in a medical device company seeking to sell its products to **TCHD**District.
e. One of **TCHD's**District's Directors proposes for **TCHD**District to do business with a consulting firm which employs or is controlled by the Director's husband.

E. **PROCEDURES:**

1. On an annual basis, every District director, officer and employee shall review this Policy 8750-570 and complete, sign and date the Conflicts of Interest Attestation attached hereto.
2. Each new director **Board member**, officer**Senior Executive Management** and employee **Directors** shall review Policy 8750-570 and complete, sign and date the Conflicts of Interest Attestation attached hereto within 60 days of his or her appointment or employment **and annually**.
3. In the event that, in the period between executing the last annual Conflicts of Interest Attestation and executing the next annual Attestation, an individual's Conflicts of Interest Attestation ceases to be accurate or complete, the affected director **Board member**, officer **Senior Executive Management** or employee **Directors** shall promptly complete, sign and date a new Attestation.
4. All Attestations must be provided to the Chief Compliance Officer, who will review them and maintain them in compliance with the **TCHD's**District's document retention policies.
5. Any director **Board member**, officer **Senior Executive Management** or employee **Directors** who believes that he or she has or may have a Conflict of Interest with respect to any **TCHD**District matter or decision must bring his or her concern to the immediate attention of the **Chief** Compliance Officer.
6. The Chief Compliance Officer will review all Conflict of Interest disclosures (whether in the form of the Attestation or otherwise) and with the assistance of legal counsel, as appropriate, determine whether the affected individual must recuse himself or herself from the matter or decision or take some other action in the best interests of the **TCHD**District.
7. The Chief Compliance Officer shall provide day-to-day guidance with respect to matters falling under this Policy 8750-570.
8. The failure fully, accurately and promptly to disclose actual, potential or perceived Conflicts of Interest may result in corrective action, including disciplinary action.

F. **DOCUMENTATION:**

1. As set forth above, all Conflicts of Interest Attestations, as well as all other documents relating to Conflicts of Interest and their resolution, shall be maintained in the **TCHD's**District's Compliance Program files consistent with **TCHD's**District's document retention policies.

G. **MONITORING AND AUDITING:**

1. Compliance with 8750-570 shall be monitored and audited in compliance with **TCHD's**District's Monitoring and Auditing Policies. Such monitoring and auditing shall be documented in the Compliance Program files.

H. **FORMS:**

1. Conflict of Interest Attestation

CONFLICT OF INTEREST ATTESTATION

I, _____, acknowledge the receipt of this policy, Conflicts of Interest, and attest that I have read it. I further agree and attest that I understand the significance of this policy and will not engage in any conduct that could be a violation of the same, In the event that I believe I have a conflict, then I shall report it to the Chief Compliance Officer promptly. In the event that I am aware of any other individual or situation that may give rise to or present a conflict of interest, I understand that I have a duty to report it to the Chief Compliance Officer.

_____ Date_____
Signature

_____
Printed Name

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 05/12

SUBJECT: ~~Education and Training; As-Needed Education~~**Compliance Education and Training**

REVISION DATE: 05/12

POLICY NUMBER: 8750-549

Department Approval:	**07/17**
Administrative Policies and Procedures Approval:	**07/17**
Organizational Compliance Committee Approval:	**08/17**
Medical Executive Committee Approval:	**09/17**
Audit, Compliance and Ethics Committee Approval:	**10/17**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. Policy 8750-549 provides ~~(1)~~ a statement of the District's policies regarding the provision of ~~as-needed~~ compliance education and training programs.

B. **PROVISION OF ~~AS-NEEDED~~COMPLIANCE ~~TRAINING~~EDUCATION & TRAINING:**

1. ~~The~~ **Tri-City Healthcare** ~~District~~ **District (TCHD)** shall provide ~~individual employees (or groups of employees) and Covered Contractors with~~ compliance education and training **to TCHD employees, Covered Contractors, and the Board of Directors (BOD)** on an ~~as-needed~~**annual** basis~~.s.~~

~~1. If the Chief Compliance Officer learns that an employee does or may not understand, or is not adhering to, the Compliance Program Code of Conduct or Policies, the Chief Compliance Officer shall provide appropriate education and training as soon as practical after learning about the problem.~~

2. If a new employee begins working at ~~the District~~**TCHD** at a time when ~~(1)~~ the next scheduled ~~General Training~~**New Hire Orientation** Program and/or ~~(2)~~ applicable Specific Training Program will not occur within 30 days of his or her date of hire, an as-needed general compliance training session and any applicable specific training programs ~~shall~~ **may** be provided.

~~2. The Chief Compliance Officer shall determine whether and, if so, which, Covered Contractors require as-needed training. **This is subjective**~~

C. **~~IDENTIFICATION OF~~DETERMINING NEED FOR AS-NEEDED COMPLIANCE EDUCATION & TRAINING:**

1. ~~To identify the necessity of as-needed education and training session, supervisors and the Chief Compliance Officer (like all supervisors, all supervisor's supervisors, and the Human Resources Department) shall have an "open door" policy, pursuant to which employees and Covered Contractors shall be free to seek compliance-related guidance — in person, over the telephone, by e-mail or otherwise — at any time.~~**The Chief Compliance Officer may determine if there is a need for "as-needed" Compliance Training and Education by ~~m~~many means which may include but are not limited to:**

- **a. Values Line reports,**
- **b. RL Solutions,**
- **c. Direct communication with:**
  - **i. TCHD employees**
  - **ii. District BOD ~~or~~**

iii. Members of the Medical Staff, or
iv. Community Members
d. Regulatory Agency reports

~~**B. FORMAT OF AS-NEEDED TRAINING: (DELIVERY (SECTION D) ADDRESSES THIS)**~~
~~The Chief Compliance Officer shall use his or her discretion in determining the most effective format for providing as-needed education and training. Options include (but are not limited to):~~
~~1. A targeted education and training session for all employees/Covered Contractors.~~
~~2. A targeted education and training session for particular employees/Covered Contractors or groups/departments.~~
~~3. A memorandum discussing the relevant problem(s) or issue(s).~~
~~4. Some combination of the above (or other) measures.~~

D. **DELIVERY:**

1. ~~As needed~~**Compliance** training may be presented in any manner the Chief Compliance Officer determines to be effective. This may include, ~~for example,~~ in-person training, videoconference training, computerized training or telephone conference training.

E. **DOCUMENTATION:**

1. ~~The District~~**TCHD** shall maintain, consistent with its record retention policies~~, the following in the Compliance~~**:**
~~2. Program files:~~
   a. Any documents reflecting requests for compliance education and training; and
   b. Documents concerning the response to requests for compliance education and training, including the guidance offered.

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

September 28, 2017 – 1:30 o'clock p.m.
Assembly Room 1 – 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 September 28, 2017.

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

Director James J. Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Financial Officer
Norma Braun, Chief Human Resource Officer
Carlos Cruz, Chief Compliance Officer
Susan Bond, Director of Legal Services
Victor Souza, 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 Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2 Approval of Agenda

It was moved by Director Kellett to approve the agenda as presented. 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 September 28, 2017 Regular Board of Directors Meeting Agenda.

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

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the September 28, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; one (1) matter of Potential Litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Approval of Closed Session Minutes and Evaluation of Legal Counsel Services.

5 Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Schallock to go into closed session. The motion passed unanimously (7-0).

6 The Board adjourned to Closed Session at 1:35 p.m.

8 At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James J. Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

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
Carlos Cruz, Chief Compliance Officer
Susan Bond, Director of Legal Services
Greg Moser, General Legal Counsel
Victor Souza, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9 Chairman Dagostino reported no action was taken in open session.

10 Director Kellett led the Pledge of Allegiance.

11 Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12 Introduction –

Carlos Cruz, Chief Compliance Officer

Mr. Steve Dietlin, CEO introduced Chief Compliance Officer, Carlos Cruz. Mr. Cruz provided a summary of his background and experience.

13 Special Presentation

1) Presentation of Patient Satisfaction Award to Emergency Department

Ms. Sharon Schultz, Chief Nurse Executive reported our Emergency Department made the most improvements over the past year in customer service for our patients and our vendor Healthstream has given us an award to present to the Emergency Department for the most improved. Ms. Schultz stated the Emergency Department has done a lot of initiatives over the year with changes in the Triage process that include getting patients in faster. Ms. Schultz stated in addition we have more construction coming up for the Emergency Department to open the Triage area up even more. Ms. Schultz introduced and acknowledged the Director of the Emergency Department, Candace Parres. Ms. Schultz expressed her appreciation to the Emergency Department for all that they do every day.

Chairman Dagostino stated the Emergency Department is our first face to the community and excellent customer service is critical.

Director Nygaard commented that the Finance Committee receives regular updates on the Emergency Department and it is amazing what they have done. She stated they have cut 50 minutes off wait time which is outstanding. She stated the Tri-City Emergency Department is a wonderful gift to the community and the place to come if you need emergent care.

2) Presentation of Certificate of Appreciation to Jack Cumming for his participation on the Audit, Compliance & Ethics Committee

Director Schallock stated Mr. Jack Cumming is a community member on the Audit, Compliance & Ethics Committee who has completed two two-year terms of service and is no longer eligible to serve on the committee. Director Schallock stated Mr. Cumming was not able to be here today however he wanted to publicly thank him for participation, his knowledge and level of expertise in finance and audits. Director Schallock stated Mr. Cumming brings a very professional insight into what is going on at the committee and has been an asset to the committee.

14 Report from TCHD Auxiliary – Mary Gleisberg, President

Ms. Mary Gleisberg reported Team Auxiliary will be walking in the American Heart Association walk this Saturday with other Tri-City Medical Center teams. She stated the Auxiliary's second Vice President, Linda Wolfe has been the coach for the walk and they are very excited to be able to participate and support the hospital and the American Heart Association.

Ms. Gleisberg reported the Auxiliary has donated $70,000 to the hospital to assist in the purchase and implementation of the FEES program (Fiber Optic Endoscopic Evaluation). She stated this equipment was currently not available at the hospital and the Auxiliary is delighted to be able to be a part of making this proposal available to the patients at the hospital.

Ms. Gleisberg stated going forward she plans to bring some of the Auxiliary Chairs to the meeting so the Board and public can get a better understanding of what they do in terms of running their departments.

In terms of orientation, Ms. Gleisberg reported there are 27 different departments that the Auxiliary serves, including a wide variety of areas of the hospital as well as the Shuttle and Pet Therapy, to name a few.

Ms. Gleisberg reported the Auxiliary receives approximately 30 applications a month from community members who are interested in joining the Auxiliary, however before they can join they do have to go through an orientation. She stated that it is important that training and orientation is done with the volunteers and they also are required to do a TB test, receive the flu vaccine and go through a background check. In March the Auxiliary holds mandatory refreshers.

Director Grass commented on an incident she witnessed in which former President Pat Morocco handled a very difficult patient with grace, dignity and respect. She stated she did not have the opportunity to thank Mr. Morocco for the way he handled that very difficult situation and wanted to express her appreciation to not only Mr. Morocco but to all the Auxilians.

No action was taken.

15 Report from Chief Executive Officer

Mr. Steve Dietlin, CEO commented briefly on the Emergency Department Healthstream award. He stated the ED has been an area that we focused on over the past year in multiple ways, including the expanded Triage area, the Crisis Stabilization Unit and 512 Scanner and it is great to see the wait times come down. Mr. Dietlin congratulated the Emergency Department for their efforts.

Mr. Dietlin expressed his appreciation to the Auxiliary who are here every day and not only do they make a difference, they made a donation as well. Their efforts have an impact on our patients every day.

Mr. Dietlin stated he had the opportunity to attend the Medical Executive Committee meeting this week and wanted to complement Dr. Souza. He stated Dr. Souza brought to our attention that a little bit of simple appreciation goes a long way and reminds people to say thank you. Mr. Dietlin expressed his appreciation to the Medical Staff for everything they do every day. Mr. Dietlin stated there are literally thousands of people every day working to deliver the quality healthcare here at Tri-City.

Mr. Dietlin provided a few highlights on the financials. He stated we saw a year-to-year improvement in days' cash on hand from 36 to 71 which is a metric that we follow. In addition, current ratio which is the ability to cover current liabilities as they come due with current assets moved from 1.02 to 1.7. Mr. Dietlin noted we also returned to a positive bottom line from a negative bottom line in the previous year. Mr. Dietlin stated as you will hear from the auditors, there were no proposed audit adjustments from the independent auditors which is extremely important when you go out to get financing. As mentioned previously, we financed 25 year long term debt at a favorable rate, 4.32% over 25 years and we were able to release some much

needed liquidity for the facility. He stated financial outcomes, just like clinical outcomes do not happen overnight.

With regard to clinical outcomes, we have excellent clinical outcomes and the highest safety rating in North County.

Mr. Dietlin stated we need to keep laser focused on long term sustainability and look at the long term to preserve quality healthcare right here in this community for decades to come.

Lastly, Mr. Dietlin reported the inaugural North County American Heart Association Heart Walk is this Saturday. He stated it is a pleasure to partner with the American Heart & Stroke Association because 80% of events are actually preventable. Mr. Dietlin stated it is important that we focus on community education and wellness and really get the word out on the high quality healthcare that is available right here at Tri-City and also focus on prevention so people have elective events rather than emergent events.

No action was taken.

16 Reports from Chief Financial Officer

Mr. Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Operating Revenue – $ 60,502
- Operating Expense – $62,190
- EBITDA- $1,762
- EROE – ($824)

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 176
- Adjusted Patient Days – 19,346
- Surgery Cases – 1,079
- Deliveries – 432
- ED Visits – 10,886

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $30,902
- Operating Expense – $31,770
- EBITDA - $864
- EROE – ($429)

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 182
- Adjusted Patient Days – 10,125
- Surgery Cases – 568
- Deliveries – 222
- ED Visits – 5,344

Mr. Rivas reported on the following indicators for FY18 Average:

- Net Patient Accounts Receivable - $44.5
- Days in Net Accounts Receivable – 47.7

Mr. Rivas stated in the current month we had strong volumes and one of our highest months in gross charges which is usually a good indicator for us. He stated we had anticipated a little more net revenue however it did not materialize due to our payor mix. Mr. Rivas explained when self-pay/uninsured get covered with MediCal we will be able recognize revenue at that point.

No action was taken.

17 New Business

a. Consideration to accept the FY2017 Financial Statement Audit

Mr. Ray Rivas introduced Ms. Stacey Stelzeride, Managing Partner on this audit.

Ms. Stelzeride provided a brief overview of the FY17 Financial Statement Audit. She stated results of the FY17 Financial Statement Audit were presented in detail to the Audit Committee this past week. She stated Moss Adams was engaged to audit the financial statements of the district for the year ended June 30, 2017 which this year also included an audit under the single audit requirements due to our HUD loan. She explained that the single audit is essentially a compliance audit to make sure we are complying with the HUD Regulatory Agreement and all of the elements within it. Ms. Stelzeride stated she is pleased to report Moss Adams will issue an unmodified opinion. Ms. Stelzeride reported the auditors did identify one compliance finding which was related to the timeliness of the filing of the reports that HUD requires. She stated the reports have been filed so that issue has been rectified. In addition, no material weaknesses were noted and no significant deficiencies were noted

Ms. Stelzeride commented on the NOTES, specifically Note 3 (Patients Service Revenue) which talks about the reimbursement methods, how the organization receives and reports revenue, short term and long term debt. She stated this is disclosed due to the new HUD loan. Also, Note 14 which was related to the commitment and contingencies and subsequent events.

Ms. Stelzeride stated she believes the amount recorded in the financials and the disclosures appropriately include or represent the current status of the Medical Office Building legal matter. She explained currently there is an asset on the books of approximately $22 million related to deposits that the court ordered that the hospital make. Ms. Stelzeride stated there are a number of different scenarios about how that might settle out, but at this point based on the current status of both of our inquiries with our legal counsel, discussion with management and our review of the legal documents as well, we believe the amounts reported in the disclosures are appropriate.

Ms. Stelzeride there were no significant difficulties in the audit. Management was very cooperative and forthcoming in providing what was needed to complete the audit.

Ms. Stelzeride reported no matters related to non-compliance in laws or regulations came to their attention in the audit.

Ms. Stelzeride presented some metrics including days cash on hand. She stated one of the major reasons this went up from 2016 is we refinanced our debt and released approximately $50 million that had been held as collateral. With regard to the current ratio, Ms. Stelzeride stated you want this number to be greater than 1 and 1.7 is certainly strong and much improved over the prior years as well.

Ms. Stelzeride stated for a district hospital with the payor mix that we have this is a very good number to have. Operating revenue is also trending in the right direction. She explained with the supplemental funding the District receives it is challenging to know when it is going to come in and when it is going to get recorded.

Ms. Stelzeride congratulated management on their efforts and stated the Board should take comfort that the financial information coming out of finance on a monthly basis is reliable.

Director Reno asked questions related to days' cash on hand and debt to capitalization. Ms. Stelzeride stated the days' cash on hand is low but is trending in the right direction and expects it to continue to go up. With regard to debt to capitalization, Ms. Stelzeride stated that is our total debt divided by our net position.

Chairman Dagostino questioned if the District is fiscally sound. Ms. Stelzeride stated she does believe we are fiscally sound and although days cash on hand is low, other district hospitals are in the same position She explained there is a lot of supplemental funding variables that we don't have control over which is what all district hospitals are facing. She commented that in reality it is not that low for a district hospital.

Director Nygaard commented that the District is doing significantly better than last year and we have a very good financial foundation to move forward.

It was moved by Director Schallock that Tri-City Healthcare District Board of Directors accept the FY2017 Financial Statement Audit as recommended by the Audit, Compliance & Ethics Committee. Director Nygaard seconded the motion.

Director Reno stated there is information in the audit report that relates to the Medical Office Building and because she has been recused from much of that discussion she is not comfortable voting. General Counsel stated Director Reno could abstain however voting has no potential financial impact on her and the matter is being discussed in public session; therefore the attorney client privilege is not affected and she can participate.

Director Kellett expressed his appreciation to Moss Adams for completing the audit in a timely manner and finding no contingencies. Director Kellett stated the Board should be happy that we have an administration in place that is ready for the auditors, gets the job done and the numbers are accurate.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

Director Reno clarified that the audit report was outstanding and is only abstaining due to her lack of knowledge in the Medical Office Building matter.

b. Public Hearing Regarding Change from At Large to District Based Election – Elections Code §10010(a) (1)

Chairman Dagostino stated public members who have indicated a desire to ask questions may do so at this time. He stated questions will be recorded and answered at the conclusion of the hearing.

Mr. Doug Johnson presented a Power Point on Tri-City Healthcare 2017 Redistricting. He explained this is a change to by-zone election of the seven Board members and the change only impacts elections. All votes continue to require a majority of the Board and Board members have no special authority or power over issues within their zone. Mr. Johnson reviewed the proposed timeline which includes four public hearings prior to the adoption of the appropriate maps. Mr. Johnson reviewed Traditional Districting Criteria which includes Federal Laws and Traditional Criteria. Federal Criteria includes equal population, Federal Voting Rights Act, no racial gerrymandering. Traditional Criteria consists of communities of interest, compact, contiguous, visible boundaries and respect for voters' wishes and continuity in office.

Director Mitchell questioned where the maps will be made available for viewing. Ms. Ochoa stated the maps will be published on the Tri-City website and can be made available through the administrative offices. She stated once the proposed draft maps are drawn we are required to make them available to the public at least seven days before the next public hearing on those maps. Director Reno suggested copies be made available at the main reception desk at the hospital.

Chairman Dagostino questioned if the public can make comments on the interactive website. Mr. Johnson stated there will be no built in mechanism for comments and the public should comment through a letter or e-mail to the District. Ms. Ochoa stated your best opportunity to be heard is to come to a public hearing.

Director Schallock questioned if community members can submit their own specific proposals. Mr. Johnson stated it would be difficult due to the size of our jurisdiction. He stated if a community member has mapping capability they should e-mail the District or Mr. Johnson and he can send the mapping software file.

Director Kellett asked if there is a "fudge factor" related to variances on population. Mr. Johnson stated the balance should be as close as possible however must be within 10% of each other.

Director Grass requested that Board members be provided with a copy of the proposed timeline. It was also suggested that the timeline be loaded onto the district's website for easy accessibility.

Ms. Ochoa stated we received a request from a public member to hold meetings outside the scheduled meetings we have planned. The individual also requested that meetings be held in the evening to accommodate the working folks.

It was moved by Director Grass to schedule one public meeting in each

of the three cities – Carlsbad, Oceanside and Vista. Director Schallock seconded the motion.

Mr. Moser recommended the vote on the motion be held until after hearing from the public.

Chairman Dagostino questioned if anyone would like to speak in opposition or in favor of the three public meetings.

Chairman Dagostino recognized Mr. Victor Roy who explained how the process was done in the cities. He commented that the whole point is to give the public direct access.

Chairman Dagostino recognized Ken Kalpe who suggested a link be provided on the website for the public to comment directly on the maps.

Director Mitchell recommended the public hearings be held in the evenings.

Ms. Ochoa clarified that a quorum of the Board does not need to be present at all meetings, just two of the meetings. Ms. Ochoa requested clarification if the public meetings should be noticed as a Board meeting or a public forum. Mr. Moser suggested the notice state that it would be considered a Board meeting if a quorum of the Board is present.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Chairman Dagostino recognized Ms. Gwen Sanders who asked the following questions:

1) When making zones will you draw equal population and is that based on the 2010 census?

2) Will the zones be based on total population or voting age population?

3) Who makes the decision as to which maps are accepted and put into place? She believes we need to remove the perception that Board members are voting for their best interest and consider having Board committee members make the decision.

4) Hypothetically if all three board members fall into one zone what happens?

Chairman Dagostino recognized Kim Stone, Oceanside resident who made the following comment:

Once zones are determined that a percentage of protected classes are identified in each zone.

Chairman Dagostino recognized Jane Mitchell who asked the following questions:

1) How will you decide which districts are part of the 2018 election. She stated currently Vista has no representation on the Board and if the zones selected don't include Vista she will be extremely disappointed.

Ms. Ochoa responded to the questions as follows:

1. Zones will be drawn based on 2010 Census data.
2. Zones will be based on total population rather than voting population.
3. The Board makes the decision on the map that is selected.
4. By law no one other than the Board can adopt the maps.
5. The percentage of protected classes will be reflected when we have the maps.
6. Draft maps will include place of residence for the Trustees. In addition, a proposed sequence of election will be available.

Ms. Ochoa stated an individual must be a member of the zone for at least 30 days and currently live in the zone to pull papers.

Chairman Dagostino summarized that there will be two public hearings on site and a public hearing held in Carlsbad, Oceanside and Vista.

The public hearing was concluded.

c. Consideration of Resolution No. 789, a Resolution of the Tri-City Healthcare District Board of Directors in Support of *Live Well San Diego* Initiative.

Mr. David Bennett, Chief Marketing Officer introduced Ms. Kerry Richatelli, Manager for the Health & Human Services Agency who spoke with the Community Healthcare & Alliance Committee several months ago regarding the *Live Well San Diego* Initiative. Ms. Richatelli stated 310 organizations belong to the *Live Well San Diego* and 93 of those are in North County. Mr. Bennett encouraged the Board to approve the partnership. He stated the Initiative also supports data tracking and measures outcomes and collaborates with a growing network of champions.

Director Nygaard questioned if there is a cost to join the Initiative. Mr. Bennett stated there is no cost and the Resolution is simply agreeing to partner with this broader network of entities.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve Resolution, No. 789, a Resolution of the Tri-City Healthcare District Board of Directors in Support of *Live Well San Diego* Initiative. Director Kellett seconded the motion.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18 Old Business

a) Update on LAFCO Application/Annexations

Ms. Ochoa reported we have received maps from the County Assessor's office and have submitted our application, resolution and payment to LAFCO. She stated she has been in contact with both Palomar and Fallbrook and does not anticipate any objections.

b) Update on Board Portal

Director Mitchell provided a brief update on the Board Portal. She stated the Ad Hoc Committee met with the VP of IT and we have a projected to "go live" in December.

c) Board Retreat Follow-up

Chairman Dagostino reported the Board recently held a workshop with Board Facilitator Mr. Rice. He noted Mr. Rice also facilitated a workshop for the Board approximately two years ago. The Board participated in a self-evaluation and Mr. Rice provided an assessment of the Board and did a comparison of how well we did in comparison to the previous assessment. Chairman Dagostino stated he wanted to take advantage of the assessment and follow through with some of Mr. Rice's recommendations. He stated the mission today is to discuss the Rice document to determine its validity. Chairman Dagostino proposed nine concrete proposals that could be considered or modified. Each action had a prescribed time line.

Chairman Dagostino questioned if the Board agreed with Mr. Rice's assessment? Director Grass stated it was intuitive. Not hearing any disagreement with Mr. Rice's assessment, Chairman Dagostino commented on a proposal with regard to expanded community linkage.

The first proposal considered is to have the Grant Ad Hoc Committee continue and make a recommendation to the Board by December 2017. Director Nygaard stated the Ad Hoc Committee is making good progress and the committee will develop a structured plan for presentation in December.

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors direct the Grant Ad Hoc Committee to make a recommendation to the Board regarding the Grant Program at the December Regular meeting. Director Schallock seconded the motion.

Director Kellett questioned if a motion is needed for an Ad Hoc Committee. Mr. Moser stated a motion is not needed however the Board can certainly give direction.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

2. Consideration to direct Administration to make a recommendation to the Board on ways to strengthen support as outlined in Governance Enhancement Plan.

Chairman Dagostino commented on the importance of strengthening physician relationships. He stated the motion for consideration is to develop a program in which Administration would take the lead and work with Board members to find better ways to honor our physician colleagues and come up with a more comprehensive plan for 2018. Director Reno stated she would like to see physicians recognized at Board meetings with plaques.

It was moved by Director Mitchell moved that the Tri-City Healthcare District Board of Directors direct Administration make a recommendation to the Board on ways to strengthen physician support as outlined in the Governance Enhancement Plan. Director Reno seconded the motion.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

3. Consideration to direct Board Committee Chairs to make recommendation to Board at the October meeting regarding committee composition and meeting frequency.

Chairman Dagostino stated Mr. Rice recommended the Board consider streamlining their committees. He stated the motion on the floor would be to consider having the Board Committee Chairs recommend to the Board how each of their committees can be more efficient which might include a discussion at the committee level on structure and meeting frequency.

Director Reno stated the majority of material at the Professional Affairs Committee is administrative and how much do you want the Board involved in administrative activities. Chairman Dagostino stated there is a Title 22 Requirement that the Board is responsible for oversight of Medical Policies and Procedures

It was moved by Director Grass that the Tri-City Healthcare Board of Directors direct Board Committee Chairs to make a recommendation to the Board at the October meeting regarding committee composition and meeting frequency. Director Kellett seconded the motion.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

4. Consideration to add standard 15 minute Educational Session to every Regular Board Agenda beginning with the October Board meeting.

Chairman Dagostino stated Mr. Rice recommended an educational session for the Board at each Board meeting. Chairman Dagostino stated he has been working with CHA on a webinar on how hospitals are reimbursed for care. Chairman Dagostino stated he has a commitment from CHA to do a webinar at our December Board meeting. Director Nygaard stated the Board may benefit from a Board meeting that is focused solely on education. Mr. Moser stated the motion does not preclude you from having a longer educational session it simply states that every Board meeting will include an educational component.

It was moved by Director Mitchell to add a standard 15 minute Educational Session to every Regular Board Agenda beginning with the October Board meeting. Director Grass seconded the motion.

Director Schallock moved to amend the motion to include #5 Consideration to direct Board Chair to solicit professional presentation on reimbursement to enhance the Board's financial literally and present in 2018. Director Mitchell accepted the amendment.

With regard to #5 Director Reno stated she believes it is important to have a finance seminar for the Board to understand hospital finances. Chairman Dagostino stated he believes the webinar with the CHA will be a good beginning in that direction. Director Reno stated she has a gentleman in mind, Mr. Dennis Miller. Chairman Dagostino suggested we begin with the webinar and expand to a full financial literacy presentation if needed.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19 Chief of Staff

a. Consideration of September 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 25, 2017.

It was moved by Director Kellett to approve the September 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 25, 2017. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration of AHP Nurse Practitioner – Interventional Radiology Standardized Procedures

It was moved by Director Nygaard to approve the AHP Nurse Practitioner – Interventional Radiology Standardized Procedures as recommended by the Medical Executive Committee at their meeting on September 25, 2017. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20 Consent Calendar

It was moved by Director Kellett to approve the Consent Calendar. Director Schallock seconded the motion.

It was moved by Director Dagostino to pull item 20 D 8) and 9) related to agreements with Dr. Bilal Choudry for the Neuroscience Health Institute – Operations Committee and Neuroscience Health Institute - Quality Committee and item 20 A 2(a) Alcohol & Drug Testing for Employees Policy. Director Kellett seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Discussion of items pulled from Consent Agenda

Chairman Dagostino who pulled item 20 D 8) and 9) related to agreements with Dr. Bilal Choudry for the Neuroscience Health Institute – Operations Committee and Neuroscience Health Institute - Quality Committee requested that Mr. Scott Livingstone clarify the amount. Mr. Livingstone stated Dr. Choudry's Medical Director agreements for the Neuroscience Health Institute under the Operations Committee as well as the Quality committee was presented to the Finance, Operations & Planning Committee at a rate of $210.00/hour however it was later identified that the hourly rate is actually $200.00 hour. Mr. Livingstone stated the request is to approve both agreements with the hourly rate of $200.00.

It was moved by Director Schallock to approve items 20 D 8) and 9) related to agreements with Dr. Bilal Choudry for the Neuroscience Health Institute – Operations Committee and Neuroscience Health Institute - Quality Committee with an hourly rate of $200.00. Director Mitchell seconded the motion.

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Chairman Dagostino who pulled item20 A 2(a) Alcohol & Drug Testing for Employees Policy stated the policy needs to go through the Administrative Policies & Procedures Committee prior to coming to the Board for approval.

It was moved by Director Kellett to table the policy and refer to the Administrative Policies & Procedures Committee. Director Mitchell seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno stated she would be voting on the minutes.

22 Reports (Discussion by exception only)

23 Legislative Update –

Chairman Dagostino referred the Board to his report on the ACHD Annual Meeting and discussed in detail items of interest to the District.

Mr. Moser suggested the Board make suggestions of areas of District Law that we would like to see updated and forward on to ACHD for consideration. Director Schallock suggested the Governance Committee discuss this matter.

24 Comments by members of the Public

Chairman Dagostino recognized Vanita Ramsey, RN in the Progressive Care Unit. Ms. Ramsey urged the Board to do the right thing and prioritize our community RNs and listen to our nurses.

25 Additional Comments by Chief Executive Officer

Mr. Dietlin stated he looks forward to seeing everyone Saturday morning for the Heart Walk.

26 Board Communications

Director Schallock stated he is looking forward to seeing everyone at the AHA Heart Walk and commented on the importance of keeping ourselves healthy and our heart ticking.

Director Schallock stated Drug Take Back Day is October 28th. He stated in the April Drug Take Back Day, nationally 450 tons of medication were turned in. He encouraged everyone to get medications out of the house and off the street if you are not using them.

Director Reno stated she received two complimentary letters and phone calls from patients who received excellent care here.

Secondly, Director Reno commented on a patient who she spoke with who had a procedure done by Dr. Gramins and received wonderful cardiac care here.

Director Nygaard stated there is a lot of concern surrounding the Hepatitis A epidemic and she suggested the County Medical Officer come up and tell us what they are doing in regards to the Hepatitis A epidemic in North County.

Director Grass stated October is Breast Cancer Awareness month. She encouraged women to make their appointments for their mammograms.

Director Mitchell thanked all who will be participating in the Heart Walk on Saturday and stated she would be there in spirit.

Director Kellett expressed his appreciation to Administration for the timely and clean audit.

Director Kellett stated the Employee Fiduciary Subcommittee supervises the pension plan for everyone who works at Tri-City. He stated the plan is fully funded and over $300 million.

27 Reports from Chairperson

Chairman Dagostino had no comments.

33 Hearing no further business, Chairman Dagostino t adjourned the meeting at 6:00 p.m.

James J Dagostino, DPT
Chairman

ATTEST:

Laura E. Mitchell, Secretary

HealthCare Compliance Association
6500 Barrie Rd
Suite 250
Minneapolis, MN 55435
888-580-8373 * 952-988-0141 * Fax 952-988-0146

Tuesday, October 17, 2017
Invoice # 737986

DUES RENEWAL INVOICE

RoseMarie Reno
Board Chairwoman
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056
United States

Membership # 00127016 Expiration Date: 12/01/2017

Dear RoseMarie:

HCCA values you as a member. Your membership is due for renewal. By renewing now, you will be assured of participation in the ever increasing benefits of being a member of HCCA. We continually strive to make your membership in HCCA the best compliance investment you can make.

I look forward to your continued participation in HCCA. And, as always, we welcome your suggestions, comments and questions.

Sincerely,
Urton Anderson, President

Amount Due: $250.00 **Please pay invoice within 21 days of Expiration Date**

----------Please remit this portion with your payment----------

Please take a moment to update your contact information:

RoseMarie Reno
Board Chairwoman
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Phone: (760) 940-3347
Email: donnellantl@tcmc.com

Membership #: 00127016
Invoice #: 737986

Amount Due: $250.00

[ ] Check enclosed payable to HCCA
[ ] Charge my VISA, MasterCard, American Express, Discover

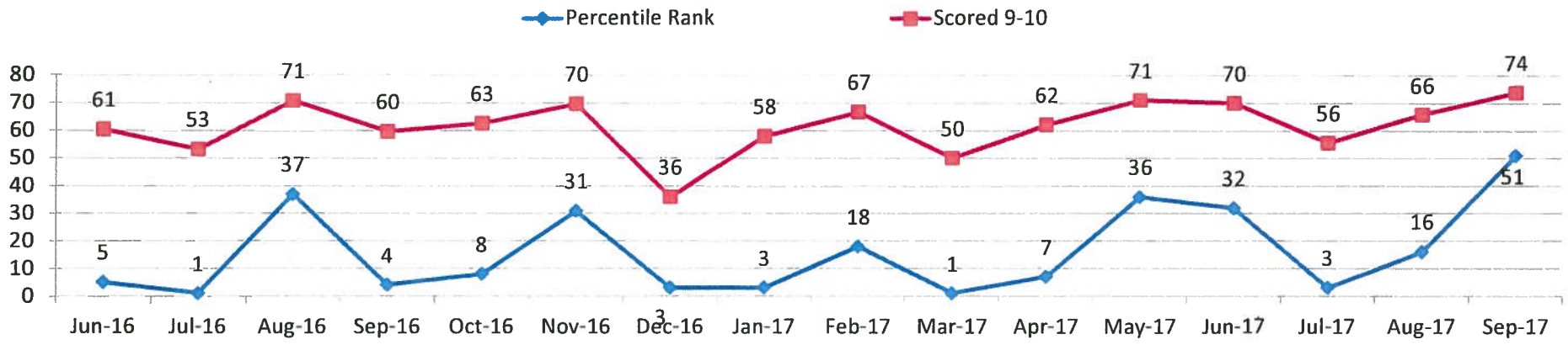
Card# _____ Exp. Date: _____

Signature: _____

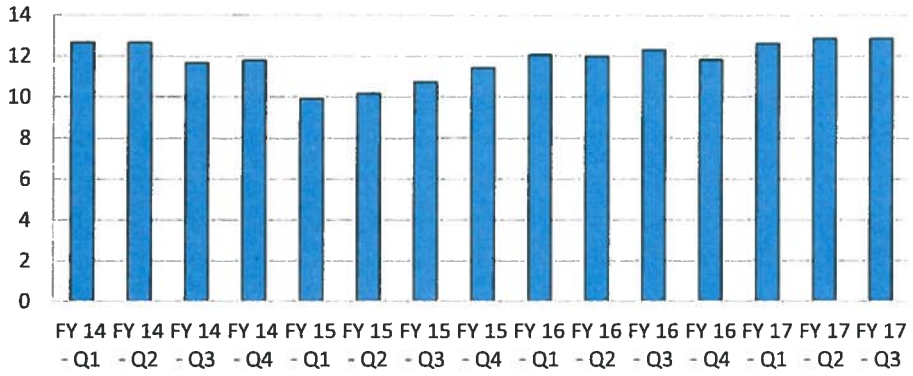
Online: www.hcca-info.org **By Fax:** 952-988-0146 **Over the phone:** (952)988-0141

Stakeholder Experiences

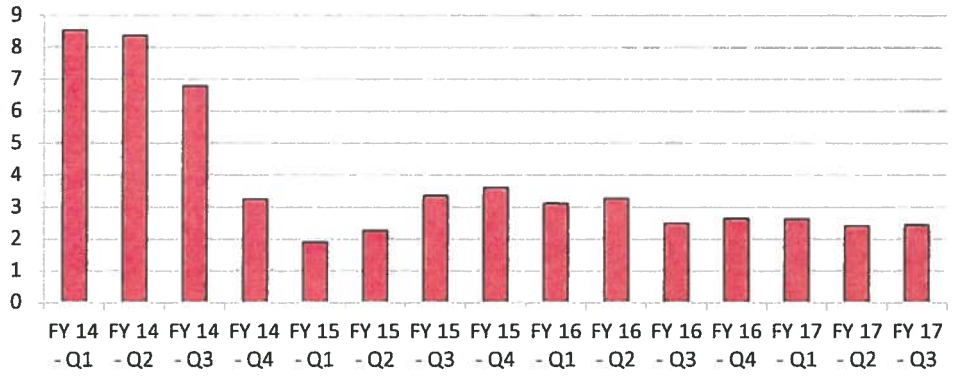
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

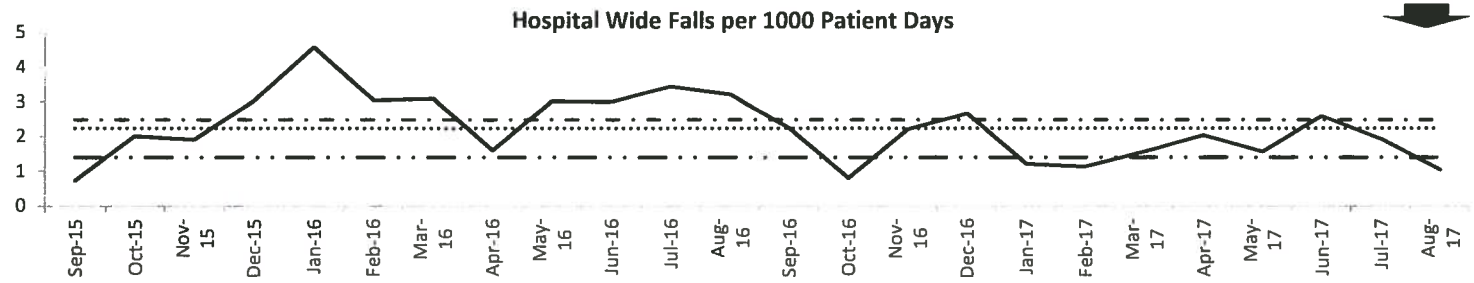


Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

Hospital Wide Falls per 1000 Patient Days

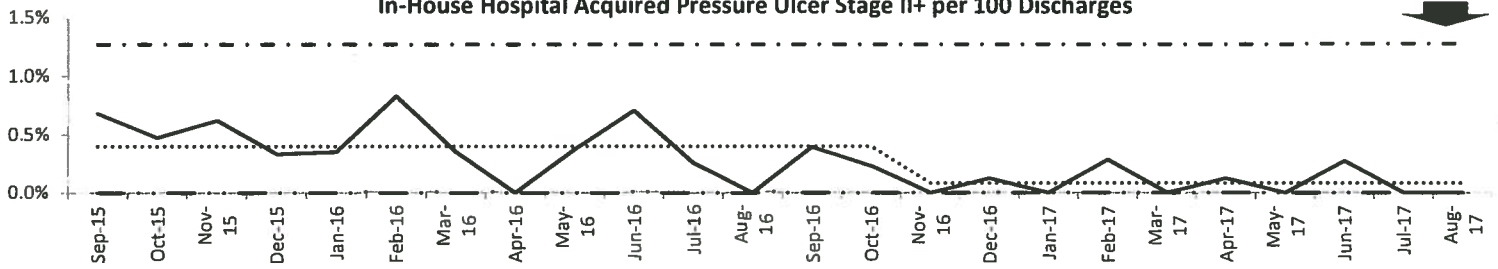
Better



Action Plan

In-House Hospital Acquired Pressure Ulcer Stage II+ per 100 Discharges

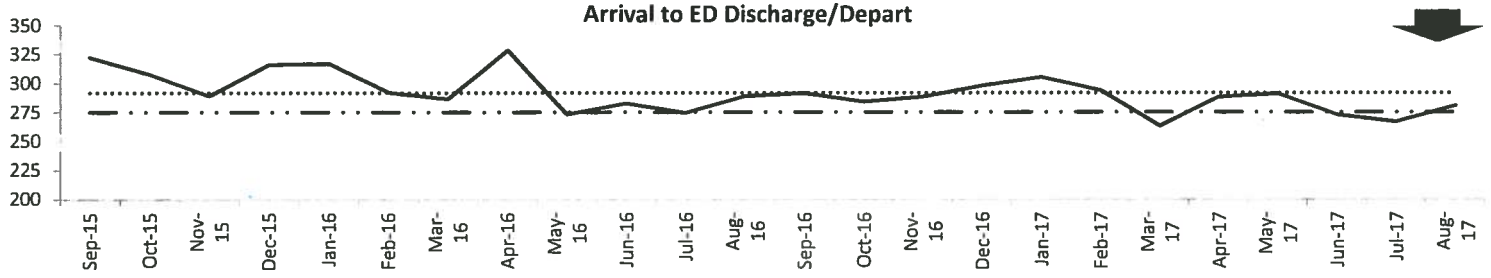
Better



Action Plan

Arrival to ED Discharge/Depart

Better

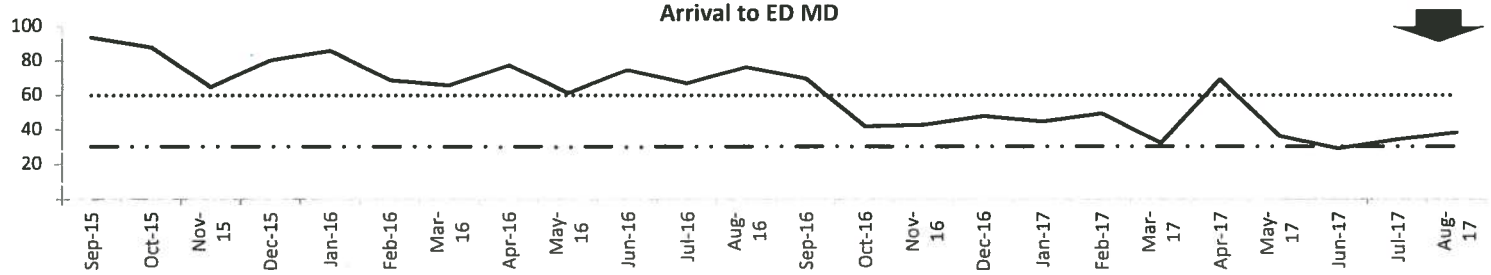


Action Plan

Current Trending Measures

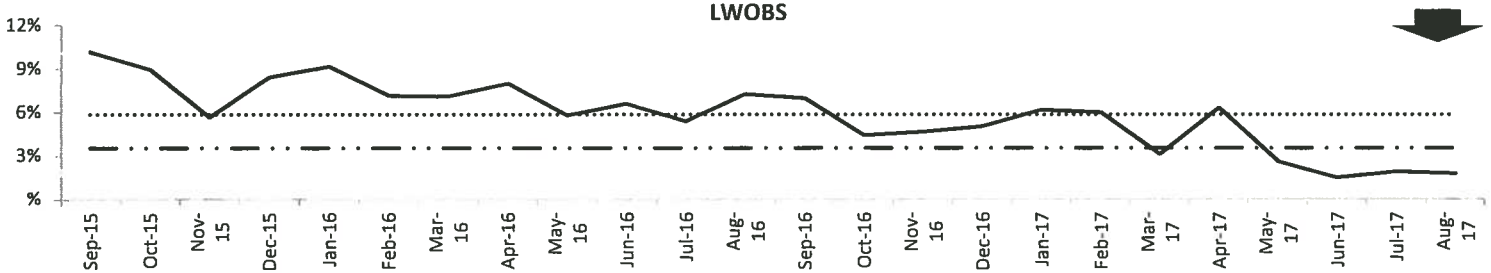
TCMC Rate — Mean — CA Mean — TCMC Target

Arrival to ED MD



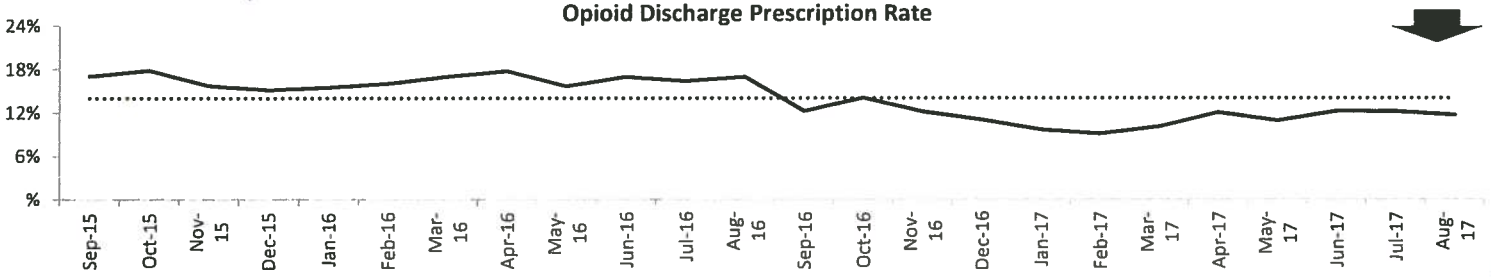
Action Plan

LWOBS



Action Plan

Opioid Discharge Prescription Rate

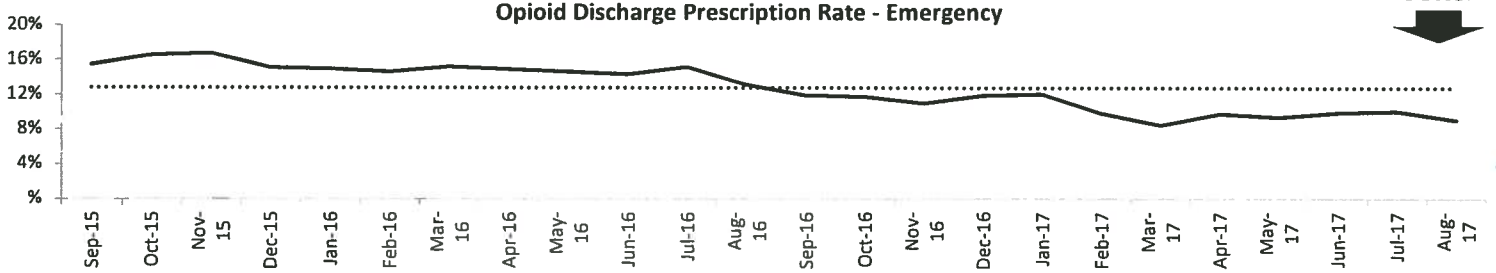


Action Plan

Current Trending Measures

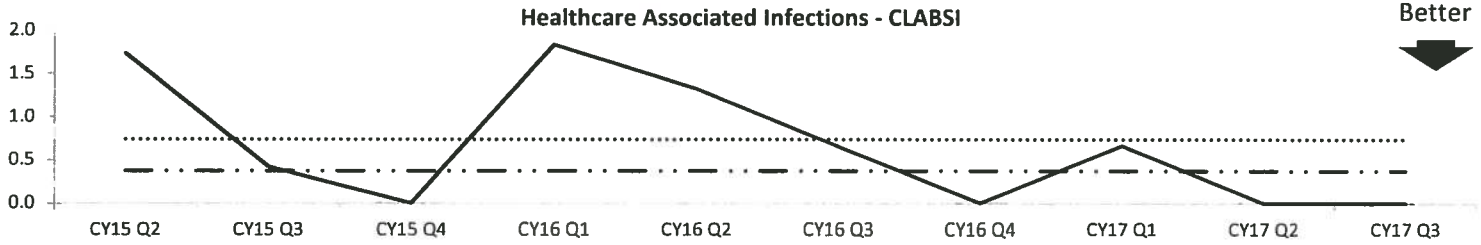
TCMC Rate Mean CA Mean TCMC Target

Opioid Discharge Prescription Rate - Emergency



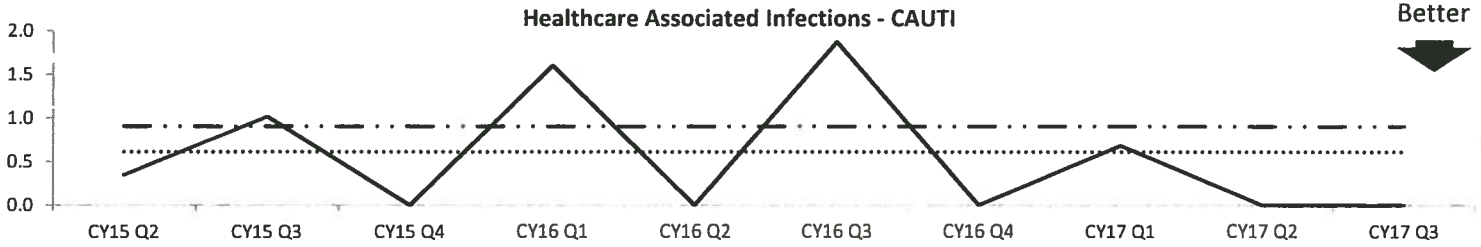
Action Plan

Healthcare Associated Infections - CLABSI



Action Plan

Healthcare Associated Infections - CAUTI

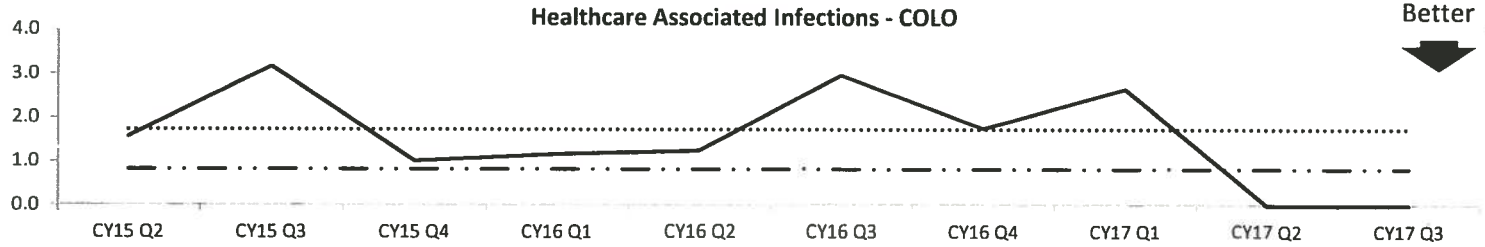


Action Plan

Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target

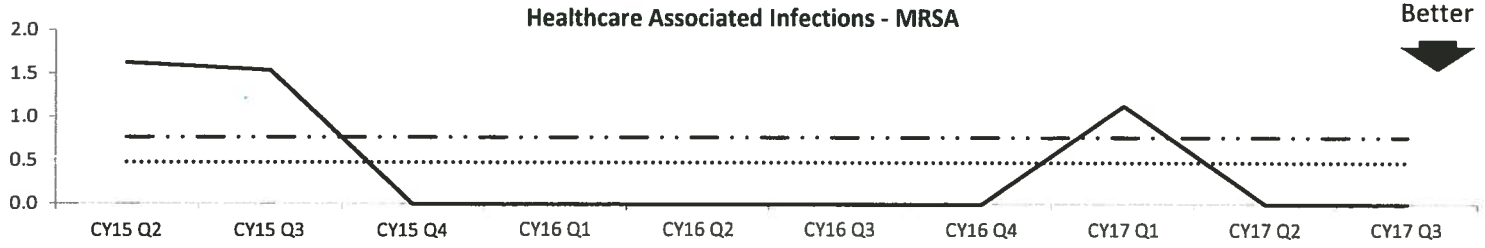
Healthcare Associated Infections - COLO



Better

Action Plan

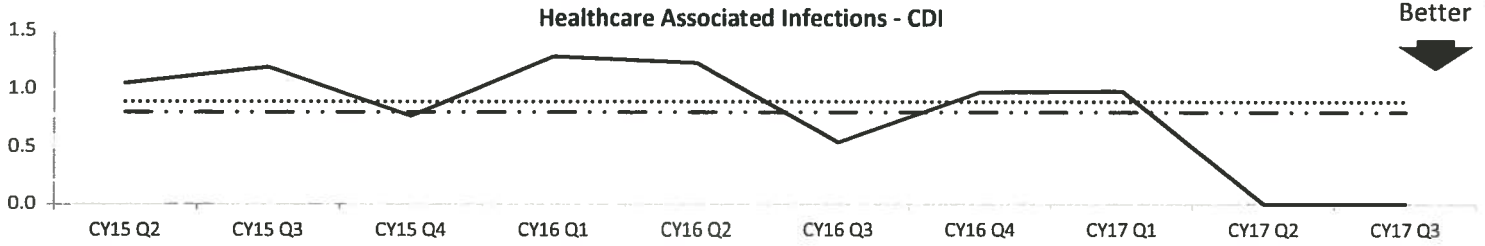
Healthcare Associated Infections - MRSA



Better

Action Plan

Healthcare Associated Infections - CDI



Better

Action Plan

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	26	23	23										72
FY17	28	22	13	25	27	23	19	24	25	25	30	20	281

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	14	6	7										27
FY17	9	9	5	13	12	11	10	8	15	8	12	10	122

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	11	12	12										35
FY17	8	11	8	13	12	8	12	10	12	11	17	21	143

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15	20	20										55
FY17	18	18	17	14	20	22	20	16	18	13	17	19	212

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	48	37	33										118
FY17	31	35	29	42	34	29	31	30	31	37	28	41	398

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15.7	14.5	16.2										15.5
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1	16.5	16.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	9.0	6.7	6.2										7.3
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	8.0	9.4	6.7

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	11.3	16.4	12.4										13.4
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7	8.8	10.0	11.8	13.9

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	169.7	181.9	163.4										171.8
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9	168.4	179.5

Performance compared to prior year: Better | Same | Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	210	222	194										626
FY17	223	239	274	230	197	200	217	197	202	172	188	175	2,514

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	12	11	11										34
FY17	12	11	12	16	11	14	15	11	6	15	12	18	153

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	4	7	7										18
FY17	4	4	6	6	5	7	2	2	7	9	6	1	59

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	8	7	7										22
FY17	10	9	8	7	6	9	8	6	16	9	6	6	100

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	1.75	1.80	1.81										1.79
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73	1.64	1.71	1.76	1.70

Performance compared to prior year: Better Same Worse

Financial Strength

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
FY18	47.7	47.8	48.9										48.1	48-52
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8	49.4	48.1	46.5	50.0	

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
FY18	82.1	79.1	78.8										80.0	75-100
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6	79.9	74.6	79.9	81.5	81.9	82.3	

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
FY18	($394)	($429)	($224)										($1,048)	($1,187)
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296	$1,510	$1,246	

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
FY18	-1.33%	-1.39%	-0.76%										-1.16%	-1.33%
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%	-0.22%	0.99%	5.04%	1.49%	

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
FY18	$898	$864	$1,091										$2,853	$2,672
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010	$1,428	($1,630)	$1,213	$1,558	$2,741	$5,094	

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
FY18	3.03%	2.80%	3.69%										3.17%	2.99%
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%	4.23%	5.21%	9.16%	6.09%	

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
FY18	6.51	5.92	6.90										6.42	6.25
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18	6.56	5.88	

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	
FY18	1.57	1.48	1.40										1.10	
FY17	1.37	1.37	1.37	1.59	1.73	1.50	1.35	1.37	1.51	1.32	1.35	1.65	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY18	$58.5	$49.8	$42.3										
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6	$74.3	$77.9	$64.0	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending September 30, 2017

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.48	(a)	44,164.55	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	1,558	$2.39	(a)	4,917.74	01/27/17	05/31/20	**PCP Clinic - Venus** 2067 W. Vista Way, Ste 160 Vista, CA 92083
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.80	(a)	10,463.02	4/1/2016	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.63	(a)	20,106.00	2/1/2015	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	15,184.80	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,642.26	12/01/15	12/31/20	**PCP Clinic - Clancy** 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	09/30/17	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.86	(a)	10,452.23	09/01/12	09/30/17	**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	$1.35	(a)	10,101.01	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.00	(a)	25,580.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$1.10	(a)	5,039.70	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri-City Orthopedic Bldg Partners 3905 Waring Road Oceanside, CA 92056 **V#83020**	10,218	$2.50	(a)	27,970.32	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Total				**$ 187,019.78**			

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending 9/30/17

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6340	BEHAVOIRAL HEALTH CONFERENCE	82817	202.62	80707	JOY MELHADO
8510	CERNER CONFERENCE	82917	528.78	82086	RICK SANCHEZ
8650	HR SHRM CONFERENCE	83117	395.00	81163	FRANCES CARBAJAL
8700	IRF PPS CONDING-WEBINAR	90517	196.00	55297	KENNETH R. REITZ
8700	FISCAL YEAR 2017 ICD-10-CM/PCS UPDATES	83117	255.00	81163	KRISTIN OROZCO
8700	PROTECTING & RELEASING HEALTH INFO	92217JENKINS	265.00	15106	NORRINE JENKINS
8700	PROTECTING & RELEASING HEALTH INFO	92217SAGALE	265.00	15106	LEILANI SAGALE
8740	INTRO TO RADIATION	90717	109.00	83059	FRANCISCO LOZANO
8740	ACLS RENEWAL COURSE	83017	180.00	80676	CHANDRANI COLLURE
8740	ACLS RENEWAL COURSE	90717	200.00	80547	ALYCE BUDDE

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

October, 12, 2017

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

Governance Forum, California Hospital Association, October 10, 2017 Sacramento, California

I attended the Governance Forum of CHA. The Governance Forum is a subcommittee of the CHA board that allows trustees input into the legislative agenda. This forum represents both public and private hospitals along with CHA staff and board members.

An overview of 2017 California Legislation was presented including the bills sitting on the Gov.'s desk to be signed. Former Sen. Bill Emmerson, discussed board's efforts to prepare for the 2018 legislative season. Duane Dauner, CEO, entered into preliminary discussions of both the state and federal legislative outlook. Duane felt that SEIU ballot initiatives are in preparation and may deal with CEO compensation, staffing for freestanding dialysis centers, and ratios of administrative to patient care costs to hospitals.

Anne O'Rourke, Senior Vice President of Federal Relations presented the federal legislative report. As most probably already known, much of the funding for Medicare and Medicaid is quite fluid. Alyssa Keefe, VP regulatory affairs, discussed many of the items that were in my last report.

Amber Kemp, presented the Covered California Health Insurance Plan Rates for 2018. As has been widely published, California plans to see generally a 12% increase in Covered California health insurance plans. Patients will be encouraged to move into lower tiered plan if they are to keep their premium costs down.

Two special reports were given. The first was on the status of the Northern California fires. Two facilities Kaiser and Sutter were evacuating and all healthcare institutions are working in concert to try to shift those patients. Healthcare workers have lost their homes and it is unclear where they will be relocated. The greatest difficulty will be is relocating them back to this area. Kaiser is providing temporary housing for all displaced nurses and healthcare workers.

A second report was given by Judith Yates about hepatitis A problem in San Diego. It was noted that this hepatitis strain is a mutant and is best control by hand washing versus alcohol-based products. Hospital Association of San Diego is working with the county to assist in any manner.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

October 10, 2017

TO: Governance Forum

FROM: Anne O'Rourke, Senior Vice President, Federal Relations

SUBJECT: Federal Update

A. Federal Legislative Report

The House and Senate returned from summer recess on September 5, 2017, to a very busy agenda with several important deadlines looming. The federal fiscal year (FFY) expired on September 30, 2017, and with it, funding for operating the federal government. In addition, the federal government's borrowing authority was set to expire at the end of the month. President Trump surprised GOP congressional leaders by striking a deal quickly with House Minority Leader Nancy Pelosi and Senate Minority Leader Charles Schumer to fund the government, and extend the debt ceiling through December 8, 2017, along with a package of emergency spending for hurricane relief.

The deal on the federal spending and debt issues left a relatively open calendar and Senators Graham (R-SC) and Cassidy (R-LA) worked quickly to fill the void with momentum for their plan to repeal and replace the Affordable Care Act (ACA). They promoted a plan that would end ACA's premium tax credits, CSR payments, and enhanced Medicaid expansion funding and replace them with block grants to states. The measure would also eliminate the state funding requirements, which in California would reduce the ability to utilize provider financing, including the hospital fee. Early estimates are that California would be hit the hardest, with a $57.5 billion reduction in Medicaid financing in 2027 and billions more before then.

While momentum for the bill seemed to be growing, several republican senators voiced their opposition to the plan and by Wednesday, September 27, it was clear that there were not the 50 votes needed and Leader McConnell canceled the vote.

The dramatic demise of the Senate's effort to repeal, replace or reform the ACA bill halts, for now, GOP efforts to repeal and/or replace the ACA. The impulse to act on ACA repeal in some form remains strong for the GOP and some continue to work to address the imminent need to continue ACA cost sharing reduction (CSR) payments and stabilize the insurance markets. Senate Health, Education, Labor, and Pensions (HELP) Committee Chair Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) lead the effort in the Senate.

President Trump has not yet committed to continue funding for CSR payments, which help reduce the amount certain low-income individuals have to pay for health insurance. Without Administrative action to continue the payments, legislation will be needed to ensure CSR payments flow and markets are stabilized.

On the House side, a bipartisan group of about 40 members of the U.S. House of Representatives, known as the "Problem Solvers Caucus," co-chaired by Representatives Tom Reed (R-Corning) and Josh Gottheimer (D-NJ), released a set of proposals principally geared toward ensuring ACA CSRs are paid and markets stabilized. The plan also would apply the ACA's employer mandate only to employers with 500+ employees.

The Problem Solvers Caucus plan emphasizes the need for the cost of these policies to be offset and suggests cutting payments to providers to do so. Cuts to Medicare bad debt payments and Medicare reductions via post-acute bundling arrangements are among the specified "possible" offsets included in the Caucus' proposal.

CHA welcomes a return to bipartisanship and regular order, where committees of jurisdiction openly debate healthcare policy and the implications of policy changes, while seeking input from stakeholders. We remain deeply concerned about proposals that include significant entitlement reform and provider payment reductions as offsets and proposals that would weaken coverage through elimination of the employer mandate.

CHA core principles for the ACA effort remain: Medicaid expansion and Covered California, our state-based exchange, are working well and provide health care coverage to 91 percent of all Californians. CHA supports bipartisan efforts to stabilize marketplaces in states that are struggling — but not at the expense of states like California. Cutting provider payments to pay for market stabilization would erode, not strengthen, access to care.

While the Problem Solvers Caucus will not officially make its membership public, members of the California Congressional Delegation who have made their membership known include Representatives Costa (CA-D-16), Peters (CA-D-52), Carbajal (CA-D-24) and Bera (CA-D-7).

Additionally, a plan released by the New Dem Coalition, a group of more than 60 Democrats in the House, put forth proposals aimed at stabilizing and improving the individual market. Californians in this coalition include Representatives Costa (CA-D-16), Peters (CA-D-52), Carbajal (CA-D-24), Torres (CA-D-35), Bera (CA-D-7), Brownely (CA-D-26).

B. CHIP

The Senate Finance and House Energy and Commerce Committees have scheduled hearing on the Children's Health Insurance Program (CHIP) funding. Authorization for CHIP funding expired on September 30. CHA urges a quick resolution to ensure stable CHIP funding moving forward.

C. Medicaid DSH & 340B

CHA strongly supported a nationwide effort lead by the American Hospital Association to secure signatures on letters outlining two priority issues. The first letter called for a delay in the implementation of the Medicaid disproportionate share hospital (DSH) payments set to take effect on Oct. 1 and the second called on the Centers for Medicare and Medicaid Services (CMS) to abandon its proposal to reduce payments for certain drugs under the 340B program. Both letters garnered more than 220 signatures, a majority in the House. Twenty-eight members of the California delegation signed the 340B letter and thirty-nine signed the Medicaid DSH letter.

CHA will continue to advocate for these issues, as well as the extension of rural hospital provisions through the end of the legislative session.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

October 10, 2017

TO: Governance Forum

FROM: Alyssa Keefe, Vice President, Federal Regulatory Affairs
presented by Megan Howard on behalf of Alyssa Keefe

SUBJECT: Federal Regulatory Update

The Centers for Medicare & Medicaid Services (CMS) is nearing the end of its annual rulemaking cycle for the federal fiscal year (FFY) and calendar year (CY) 2018 Medicare payment regulations. CMS finalized its FFY 2018 Medicare payment regulations, including the inpatient prospective payment system (IPPS), in early August, and CHA expects final rules for CY 2018 regulations, including the outpatient prospective payment system (OPPS) and physician fee schedule (PFS) and the Home Health proposed rule, to be released by November 1.

Going into the fall, CHA's top regulatory advocacy priority remains fighting cuts to hospitals as included in these proposed and final rules. The CY 2018 OPPS proposed rule would drastically cut Medicare payments for drugs that are acquired under the 340B Drug Pricing Program. Specifically, CMS proposed to pay separately payable, non pass-through drugs (other than vaccines) purchased through the 340B program at the average sales price minus 22.5 percent, rather than average sales price plus 6 percent. CHA submitted comments strongly opposing the proposal, and urged the agency to withdraw this policy from consideration. CHA believes that the proposal, as outlined, lacks sufficient policy rationale and will have unintended consequences contrary to the intended goals CMS laid out in the proposed rule, while doing nothing to address the underlying issues of rising drug costs. In addition, CHA issued an Advocacy Alert urging members to contact their representatives in support of a letter urging the administration to withdraw the proposal.

The CY 2018 PFS proposed rule included a proposal to further reduce payments to non-excepted, off-campus provider-based departments to 25 percent, rather than 50 percent as finalized for 2017, of the OPPS rates. As a reminder, Section 603 of the Bipartisan Budget Act of 2015 required that, with the exception of dedicated emergency department services, services furnished in off-campus provider-based departments (PBDs) that began billing under the OPPS on or after Nov. 2, 2015 (referred to as "non-excepted services) would no longer be paid under the OPPS, but rather under another applicable Part B payment systems. In comments CHA strongly opposed the proposal. CHA believes the proposal's methodology is inadequate and does not address differences in patient and service mix, and could jeopardize patient access to care across California, especially in rural areas. CHA urged CMS to at least continue payment for non-excepted off-campus PBDs at 50 percent of the OPPS rate. CHA continues to advocate with

CMS staff on a regular basis on each of the regulations and will keep members informed through CHA News.

CHA recently hosted a member forum on the CMS proposed rule that cancels the cardiac episode payment models and makes changes to mandatory participation requirements for the Comprehensive Care for Joint Replacement (CJR) model. The member forum also included a strategic discussion on alternative payment model development, including CMS' recent request for information on a new direction for the CMS Innovation Center (CMMI) and implications for hospital and physician alignment under requirements of the Medicare Access and CHIP Reauthorization Act (MACRA). CHA continues to seek member input on this proposed rule and the CMMI RFI. Comments on the proposed rule were submitted on October 16 and comments on the RFI will be submitted on November 20.

CHA also continues to oppose the use of Worksheet S-10 for calculating Medicare DSH reductions, as finalized in the FFY 2018 IPPS final rule, until such time as CMS has made significant efforts to improve the data. On September 29, CMS issued revised instructions to Worksheet S-10. CHA is working with cost report experts to understand the impact of the revised instructions, and will provide members with additional information in a member forum scheduled for October 16 at 11 a.m. (PT). Please register by October 13 at https://www.surveymonkey.com/r/98WNNHN. CMS also granted an extension to hospitals for the resubmission of certain Worksheet S-10 data for the FFY 2014 and FFY 2015 cost reports. **CMS states that for any revision to be considered, the provider's amended FFY 2014 and FFY 2015 cost reports due to their changes in Worksheet S-10, must be received by their MAC on or before October 31, 2017**.

Each of the post-acute care (PAC) prospective payment systems (PPS) systems was limited to a 1 percent update as mandated by MACRA for FFY 2018. CMS proceeded in implementing this provision across the rules. In addition, CMS has proposed significant PPS changes in SNF and Home Health this year and continues to implement several provisions related to the IMPACT Act. CHA and the Center for Post-Acute Care remain engaged with CMS regarding the rollout and implementation of the IMPACT Act to ensure members are aware of the significant changes that are expected in the coming years. In response to comments, including CHA's, related to the significant increase in data collection elements across the LTCH, IRF and SNF rules, CMS did not finalize additional components of the proposed standardized patient assessment data items citing administrative burden and a willingness to look to other alternatives to collect data other than the patient assessment tools. CMS will begin a nationwide beta test in November and it will conclude in June 2018.

Finally, CHA continues to work with Administration in identifying opportunities for reducing regulatory burden on hospitals. CHA recently responded to a request from the House Ways and Means Committee on its new initiative to reduce legislative and regulatory burdens on Medicare providers. CHA's letter outlined some of our biggest priorities for legislative, oversight and administrative actions. Notably, CHA urged Congress and the administration to pay particular attention to California's strict anti-kickback laws and ban on physician employment, and

consider establishing a "safe harbor" that would exempt certain clinical integration agreements from Stark Law and Civil Monetary Penalties Law requirements. CHA also described the many challenges providers face in obtaining equipment under the Medicare Competitive Bidding Program and asked that the Government Accountability Office study the issue further. Other recommendations include modernizing the CMS Survey and Certification process, preserving Medicaid supplemental payments in managed care, withdrawing recent proposed changes to the 340B Drug Pricing Program, cancelling Stage 3 of meaningful use and revisiting measures used in hospital quality reporting.

More detailed information on the Medicare payment rules as well as and other regulations including implementation of Medicaid DSH cuts proposed rule is available on CHA's Federal Regulatory Tracker. CHA posts all information, including comments letters, rule summaries and analysis at http://www.calhospital.org/publication/cha-regulatory-tracker.

October 5, 2017

Amber King
Senior Legislative Advocate
Association of California Healthcare Districts
1215 K Street, Suite 2005
Sacramento, CA 95814

Dear Amber:

When I attended The ACHD Annual Meeting in San Diego, we discussed the possibilities of running an Omnibus bill to update District Law through the California Legislature in 2018. In your legislative presentation we discussed incorporating the Little Hoover Commission recommendations plus any changes that ACHD may find viable.

The Tri-City Healthcare District Board has discussed this issue and worked with our Counsel to make recommendations that will help our District. The proposed changes to District Law and the Brown Act will allow us to level the playing field as we compete with private institutions. Most important to my Board is modification of the compensation section (Section 32103). I believe all of the recommendations suggested by our Board have benefit to all District institutions.

Attached are three proposals to amend compensation for Board Members. General Counsel Greg Moser has incorporated the most politically viable solution to the compensation issue in his Memorandum.

Please consider our recommendations and we would be intimately involved in the legislative process to move the ACHD bill forward.

Thank you for your consideration.

Sincerely,

James J. Dagostino
Board Chairman
Tri City Healthcare District

Attachs.

Procopio

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525 B Street
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T. 619.238.1900
F. 619.235.0398

AUSTIN
DEL MAR HEIGHTS
PHOENIX
SAN DIEGO
SILICON VALLEY

MEMORANDUM

TO: Jim Dagostino, Board Chair
Tri-City Healthcare District

FROM: Gregory V. Moser, General Counsel **CC:** Steve Dietlin, CEO

DATE: October 4, 2017

RE: Recommended Updates to Healthcare District Law

You have asked for recommendations for updating the Local Healthcare District Law, based on our experience with the Tri-City Healthcare District and other hospital districts.

1. **Moving to Zoned Elections from At-Large Elections.** Revise Section 32100.1 to be consistent with the California Voting Rights Act as to the process for establishing elections by zones, and with Government Code section 1770 et seq., as to the process for filling vacancies, to read as follows:

32100.1. A petition for election of directors by zones may be signed and filed with the board of directors by registered voters residing within a local hospital district, equal in number to at least 15 percent of the number of votes cast in that district for the office of Governor at the last preceding election at which a Governor was elected. Upon receipt of this petition the board of directors shall, by resolution, divide the local hospital district into zones and number the zones consecutively.

Alternatively, and without a petition, the board of directors may adopt a resolution to divide the district into zones and number the zones consecutively.

In establishing these zones, the board of directors shall *comply with the provisions of the California Voting Rights Act, including but not limited to Elections Code section 10010.*~~provide for representation in accordance with demographic, including population, and geographic factors of the entire area of the local hospital district. The board of directors shall fix the time and place for a hearing on the proposed establishment of zones. At this hearing any elector of the district may present his or her views and plans in relation to the proposed zoning, but the board of directors shall not be bound thereby and their decision, in the resolution adopted, shall be final.~~

~~The zones shall be effective for the next district election after the resolution of the board for which there is time to implement the zones and elections within the zones, unless a petition requesting an election on the resolution, containing the signatures of not less than 5 percent of the~~

~~qualified registered voters of the district, is filed with the county elections official within 60 days after passage of the resolution. The form of the petition and the requirements and procedures applicable thereto shall be governed by Article 2 (commencing with Section 9140) of Chapter 2 of Division 9 of the Elections Code, except that all computations referred to in those sections shall be construed to refer to comparable computations of the district, and references to "ordinance" shall be construed to refer to "resolution." For purposes of this section, the electors of the district shall be the electors of the territory entitled to vote at elections for members of the board. If a valid and timely petition is filed with the county elections official, then the board shall prepare a measure to be printed on the ballots used at the next general hospital district election, or at a special election to be held for that purpose. The measure shall be printed on the ballots substantially as follows:~~

~~"Shall members of the board of directors be elected by zones, as described in the resolution of the board of directors dated ____?", with the words "Yes" and "No" so printed in connection therewith that the voters may express their choice.~~

~~The county elections official shall accept arguments for and against the measure, to be mailed to each registered voter in the district, in accordance with Article 3 (commencing with Section 9160) of Chapter 2 of Division 9 of the Elections Code.~~

~~The returns of the election shall be canvassed and declared as at other general hospital district elections, and if it appears that a majority of the votes cast in the election are in favor of the measure, the board of directors shall by resolution declare the zones established and shall describe the boundaries of the zones. At the expiration of the terms of office of the members of the board of directors then in office, and thereafter, these members of the board of directors shall be elected by zones. One member of the board of directors shall be elected by the electors of each of the zones. No person shall be eligible to hold the office of member of the board of directors unless he or she has been a resident of the zone from which he or she is elected for 30 days next preceding the date of the election.~~

The formation of a local hospital district may provide for the election of members of the board of directors by zones ~~by substantially including in the petition for formation the provisions required by this section to be included in the measure~~, and the members of the board of directors shall be elected from the zones as described in the petition, except that the first board of directors shall be appointed, upon the formation of the district, by the board of supervisors of the county in which the land or a greater part of the land in the district is situated. One member of the board shall be appointed from each zone.

The terms of the members of the first board of directors appointed under this section shall be determined by lot. Three members shall hold office for four years, and two members shall hold office for two years. Thereafter, the term of office for all members shall be four years.

~~Any vacancy upon the board shall be filled by appointment by the remaining members of the board, from the zone left unrepresented on the board of directors. Any person appointed to fill the vacancy shall hold office for the unexpired term.~~

2. **Vacancies.** Repeal Section 32100.2, and allow Government Code Section 1770 et seq. to apply. The current provision is susceptible to abuse, such as scheduling a series of special

meetings when an unpopular board member is away on vacation. Why should there be a different rule for vacancies at healthcare districts than other local agencies? The section should be repealed.

~~32100.2. Notwithstanding any other provision of law, the terms of any member of the board of directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive meetings of the board and the board by resolution declares that a vacancy exists on the board.~~

3. **Board Compensation.** Section 32103 should be updated to allow healthcare district boards to receive compensation under the same rules as water agencies, fire districts, public utility districts, cemetery districts, county sanitation districts, and other special districts. Water Code section 20200 sets forth a public hearing process for setting board compensation which is used by many local agencies. Revise section 32103 to read:

32103. *(a) Subject to subdivision (b) t*~~T~~he board of directors shall serve without compensation except that the board of directors, by a resolution adopted by a majority vote of the members of the board, may authorize the payment of not to exceed one hundred dollars ($100) per meeting not to exceed five meetings a month as compensation to each member of the board of directors.

(b) The district board, by ordinance adopted pursuant to Chapter 2 (commencing with Section 20200) of Division 10 of the Water Code, may increase the compensation received by the district board members above the amount prescribed by subdivision (a).

(c) For purposes of this section, the determination of whether a director's activities on any specific day are compensable shall be made pursuant to Article 2.3 (commencing with Section 53232) of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code.

(d) Each member of the board of directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of the district as approved by the board. ~~For purposes of this section, the determination of whether a director's activities on any specific day are compensable shall be made pursuant to Article 2.3 (commencing with Section 53232) of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code.~~ Reimbursement for these expenses is subject to Sections 53232.2 and 53232.3 of the Government Code.

4. **Allow Healthcare Districts to Compete.** Board meetings are subject to the Brown Act. An existing provision for healthcare districts allows them to discuss new district services, programs and facilities in closed session as trade secrets. However, other trade secrets, such as proposed changes or improvements to existing services, programs or facilities must be discussed in open session in full view of competitors. Moreover, current law does not allow action to be taken in the closed session. We propose to eliminate these limitations to allow districts to better compete. Section 32106 would be revised to read:

32106. (a) Except as provided in this section, Section 32155, or the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code) all of the sessions of the board of directors, whether regular or special, shall be open to the

public, and a majority of the members of the board shall constitute a quorum for the transaction of business.

(b) The board of directors may order that a meeting held *to consider* ~~solely for the purpose of discussion or deliberation, or both, of reports involving~~ district trade secrets be held in closed session. Except as provided in this subdivision, the closed session shall meet all applicable requirements of Chapter 9 (commencing with Section 54950) of Division 2 of Title 5 of the Government Code, including Section 54957.7.

(c) "Health care facility trade secrets," as used in this section, means a "trade secret," as defined in subdivision (d) of Section 3426.1 of the Civil Code, and in addition meets all of the following:

(1) Is necessary to initiate *or modify* a ~~new~~ district service or program or add *or modify* a district health care facility.

(2) Would, if prematurely disclosed, create a substantial probability of depriving the district of a substantial economic benefit.

(d) ~~The exception provided in subdivision (b) to the general open meeting requirements for a meeting of the board of directors, shall not apply to a meeting where there is action taken, as defined in Section 54952.6 of the Government Code.~~

~~(e)~~ Nothing in this section shall be construed to permit the board of directors to order a closed meeting for the purposes of discussing or deliberating, or to permit the discussion or deliberation in any closed meeting of any proposals regarding:

(1) The sale, conversion, contract for management, or leasing of any district health care facility or the assets thereof, to any for-profit or nonprofit entity, agency, association, organization, governmental body, person, partnership, corporation, or other district.

(2) The conversion of any district health care facility to any other form of ownership by the district.

(3) The dissolution of any district.

5. **Adjust Bidding Limits.** Healthcare districts operating hospitals are currently subject to strict bidding requirements that have not been adjusted for over 20 years, imposing burdensome requirements on daily operations. Section 32132 should be revised to read:

32132. (a) Except as otherwise provided in this section, or in Chapter 3.2 (commencing with Section 4217.10) of Division 5 of Title 1 of the Government Code, the board of directors shall let any contract involving an expenditure of more than ~~twenty-five thousand dollars ($25,000)~~*one hundred thousand ($100,000)* for materials and supplies to be furnished, sold, or leased to the district, or any contract involving an expenditure of more than ~~twenty-five thousand dollars ($25,000)~~*one hundred thousand ($100,000)* for work to be done, to the lowest responsible bidder who shall give the security the board requires, or else reject all bids.

~~Except as otherwise provided in this section, for a local health care district that is a small and rural hospital, as defined in Section 124840, the board of directors shall acquire materials and supplies that cost more than twenty five thousand dollars ($25,000), but less than fifty thousand dollars ($50,000), through competitive means, except when the board determines either that (1) the materials and supplies proposed for acquisition are the only materials and supplies that can meet the district's need, or (2) the materials and supplies are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety. As used in this paragraph, "competitive means" has the same meaning as used in subdivision (b) of Section 32138.~~

(b) Subdivision (a) shall not apply to medical or surgical equipment or supplies, to professional services, or to electronic data processing and telecommunications goods and services.

(c) Bids need not be secured for change orders that do not materially change the scope of the work as set forth in a contract previously made if the contract was made after compliance with bidding requirements~~, and if each individual change order does not total more than 5 percent of the contract~~.

(d) As used in this section, "medical or surgical equipment or supplies" includes only equipment or supplies commonly, necessarily, and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in a hospital.

(e) Nothing in this section shall prevent any district health care facility from participating as a member of any organization described in Section 23704 of the Revenue and Taxation Code, nor shall this section apply to any purchase made, or services rendered, by the organization on behalf of a district health care facility that is a member of the organization.

6. **Adjust limits for data processing and telecommunications procurements.** Competitive procurements are required for systems with a cost of over $25,000. The cost for electronic medical records systems for a single physician's office can easily exceed this amount, which has not been adjusted for 25 years. Section 32138 would be revised to read:

32138. (a) The board of directors shall acquire electronic data processing and telecommunications goods and services with a cost to the district of more than ~~twenty five~~ *two hundred fifty* thousand dollars ($250,000) through competitive means, except when the board determines either that (1) the goods and services proposed for acquisition are the only goods and services which can meet the district's need, or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety.

(b) As used in this section, "competitive means" includes any appropriate means specified by the board, including, but not limited to, the preparation and circulation of a request for a proposal to an adequate number of qualified sources, as determined by the board in its discretion, to permit reasonable competition consistent with the nature and requirements of the proposed acquisition.

(c) When the board awards a contract through competitive means pursuant to this section, the contract award shall be based on the proposal which provides the most cost-effective solution to the district's requirements, as determined by the evaluation criteria specified by the board. The

evaluation criteria may provide for the selection of a vendor on an objective basis other than cost alone.

7. **Consideration of medical audit and quality assurance matters.** Currently, Section 32155 allows hearings on physician and allied health professionals credentialing matters to be heard in closed session, unless the applicant or medical staff member wishes the hearing to be held in open session. In addition, for quality control, risk management, accreditation and licensing purposes, health care district boards must consider reports from medical audit and quality assurance committees. The current language of Section 32155 should be clarified to clearly permit such briefings. Section 32155 should be revised to read:

32155. The board of directors may order that the hearing pursuant to this article, and *consideration of* ~~hearings on~~ the reports of the hospital medical audit or quality assurance committees, be held in *closed* ~~private or executive~~ session, provided, that an applicant or medical staff member whose staff privileges are the direct subject of a hearing may request a public hearing. Deliberations of the board of directors in connection with matters pertaining to this article may be held in *closed* ~~executive~~ session.

Health and Safety Code Division 23 Hospital Districts (32000 - 32492

Proposal 1

Section 32103- The Board of Directors shall serve without compensation except that the Board of Directors, by a Resolution adopted by a majority vote of the members of the Board, may authorize a payment not to exceed ($150) per meeting, not to exceed six meetings a month as compensation to each Board member.

Board Chairs and Chairs of Committees may, by a Resolution adopted by a majority of the members of the Board, may authorize an additional monthly stipend not to exceed $200 per month for the Board Chair and $100 per month for Committee Chairs.

A district may, by a Resolution adopted by a majority vote of the members of the Board may authorize in lieu of any meeting or additional stipend a monthly stipend of no greater than $1,200 per Board Member, and Chair of the Board $1,500 per month.

Proposal 2

Section 32103- The Board of Directors shall serve without compensation except that the Board of Directors , by a Resolution adopted by a majority vote of the members of the Board, may authorize the payment of not to exceed $100 per meeting, not to exceed (5) five meetings a month as compensation to each Board Member.

A District Board of Trustees by ordinance adopted pursuant to Chapter 2 (commencing with section 20200 of the Division of the Water Code may increase compensation received for attending meetings of the Board.

Proposal 3

The Board of Directors shall serve without compensation, but by Resolution may place limits on a compensation strategy not to exceed $1,500 per month.

Rationale- The present compensation limits reduce the pool of citizens who will run for District Board elected offices. At present, only fully retired independently financially well-off individuals can commit the time. A working individual must interfere with the workday to fulfill a board commitment. More reasonable compensation will allow individuals the motivation to adjust their work schedule and possibly take a reduction in pay to serve in this capacity. A more important factor is the cost of running an election. District Boards have become more political and these candidates are required to commit to the election process as any other candidate. Setting up committees, fundraising, candidate forums and other events are the norms for campaigning. Many of these downstream elections cannot attract the contributions so many candidates are out of pocket to fund their own elections. This usually means a net loss of money before you take the job. Many Board Members must be a part of the social scene of the hospital which usually means attending community events and fundraising. Usually Board Members donate their funds at these events as an example to prime the community to support the District.
The workload and time commitment is out of sync with the compensation limits. Board meetings for many District Hospitals are monthly. For example, Tri City Hospital schedules meetings that require five (5) hours of meeting time. Some of the time is in closed session to plan for business opportunities, review operations programs and discuss legal matters. Board members are also assigned to seven committees that meet monthly during the week. These meetings are scheduled for at least 3 hours. Committee members receive agendas for these meetings, as well as the Board Meeting that require

analysis of the proposals prior to the meetings. That takes about 1 to 3 hours per meeting of analysis and review. Committee Chairs have extra responsibility in setting agendas and working with staff to expedite the agenda. This usually requires about an extra 3 hours per month per committee.
The Board Chair has an inordinate amount of pre-planning and work prior to the Board meetings. The Board Chair reviews all committee work prior to the Board meeting. The Board Chair has an agenda conference with staff prior to a Board meeting. The Board Chair also has many impromptu meetings when problems arise at the hospital or external meetings with agencies and administration. The Board Chair probably puts in an additional 10 to 20 hours per week to perform their job.

The compensation needs to adequately reflect the amount of work and personal financial requirements performed by these elected officials. The proposed legislation more closely reflects reimbursement for the time and money devoted to do the job the people have elected these officials to do.

Amber,

At the ACHD Conference I spoke with Bob Hemker from Palomar and the Los Medanos gang, Arthur, Lee, and Linda and there was some support for stipend increases.

Jim