### TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A REGULAR MEETING

April 26, 2018 – 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 Aliotted	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 Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4  1) RoseMarie Reno vs. Tri-City Healthcare District Superior Court Case No. 37-2017-00040507-CU-CR		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Approval of prior Closed Session Minutes		
	d. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 1 Matter)		
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) .		

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
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	Introduction:		
<u>.</u>	Colin Coffey, Archer Norris – Board Counsel	3 min.	Chair
13	Educational Session		
	California Special District's Association (CSDA) – Chris Palmer	20 min.	Chair
14	Compliance Update	10 min.	CCO
15	Report from TCHD Auxiliary – Mary Gleisberg, President	10 min.	Standard
16	Report from Chief Executive Officer	10 min.	Standard
17	Report from Chief Financial Officer	10 min.	Standard
18	New Business		
	a) PUBLIC HEARING ON PROPOSED ESTABLISHMENT OF ZONES PURSUANT TO HEALTH AND SAFETY CODE 32100.1	10 min.	A. Ochoa/D. Johnson
	b) Consideration and selection/approval of a map for zone-based District elections, and a sequence of elections for zone-based District Elections	15 min.	A. Ochoa/D. Johnson
	c) Consideration to approve Resolution No. 791, a Resolution of the Tri-City Healthcare District Board of Directors to Divide the District into Zones and Transition from At Large to Zone Based Elections Pursuant to Elections Code 10010 and Health and Safety Code 32100.1.	15 min.	A. Ochoa/D. Johnson
	<ul> <li>d) Consideration to approve Resolution No. 792, a Resolution of the Tri-City Healthcare District Board of Directors to Change the Mailing Address for Retail Pharmacy and Main Hospital Pharmacy</li> </ul>	5 min.	coo
19	Old Business - none		
20	Chief of Staff	5 min.	Standard
	<ul> <li>a. Consideration of March Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on March 26, 2018</li> <li>b. Consideration of Medical Staff Standardized Procedures: <ol> <li>NP Standardized Procedure – Gastroenterology &amp; Privilege List</li> <li>NP Standardized Procedure – Neurology &amp; Updated Privilege List</li> <li>NP Standardized Procedure – Psychiatry CSU &amp; Privilege List</li> <li>PA – Emergency Medicine Privilege Card Revision</li> </ol> </li> </ul>		
	c) Consideration of CME Mission Statement		

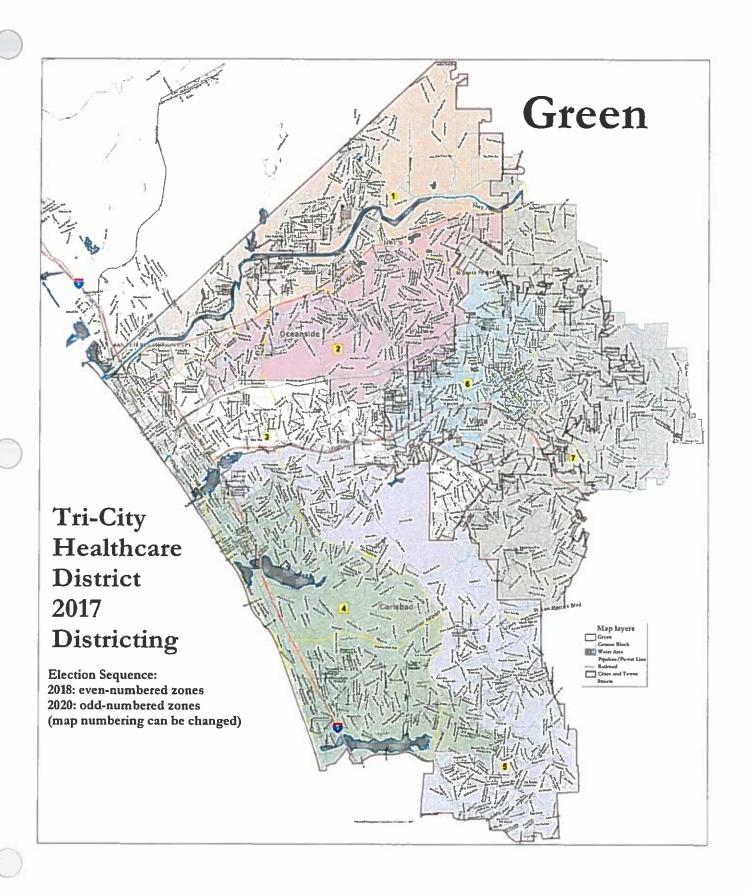
	Agenda Item	Time Allotted	Requestor
21	Consideration of Consent Calendar	5 min.	Standard
	(1) Board Committees		
	<ul> <li>(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.</li> <li>(2) All items listed were recommended by the Committee.</li> <li>(3) Requested items to be pulled require a second.</li> </ul>		
	A. Human Resources Committee Director Kellett, Committee Chair Open Community Seats – 0		HR Comm.
	a) Approval of Gwen Sanders to serve an additional two-year term on the Human Resources Committee		
	<ul> <li>b) Approval of Administrative Policies &amp; Procedures:</li> <li>1) 8610-403 – Discrimination, Harassment &amp; Retaliation Prevention Policy</li> <li>2) 8610-455 – Confidentiality</li> </ul>		
:	B. Employee Fiduciary Retirement Subcommittee     Director Kellett, Subcommittee Chair     Open Community Seats – 0		Emp. Fid. Subcomm.
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes)		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes)		FO&P Comm.
	a) Approval of Mr. Jack Cumming to serve a two-year term on the Finance, Operations & Planning Committee.		
	b) Approval of an agreement with Dr. Dennis Ordas for the Co-Medical Directorship for a term of 26 months, beginning May 1, 2018 and ending June 30, 2020, for an hourly rate of \$140, an annual cost of \$86,640 and a total cost for the term of \$187,720.		
	c) Approval of an agreement with Becton, Dickinson and Company for Blood Culture Bottle Consumables for a term of 36 months, beginning May 1, 2018 and ending April 30, 2021, for an annual cost of \$90,300 and a total cost for the term of \$270,900.		
į	d) Approval of an agreement with West-Com & TV, Inc. for \$593,000 and the total project budget of \$835,463 for replacement of the Nurse Call system in the ICU.		

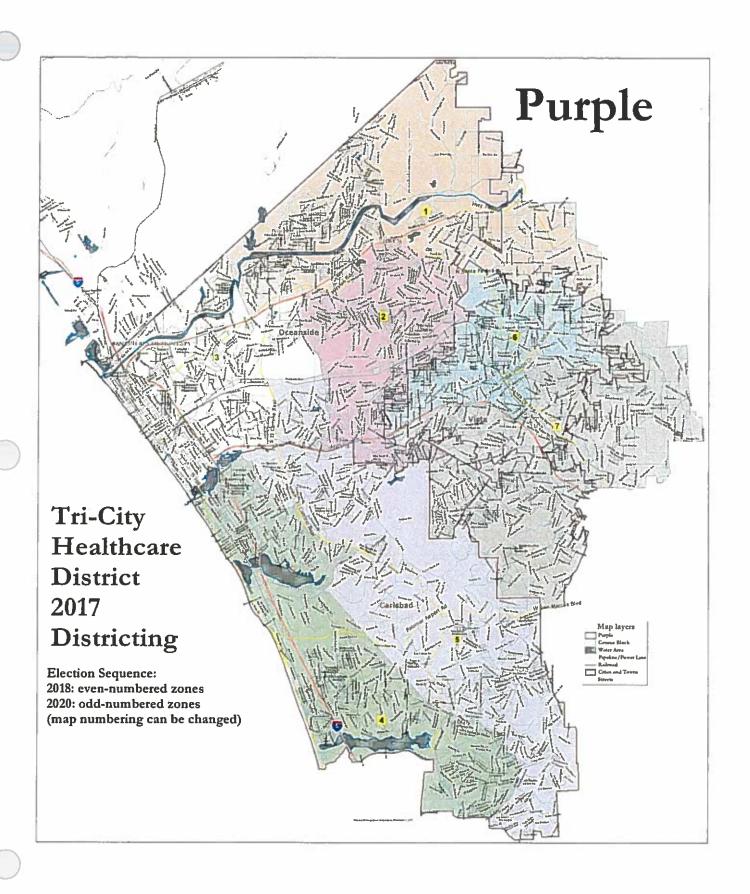
Agenda Item	Time Allotted	Requestor
e) Approval of an agreement with Drs. Christopher Deveraux, Thomas Krol, Javaid Shad, Michael Shim and Matthew Viernes as the Gastroenterology General & ERCP ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019, at a daily rate of \$700 for GI for an annual cost of \$255,500 and ERCP at a daily rate of \$500 for an annual cost of \$182,500 and a total cost for the term of \$438,000.		
<ul> <li>f) Approval of an agreement with Drs. David Amory, Eric Stark, David Daugherty, Andrew Hartman, Harish Hosalkar and Grant Seiden as the Orthopedic ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2018 through June 30, 2020, at a daily rate of \$1,500 Monday-Friday and \$1,650 for Saturday and Sunday and TCMC recognized holidays that are not on the weekend, for a total cost of \$1,129,950.</li> <li>g) Approval of an agreement with Drs. Caroline Vilchis, Bradley Frasier, Michael Guerena, Jason Phillips, Arthur Warshawsky and Aaron Boonjindasup as the Urology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019 at a daily rate of \$600, for an annual and term cost of \$219,000.</li> <li>h) Approval to add Drs. Lisa Leonard and Maria Quan to the</li> </ul>		
currently existing ED On-Call Coverage Panel for OB/GYN for a term of two months, beginning May 1, 2018 and ending June 30, 2018.  i) Approval of an agreement with Team Physicians of Southern California Medical Group for Emergency Medicine Physician and Allied Health Coverage for a term of 24 months, beginning June 1, 2018 and ending May 31, 2020.		¥-
E. Professional Affairs Committee Director Grass, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes)  1) Patient Care Policies and Procedures a) Abbreviations, Use of b) Automatic Stop Orders Policy c) Continuous Ambulatory Peritoneal Dialysis Procedure d) Emergency Department Standardized Procedure e) Fall Risk Procedure and Score Tool Procedure f) Infusion Pump Syringe or PCA Module System with Guardrails Procedure g) Infusion Pumps, Intravenous Therapy Policy h) Point of Care Testing Competency Assessment Procedure i) Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure		PAC
Administrative     a) Non-Beneficial Treatment 399		
3) Unit Specific Behavioral Health Services		

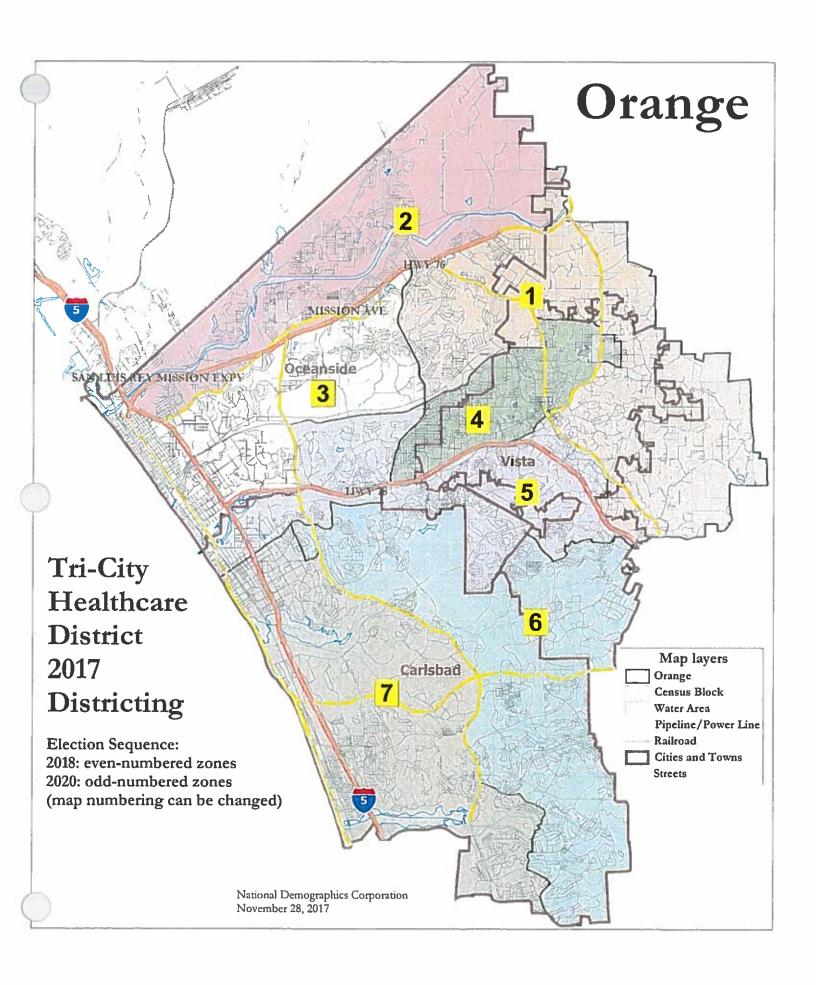
Agenda Item	Time Allotted	Requestor
a) AMA Discharges b) Managing the Medical Record for ED visits c) Notification of MediCal Beneficiary of Denial of Benefits Notification of Responsible Persons d) One to One Observation of Patients e) One to One Patient Supervision f) Orientation of New Patients g) Pastoral Care h) Patient Belongings i) Patient Discharge Types j) Patient Responsibilities k) Patient Satisfaction Surveys l) Psychiatric Advanced Directive m) Release of Information n) Role of Medical Staff Leadership in Behavioral Health Services o) Scabies Lice Fleas in the BHU p) Scope of Service - Behavioral Health Unit q) Smoking Guidelines for Behavioral Health Unit r) Solicitation of Patients/Referrals to Self s) Telephone Use t) Treatment of Patients u) Unit Staff Meetings v) Utilization Management w) Visiting in Behavioral Health Unit x) Vital Signs y) Washer Dryer Use		requestor
4) Unit Specific Infection Control		
a) Department Specific Infection Control Behavioral Health Services - IC 7		
5) <u>Unit Specific Women &amp; Newborn Services</u>		
<ul> <li>a) Breast Milk, Pumping, Handling and Storage of</li> <li>b) Formula Feeding Procedure</li> <li>c) Infant Feedings</li> </ul>		ri
6) Formulary Requests		
a) Albuterol/Ipratropium inhaler b) Bupropion c) Combivir d) Darunavir e) Droperidol f) Exparel g) Fluticasone inhaler h) Fluticasone/Salmeterol inhaler i) Genvoya j) Ipratropium inhaler k) Lansoprazole solu-tabs l) Medium chain triglycerides m) Mepivacaine n) Nitroglycerin 0.3 mg and 0.6 mg sublingual tablets o) Nitroglycerin 0.4 mg spray p) Raltegravir		

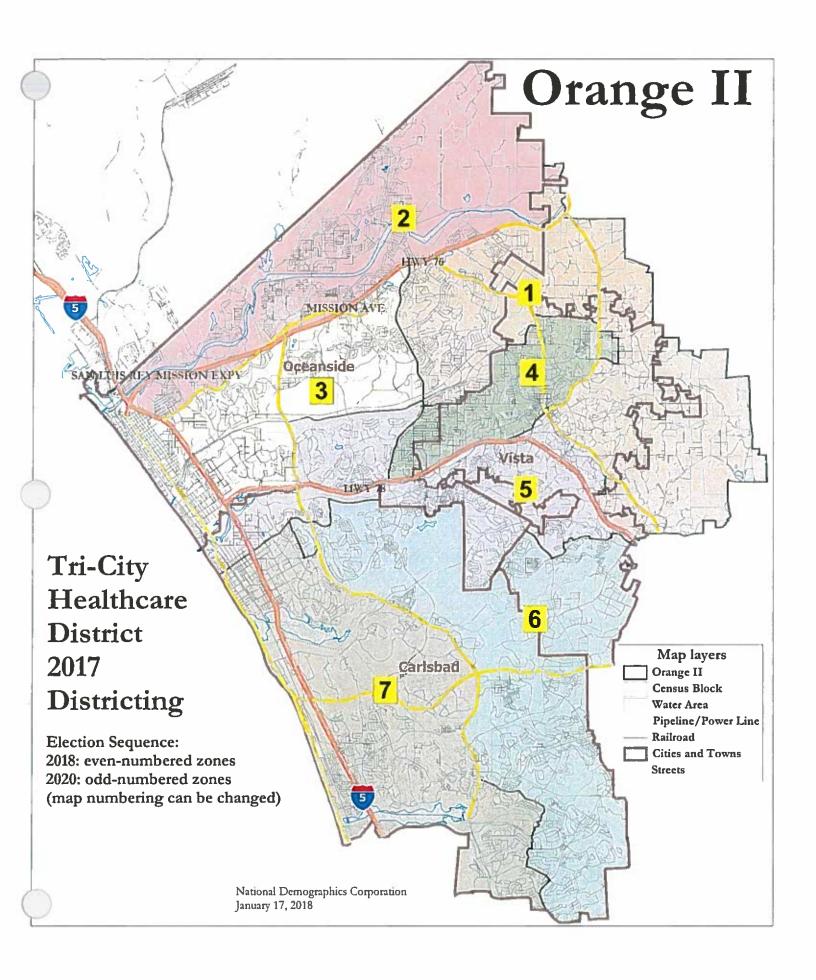
	Agenda Item	Time Allotted	Requestor
	q) Salmeterol inhale s) Tivicay t) Verapamil SR  F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 0 (No meeting held in April, 2018)  G. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes)  a) Approval of FY2018 Financial Statement Audit Proposal  b) Approval of Administrative Policies & Procedures: 1) Fraud Recognition Response #395 2) Hospital Issued Notice of Non-coverage of Medicare-Covered Services (HINN) #398 3) Important Message from Medicare & Notification of Hospital Discharge Appeal Rights - #392 4) Medical Directorships - #572 5) Monitoring Compliance - Auditing & Reporting - Annual Compliance Work Plan - #552 6) Monitoring Compliance Auditing & Reporting - Compliance Reviews and Audits - #553 (DELETE) 7) Physician & Allied Health Professional Service Contracts - #580 8) Sales of Items or Services to Physicians and Other Potential Referral Sources - #575		Audit, Comp. & Ethics Comm.
	<ul> <li>(2) Minutes – Approval of:</li> <li>a) Regular Board of Directors Meeting – March 29, 2018</li> <li>b) Special Board of Directors Meeting – March 22, 2018</li> <li>c) Special Board of Directors Meeting – March 27, 2018</li> <li>(3) Meetings and Conferences – None</li> <li>(4) Dues and Memberships - None</li> </ul>		Standard
22	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
23	Reports (Discussion by exception only)  (a) Dashboard  (b) Construction Report – Included  (c) Lease Report – (March, 2018)  (d) Reimbursement Disclosure Report – (March, 2018)  (e) Seminar/Conference Reports - None	0-5 min.	Standard
24	Legislative Update	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
25	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
26	Additional Comments by Chief Executive Officer	5 min.	Standard
27	Board Communications (three minutes per Board member)	18 min.	Standard
28	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2 hours/ 45 min.	
29	Oral Announcement of Items to be Discussed During Closed Session		<u> </u>
30	Motion to Return to Closed Session (if needed)		
31	Open Session		
32	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
33	Adjournment		









#### **RESOLUTION NO. 791**

RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING AND IMPLEMENTING ZONE-BASED ELECTIONS PURSUANT TO ELECTIONS CODE 10010(e)(3)(A)

WHEREAS, TRI-CITY HEALTHCARE DISTRICT (the "District") is a California healthcare district duly organized and existing under the laws of the State of California, particularly the Local Health Care District Law, constituting Division 23 of the Health and Safety Code of the State of California, and more particularly, Health and Safety Code §§ 32000 et seq.; and

WHEREAS, the governing board is currently composed of seven Directors who are voted into office by an "at-large" election method, meaning one in which the voters of the entire jurisdiction elect the members to the governing body; and

WHEREAS, on May 25, 2017, the District Board of Directors approved Resolution No. 785, 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); and

WHEREAS, as reflected in Resolution No. 785, the Board of Directors wishes to effectuate this transition from at-large to zone-based elections in order to ensure the District maintains an election method that does not impair the ability of any protected class to elect candidates of its choice or its ability to influence the outcome of an election, as a result of the dilution or the abridgement of the rights of voters who are members of a protected class, as defined by Elections Code section 14026; and

WHEREAS, as also reflected in Resolution No. 785, the San Diego Local Agency Formation Commission ("LAFCO") identified, as part of a five-year sphere of influence and service review report on San Diego County healthcare services published on May 4, 2015, certain areas for potential boundary changes that LAFCO recommended that the District annex into the District's boundaries including areas within Vista and Carlsbad which would, if annexed, increase the District's population by at least an estimated 60,000 residents aged 18 and over; and

WHEREAS, as also reflected in Resolution No. 785, the District Board of Directors found it is in the best interest of the District, in order to ensure the most effective expenditure of the District's resources and avoid a waste of public funds, to consider potential annexations as part of transitioning to the district-based election method; and

WHEREAS, on July 27, 2017, the District Board of Directors approved Resolution No. 787, Resolution of Application to San Diego Local Agency Formation Commission from the Board of Directors of Tri-City Healthcare District for the Annexation of Territory & Amendment of Tri-City Healthcare District's Sphere of Influence ("LAFCO Resolution of Application"), and

WHEREAS, the LAFCO Resolution of Application proposes a number of annexations and detachments to change TCHD's current boundaries to be generally more coterminous with the District's three cities' boundaries; and

WHEREAS, the District Board of Directors 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, believing 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; and

WHEREAS, in an abundance of caution, the District proceeded with drawing proposed maps for both scenarios — one contemplating the District's current boundaries, and one contemplating the District's projected boundaries after the reorganization is approved; that way, the District could assure the public that it will have zone-based elections for the November 2018 elections, irrespective of whether or not the LAFCO reorganization was finalized before the next election cycle; and

WHEREAS, on August 31, 2017, at a regular meeting of the Board of Directors, the District held a public hearing in accordance with Elections Code section 10010(a)(1) at which the public was invited to provide input regarding the composition of the Zones before any map or maps of proposed boundaries were drawn, and the Board of Directors considered and discussed the same; and

WHEREAS, on September 28, 2017, at a regular meeting of the Board of Directors, the District held a second public hearing in accordance with Elections Code section 10010(a)(1) at which the public was invited to provide input regarding the composition of the Zones before any map or maps of proposed boundaries were drawn, and the Board of Directors considered and discussed the same; and

WHEREAS, on October 19, 2017, the District first published and made available for the public four versions of draft maps (two for the District's current boundaries, two for the proposed new boundaries), all four of which divided the District into seven (7) single-member zones, and proposed corresponding sequences of elections; and

WHEREAS, on October 26, 2017, at a regular meeting of the Board of Directors, the District held the first of five public hearings at which the public was invited to provide input regarding the content of the draft maps and the proposed sequence of elections, and the Board of Directors considered and discussed the same; and

WHEREAS, on November 28, 2017, as a result of public input on the first four maps, the District published and made available two additional maps (one for the District's current boundaries, one for the proposed new boundaries), both of which divided the District into seven (7) single-member zones; and

WHEREAS, on November 29, 2017, at 5:00 p.m., at a special meeting of the Board of Directors, the District held the second of five duly noticed public hearings at the El Corazon Senior Center located at 302 Senior Center Drive, Oceanside, CA 92054, at which meeting the

public was invited to provide input regarding the content of the draft maps and the proposed sequence of elections, and the Board of Directors considered and discussed the same; and

WHEREAS, on November 29, 2017, at 7:00 p.m., at a special meeting of the Board of Directors, the District held the third of five duly noticed public hearings at the Carlsbad City Library located at 1775 Dove Lane, Carlsbad, CA 92001, at which meeting the public was invited to provide input regarding the content of the draft maps and the proposed sequence of elections, and the Board of Directors considered and discussed the same; and

WHEREAS, on November 30, 2017, at 5:30 p.m., at a special meeting of the Board of Directors, the District held the fourth of five duly noticed public hearings at the Morris B. Vance Community Room located at 200 Civic Center Drive, Vista, CA 92084, at which meeting the public was invited to provide input regarding the content of the draft maps and the proposed sequence of elections, and the Board of Directors considered and discussed the same; and

WHEREAS, on December 7, 2017, at 3:00 p.m., at a special meeting of the Board of Directors, the District held the fifth of five duly noticed public hearings at the District assembly room, at which meeting the public was invited to provide input regarding the content of the draft maps and the proposed sequence of elections, and the Board of Directors considered and discussed the same; and

WHEREAS, on March 5, 2018, LAFCO unanimously approved the District's LAFCO Resolution of Application for reorganization, which approval modifies the jurisdictional boundaries of the District; and

WHEREAS, on April 26, 2018, at 3:30 p.m., at a regular meeting of the Board of Directors, the District held a public hearing on the proposed establishment of Zones pursuant to Health and Safety Code section 32100.1, and at that hearing, any elector of the District was permitted to present his or her views and plans in relation to the proposed zoning; and also at that hearing, the Board selected one of the proposed draft maps previously published and made available for public comment and consumption for the new jurisdictional boundaries of the District, and determined a sequence of elections by assigning consecutive numbers to specific Zones; and

WHEREAS, the purpose of this Resolution is to enact, pursuant to Health and Safety Code section 32100.1 and Elections Code section 10010, a resolution providing for the division of the District into seven (7) zones as reflected in Exhibit A to this Resolution, and for the election of members of the Board of Directors by-zone in the seven single-member zones reflected in Exhibit A to this Resolution, in furtherance of the California Voting Rights Act of 2001 and in the best interests of the District; and

WHEREAS, in establishing these Zones, the Board of Directors intends to and does provide for representation in accordance with demographic, including population, and geographic factors of the entire area of the local hospital district in accordance with Health and Safety Code section 32100.1; and

WHEREAS, in determining the final sequence of the District elections, the District Board of Directors gives special consideration to the purposes of the California Voting Rights Act of

2001, and it takes into account the preferences expressed by members of the seven proposed zones; and

NOW, THEREFORE, this Board of Directors of Tri-City Healthcare District does hereby resolve:

- Section 1. The foregoing recitals are true and correct.
- Section 2. The Tri-City Healthcare District is hereby divided into seven (7) consecutively numbered Zones and the boundaries of the Zones are more particularly described in **Exhibit A**, which is attached hereto and incorporated by this reference. Exhibit A also shows the Zone numbers assigned to each Zone, from one (1) through seven (7).
- Section 3. At the November 2018 General Election, three members of the Tri-City Healthcare District Board of Directors shall be elected on a by-zone basis from the three even-numbered single-member Zones (specifically, Zones 2, 4, and 6, as such Zones may be amended), and every four years thereafter. At the General Election in November 2020, four members of the Tri-City Healthcare District Board of Directors shall be elected from the four odd-numbered single-member Zones (specifically, Zones 1, 3, 5, and 7, as such Zones may be amended), and every four years thereafter.
- Section 4. Upon implementation of this Resolution and beginning with the November 2018 General Election, the member of the Board of Directors elected to represent a Zone must be a resident of the zone from which he or she is elected for 30 days preceding the date of the election and must be a registered voter in that Zone, and any candidate for the Tri-City Board of Directors must reside in, and be a registered voter in, the Zone in which he or she seeks election at the time nomination papers are issued pursuant to Health and Safety Code section 32100.1 and Elections Code section 201.
- Section 5. Termination of residency in a Zone by a member of the Board of Directors shall create an immediate vacancy for that Zone unless a substitute residence with the Zone is established within thirty (30) days after the termination of residency.
- Section 6. Any vacancy upon the Board shall be filled by appointment by a majority of the remaining members of the Board of Directors consistent with Health and Safety Code section 32100.1. The person appointed to fill the vacancy must reside within the Zone left unrepresented on the Board of Directors. Any person appointed to fill the vacancy shall hold office for the duration of the unexpired term.
- Section 7. Notwithstanding any other provision of this Section, and consistent with the requirements of Government Code section 36512, the members of the Board of Directors in office at the time this Resolution takes effect shall continue in office until the expiration of the full term to which he or she was elected and until his or her successor is elected or appointed, and sworn in. At the end of the term each member of the Board of Directors, that Board Director's successor shall be elected on a by-zone basis in the Zones established in this Resolution.

- Section 8. The Tri-City Healthcare Board of Directors Board Secretary or designee shall maintain a map of the District showing the current boundaries and Zone numbers of each District Zone as may be established and amended from time to time by resolution of the Board of Directors.
- Section 9. If necessary to facilitate the implementation of this Resolution, the Chief Executive Officer is authorized to make technical adjustments to the District boundaries that do not substantively affect the populations in the Zones, the demographics in the Zones, eligibility of candidates, the residence of elected officials within any Zone, and that do not contradict the intent or terms of the California Voting Rights Act of 2001. The Chief Executive Officer shall consult with the Board Chair and the District General Counsel concerning any technical adjustments deemed necessary and shall advise the Board of Directors of any such adjustments required in the implementation of the Zones.
- Section 10. To the extent the terms and provisions of this Resolution may be inconsistent or in conflict with the terms or conditions of any prior District resolution, motion, rule, regulation, or bylaw governing the same subject, the terms of this Resolution shall prevail with respect to the subject matter thereof.
- Section 11. In interpreting this Resolution or resolving any ambiguity, this Resolution shall be interpreted in a manner that effectively accomplishes its stated purpose.
  - Section 12. This Resolution shall take effect immediately upon its adoption.

ADOPTED, PASSED AND APPROVED this 26th day of April, 2018, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

AYES:	
NOES:	
ABSTAIN/ABSENT:	
ATTEST: By:	By:Chairperson, Board of Directors
Secretary, Board of Directors	

#### **RESOLUTION NO. 792**

### A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT CHANGING THE MAILING ADDRESS FOR THE MAIN HOSPITAL PHARMACY

WHEREAS, TRI-CITY HEALTHCARE DISTRICT is a California healthcare district duly organized and existing under the laws of the State of California, particularly the Local Health Care District Law, constituting Division 23 of the Health and Safety Code of the State of California, and more particularly, Health and Safety Code§§ 32000 et seq.;

WHEREAS, Tri-City Healthcare District, a California local healthcare district, on behalf of Tri-City Medical Center currently operates an inpatient pharmacy in the basement of Tri-City Medical Center licensed under the name "Tri-City Hospital" and desires to open and operate an outpatient, retail pharmacy on the first floor of Tri-City Medical Center;

WHEREAS, the California State Board of Pharmacy (State Board) requires a completed Change of Permit Application, indicating a change of address for the main hospital pharmacy before the State Board can process Tri-City's application to license the outpatient retail pharmacy (License type & numbers: LSE 100104 and HPE 15524) on the main floor of Tri-City Medical Center;

#### NOW THEREFORE, BE IT RESOLVED:

The Tri-City Healthcare District Board of Directors authorizes the change in the mailing address for the Main Hospital Pharmacy to:

Tri-City Hospital, Main Pharmacy; 4002 Vista Way, Basement; Oceanside California, 92056

ADOPTED, PASSED AND APPROVED this 26th day of April, 2018, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

	AYES:	Directors:	
	NOES: ABSTAIN/ABSENT:	Directors:	
ATTEST:			James J. Dagostino Chairperson
Leigh A	nne Grass		



# TRI-CITY MEDICAL CENTER MEDICAL STAFF INITIAL CREDENTIALS REPORT April 11, 2018

Attachment A

#### INITIAL APPOINTMENTS (Effective Dates: 4/27/2018 - 3/31/2020)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 4/27/2018 through 3/31/2020:

- HENDERSON, Patrick MD/Teleradiology (StatRad)
- KHALILI. Michael MD/Teleradiology (StatRad)
- LEE. David MD/Teleradiology (StatRad)
- ROZENFELD, Michael MD/Teleradiology (StatRad)
- THOMAS, Steven MD/Perinatology (UCSD)
- WOELKERS, Douglas MD/Perinatology (UCSD)
- YUH, Theresa MD/Teleradiology (StatRad)



## TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3 April 11, 2018

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 April 30, 2018.

• EBRAHIMI ADIB. Tannaz MD OB/GYN

#### REOUEST FOR EXTENSION OF PROCTORING REOUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by October 31, 2018 would result in these privileges automatically relinquishing.

- PASHMFOROUSH, Mohammad MD Cardiology
- SHAHIDI-ASL, Mahnaz MD Pathology



# TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – 1 of 3 April 11, 2018

Attachment B

#### BIENNIAL REAPPOINTMENTS: (Effective Dates 5/01/2018 -4/30/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 05/01/2018 through 4/30/2020, 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:

- BAROUDI. Sam MD/Internal Medicine/Active
- BISHAY, Emad/Internal Medicine/Active
- BLOOM, Irving MD/Internal Medicine/Active
- CADMAN, Karen MD/Internal Medicine/Refer and Follow
- CLANCY, John DO/Internal Medicine/Refer and Follow
- DEVEREAUX, Christopher MD/Gastroenterology/Active
- DOAN, Lien MD/Radiology/Active Affiliate
- GOMEZ, Denise MD/Internal Medicine/Refer and Follow
- GOODING, Justin MD/Radiology/Active
- HANNA, Karen MD/General Surgery/Active
- HAWKINS, Melissa MD/Obstetrics & Gynecology/Active
- HONG, Raymond MD/Radiology/Active
- IYENGAR, Radha MD/Pediatrics/Active
- KROENER, John MD/General and Vascular Surgery/Active
- MADANI, Michael MD/Cardiothoracic Surgery/Provisional
- PINNELL, Sean MD/Radiology/Active
- PONEC, Donald MD/Radiology/Active
- THISTLETHWAITE, Patricia MD/Thoracic Surgery/Provisional



# TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – 1 of 3 April 11, 2018

Attachment B

- TRAN. Ouoc MD/Family Medicine/Active
- UHER, Romana MD/Neonatology/Active

#### **RESIGNATIONS:** (Effective date 4/30/2018 unless otherwise noted)

#### **Automatic Resignation**

PARKER, Sherine MD/Pediatrics

#### Voluntary:

- AFSHAR, Maryam MD/Dermatology
- HAAS, Gerald MD/Anesthesiology
- <u>IAFARI. Omid MD/Teleradiology</u>
- IONES. Pamela MD/Neurosurgery
- KRISHNA, Sheila MD/Dermatology
- RAO, Sanjay MD/Psychiatry
- SALTZ, Steven MD/Anesthesiology
- SMITH, Ryan A DO/Cardiology
- TRULLENDER, Brett MD/Emergency Medicine
- WANG, Iovce MD/Emergency Medicine



# TRI-CITY MEDICAL CENTER CREDENTIALS COMMITTEE REPORT – Part 3 of 3 April 11, 2018

Attachment C

### PROCTORING RECOMMENDATIONS (Effective 4/30/18, unless otherwise specified)

HOKE, Eileen MD

**Neonatology** 

<u>LEONARD. Lisa MD</u>
 Release from Proctoring:

OB/GYN



# TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT April 18, 2018

Attachment A

#### INITIAL APPOINTMENTS (Effective Dates: 4/27/2018 - 1/31/2020)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 4/27/2018 through 1/31/2020:

- FREEMAN, Wanda NP/Psychiatry
- LONGACRE, Brett NP/Psychiatry
- RENNE, Brittany AUD/Audiology



# TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3 April 18, 2018

Attachment B

ADDITIONAL PRIVILEGE REQUEST (Effective 04/30/2018, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

ALLEN, Matthew PA-C

Allied Health Professional

BUCKLEY. Alicia OT

**Allied Health Professional** 

#### REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by October 31, 2018 would result in these privileges automatically relinquishing.

KAUR, Manpreet PA-C

**Allied Health Professional** 



#### TRI-CITY MEDICAL CENTER

### INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT - 1 of 3 April 18, 2018

Attachment B

#### BIENNIAL REAPPRAISALS: (Effective Dates 5/1/2018 - 4/30/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 5/1/2018 through 4/30/2020, 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:

- BOHN, Sarah PhD/Allied Health Professional
- CARLTON, Vivian PA-C/Allied Health Professional
- GUTHRIE, Lesli AuD/Allied Health Professional
- LAFORTEZA, Jozelle NP/Allied Health Professional
- MCOUEEN, Paula CNM/Allied Health Professional
- TAYLOR. Phyllis NP/Allied Health Professional

#### **RESIGNATIONS:**

Automatic

• SHUFORD, SCOTT/Allied Health Professional



# TRI-CITY MEDICAL CENTER INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3 April 18, 2018

Attachment C

#### PROCTORING RECOMMENDATIONS (Effective 4/30/18, unless otherwise specified)

HUNT, Chris Teena AuD

**Allied Health Professional** 

## Tri-City Medical Center Allied Health Professional

Nurse Practitioner – Gastroenterology Standardized Procedures

Approvals			
Gastroenterology Division (Signatu	re):	4/1/8	
Medicine Department (Signature):	MASalopMO	4/10/18	
Interdisciplinary Practice Committe	e (Date):		<u></u>
Medical Executive Committee (Date	):		
Board of Directors (Date):			

#### NURSE PRACTITIONER STANDARDIZED PROCEDURES

#### TABLE OF CONTENTS

- I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
- II. Setting and Scope of NP Practice (Functions)
- III. Management of Controlled Substances by the NP
- IV. Supervision of the NP by Physician
- V. NP Qualifications Education and Licensing
- VI. Quality Improvement

#### I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

- 1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.
- 2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.
- Standardized procedures are maintained in the allied professional's file in the medical staff office.
  - a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
  - b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

#### II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

#### 1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

#### 2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Gastroenterology NP will:

- a) Assume responsibility for the *Gastroenterology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
  - i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP

responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

- b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
- c) Order medications as included in the Medicine Department Cerner Power Plans.
  - i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.
  - ii) The NP orders the medication and documents the information into the chart and in the clinical notes.
  - iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician cosignature.
- c) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
- d) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.
- e) Order and interpret specific laboratory studies for the patient as included in the Neurology Power Plans.
- f) Provide or ensure case management and coordination of treatment.
- g) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
- h) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.
- i) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
- j) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
- k) Formulate recommendations to improve mental health care and patient outcomes.
- I) Provide patient health education related to medications, psychiatric conditions and health issues.
- m) The PowerPlans for the Gastroenterology are as follows:
  - Gl Bleed

- GI Diverticulitis
- GI H pylori Eradication
- Gl Liver Diagnosis Workup
- GI Pancreatitis
- GI Post Endoscopy Inpatient
- GI Pre Endoscopy Inpatient
- GI Prophylaxis

#### III. MANAGEMENT OF CONTROLLED SUBSTANCES

- 1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.
- 2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
  - a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
    - i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
  - b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Medicine.

### IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

- Supervision for purposes of this standardized policy is defined as supervision by an MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
- 2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
- No physician shall provide concurrent supervision for more than four NPs.
- 4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
- 5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
  - a) Additional Supervision occurs as described below under "Quality Improvement."
- Supervisor notification and consultation is obtained under the following circumstances:

- a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
- b) Acute exacerbation of a patient's situation;
- c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
- d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
- e) Upon request of the patient, another clinician or Supervisor.
- f) Upon request of the NP.
- g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

#### V. QUALIFICATIONS - EDUCATION AND LICENSING

- 1. Education and training:
  - a) Master's degree in Nursing from an accredited college or university; AND
  - b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
- 2. Licenses and Certification:
  - a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse:
  - b) Currently certified by the State of California as a Nurse Practitioner;
  - c) Possession of a California State-issued medication Furnishing Number;
  - d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
  - e) BLS or ACLS in accordance with the specialty requirement.
  - f) CNOR Certification, if assisting in surgery.

#### VI. QUALITY IMPROVEMENT

- 1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
  - a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
  - b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
  - c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
  - d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
  - e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

2. The NP will maintain and upgrade clinical skills as required to meet professional standards.

a) Documentation of participation in relevant continuing education activities.

#### VII. Practice Prerogatives

1. As determined by the NP - Gastroenterology Privilege Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date

### Tri-City Medical Center **Delineation of Privileges**

NP - Gastroenterology

Request	Privilege	Action
		MSO Use Only
	Initial Criteria: The nurse practitioners must have the following: 1. Valid, California Registered Nurse license; 2. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner; 3. Successful completion of a Board of Registered Nursing approved Nurse Practitioner program; 4. Successful completion of the Family, Geriatric, or Adult nurse practitioner Credentialing Examination or equivalent national specialty certification; 5. Furnishing number from the State of California Board of Registered Nursing; 6. Valid, current DEA number and BRN approved 3 hour continuing education course	
	Proctoring: First ten (10) cases from this privilege card must be proctored.	
	The following privileges may be performed by the Nurse Practitioner at Tri-City Medical Center, including TCMC outpatient settings, in accordance with standardized procedures and protocols.	
_	Initiate admissions (Note: Patients may only be admitted on the order of a physician)	_
_	Perform history and physical examination	-
_	Make daily rounds with or without the physician	_
_	Manage and treat acute/episodic illnesses, trauma, chronic conditions, infectious disease contacts, routine gynecological problems, health promotion exams and order durable medical equipment	
_	Common nursing functions of health promotion	
_	General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)	
-	Order or transmit an order for lab, x-ray, or other studies as appropriate	_
_	Furnish medications following the Drugs and Devices protocol as described in the standardized procedures	
	Recommend therapeutic diets and exercise as indicated by disease process and patient condition	_
_	Refer to Specialty Clinics and appropriate health facilities, agencies, and resources in the community when indicated	
	Provide patient education and counseling appropriate to the disease process, patient condition, and procedure recommended	
	APPLICANT: I agree to exercise only those privileges specifically granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.	
	Print Applicant Name	
	Applicant Signature	

\*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

Printed on Thursday, April 05, 2018

### Tri-City Medical Center **Delineation of Privileges**

NP - Gastroenterology

	er Name:	1
est	Privilege	Acti
		MSD
		On
	SPONSORING PHYSICIAN:	
	As sponsoring physician of this Allied Health Professional, I have reviewed the requested privileges and agree they are appropriate to the capacity in which this Allied Health Professional will function. I further agree to be held responsible for his/her performance while providing services at Tri-City Medical Center	
	Print Name of Sponsoring Physician	
	Fillic Name of Sponsoring Physician	
	Sponsoring Physician Signature	
	Date	
	I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting	
	Information, and that the recommendations as noted below have been made with all pertinent factors considered.	
	Approval:	
	Division/Department Signature	
	Districtly department dignarate	

Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Neurology Standardized Procedures

<u>Approvals</u>
Neurology Division (Signature): 4/11/18  Medicine Department (Signature): 4/16/18  Medicine Department (Signature): 4/16/18
Interdisciplinary Practice Committee (Date):
Medical Executive Committee (Date):
Board of Directors (Date):

#### NURSE PRACTITIONER STANDARDIZED PROCEDURES

#### TABLE OF CONTENTS

- I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
- II. Setting and Scope of NP Practice (Functions)
- III. Management of Controlled Substances by the NP
- IV. Supervision of the NP by Physician
- V. NP Qualifications Education and Licensing
- VI. Quality Improvement

#### I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

- 1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.
- 2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.
- Standardized procedures are maintained in the allied professional's file in the medical staff office.
  - a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
  - b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

#### II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

#### 1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

#### 2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Neurology NP will:

- a) Assume responsibility for the *Neurology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
  - i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

- b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
- c) Order medications as included in the Medicine Department Cerner Power Plans.
  - i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.
  - ii) The NP orders the medication and documents the information into the chart and in the clinical notes.
  - iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician cosignature.
- c) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
- d) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.
- e) Order and interpret specific laboratory studies for the patient as included in the Neurology Power Plans.
- f) Provide or ensure case management and coordination of treatment.
- g) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
- h) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.
- i) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
- j) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
- k) Formulate recommendations to improve mental health care and patient outcomes.
- Provide patient health education related to medications, psychiatric conditions and health issues.
- m) The PowerPlans for the Neurology are as follows:
  - Neuro Heparin (Stroke)
  - Neuro Intrathecal Medication Trial
  - Neuro Post Operative Multi Phase

- Neuro Stroke Hemorrhagic
- Neuro Stroke Ischemic
- Neuro Ventriculostomy (ICP) Management
- Neuro Video EEG Monitoring

### III. MANAGEMENT OF CONTROLLED SUBSTANCES

- 1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.
- 2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
  - a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
    - This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
  - b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Medicine.

### IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

- Supervision for purposes of this standardized policy is defined as supervision by an MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
- 2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
- 3. No physician shall provide concurrent supervision for more than four NPs.
- 4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
- 5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
  - a) Additional Supervision occurs as described below under "Quality Improvement."
- 6. Supervisor notification and consultation is obtained under the following circumstances:
  - a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
  - b) Acute exacerbation of a patient's situation;
  - c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.

- d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
- e) Upon request of the patient, another clinician or Supervisor.
- f) Upon request of the NP.
- g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

### V. QUALIFICATIONS - EDUCATION AND LICENSING

- Education and training:
  - a) Master's degree in Nursing from an accredited college or university; AND
  - b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
- 2. Licenses and Certification:
  - a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse:
  - b) Currently certified by the State of California as a Nurse Practitioner;
  - c) Possession of a California State-issued medication Furnishing Number;
  - d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
  - e) BLS or ACLS in accordance with the specialty requirement.
  - f) CNOR Certification, if assisting in surgery.

#### VI. QUALITY IMPROVEMENT

- 1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
  - a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
  - b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
  - c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
  - d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
  - e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.
- 2. The NP will maintain and upgrade clinical skills as required to meet professional standards.
  - a) Documentation of participation in relevant continuing education activities.

### VII. Practice Prerogatives

1. As determined by the NP - Neurology Card.

### Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	

## Tri-City Medical Center **Delineation of Privileges**

NP - Neurology

Request	Privilege	Action
		MSO Use Only
	Initial Criteria:	
	The nurse practitioners must have the following:  1. Valid, California Registered Nurse license;	
	<ol> <li>Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner;</li> <li>Successful completion of a Board of Registered Nursing approved Nurse Practitioner program;</li> <li>Successful completion of the Family, Geriatric, or Adult nurse practitioner Credentialing Examination or equivalent national specialty certification;</li> <li>Furnishing number from the State of California Board of Registered Nursing;</li> </ol>	
	6. Valid, current DEA number and BRN approved 3 hour continuing education course	
	Proctoring: First ten (10) cases from this privilege card must be proctored.	
	The following privileges may be performed by the Nurse Practitioner at Tri-City Medical Center, including TCMC outpatient settings, in accordance with standardized procedures and protocols.	
_	Facilitate a comprehensive History and Physical exam on elective admissions.	
	Record and document daily on progress notes	-
	Diagnose and manage Primary Care conditions (e.g., vertigo, shingles, otitis media, chronic conditions, and health care maintenance)	
_	Evaluate and treat secondary care conditions (e.g., acute onset of seizures, unremitting headache with other neurological symptoms, TIAs) in conjunction with supervising physician	-
_	Evaluate Tertiary Care conditions (e.g., acute, life-threatening conditions such as CVA, status epilepticus, head trauma, Myasthenic crises, acute Guillain-Barre) with concomitant notification of and immediate management by a physician	797-361
	Trigger point injections	- 10/2
_	Epley's maneuver	12
_	Electromyogram (EMG)	<u>-</u> 
_	Occiptal nerve block	
_	Lumbar puncture	
_	Botox injections	
_	Vagal Nerve Stimulation (VNS) and baclofen pump programming	<u> </u>
_	Order, or transmit order for, and collect laboratory tests (e.g., CBC, chem panel, urinalysis, basic imaging studies, MRI, MRA, CAT scans, ESR, VDRL, thyroid studies, B12 levels, coagulation studies, EEG, BAER, VER, SSEP) as appropriate to Healthcare Management standardized procedures and protocols.	
_	Order or transmit order for diagnostic studies (e.g., EEG telemetry, MRI, spectroscopy, catheter angiography, and biopsies) in conjunction with the sponsoring physician.	_
<del></del>	Order or transmit order for therapy (e.g., occupational, speech-language pathology, and physical) and psychological counseling as part of a treatment plan implemented per Health Care Management standardized procedures and protocols.	_
	Order, or transmit order for, initiate, and discontinue medications.	

Printed on Wednesday, April 18, 2018

# Tri-City Medical Center **Delineation of Privileges**NP - Neurology

quest	Privilege	Action
		MSO Use Only
_	Order, or transmit order for, initiate, and discontinue medical devices.	
	APPLICANT: I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.	
	Print Applicant Name	
	Applicant Signature	
	Date	
	*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:	
	SPONSORING PHYSICIAN: As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center	
	Print Name of Sponsoring Physician	
	Sponsoring Physician Signature	
	Date	
	I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.	
	Approval:	
	Division/Department Signature	

Printed on Wednesday, April 18, 2018

## Tri-City Medical Center Allied Health Professional

Nurse Practitioner – Psychiatry Division/CSU Standardized Procedures

<u>Approvals</u> Psychiatry Division (Signature):	Bh.	3/28/18
Medicine Department (Signature):	· Mark D	J-2011 10. 4/10/18
Interdisciplinary Practice Committee (I	Date):	<u> </u>
Medical Executive Committee (Date):		
Board of Directors (Date):		

### NURSE PRACTITIONER STANDARDIZED PROCEDURES

### **TABLE OF CONTENTS**

- I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
- II. Setting and Scope of NP Practice (Functions)
- III. Management of Controlled Substances by the NP
- IV. Supervision of the NP by Physician
- V. NP Qualifications Education and Licensing
- VI. Quality Improvement

### I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

- 1. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.
- 2. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.
- 3. Standardized procedures are maintained in the allied professional's file in the medical staff office.
  - a) All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
  - b) Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

### II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

#### 1. SETTING

The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

### 2. SCOPE OF NP PRACTICE (FUNCTIONS)

The Psychiatry Division NP will:

- a) Assume responsibility for the *Psychiatry* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
  - i) Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

- b) Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
- c) Order medications as included in the Psychiatry division Cerner Power Plans.
  - i) The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.
  - ii) The NP orders the medication and documents the information into the chart and in the clinical notes.
  - iii) If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician cosignature.
- d) Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
- e) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.
- f) Order and interpret specific laboratory studies for the patient as included in the Psychiatry division Power Plans.
- g) Provide or ensure case management and coordination of treatment.
- h) Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
- Document in the patient's medical record, goals, interventions clinical outcomes and the
  effectiveness of medication in sufficient detail so that any Practitioner can review and
  evaluate the effectiveness of the care being provided.
- j) Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
- k) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
- Formulate recommendations to improve mental health care and patient outcomes.
- m) Provide patient health education related to medications, psychiatric conditions and health issues.
- n) The PowerPlans for the Psychiatry Division are as follows:
  - a) CSU Admit Orders by Psychiatry
  - b) Discharge CSU
  - c) ED CSU Emergency Medications

### III. MANAGEMENT OF CONTROLLED SUBSTANCES

- 1. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.
- 2. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
  - a) Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
    - i) This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
  - b) When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of Psychiatry.

### IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

- Supervision for purposes of this standardized policy is defined as supervision by and MD or DO
  for the performance of standardized procedure functions and for the furnishing or ordering of
  drugs by a NP pursuant to California (CA) Business & Professions Code.
- 2. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
- 3. No physician shall provide concurrent supervision for more than four NPs.
- 4. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
- 5. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
  - a) Additional Supervision occurs as described below under "Quality Improvement."
- 6. Supervisor notification and consultation is obtained under the following circumstances:
  - a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
  - b) Acute exacerbation of a patient's situation;
  - c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
  - d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
  - e) Upon request of the patient, another clinician or Supervisor.
  - f) Upon request of the NP.

g) The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

### V. QUALIFICATIONS - EDUCATION AND LICENSING

- Education and training:
  - a) Master's degree in Nursing from an accredited college or university; AND
  - b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
- 2. Licenses and Certification:
  - a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
  - b) Currently certified by the State of California as a Nurse Practitioner;
  - c) Possession of a California State-issued medication Furnishing Number;
  - d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
  - e) BLS or ACLS in accordance with the specialty requirement.
  - f) CNOR Certification if assisting in surgery.

### VI. QUALITY IMPROVEMENT

- 1. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
  - a) The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
  - b) The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
  - c) NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
  - d) The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
  - e) The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.
- The NP will maintain and upgrade clinical skills as required to meet professional standards.
  - a) Documentation of participation in relevant continuing education activities.

### VII. Practice Prerogatives

1. As determined by the NP - Psychiatry Division Card.

**Acknowledgement Statements:** 

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date

## Tri-City Medical Center **Delineation of Privileges**

NP - Psychlatry Division 04/12

Provi	ider	Na	me:

Request	Privilege	Action
		MSO Use Only

#### CRITERIA FOR OBTAINING PRIVILEGES:

The nurse practitioner must have the following:

- 1. Masters degree in Nursing from an accredited college or university;
- Completed an approved Adult, Child, or Family Nurse Practitioner program; OR completed an approved Master's level Psychiatric Mental Health Nurse Practitioner Program issued by an accredited college or university;
- 3. Valid California Registered Nurse (RN) license;
- 4. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner;
- 5. A Furnishing Number from the State of California Board of Registered Nursing;
- 6. A DEA number from the US Department of Justice, Drug Enforcement Agency that includes Schedule II through Schedule V.

Proctoring: Slx (6) cases

The following privileges may be performed by the Nurse Practitioner in accordance with standardized procedures and protocols under supervision of sponsoring physician:

**INPATIENT** - 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.

Perform a comprehensive psychiatric history and assessment.

Perform a comprehensive medical history and health assessment.

Assume principal responsibility for the psychlatric services required by the patient subject to TCMC medical staff supervision requirements.

Document in patient's chart (e.g. goals, interventions, clinical outcomes).

#### **MEDICATION MANAGEMENT**

Provide the initial medication assessment with the agreement and under the supervision of the psychiatrist.

Furnish and administer medications. Documented consult with Furnishing Supervisor and initiation of a patient-specific furnishing protocol required when furnishing outside of Parameters for the Use of Psychoactive Medications.

Document in patient's chart effectiveness of psychiatric medication.

### **GENERAL PRIVILEGES**

Order and interpret laboratory studies.

Oversee case management and coordination of treatment.

Make referrals as needed (e.g. primary care provider or for specialized consultation).

Provide patient health education.

#### APPLICANT:

I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

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## Tri-City Medical Center **Delineation of Privileges**

NP - Psychiatry Division 04/12

	er Name:	1 A -41
uest	Privilege	Action
		MSO Us Only
,		
	Applicant Signature	
	Date	
	*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:	
	SPONSORING PHYSICIAN: As sponsoring physician of this Ailied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center	
	Print Name of Sponsoring Physician	
	Sponsoring Physician Signature	
	Date	
	I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.	
	Approval:	
	Division/Department Signature	
	Date	

### Tri-City Medical Center **Delineation of Privileges** PA - Emergency Medicine 02.2018

Request	Privilege	Action
		MSO Use Only
	CRITERIA FOR OBTAINING PRIVILEGES:	
	PAS must:  1. be certified by the National Commission on Certification of Physician Assistants (NCCPA) or be board eligible and actively pursuing Board Certification as Physician Assistants through the NCCPA. Board certification is required within two (2) years of appointment and must be maintained at all times.  2. hold a current valid California PA license issued by the Physician Assistant Examination Committee of the State of California.	
_	GENERAL PATIENT CARE PRIVILEGES (Includes all privileges below through Assist Only	-
	Procedures) As part of General Patient Care Privileges, all physician assistants are authorized to:	
	<ol> <li>Perform occult blood testing</li> <li>Order x-ray, other studies, therapeutic diets, physical/rehab, occupational/speech, and respiratory therapies, and nursing services unless otherwise indicated.</li> </ol>	
	Initial:  PA may be authorized to perform these privileges when competency is established by the Department of Emergency Medicine, taking into account training and experience.	
	Proctoring: Twenty-five (25) cases of General Patient Care privileges.	
	Reappointment: Two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC) per two-year reappointment cycle.	
_	Take a focused or complete medical history, which will include the Medical Screening Exam, including past medical, family, social history, review of systems, and performing focused or complete physical exam.	-
_	Evaluation, emergency management and triage of neonatal, infants, pediatric, adolescents, adults, and geriatric patients.	_
_	Ordering and/or administration of medicine by all routes (orally, IM, IV, PR, aerosolized, inhaler, other) in the Department, and by prescription.	_
	ANESTHESIA CATEGORY (Choose from the procedures below):	
	Dental nerve block	
_	Nerve blocks	_
_	Subcutaneous local anesthetic	-
_	CARDIOVASCULAR CATEGORY (Choose from the procedures below):	-
	Taking of EKG and recognition of gross abnormalities	
	DERMATOLOGY CATEGORY (Choose from the procedures below):	
	Digital nail removal	
_	Subungual hematoma drainage	_
_	Treatment of minor 1st and 2nd degree burns	
	GASTROENTEROLOGY CATEGORY (Choose from the procedures below):	

Page 1

Printed on Wednesday, April 11, 2018

## Tri-City Medical Center **Delineation of Privileges**

PA - Emergency Medicine 02.2018

	Name:

Request	Privilege	Action
		MSO Use Only
_	Collection of specimen: stool	-
	Digital rectal exam	_
_	Hernia reduction	
_	Nasogastric intubtion and gastric lavage	_
_	Performance of anoscopy	_
	Removal of foreign bodies from rectum, and other	
_	Thrombosed external hemorrhoids	
	GENERAL SURGERY CATEGORY (Choose from the procedures below):	
_	Arrest of hemorrhage	2_3
_	Debridement, suture, and care of superficial wounds/lacerations (including facial lacerations)	
	Incision and Drainage of superficial skin infections, abscess, Bartholin's abscess	
_	Removal of foreign bodies from skin and soft tissue, and other	-
_	Removal of sutures	-
	Soft tissue aspiration	
	IMAGING CATEGORY (Choose from the procedures below)	
	Taking of EKG and recognition of gross abnormalities	
-	Preliminary interpretation of X-rays	_
	NEUROLOGY / NEUROSURGERY CATEGORY (Choose from the procedures below):	
_	Neurologic examination	<del></del> 2
_	Spinal immobilization	-
	ORTHOPEDIC CATEGORY (Choose from the procedures below):	
_	Dislocation management	
-	Emergency fracture management	1000
_	Measurement of compartment pressures	
_	Splinting/Casting	_
_	Strapping and immobilizing of sprains/fractures	_
	OBSTETRICS / GYNECOLOGY CATEGORY (Choose from the procedures below):	
_	Gyn exam	_
_	Removal of foreign bodies from vagina, and other	

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Printed on Wednesday, April 11, 2018

### Tri-City Medical Center **Delineation of Privileges** PA - Emergency Medicine 02.2018

Provide	er Name:
Request	Privilege
-	

		MSO Use Only
	Incision and drainage of Bartholin's abscess	
_	Performance of pelvic exam and pap smear	<u> </u>
	OPHTHALMOLOGY CATEGORY (Choose from the procedures below):	
_	Measure intraocular pressure (Tonometry)	<u></u>
	Ocular irrigation	<u> </u>
_	Ophthalmic, visualization of fundus	<u> </u>
_	Removal of foreign bodies from eyes, and other	<u></u> -
_	Slit lamp examination	12.0
	OTOLARYNGOLOGY CATEGORY (Choose from the procedures below):	
_	Removal of impacted cerumen	
_	Collection of specimens: nasopharyngeal and throat	<u> </u>
	Removal of foreign bodies from ear, nose, throat, other	_
	Nasal cautery	-
_	Anterior nasal packing for epistaxis	
	Performance of otoscopy and nasoscopy	
_	Peritonsillar abscess drainage	
	RESPIRATORY CATEGORY (Choose from the procedures below):	
_	Drawing ABGs and interpretation	<u></u>
	Bronchodilator treatment	-
_	BVM ventilation	
	UROLOGY CATEGORY (Choose from the procedures below)	
_	Catheterization and routine urinalysis	
_	Management of urinary retention	<u> </u>
	Suprapubic cystotomy placement	
	VASCULAR ACCESS CATEGORY (Choose from the procedures below)	
_	Arterial puncture	
	Drawing of venous blood from peripheral site and peripheral IV placement	<u>-,</u> 9
	ASSIST ONLY PRIVILEGES (Choose from the procedures below):	
_	Blood transfusion, assist	

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Printed on Wednesday, April 11, 2018

Action

### Tri-City Medical Center

## **Delineation of Privileges** PA - Emergency Medicine 02.2018

Request	Privilege	
		MSO Use Only
	Cardioversion/defibrillation, assist	<u> </u>
	Emergency childbirth, assist	_
_	Emergency C-section, assist	
	Open thoracotomy, assist	
	Pericardiocentesis, assist	_
	Performing CPR, assist	
_	Starting thrombolytic medication, assist	
	Surgical airway placement, assist	
	Transthoracic and transcutaneous pacing, assist	
	PROCEDURAL PRIVILEGES - PROCTORING REQUIRED: Initial: PA may be authorized to perform these procedures when competency is established by the Department of Emergency Medicine, taking into account training and experience. See additional privilege-specific criteria below.	
	Proctoring: Three (3) cases of <u>each</u> procedure; <u>with the exception of "thoracentesis and paracentesis" where any combination of three (3) cases is acceptable (i.e. three thoracentesis and no paracentesis or visa versa.</u> ). Thereafter, supervising physician must be physically present in the Emergency Department before the procedural privileges can be carried out.	
	Reappointment: Included in the above required two-hundred (200) typical General Patient Care cases (100 must be performed at TCMC)	
	Arterial line access	-
_	Arthrocentesis	100
	Central IV access, includes midline catheters Initial: Emergency Ultrasound privileges must be held by the PA in order to be eligible for Central IV access privileges in a non-"assist only" role.	1200
_	Endotracheal intubations	_
	Intraosseous line placement, in adults and infants/children	12
—	Lumbar puncture	_
	Reduction of major joints	_
	Repair of complex lacerations	250
_	Paracentesis Initial: Emergency Ultrasound privileges must be held by the PA in order to be eligible for Thoracentesis or Paracentesis privileges in a non-"assist only" role.	
	Thoracentesis and paracentesis Initial: Emergency Ultrasound privileges must be held by the PA in order to be eligible for Thoracentesis or Paracentesis privileges in a non-"assist only" role.	
_	Tube/needle thoracostomy	
	EMERGENCY ULTRASONOGRAPHY (Per Medical Staff Policy 8710-522)	

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Printed on Wednesday, April 11, 2018

### Tri-City Medical Center **Delineation of Privileges** PA - Emergency Medicine 02.2018

quest	Privilege	Action
		MSO Use Only
_	Limited abdominal ultrasonography	-
	Ultrasound guidance for approved procedures	_
_	Limited obstetrical ultrasonography	-
	APPLICANT: I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.	
	Print Applicant Name	
	Applicant Signature	
	Date	
	*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:	
	SPONSORING PHYSICIAN: As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center	
	Print Name of Sponsoring Physician	
	Sponsoring Physician Signature	
	Date	
	I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.	
	Approval:	
	Division/Department Signature	
	Date	

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Printed on Wednesday, April 11, 2018



## CONTINUING MEDICAL EDUCATION MISSION STATEMENT 2015-20162018-2019

Tri-City Medical Center's Healthcare District's purpose is to support, foster, and direct comprehensive, cost-effective, high quality patient care.

As an accredited provider of Continuing Medical Education (CME), we provide quality educational opportunities that increase clinical awareness of illness and disease among potentially high-risk populations and enhance the knowledge base and clinical competency of physicians affiliated with Tri-City Medical Center Healthcare District. At TCMCTCTD, we enable our physicians to practice more effectively and efficiently in our community.

The expected results of Tri-City Medical Center's Healthcare District's CME Program are improved physician performance and competence with the goal of producing better patient outcomes. A variety of outcomes assessments will may be used to collect and analyze data. Assessment tools include a post-knowledge assessment through evaluation as well as and may include follow up surveys as to specific changes in practice. In some activities, a pre-post assessment or patient outcome data may be utilized. The results of the findings from multiple methodologies will be used as an educational needs assessment for future CME activities and overall CME Program improvement.

The CME mission is congruent to the mission statement of Tri-City Medical Center Healthcare District in its commitment to promote an organization-wide commitment to quality of care, ongoing performance improvement, education, and the evaluation of outcomes that enhance our patient care.



# TRI-CITY MEDICAL CENTER HUMAN RESOURCES COMMITTEE OF THE BOARD OF DIRECTORS April 10, 2018

Voting Members Present: Chair Cyril Kellett, Director Rosemarie Reno, Director Leigh Anne Grass, Gwen Sanders, Joe Quince

Non-Voting Members Present: Steve Dietlin, CEO; Scott Livingstone, COO; Sharon Schultz, CNE; Esther Beverly, VP of HR; Susan Bond,

**General Council** 

Others Present: Director Laura Mitchell

Members Absent: Dr. Gene Ma; Dr. Hamid Movahhedian; Dr. Victor Souza; Carlos Cruz, COO

	Topic	Discussion	Action Follow-up	Person(s) Responsible
1.	Call To Order/Opening Remarks	Chair Kellett called the meeting to order at 12:32 p.m.		Chair Kellett
2.	Approval of Agenda	Chair Kellett called for a motion to approve the agenda of April 10, 2018. Director Reno moved to approve and Director Grass seconded the motion. The motion was carried unanimously.		Chair Kellett
3.	Public Comments – Announcement	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 October 10, 2017 meeting. Director Reno moved to approve and Director Grass seconded the motion. The motion was carried unanimously.		Chair Kellett
5.	Old Business	None		
6.	New Business			
	a. B.O.D Dashboard-	Informational review of HCAHPS Stakeholder		Chair Kellett

	Topic	Discussion	Action Follow-up	Person(s) Responsible
	"Stakeholder Experience"	Experience. Tri-City currently utilizes Press Ganey for HCAHPS, contract ending in June. Administration is reviewing companies and may switch back to National Research Health (NRC).		
b.	Consideration to appoint Gwen Sanders to a second term on the Employee Fiduciary Retirement Subcommittee	Chair Kellett called for a motion to approve Gwen Sanders to a second term on the Employee Fiduciary Retirement Subcommittee. Director Grass moved to approve and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
C.	Review HR Metrics- Quinn Abler, Director of Compensation and Benefits	Quinn Abler, Director of Compensation and Benefits presented the HR Metrics and reviewed employment year to date data and turnovers.		Esther Beverly
d.	Key Grievance/ER-LR Data	Esther Beverly, VP of HR presented the Employee Relations Grievances for 2017 Q2 and 2018 Q3 broken out by SEIU, CNA, and Fair Treatment and clarification of the grievance process.		Esther Beverly
e.	Review and Discussion of Administrative Policies			Esther Beverly
	403- Discrimination, Harassment & Retaliation Prevention Policy	The Committee reviewed Policy 8610-403. Director Reno called for a motion to send Policies 8610-403 to the Board of Directors for approval. Director Grass moved and Director Kellet seconded the motion. The motion was carried with majority vote, Gwen Sanders opposing.	Policy 8610-403 to be sent to Board of Directors for approval.	
	455- Confidentiality	The Committee reviewed Policy 8610-455. Director Reno called for a motion to send Policies 8610-455 to the Board of Directors for approval. Director Grass moved and Director Kellet seconded the motion. The motion was carried with majority vote, Gwen Sanders opposing.	Policy 8610-455 to be sent to Board of Directors for approval.	

Human Resources Committee 2 April 10, 2018

Торіс	Discussion	Action Follow-up	Person(s) Responsible
485- Hiring and Employment; Screening Current Employees	The Committee reviewed Policy 8610-485. Director Reno called for a motion to send Policies 8610-485 to the Board of Directors for approval. Director Grass moved and Director Kellet seconded the motion. The motion was carried with majority vote, Gwen Sanders opposing.	Policy 8610-485 to be reviewed by Susan Bond and sent to Board of Directors for approval if no changes.  Review policy changes vs. no-changes at next committee meeting under Old Business.	
7. Work Plan	The current 2018 Work Plan was reviewed and discussed.		Chair Kellett
8. Committee Communications	Director Reno gave a positive summary of Fiduciary Plan and discussion on California moving towards regulating all registration fees for hospitals.		Chair Kellett
9. Date of Next Meeting	July 10, 2018		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 12:59 p.m.		Chair Kellett



### Administrative Policy Human Resources

ISSUE DATE: 05/83

SUBJECT:

DISCRIMINATION, HARASSMENT

AND RETALIATION PREVENTION

**POLICY** 

REVISION DATE(S): 01/09, 04/12, 02/13, 12/13, 11/14

**POLICY NUMBER: 8610-403** 

Department Review:

Administrative Policies and Procedures Approval:

Human Resources Committee Approval:

Governance Council Committee Approval:

11/14

Board of Directors Approval:

11/14

### A. POLICY:

1. Equal Employment Opportunity

- a. Tri-City Healthcare District ("TCHD") is committed to equal employment opportunity and to compliance with federal antidiscrimination laws. We also comply with California law, which prohibits discrimination and harassment against employees, applicants for employment, individuals providing services in the workplace pursuant to a contract, unpaid interns and volunteers based on their actual or perceived: race, religious creed, color, national origin, ancestry, physical or mental disability, medical condition, genetic information, marital status (including registered domestic partnership status), sex and gender (including pregnancy, childbirth, lactation and related medical conditions), gender identity and gender expression (including transgender individuals who are transitioning, have transitioned, or are perceived to be transitioning to the gender with which they identify), age (40 and over), sexual orientation, Civil Air Patrol status, military personnel and veteran status and any other consideration protected by federal, state or local law (collectively referred to as "protected characteristics").
- b. For purposes of this policy, discrimination on the basis of "national origin" also includes discrimination against an individual because that person holds or presents the California driver's license issued to those who cannot document their lawful presence in the United States. An employee's or applicant for employment's immigration status will not be considered for any employment purpose except as necessary to comply with federal, state or local law. Our commitment to equal opportunity employment applies to all persons involved in our operations and prohibits unlawful discrimination and harassment by any employee, including supervisors and co-workers.
- c. TCHD will not tolerate discrimination or harassment based upon these protected characteristics or any other characteristic protected by applicable federal, state or local law. TCHD also does not retaliate or otherwise discriminate against applicants or employees who request a reasonable accommodation for reasons related to disability or religion.
- 2. Prohibited Harassment
  - a. TCHD is committed to providing a work environment that is free of illicit harassment based on any protected characteristics. As a result, TCHD maintains a strict policy prohibiting sexual harassment and harassment against employees, applicants for employment, individuals providing services in the workplace

pursuant to a contract, unpaid interns or volunteers based on any legally-recognized basis, including, but not limited to, their actual or perceived race, religious creed, color, national origin, ancestry, physical or mental disability, medical condition, genetic information, marital status (including registered domestic partnership status), sex and gender (including pregnancy, childbirth, lactation and related medical conditions), gender identity and gender expression (including transgender individuals who are transitioning, have transitioned, or are perceived to be transitioning to the gender with which they identify), age (40 or over), sexual orientation, Civil Air Patrol status, military and veteran status, immigration status or any other consideration protected by federal, state or local law. For purposes of this policy, discrimination on the basis of "national origin" also includes harassment against an individual because that person holds or presents the California driver's license issued to those who cannot document their lawful presence in the United States. All such harassment is prohibited.

- b. This policy applies to all persons involved in our operations, including coworkers, supervisors, managers, temporary or seasonal workers, agents, clients, vendors, customers, or any other third party interacting with TCHD ("third parties") and prohibits proscribed harassing conduct by any employee or third party of TCHD, including nonsupervisory employees, supervisors and managers. If such harassment occurs on TCHD's premises or is directed toward an employee or a third party interacting with TCHD, the procedures in this policy should be followed.
  - i. Sexual Harassment Defined
    - 1) Sexual harassment includes unwanted sexual advances, requests for sexual favors or visual, verbal or physical conduct of a sexual nature when:
      - Submission to such conduct is made a term or condition of employment; or
      - b) Submission to, or rejection of, such conduct is used as a basis for employment decisions affecting the individual; or
      - c) Such conduct has the purpose or effect of unreasonably interfering with an employee's work performance or creating an intimidating, hostile or offensive working environment.
    - 2) Sexual harassment also includes various forms of offensive behavior based on sex and includes gender-based harassment of a person of the same sex as the harasser. The following is a partial list:
      - a) Unwanted sexual advances.
      - Offering employment benefits in exchange for sexual favors.
      - c) Making or threatening reprisals after a negative response to sexual advances.
      - d) Visual conduct: leering; making sexual gestures; displaying sexually suggestive objects or pictures, cartoons, posters, websites, emails or text messages.
      - e) Verbal conduct: making or using derogatory comments, epithets, slurs, sexually explicit jokes, or comments about an employee's body or dress.
      - f) Verbal sexual advances or propositions.
      - g) Verbal abuse of a sexual nature; graphic verbal commentary about an individual's body; sexually degrading words to describe an individual; suggestive or obscene letters, notes or invitations.
      - h) Physical conduct: touching, assault, impeding or blocking movements.

- i) Retaliation for reporting harassment or threatening to report sexual harassment.
- 3) An employee may be liable for harassment based on sex even if the alleged harassing conduct was not motivated by sexual desire. An employee who engages in unlawful harassment will be personally liable for harassment even if TCHD had no knowledge of such conduct. TCHD cannot be liable for harassment complaints if it has not been brought to the attention of the employee's supervisor, Human Resources Department (HR) and/or the Compliance Department. Any harassing conduct must be reported through the appropriate channels. TCHD discourages dating in the workplace, but if employee(s) date, there can never-be any-acts-of-bias, preferential-treatment, and if the dating interferes with their job performance, they must terminate the dating relationship. If the dating results in a bad outcome, the alleged victim MUST-through proper channels. TCHD discourages romantic or sexual relationships between co-workers because such relationships tend to create compromising conflicts of interest or the appearance of such conflicts. In addition, such a relationship may give rise to the perception by others that there is favoritism or bias in employment decisions affecting the staff employee which is prohibited. If a relationship exist that creates harassment or a conflict of interest, it must be reported to the supervisor, HR or the Compliance Department.

### ii. Other Types of Harassment

- 1) Harassment on the basis of any legally protected characteristic, as identified above, is prohibited. Prohibited harassment may include behavior similar to the illustrations above pertaining to sexual harassment. This includes conduct such as:
  - Verbal conduct including threats, epithets, derogatory comments or slurs based on an individual's protected characteristic;
  - b) Visual conduct, including derogatory posters, photographs, cartoons, drawings or gestures based on protected characteristic; and
  - c) Physical conduct, including assault, unwanted touching or blocking normal movement because of an individual's protected characteristic.

#### 3. Abusive Conduct Prevention

- a. It is expected that TCHD and persons in the workplace perform their jobs productively as assigned, and in a manner that meets all of managements' expectations, during working times, and that they and refrain from any malicious, patently offensive or abusive conduct including but not limited to conduct that a reasonable person would find offensive based on any of the protected characteristics described above. Examples of abusive conduct include repeated infliction of verbal abuse, such as the use of malicious, derogatory remarks, insults, and epithets, verbal or physical conduct that a reasonable person would find threatening, intimidating, or humiliating, or the intentional sabotage or undermining of a person's work performance.
- 4. Protection against Retaliation
  - a. Retaliation is prohibited against any person by another employee or by TCHD for using TCHD's complaint procedure, reporting proscribed discrimination or harassment or filing, testifying, assisting or participating in any manner in any investigation, proceeding or hearing conducted by a governmental enforcement agency. Prohibited retaliation includes, but is not limited to, termination,

- demotion, suspension, failure to hire or consider for hire, failure to give equal consideration in making employment decisions, failure to make employment recommendations impartially, adversely affecting working conditions or otherwise denying any employment benefit.
- 5. Discrimination, Harassment, Retaliation and Abusive Conduct Complaint Procedure
  - Any employee who believes that he or she has been harassed, discriminated against, or subjected to retaliation or abusive conduct by a co-worker, supervisor, agent, client, vendor, customer, or any other third party interacting with TCHD in violation of the foregoing policies, or who is aware of such behavior against others, should immediately provide a written or verbal report to his or her supervisor, any other member of management, HR or the Compliance Department either directly, or through the Compliance Hotline. Employees are not required to make a complaint directly to their immediate supervisor, but they must report any conduct to the HR or Compliance Department. Supervisors and managers who receive complaints of misconduct must immediately report such complaints to the HR and/or the Compliance Department, who will attempt to resolve issues internally. When a report is received, TCHD will conduct a fair, timely, thorough and objective investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected. TCHD expects all employees to fully cooperate with any investigation conducted by TCHD into a complaint of proscribed harassment, discrimination or retaliation, or regarding the alleged violation of any other TCHD policies. TCHD will maintain confidentiality surrounding the investigation to the extent possible and to the extent permitted under applicable federal and state law.
  - b. Upon completion of the investigation, TCHD will communicate its conclusion as soon as practical. If TCHD determines that this policy has been violated, remedial action will be taken, commensurate with the severity of the offense, up to and including termination of employment. Appropriate action will also be taken to deter any such conduct in the future.
  - a. The federal Equal-Employment Opportunity Commission (EEOC) and the California-Department of Fair Employment and Housing (DFEH)-will-accept and investigate charges of unlawful discrimination-or-harassment at no charge to the complaining party. Information-may-be-located by visiting the agency website at www.eeoc.gov or www.dfeh.ca.gov.
  - c. All employees, regardless of their positions, are covered by and are expected to comply with this policy and to take appropriate measures to ensure that prohibited conduct does not occur. Appropriate disciplinary action will be taken against any employee who violates this policy. Based on the seriousness of the offense, disciplinary action may include verbal or written reprimand, suspension or termination of employment.
  - d. TCHD mandates that if any employee feels they are being harassed in any way, the employee must make a formal written complaint with HR and/or the Compliance Department. If an alleged victim does not report timely, TCHD cannot be held responsible for any alleged bad conduct. TCHD will courteously treat any person who invokes the complaint procedure, and will handle all complaints swiftly and confidentially to the extent possible in light of the need to take appropriate corrective action. Lodging a complaint will in no way be used against the employee or have an adverse impact on the individual's employment status. Because of the damaging nature of harassment to the victims and the alleged violator, and to the entire workforce, aggrieved employees are strongly urged to report immediately so that an immediate investigation can take place. However, filing groundless or malicious complaints is an abuse of this policy and will be treated as a violation. No formal action will be taken against any person under this policy unless HR and or the Compliance Department has received a written and

signed complaint containing sufficient details to determine if the policy may have been violated.

### B. <u>EXTERNAL LINK(S):</u>

- 1. Equal Employment Opportunity Commission <a href="https://www.eeoc.gov/">https://www.eeoc.gov/</a>
- 2. California Department of Fair Employment and Housing https://www.dfeh.ca.gov/

### C. REFERENCE(S):

- 1. California Fair Employment and Housing Act, FEHA §§ 12900 12996 (1959).
- Title VII of the Civil Rights Act, Pub L. §§ 88 352 (1964).

### A. PURPOSE:

1. — Tri-City Healthcare District (TCHD) is committed to providing a workplace free of harassment, based on race, religious creed (including religious dress and grooming practices), color, national origin, ancestry, physical disability, mental disability, medical condition (including-AIDS and/or HIV status), genetic information, military and veteran-status, marital status, sex, gender, gender identity, gender expression, age, sexual-orientation, pregnancy, childbirth, breastfeeding, and/or related medical conditions. These characteristics are defined as "protected classes." TCHD-will not-tolerate harassment of employees or non-employees by managers, supervisors, employees, co-workers, vendors, or third party providers.

### B. <u>DEFINITIONS OF SEXUAL HARRASSMENT:</u>

- QUID-Pro Quo Sexual Harassment:-Submission to unwelcome sexual advances or requests for sexual favors that are made a condition of employment or the receipt of employment opportunities (If you-do-this; I'll do that.).
- 2. Hostile Work Environment: Unwelcome verbal, physical, or visual conduct of a-sexual nature that—unreasonably interferes with an-individual's work performance or creates an intimidating, hostile, or offensive working environment.

### C. EXAMPLES OF SEXUAL HARRASSMENT:

- Unlawful harassment-includes any of the following:
  - the protected classes defined above, verbal sexual advances, repeated unwelcome sexual flirtations or propositions and requests for sexual favors. Additionally, continued or repeated comments of a sexual nature, graphic verbal commentaries about an individual's body, bullying, sexually degrading words used to describe an individual, or suggestive or obscene letters, notes, or invitations, also constitute verbal harassment.
  - b. Physical-Harassment: Includes conduct-such as unwanted touching, spanking, offensive or-abusive contact, assault, impeding or blocking movement, bullying, or physical interference-with normal work or movement.
  - c. Visual-Forms of Harassment: Include-derogatory posters, notices-bulletins, cartoons or drawings on the basis of any protected class. Leering, making sexual gestures, and displaying-sexually suggestive objects or pictures also constitute harassment (e.g. displaying on walls, cubicles, file cabinets and computer screens).
- Sexual harassment, as prohibited by law, is distinguished from a consensual-sexual relationship by the elements of coercion, threat, unwanted attention, unwelcome or unwanted sexual advances, requests for sexual favors, and other verbal, visual or physical conduct of sexual nature, without regard to the sex of the harasser and victim where either:
  - a. Submission to or rejection of such conduct is made either explicitly a term or condition of employment or participation in other TCHD activities; or
  - b. Submission to or rejection-of such conduct by an-individual is used-as a basis for evaluation-in-making personnel decisions affecting an individual; or
  - c. Such conduct unreasonably interferes with an individual's performance or creating an intimidating, bullying, hostile, or offensive work environment.
- 3. It is also unlawful and inappropriate for a patient to receive unwanted-sexual advances or to be

the subject of an intimidating, bullying, hostile or offensive patient care environment by a TCHD employee.

### D. POLICY:

- Every incidence of harassment will be investigated promptly, thoroughly, and in as confidential a manner as possible.
- 2. TCHD will not tolerate retaliation against any employee for cooperating in an investigation or reporting or making a complaint of harassment. Retaliation is an unwarranted, adverse action taken against an employee who reports misconduct. Retaliation may include, but is not limited to, changing the employee's work schedule without legitimate business justification, unwarranted negative performance review, disciplinary action taken against the employee without legitimate business reasons.
- If TCHD determines that an employee has engaged in harassment or retaliation, apprepriate
  disciplinary action will be taken. Disciplinary action for a violation of this policy can range from
  verbal or written warnings up to and including termination of employment.
- Medical Staff members are required to uphold federal and state laws prohibiting harassment.
   TCHD takes any complaints of violations of this policy by Medical Staff seriously. Violations of this policy regarding harassment are grounds for corrective action in accordance with the Medical Staff Bylaws and policies.

### PROCEDURE:

- Any incident of harassment whether directed to the employee or everseen or everheard by another employee should be reported promptly to the employee's supervisor or manager (or to any other member of management) or to a Human Resources representative. Managers who receive complaints or who observe harassing conduct must inform a Human Resources representative immediately. Documentation of the incident by the employee is encouraged.
- If the employee's supervisor is the individual who is harassing the employee, he/she may report
  the complaint to another manager or a Human-Resources representative.
- An employee will be advised when an investigation is completed and the results of that investigation.
- In addition to notifying TCHD about harassment or retaliation complaints, affected employees may also direct their complaints to the California Department of Fair Employment and Housing (DFEH), which has the authority to conduct investigations of the facts. The deadline for filing complaints with DFEH is one year from the date of the alleged unlawful conduct. If a matter before DFEH is not resolved through conference, consiliation, mediation or persuasion, DFEH may bring a civil action on behalf of the person claiming to be aggrieved. Employees can contact DFEH by referring to the information on TCHD's DFEH poster or by checking the state government listing in the local telephone directory.



### Administrative Policy-Manual Human Resources

**ISSUE DATE:** 

12/02

SUBJECT:

Confidentiality

**REVISION DATE:** 

02/03, 10/05, 10/08, 05/11

POLICY NUMBER: 8610-455

**Department Review:** 

12/17

**Administrative Policies & Procedures Committee Approval:** 

-n/a01/18

**Human Resources Committee Approval:** 

04/1504/18

**Board of Directors Approval:** 

04/15

### A. PURPOSE:

1. To ensure confidential patient and employee information is protected in accordance with Tri-City Healthcare District's (TCHD) legal and ethical responsibilities.

### B. SCOPE:

A.1. This policy applies to all of TCHD's Workforce Members to whom TCHD Confidential Information is disclosed and whose conduct in the performance of work for TCHD is under the direct control of TCHD or its employees, whether or not they are paid by TCHD.

### B.C. DEFINITION(S):

- 1. <u>Business Associate:</u> Non-employee relationships where a person or entity performs duties, functions or any other activity on behalf of TCHD, that will or may involve the access and use of any Confidential Information. This agreement will provide for protection of Confidential Information in accordance with State and Federal law.
- 4.2. Confidential Patient Information: Any information about a patient including medical treatment, medical condition, and diagnoses, any demographic information, collected from an individual that (a) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual and that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Confidential Patient Information includes patient identifiable information.
- 2-3. <u>Confidential Personnel Information</u>: Any information related to an employee, including social security number, home address, telephone numbers, emergency contacts, life insurance coverage and beneficiaries, benefits, salary or wages, resumes and applications for employment, reviews, warnings, and/or disciplinary action, and any other form or document found in an employee's personnel file.
- 3.4. <u>Confidential Employee Medical Information:</u> Any medical information relating to an employee including health insurance application form, life insurance application form, requests for medical leave, personal accident reports, worker's compensation reports, OSHA injury or illness reports, and any other form or document which contains private medical information related to a specific employee, and any other form or document found in an employee's personnel file.
- 4.5. TCHD Proprietary and Confidential Information: Information and physical material not generally known or available outside TCHD and information and physical material entrusted to TCHD in confidence by third parties. Examples includes, but are not limited to Confidential Patient Information, Confidential Employee Information, Confidential Employee Medical Information, TCHD's financial information, company competitive information, TCHD-developed intellectual property, business email messages, and information about TCHD's affiliates, vendors and suppliers.



- 5.6. <u>Confidential Information:</u> Confidential Patient Information, Confidential Personnel Information, Confidential Employee Medical Information, and TCHD Proprietary and Confidential Information shall be collectively referred to as "Confidential Information" for the purposes of this policy.
- 6-7. <u>Workforce Members:</u> Includes employees, non-employees (volunteers, contractors, students, and vendors), physicians (including residents and physician assistants), and physician's employees providing services at TCHD.

### G.D. POLICY:

- Workforce Member Responsibility: TCHD's Workforce Members shall be responsible for maintaining the confidentiality of all Confidential Information entrusted to it and for reporting known or suspected unauthorized use, access or disclosure of Confidential Information. Minimum responsibilities include:
  - a. Understanding and following policies and department specific procedures appropriate to individual role and responsibilities.;
  - b. Protecting information from unauthorized access, use, disclosure and transmission.;
  - c. Maintaining safeguards for protection of information.;
  - 4.d. Reporting and/or securing Confidential Information found unattended or unsecured.;
  - d.e. Reporting individuals who share passwords or who use other's passwords and/or access codes.
- 2. <u>Applicability</u> This policy applies to all of TCHD's Workforce Members to whom TCHD

  Confidential Information is disclosed and whose conduct in the performance of work for TCHD is under the direct-control of TCHD or its employees; whether or not they are paid by TCHD.
- 2-3. Confidentiality Statement: Access to TCHD's information systems and any Confidential Information is contingent upon execution of a Confidentiality Acknowledgement Agreement Form ("CAAF") upon hire, appointment or initiation of service. The CAAF, which may be amended at TCHD's discretion, is available on the shared drive and its terms are fully incorporated as if set forth separately herein.
- 3.4. Minimum Disclosures Necessary: When using, disclosing or requesting Confidential Information, reasonable efforts must be made to limit the amount of protected health information (PHI) disclosed to be the minimum amount of information necessary to accomplish the requestor's intended purpose. This restriction does not apply to disclosing medical records for treatment. This requirement will be incorporated into all policies and processes that are established for access, use and/or disclosure of Confidential Information.
- 4.5. Business Associate Agreements: A Business Associate Agreement is required in non-employee relationships where a person or entity performs duties, functions or any other activity on behalf of TCHD, that will or may involve the access and use of any Confidential Information. This agreement will provide for protection of Confidential Information in accordance with State and Federal law. The TCHD leader (for purposes of this policy, defined as manager or higher) that oversees the work of the Business Associate must ensure that a Business Associate Agreement has been executed.
- 5.6. Safeguarding of Information: Confidential Information collected, generated, and/or stored by TCHD shall be maintained in such a manner as to prevent its unauthorized disclosure. Disclosure of Confidential Information shall be restricted to those who possess a need to know those who have been authorized to know or as may be required by State and/or Federal Law.
- 2. Viewing-or-obtaining-information not needed for job-sompletion-(regardless-of-the medium of storage) constitutes unauthorized disclosure of that information and a violation of this policy. TCHD characterizes as unacceptable any activity-through-which-an-individual:
  - a. Allows-or-participates in-access; use or disclosure of Confidential Information not needed for his or her job;

  - c. Without authorization, deletes, shreds, destroys, alters, dismantles, disfigures; prevents rightful access to or otherwise interferes with the integrity of Confidential Information and/or information resources:

- Obtains-information outside of approved-channels without-obtaining documented authorization to access-such-information.
  - Accesses-one's own medical record in the electronic medical record. Use of the
    patient portal is the acceptable-way to review one's medical record; other-access
    is considered a-breach.
- d. The individual-may visit the Registration or Medical Records department to sign up-for the patient portal.
- 3. <u>Violation-of-Policy:</u> Violators of this Policy shall be subject to disciplinary action by TCHD and reporting to the Licensing Board up to, and including, loss of privileges and/or termination. Individuals who access, use or disclose Confidential Information without proper authorization, will be subject to disciplinary action by TCHD and may, under certain circumstances, incur personal liability in connection with such unauthorized conduct.
- 6.7. Prohibited Uses/Disclosures of Confidential Information:
  - a. Not Meeting Minimum Use Necessary Standard: Viewing or obtaining information not needed for job completion (regardless of the medium of storage) constitutes unauthorized disclosure of that information and a violation of this policy.
  - b. Examples of Prohibited Uses/Disclosures: TCHD characterizes as unacceptable any activity through which an individual:
    - Allows or participates in access, use or disclosure of Confidential Information not needed for his or her job.
    - ii. Removes Confidential Information, including medical records.
    - iii. Without authorization, deletes, shreds, destroys, alters, dismantles, disfigures, prevents rightful access to or otherwise interferes with the integrity of Confidential Information and/or information resources.
    - iv. Obtains information outside of approved channels without obtaining documented authorization to access such information.
    - v. Accesses one's own medical record in the electronic medical record. Use of the patient portal is the acceptable way to review one's medical record; other access is considered a breach.
      - 1) The individual may visit the Registration or Medical Records department to sign up for the patient portal.
    - vi. Discloses Confidential Information, regardless of intent, in any form, including verbal, written or electronic, to:
      - 1) Individuals not involved in the care or treatment of TCHD patients;
      - 2) Individuals who are involved or know the patient but have no need to know the information; or
    - vii. Discloses Confidential Information in a setting where that information could be overheard by individuals who have no need to know, for example in elevators, lobbies, waiting rooms, hallways, dining rooms, etc.
    - viii. Discloses Confidential Personnel and/or Employee Medical Information to any third party, whether or not a TCHD employee, who does not have a legitimate need to know such information.
      - A legitimate need to know such information may arise in connection with, and including but not limited to disciplinary actions to be taken against an employee, an employee's own emergency, and/or efforts to obtain treatment or care for an employee.
    - ix. Allows the use or disclosure of Confidential Information in a setting where information can be read or transferred from an unattended computer monitor or in violation with TCHD's Acceptable Use of Information and Computing Resources Policy is prohibited and constitutes a violation of this policy.
- 8. Termination of Employment: Individuals whose relationship with TCHD terminates (whether voluntarily or involuntarily) will continue to be obligated to maintain confidentiality as defined in this policy and as provided for in the CAAF. Individuals must surrender all of the following in

their custody or control no later than the last day of employment or other affiliation with TCHD:

- a. Access keys,
- b. Access codes, and
- 7.c. return any-Originals or copies of documents containing Confidential Information in their custody or control no later-than the last day of employment or other affiliation with TCHD.

### B. - RESPONSIBILITIES:

- 1. TCHD's Workforce Members shall be responsible for maintaining the confidentiality of all Confidential Information entrusted to it and for reporting known or suspected unauthorized use, access or disclosure of Confidential Information. Minimum responsibilities include:
  - Understanding-and following policies and department-specific procedures appropriate-toindividual-role-and responsibilities;
  - b. Protecting information from-unauthorized access, use, disclosure and transmission;
  - c. Maintaining safeguards for protection of information;
  - d. Reporting and/or-securing Confidential Information-found-unattended or unsecured;
  - e.——Reporting individuals who share passwords or who-use other's passwords and/or access codes.

### Department Supervisors shall:

- a. Determine appropriate levels-of-access to Confidential Information-for-all-of-TCHD's Workforce to ensure adequate performance of duties-while ensuring the minimum disclosures-necessary to achieve this objective.
- Establish safeguards to protect privacy and security of information.
- c. Evaluate the need for Business-Associate Agreements as appropriate.
- d. Know and follow procedures-to-report unauthorized disclosures of Confidential Information and other violations.
- e. -- Adhere to Human Resource policies for disciplinary action.
- f. Establish consistent procedures-for-appropriate disposal of documents or items containing Confidential Information.
- g. Periodic monitoring of compliance with TCHD policies pertaining-to-confidentiality, privacy-and-security.
- h. --- Provide on going education and training on privacy and security policies and procedures.
- i.a. Notify the appropriate departments of the termination of employment or relationship of any Workforce member.

### E. PROCESSPROCEDURE:

### 8-1. Supervisor Responsibility:

- a. Department Supervisors shall:
- b.a. Determine appropriate levels of access to Confidential Information for all of TCHD's Workforce to ensure adequate performance of duties while ensuring the minimum disclosures necessary to achieve this objective.
- e.b. Establish safeguards to protect privacy and security of information.
- d.c. Evaluate the need for Business Associate Agreements as appropriate.
- e.d. Know and follow procedures to report unauthorized disclosures of Confidential Information and other violations.
- f.e. Adhere to Human Resource policies for disciplinary action.
- g.f. Establish consistent procedures for appropriate disposal of documents or items containing Confidential Information.
- h.g. Periodic monitoring of compliance with TCHD policies pertaining to confidentiality, privacy and security.
- i.h. Provide on-going education and training on privacy and security policies and procedures.
- j-i. Notify the appropriate departments of the termination of employment or relationship of

any Workforce member.

- 9.2. Workforce Member Responsibility:
  - a. **Completion of CAAF:** Each member of TCHD's Workforce shall execute the CAAF as follows:
    - 10.i. Upon hire/credentialing/initiation of service (volunteers and contracted).
    - 44-ii. With each employee performance evaluation or credentialing renewal.
  - D-b. CAAF Document Retention: Executed CAAFs shall be maintained in files in either Human Resources Department or Medical Staff Services as appropriate.
    - 4.i. CAAFs for students shall be maintained in the Education Department.
    - 2-ii. CAAFs for volunteers shall be maintained in the Auxiliary Department.
  - b.c. Reporting of Suspected Violations: All members of TCHD's Workforce must report suspected violations of confidentiality through the existing compliance reporting channels:
    - e.i. Supervisor;
    - d-ii. Quality Review (QRR) Report;
    - e-iii. Patient Representative;
    - f.iv. TCHD Values Line;
    - 3.v. TCHD Privacy Officer; and/or
    - 4.vi. Human Resources
  - **Application of Standard Safeguards:** All members of TCHD's Workforce must apply standard safeguards to work processes, including:
    - 4-i. Limiting unauthorized persons from viewing, accessing or having access to Confidential Information whether in hard copy, electronic form or in any other format.
    - 2.ii. Limiting the display of patient names to first and last initials or first name and last initials on white boards used for patient tracking, in public view.
    - 3-iii. Limiting exposure of patient's name and other Confidential Information to public view.
    - 4.iv. Preventing Confidential Information from being left unattended in public areas.;
    - 5.v. Limiting viewing of computer screens containing patient identifiable information to the public.
    - 6.vi. Preventing disposal of documents or other items containing Confidential Information in the regular trash and disposing of such items in accordance with TCHD policy (i.e. shred or medical waste systems.)
    - 7.vii. Limiting discussions of Confidential Information to those necessary to the performance of one's duties or in order to provide patient care and ensuring that such discussions take place in private areas. Discussing any Confidential Information in public areas, hallways, elevators, cafeterias, restrooms etc. is strictly prohibited.
    - 8-viii. Maintaining strict confidentiality of passwords/access codes.
    - 9-ix. Establishing and/or maintaining the physical security of Confidential Information, utilizing access controls, and locking storage cabinets.
    - 40-x. Confidential Information may not be transmitted or removed from the premises, either physically or electronically, without authorization from Department Director/Designee.

### F. VIOLATIONS OF POLICY:

- C.1. Violators of this Policy shall be subject to disciplinary action by TCHD and reporting to the Licensing Board up to, and including, loss of privileges and/or termination. Individuals, who access, use or disclose Confidential Information without proper authorization, will be subject to disciplinary action by TCHD and may, under certain circumstances, incur personal liability in connection with such unauthorized conduct.
- F.G. FORM(S)-REFERENCED WHICH-CAN-BE LOCATED ON THE INTRANET:

1. Confidentiality Acknowledgement/Agreement Form

### G.H. RELATED POLICIES:

- 1. Administrative Policy: 237 Hospital Records Retention
- 2. Administrative Policy: 427 Fair Treatment for Supervisory and Management Employees
- 3. Administrative Policy: 428 Fair Treatment for Non-Management
- 4. Administrative Policy: 511 Business Associate Agreement
- 5. Administrative Policy: 513 Disclosure of Protected Health Information
- 6. Administrative Policy: 515 Use and Disclosure of Protected Health InformationPHI:—Patient Records
- 7. Administrative Policy: 518 Notice of Privacy Practices
- 8. Administrative Policy: 522 Faxing ef-Protected Health Information
- 9. Administrative Policy: 524 Disclosure of Information to Public and Media
- 10. Administrative Policy: 528 Accounting for Disclosures of Protected Health Information (PHI)
- 11. Administrative Policy: 602 Network Access
- Administrative Policy: 603 Internet Access
- 13. Administrative Policy: 604 Email Access
- 14. Administrative Policy: 609 Disciplinary Action for Breaches of Confidentiality-of-Restricted Electronic information
- 15. Code of Conduct

### H.I. REFERENCE(S):

- 1. 1974 Federal Privacy Act
- 2. California Code of Regulations, Title 22, Section 70707(b)(8)
- 3. California State Confidentiality of Medical Information Act (CMIA)
- 4. Health & Safety Code 199.20
- 5. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- 6. JCAHO Accreditation Manual Joint Commission

### Confidentiality Acknowledgement/Agreement Form

## TRI-CITY HEALTHCARE DISTRICT CONFIDENTIALITY ACKNOWLEDGEMENT & AGREEMENT FORM

	PRINT NAME:	
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ŀ	DEPARTMENT:	EXTENSIONPOSITION:

During the course of your activity at Tri-City Healthcare District (TCHD) and its affiliates, you may have access to information which is confidential and may not be disclosed except as permitted or required by law and in accord with TCHD's policies and procedures. In order for TCHD to properly care for patients and engage in successful business planning, certain information must remain confidential. Improper disclosure of confidential information can cause irreparable damage to TCHD. Confidential information includes, but is not limited to:

- 1. Medical and certain other personal information about patients.
- 2. Medical and certain other personal information about employees.
- Medical Staff records and committee proceedings.
- Personnel records and employee information.
- Work Place Investigations
- Reports, policies and procedures, marketing or financial information, and other
  information related to the business of services of TCHD and its affiliates which has not
  previously been released to the public at large by a duly authorized representative of
  TCHD.

If you have any questions at any time concerning the confidentiality or disclosure of information, you should contact the Values Line at 1-800-273-8452.

By reviewing each section and signing this Confidentiality Acknowledgment, I acknowledge and agree that:

- I will only access business information for which I have a legitimate business purpose. I will not disclose TCHD proprietary, operational, or employee information except when expressly authorized to do so by TCHD.
- 2. Medical Information is confidential and my access is restricted to my legitimate medical need to know for diagnosis, treatment and care of a particular patient.
- I am obligated to hold confidential information in the strictest confidence and not to disclose the information to any person or in any manner which is inconsistent with applicable policies and procedures of TCHD.
- 4. I will print information from any hospital information system only when necessary for a legitimate business purpose. I understand that patient medical information may only be stored in authorized locations such as the hard copy medical record jacket located in the Health Information Department. Exceptions may be incorporated into departmental policy when the exception is approved in writing by Tri-City Healthcare District's Director of Legal Services.



- I will shred or dispose of all patient or employee identifiable information in a designated locked, confidential disposal bin.
- 6. Patient medical information available from any hospital information system may not be in final form. Therefore, I will not release printed hard copy to third parties, including parents/guardians, but will refer them to the Medical Records/Health Information Department for assistance. Exceptions may be incorporated into departmental policy so long as the exception is approved in writing by Tri-City Healthcare District's Director of Legal Services. Third parties or employees requesting copies of personnel and employee records will be referred to Human Resources.
- My access and use of any hospital information system information is subject to routine, random, and undisclosed surveillance by the hospital.
- Failure to comply with my confidentiality obligation may result in disciplinary action or termination of my employment/educational affiliation by Tri-City Healthcare District and its affiliates, or corrective action in conformance with current medical staff bylaws, rules and regulations.
- 9. Impermissible disclosure of confidential information about a person may result in legal action being taken against me by or on behalf of that person.
- I understand that licensed health care providers are subject to sanctions for impermissible disclosure under numerous statutes and regulations including revocation, suspension, probation, public reprimand, and arrest.
- 11. If I am issued a unique password, it is my responsibility to maintain this code in a confidential manner. This password is my signature for accessing authorized on line computer systems. My password will ensure that the data for which I am responsible will not be available to anyone else; therefore, it is mandatory that my password and access data be kept strictly confidential.
- 12. My confidentiality obligation shall continue indefinitely, including at all times after my association with Tri-City Healthcare District and its affiliates, such as termination of my employment or affiliation with Tri-City Healthcare District and its affiliates.

I HAVE READ AND UNDERSTAND THIS CONFIDENTIALITY AGREEMENT, HAVE HAD MY QUESTIONS FULLY ADDRESSED, AND HAVE RECEIVED A COPY FOR MY PERMANENT PERSONAL RECORDS.

Employee Si	gnature	Date/Time	
Print Name	TO ADDITION A COMMO	_	



## TRI-CITY MEDICAL CENTER EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE OF THE BOARD OF DIRECTORS April 10, 2018

Voting Members Present: Chair Dr. Cyril Kellett, Director Rosemarie Reno, Gwen Sanders

Non-Voting Members Present: Steve Dietlin, CEO; Scott Livingstone, COO; Esther Beverly, VP of HR

**Others Present:** 

Members Absent: Director Leigh Anne Grass; Carlos Cruz, COO; Susan Bond, General Counsel

	Topic	Discussion	Action Follow-up	Person(s) Responsible
1.	Call To Order/Opening Remarks	Chair Kellett called the meeting to order at 11:04 a.m.		Chair Kellett
2.	Approval of Agenda	Chair Kellett called for a motion to approve the agenda of April 10, 2018. Director Reno moved to approve and Gwen Sanders seconded the motion. The motion was carried unanimously.		Chair Kellett
3.	Public Comments – Announcement	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 January 9, 2018 meeting. Director Reno moved to approve and Gwen Sanders seconded the motion. The motion was carried unanimously.		Chair Kellett
5.	Old Business	None		
6.	New Business		10 0000	
	a. Lincoln Quarterly Update	Maureen Peer, Lincoln Financial Advisor presented an executive summary including an annual review of		Esther Beverly

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Topic	Discussion	Action Follow-up	Person(s) Responsible
	2017 Lincoln Alliance program as of 12/31/2017. Discussion included an increase in Deferred Compensation Plan, Money Accumulation Pension Plan, National Security and Retirement Program, plan activity summary, plan asset trend and allocation, participation, deferral, account balance, fund utilization, and portfolio utilization.  Maureen introduced Michelle Wood, Lincoln Relationship Manager who will be taking over Tri- City's account for Maureen Peer.		
b. Prudent Quarterly Update	Dena Baker, Prudent Investment Advisor presented a 2017 end of the year review with discussions of 2017 surprises and lessons, controlling costs efforts, and increases in participation and contribution rates.  Scott Simon, Prudent Investor Advisor presented the Broad and Deep Diversification Portfolio and PIA Dimensions Portfolio.		Esther Beverly
7. Committee Communications	None		Chair Kellett
8. Date of Next Meeting	July 10, 2018		Chair Kellett
9. Adjournment	Chair Kellett adjourned the meeting at 12:04 p.m.		Chair Kellett

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MEMBERS PRESENT: Chair Julie Nygaard, Director Jim Dagostino, Director Laura Mitchell, Dr. Victor Souza, Bret Schanzenbach,

Carol Herrera, Dung M. Ngo, Gigi Gleason, Guy Roney, Linda Ledesma, Jan O'Reilly, Marilou de la Rosa

Hruby, Mary Donovan, Mary Lou Clift, Rick Robinson, Scott Ashton, Ted Owen

MEMBERS ABSENT: Barbara Perez, Danielle Pearson, Darren Brent, Jack Nelson, Mary Murphy, Roma Ferriter, Rosemary

Eshelman, Sandy Tucker, Xiomara Arroyo.

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; Scott Livingstone, COO; Audrey Lopez

NON-VOTING MEMBERS ABSENT: Susan Bond, Legal Counsel; Fernando Sanudo

OTHERS PRESENT: Brian Greenwald, Gwen Sanders, Diane Bagby, Mike Bagby, Karen Godfrey, Liz Kruidenier, Kathie

Chan

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The April 19, 2018 Community Healthcare Alliance Committee meeting was called to order at 12:31pm by Chair Julie Nygaard.		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Approval Of Meeting Agenda	Director Laura Mitchell motioned to approve the April 19, 2018 meeting agenda. The motion was seconded by Director Jim Dagostino and unanimously approved.		
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Gigi Gleason motioned to approve the March 15, 2018 CHAC meeting minutes. The motion was seconded by Director Jim Dagostino and unanimously approved.  Chair Julie Nygaard abstained from the vote.		
Presentation: Karen Godfrey NAMI — North Coastal San Diego County	<ul> <li>Karen Godfrey addressed the group about NAMI – North Coastal San Diego County, and the organization's work in the North County area. Karen introduced NAMI Board Members Michael and Diane Bagby, and President Emeritus, Liz Kruidenier. Karen presented the following:</li> <li>1. NAMI is dedicated to building better lives for people suffering from mental health issues, their families and friends.</li> <li>2. NAMI was established in 1979 and has grown into a national organization.</li> <li>3. NAMI relies on gifts, charitable giving and grants to fund their programs.</li> <li>4. NAMI annually provides education, support and advocacy to 100,000+ people and family members in the United States.</li> </ul>		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Karen Godfrey NAMI – North Coastal San Diego County (Cont)	NAMI supports the following services:  1. National support hotline. 2. Fundraising walks. 3. Family to Family: A 12-week program providing education and evidence-based help through support and shared experiences. 4. In Our Own Voice: A program where individuals living with mental illness are provided the opportunity to address the public and share their personal experiences with others. This program has been very effective in helping to erase the stigma associated with mental illness. 5. Peer to Peer: A 10 session program connecting those experiencing mental illness with others experiencing similar issues. 6. NAMI Connection Groups: Peer led for adults living with mental illness. 7. Interfaith Resource Network "Faith-Net".	ACTION FOLLOW UP	
	<ul> <li>8. Friends in the Lobby: This program is used at TCMC in the BHU. The program welcomes family and friends of patients in the BHU, answers questions, and generally helps them feel less anxious.</li> <li>Following this, Karen shared her personal story of her journey through mental illness and addiction.</li> <li>Karen noted that individuals can get involved with NAMI in the following ways:</li> <li>1. Become a member</li> <li>2. Donate</li> </ul>		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Karen Godfrey NAMI — North Coastal San Diego County (Cont)	<ul><li>3. Share your story</li><li>4. Attend a National Convention</li><li>5. Participate in the NAMI walks</li></ul>		
CEO Update Steve Dietlin	<ul> <li>Steve thanked Karen for her presentation, acknowledging that this issue is a crisis across the Nation.</li> <li>Some area residents are still being affected by the flu. San Diego experienced in excess of 20,000 reported cases of the flu.</li> <li>Campus redevelopment continues. RFP's are now out for Phase 2.</li> <li>Applications are currently being accepted for the Chief Government &amp; External Affairs Officer positon. It is anticipated that this position will be filled in the near future.</li> </ul>		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update Scott Livingstone	<ul> <li>Scott Livingstone, COO, addressed the committee as follows.</li> <li>TCMC's retail pharmacy construction is close to completion. TCMC is now pursuing licensing with the State.</li> <li>Many people have been addressing the issue of recycling. Scott noted that while San Diego as a whole is one of the worst areas for recycling, Encinitas and Oceanside are among the best. Scott noted that TCMC is currently looking at ways to make the hospital more proactive in this area.</li> <li>Scott also thanked Karen for her NAMI presentation, noting that concerns raised by meeting guests about the appearance of the Crisis Stabilization Unit, are being addressed within the guidelines and regulations governing the hospital.</li> </ul>		
Chief Of Staff Update Dr. Victor Souza MD	<ul> <li>Dr. Souza addressed the committee as follows:</li> <li>Dr. Souza spoke briefly about his recent medical assistance leave noting that he would like to encourage other TCMC physicians to get involved in these types of programs that help bring medical assistance to those in need.</li> <li>TCMC is leading the charge to find additional methods to minimize hospital stays, falls and infections.</li> </ul>		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Vacancies – Oceanside District	Chair Julie Nygaard introduced Kathie Chan, a candidate for the Oceanside District Resident opening.		
Resident	Kathie spoke briefly about her history and desire to serve on the committee.		
	Upon motion made by Director Dagostino, and seconded by Director Laura Mitchell, Kathie Chan was approved to serve as the Oceanside District Resident representative for the CHAC committee.		
	There were no objections to this appointment.		
Public Communications	No public communications.		
Committee Communications	Scott Ashton reported that the Oceanside Business Expo is being held on April 19 <sup>th</sup> , and the Chamber is looking forward to hosting a 76 <sup>th</sup> District Candidate Forum on May 2 <sup>nd</sup> .		
	Gigi Gleason noted that the Oceanside Boys & Girls Club has had yet another student success story with a member of their Club. Gigi also noted that Oceanside is being considered for a State designation as a Cultural & Arts Center. A presentation on this proposal will be held on May 5 <sup>th</sup> .		
	Carol Herrera noted that studies show that social and emotional problems are increasing in area schools.		

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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Communications (Cont)	Bret Schanzenbach thanked TCMC for sponsoring the recent successful Heroes of Vista event. Bret also noted that preparations are underway for the upcoming Vista Strawberry Festival on May 27 <sup>th</sup> .  Ted Owen reported that the Carlsbad Street Fair is happening the first Sunday in May. Ted also noted that a new, highly anticipated hotel has been approved to open in the Legoland area. Ted thanked Director Dagostino for his leadership while filling in as CHAC Chair during Julie Nygaard's vacation.  Director Dagostino stated that local schools should encourage their students to get involved in the Applicant Schools should encourage their students		
Next Meeting	to get involved in the Auxiliary Scholarship programs at TCMC.  The next CHAC meeting is scheduled for Thursday, May 17, 2018 at 12:30 pm.		
Adjournment	The April 19, 2018 CHAC meeting was adjourned at 1:52pm.		





## Tri-City Medical Center Finance, Operations and nning Committee Minutes April 17, 2018

Members Present Director Julie Nygaard, Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Dr. Gene Ma, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Wayne Lingenfelter

**Non-Voting Members** 

Present: Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingston, COO, Sharon Schultz, CNE, Susan Bond, General

Counsel

Others: Director Jim Dagostino, Director Laura Mitchell, Robert Knezek, Jeremy Raimo, Tom Moore, Jane

Dunmeyer, Glen Newhart, Charlene Carty, Cristina Barrera, Jack Cumming, Maria Carapia, Esther Beverly,

Kristy Larkin, Sarah Jayyousi, Sherry Miller, Candice Parras, Tara Eagle, Debra Feller, Chris Miechowski,

Barbara Hainsworth

Members Absent: Carlos Cruz, CCO

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Call to order	Director Nygaard called the meeting to order at 12:34 p.m.		
2. Approval of Agenda		MOTION It was moved by Director Kellett, Director Grass seconded, and it was unanimously approved to accept the agenda of April 17, 2018. Members: AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Lingenfelter NOES: None ABSTAIN: None	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard

	Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
4.	Ratification of minutes of March 20, 2018	Minutes were ratified.	Minutes were ratified.  MOTION It was moved by Director Kellett, Dr. Contardo seconded, that the minutes of March 20, 2018 are to be unanimously approved, with Director Grass abstaining from the vote.	
	Old Business			
6.	New Business			
	<ul> <li>a. New Community Member Interviews / Appointment</li> <li>Mr. Jack Cumming</li> <li>Mr. Robert Knezek</li> </ul>	Both community member applicants, Mr. Jack Cumming, Mr. Robert Knezek remained outside the assembly room, and were brought in individually for their respective interviews.  Each candidate was given an opportunity to present a brief opening statement regarding their resumes, and committee members were permitted to ask questions.  Upon conclusion of the interviews the candidates were asked to remain outside the assembly room while the vote was undertaken.  Mr. Jack Cumming was the candidate receiving the majority vote to become the incoming community member and he was subsequently informed of the voting results. He was then invited to join the meeting as a participating member.  As Mr. Knezek had departed following his interview, he would be receiving a letter conveying the outcome of the vote.		Chair

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
7. Consideration of Consent Calendar:		MOTION It was moved by Director Grass to approve the Consent Calendar, Dr. Contardo seconded the motion.  Members: AYES: Nygaard, Kellett,, Grass, Contardo, Yamanaka, Ferber, Lingenfelter, Cumming NOES: None ABSTAIN: Dr. Ma ABSENT: None	Chair
<ul> <li>a. Physician Agreement</li> <li>Proposal for Outpatient</li> <li>Behavioral Health –</li> <li>Evening Program</li> <li>Dennis Ordas, M.D.</li> </ul>		Approved via Consent Calendar	Sarah Jayyousi
<ul> <li>b. Blood Culture Bottle</li> <li>Consumables</li> <li>Becton, Dickinson &amp;</li> <li>Company</li> </ul>		Approved via Consent Calendar	Tara Eagle
c. Nurse Call System Replacement - ICU  West-Com & TV, Inc.		Approved via Consent Calendar	Chris Miechowski
d. Physician Agreement for ED On-Call Coverage – Gastroenterology, General & ERCP		Approved via Consent Calendar	Sherry Miller
e. Physician Agreement for ED On-Call Coverage - Orthopedics		Approved via Consent Calendar	Sherry Miller
f. Physician Agreement for ED On-Call Coverage - Urology		Approved via Consent Calendar	Sherry Miller
g. Physician Agreement for ED On-Call Coverage – OB/GYN		Approved via Consent Calendar	Sherry Miller

Topic	Discussions, Conclusi Recommendations		Action Recommendations/ Conclusions	rson(s) Responsible
<ul> <li>Lisa Leonard, M.D. &amp; Maria Quan, M.D.</li> </ul>				
h. Emergency Medicine				01 01 11
Coverage			Approved via Consent Calendar	Sharon Schultz
Team Physicians of				
Southern California				
Medical Group				
8. Financials:	Ray Rivas presented the finance	cials		Ray Rivas
**	ending March 31, 2018 (dollars			Tay Mas
	thousands)	, ,,,		
	TCHD - Financial Summary			
	Fiscal Year to Date			
		0,422		
	Operating Expense \$ 280			
		5,414		
		6,294)		
	TCMC - Key Indicators			
	Fiscal Year to Date			
	Avg. Daily Census	178		
		5,159		
	1 * *	1,837		
	I	1,746		
		3,450		
	TCHD - Financial Summary			
	Current Month	0.040		
		0,816		
		1,844		
	EBITDA \$	963		
	TCMC - Key Indicators	(337)		
	Current Month			
	Avg. Daily Census	186		
		0,278		
	Surgery Cases	548		
	Deliveries	186		
		5,171		

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	erson(s) Responsible
	TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year Net Patient A/R Avg. (in millions) \$ 45.6 Days in Net A/R Avg. 48.7 Graphs:  TCMC-Net Days in Patient Accounts Receivable TCMC-Average Daily Census, Total Hospital-Excluding Newborns TCMC-Adjusted Patient Days TCMC-Acute Average Length of Stay		
9. Work Plan:			
a. Construction Report (quarterly)	Chris Miechowski gave a brief overview of the construction report, and responded to a few questions. Minor discussion ensued.		Chris Miechowski
b. E.D. Throughput (quarterly)	Candice Parras gave a brief PowerPoint presentation detailing the continuing efforts to improve patient flow in the Emergency Department, and also outlined some of the enhancements made toward overall patient satisfaction:  • Waiting area/Triage announcements every 2 hours in both English & Spanish  • Keeping patients informed of any delays  • Implementation of the ED Travel Guide, which discloses potential procedure wait times, as well as		Candice Parras

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
	general guidelines in both English & Spanish Candice detailed the objective continues to be a reduction in the left without being seen (LWBS) patient population. The goal for 2018 is 3%, and YTD is currently 2.34%. She cited some of the measures being taken toward this goal are PA's providing medical screen exams (MSE) on all patients presenting to Triage from 8:00 am to 2:00 am, and beginning 5/1/18, MD triage hours will be extended to 2:00 am, as well. She also updated the "No Wall Time" project for paramedic patients. The goal continues to be getting those patients brought in by paramedics into a bed within 20 minutes, thus enabling the ambulance and staff to get back in the field.		
c. Medical Director - Surgery (semi-annual)	Debra Feller gave a comprehensive PowerPoint presentation detailing the following items:  Process Improvements Per-Operative Surgical Home (PSH)  Total Block Utilization by Month Robotic Block Utilization Robotic Block Volume Surgical Volume Overall: OR Activity Analysis-Total Cases — All Specialties Inpatient: OR Activity Analysis — Inpatients		Debra Feller

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	⊋rson(s) Responsible
	<ul> <li>Outpatients: OR Activity</li></ul>		
d. Dashboard	No discussion		Ray Rivas
10. Comments by committee members	Mr. Lingenfelter welcomed incoming community member, Mr. Jack Cumming to the Finance, Operations and Planning committee.		
11. Date of next meeting	Tuesday, May 22, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 1:35 p.m.		







Physician Agreement Proposal for Outpatient Behavioral Health - New Evening Program

Type of Agreement	х	Co-Medical Directors	Panel	l X	Other: Addition of 4 hours per week
Status of Agreement		New Agreement	Renewal – New Rates		Renewal – Same Rates

Physician Name: Dennis Ordas, M.D.

Area of Service: Outpatient Behavioral Health - New Evening Program

Term of Agreement: 26 months, Beginning, May 1, 2018 – Ending, June 30, 2020

**Maximum Totals:** 

<b>Hourly Cost</b>	Monthly Cost	Annual Cost	Total Term Cost
\$140	\$6,720	\$80,640	\$174,720
40 hours	\$500	\$6,000	\$13,000
48 hours	Vacation Coverage	Vacation Coverage	Vacation Coverage
Totals	\$ 7,220	\$86,640	\$187,720

This agreement increases hours from 32 to 48 per month for the startup of an Evening Program.

### cription of Services/Supplies:

- Additional 4 hours per week for evening program
- Provide professional guidance and oversight for the Outpatient Behavioral Health department, including,
   Intensive Outpatient Program, and start-up of an evening program.
- Provide supervision for the clinical operation of the department and programs.
- Provide patient and staff education and educate providers and community members on availability of efficacy of Intensive outpatient Program services.
- Respond to insurance authorization calls and complete reports requested by patients
- Facilitate weekly treatment team meetings and evaluate appropriateness for continued stay.

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:	Х	Yes		No
Budgeted Item:		Yes	Х	No

<sup>\*\*</sup>To be included in the proposed FY Budget

Person responsible for oversight of agreement: Sarah Jayyousi, Operations Manager, Outpatient Behavioral Health / Sharon Schultz, Chief Nurse Executive

ion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Dennis Ordas for the Co-Medical Directorship for a term of 26 months, beginning May 1, 2018 and ending June 30, 2020 for an hourly rate of \$140, an annual cost of \$86,640, and a total cost for the term of \$187,720.



## FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018 Blood Culture Bottle Consumables Proposal

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

Vendor's Name:

Becton, Dickinson and Company

Area of Service:

Laboratory

**Term of Agreement:** 

36 months, Beginning, May 1, 2018 - Ending, April 30, 2021

**Maximum Totals:** 

Monthly Cost	Annual Cost	Total Term Cost
\$7,525	\$90,300	\$ 270,900

### **Description of Services/Supplies:**

- Blood cultures are drawn on patients to diagnose bacteremia and septicemia, and are a core laboratory service.
- The BD bottles are part of our BD Bactec FX Blood Culture System and no other manufacturer's bottles are usable. Becton, Dickinson and Company supplies the bottles into which the blood is drawn.
- Pricing is negotiated per Vizient GPO, and is not further negotiable.
- Agreement renewal offers \$5,300 annual cost savings (\$15,900 cost savings over the 3-year agreement term).

Document Submitted to Legal for Review:	х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	Х	No
Budgeted Item:	х	Yes		No

<sup>\*\*</sup>To be included in the proposed FY Budget

Person responsible for oversight of agreement: Tara Eagle, Operations Manager, Clinical Laboratory / Scott Livingstone, Chief Operating Officer

### Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Becton, Dickinson and Company for Blood Culture Bottle Consumables for a term of 36 months, beginning May 1, 2018 and ending April 30, 2021 for an annual cost of \$90,300, and a total cost for the term of \$270,900.



## FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018 Nurse Call System Replacement - ICU

Type of Agreement		Medical Directors	Panel	х	Other: Replacement
Status of Agreement X	V	New Agreement	Renewal -		Renewal – Same
Status of Agreement	^	MEM WEIGEINEUR	New Rates		Rates

Vendor's Name:

West-Com & TV, Inc.

Area of Service:

Intensive Care Unit (ICU)

**Term of Agreement:** 

Completion of Work

### **Maximum Totals:**

Project Proposal:	Total Expected Cost:
West-Com & TV, Inc. (equipment & installation)	\$593,000
Design, Permits, Inspections, Construction Management, Contingency	\$242,463
Total Expected Project Cost	\$835,463

### **Description of Services/Supplies:**

- This request is to replace the existing nurse call system.
- There are no repair parts available for the existing nurse call system in the South Tower.
- The Nurse Managers interviewed the top 3 nurse call vendors and West-Com received the best score.
- We negotiated West-Com to the lowest price of the RFP.

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	Х	No
Budgeted Item:	Х	Yes		No

**Person responsible for oversight of agreement:** Chris Miechowski, Director of Facilities / Scott Livingstone, Chief Operating Officer

### Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize an agreement with West-Com & TV, Inc. for \$593,000 and the total project budget of \$835,463 for replacement of the nurse call system in the ICU.



### FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018

PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Gastroenterology - General & ERCP

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

Physician's Name:

Christopher Devereaux, M.D., Thomas Krol, M.D., Javaid Shad, M.D.,

Michael Shim, M.D., Matthew Viernes, M.D.

Area of Service:

Emergency Department On-Call: Gastroenterology – General & ERCP

**Term of Agreement:** 

12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

**Maximum Totals:** 

Within Hourly and/or Annualized Fair Market Value: YES

For entire Current ED On-Call Area of Service Coverage: Gastroenterology

Rate/Day	Panel Days per Year	Annual Panel Cost
GI -\$700 ERCP-\$500	365	\$255,500 \$182,500
	Total Term Cost:	\$438,000

### **Position Responsibilities:**

- Provide 24/7 patient coverage for all Gastroenterology 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 for Review:	х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:	х	Yes		No
Budgeted Item:	х	Yes		No

<sup>\*\*</sup>To be included in the proposed FY Budget

**Person responsible for oversight of agreement:** Sherry Miller, Manager, Medical Staff Services / Scott Livingstone, Chief Operating Officer

#### Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physicians Christopher Devereaux, M.D.; Thomas Krol, M.D.; Javaid Shad, M.D.; Michael Shim, M.D.; Matthew Viernes, M.D. as the Gastroenterology General & ERCP ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at a daily rate of \$700 for GI, for an annual cost of \$255,500, and ERCP at a daily rate of \$500 for an annual cost of \$182,500, and a total cost for the term of \$438,000.





## FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018 PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Orthopedics

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

Physician's Name:

David Amory, M.D.; Eric Stark, M.D.; David Daugherty, M.D.; Andrew Hartman,

M.D.; Harish Hosalkar, M.D.; Grant Seiden, M.D.

Area of Service:

**Emergency Department On-Call: Orthopedics** 

**Term of Agreement:** 

24 months, Beginning, July 1, 2018 - Ending, June 30, 2020

**Maximum Totals:** 

Within Hourly and/or Annualized Fair Market Value: YES

For entire Current ED On-Call Area of Service Coverage: Orthopedics

Rate/Day	Annual Panel Days	Annual Panel Cost	Panel Term Cost
Mon-Fri / \$1,500	253	\$379,500	¢762,000
Widii-Fii / \$1,500	255	382,500	\$762,000
Sat-Sun / TCMC Recognized	112	\$184,800	¢267.050
Holidays: \$1,650	111	\$367,950	
	Total Term Cos	\$1,129,950	

### **Position Responsibilities:**

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

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:	Х	Yes		No
Budgeted Item:	Х	Yes		No

<sup>\*\*</sup>To be included in the proposed FY Budget

**Person responsible for oversight of agreement:** Sherry Miller, Manager, Medical Staff Services / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Orthopedic physicians David Amory, M.D.; Eric Stark, M.D.; David Daugherty, M.D.; Andrew artman, M.D.; Harish Hosalkar, M.D.; Grant Seiden, M.D., as the Orthopedic ED-Call Coverage Physicians for a term of 24 months, beginning July 1, 2018 and ending June 30, 2020 at a daily rate of \$1,500 Monday-Friday and \$1,650 for Saturday-Sunday and TCMC recognized holidays that are not on the weekend, for a total cost of \$1,129,950.



## FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018 PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Urology

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

Physician's Name:

Caroline J. Vilchis, M.D., Bradley Frasier M.D., Michael Guerena, M.D., Jason

Phillips, M.D., Arthur Warshawsky, M.D. and Aaron Boonjindasup, M.D.

Area of Service:

Emergency Department On-Call: Urology

**Term of Agreement:** 

12 months, Beginning, July 1, 2018 - Ending, June 30, 2019

**Maximum Totals:** 

Within Hourly and/or Annualized Fair Market Value: YES

For entire Current ED On-Call Area of Service Coverage: Urology

Increase of \$250 Hourly rate; annual increase of \$91,250.

Rate/Day	Panel Days per Year	Panel Annual Cost
\$600	365	\$219,000
	Total:	\$219,000

### **Position Responsibilities:**

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

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:	Х	Yes		No
Budgeted Item:	Х	Yes		No

<sup>\*\*</sup>To be included in the proposed FY Budget

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize urology physicians Caroline J. Vilchis, M.D., Bradley Frasier, M.D., Michael Guerena, M.D., Jason Phillips, M.D., Arthur Warshawsky, M.D. and Aaron Boonjindasup, M.D. as the Urology ED-Call coverage hysicians for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at a daily rate of \$600, for an annual and term cost of \$219,000.





## FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018 PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

**Physician's Names:** 

Lisa Leonard, M.D.; Maria Quan, M.D.

Area of Service:

Emergency Department On-Call: OB/GYN

**Term of Agreement:** 

2 months, Beginning, May 1, 2018 - Ending, June 30, 2018

**Maximum Totals:** 

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

Adding new physicians to existing panel, no increase in expense

OB-GYN - Rate/Day	Panel Days per Year	Panel Annual Cost	Term Cost	
Man Eri / \$800	256	\$204,800	£407.200	
Mon-Fri / \$800	253	\$202,400	\$407,200	
Sat-Sun / TCMC Recognized	109	\$109,000	4224 222	
Holidays: \$1,000	112	\$112,000	\$221,000	
	Total Te	erm Cost:	\$628,200	

### **Position Responsibilities:**

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

Document Submitted to Legal Review:	Х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:	х	Yes		No
Budgeted Item:	х	Yes		No

**Person responsible for oversight of agreement:** Sherry Miller, Manager, Medical Staff Services / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Lisa Leonard, M.D. and Maria Quan, M.D. to the currently existing ED On-Call Coverage Panel for OB/GYN or a term of 2 months, beginning May 1, 2018 and ending June 30, 2018.





## FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: April 17, 2018 Emergency Medicine Coverage

Type of Agreement	Medical Directors	Panel		Other:
Status of Agreement	 New Agreement	Renewal – New Rates	IX:	Renewal – No Reimbursement

Vendor's Name:

Team Physicians of Southern California Medical Group

Area of Service:

**Emergency Department** 

Term of Agreement:

24 months, Beginning, June 1, 2018 - Ending, May 31, 2020

**Maximum Totals:** 

Monthly Cost	Annual Cost	Total Term Cost
N/A	N/A	N/A

### **Description of Services/Supplies:**

Provide 24/7 medical care, intervention and treatment to all who present to the ED

LWBS: 3% (median) (was 3.5%)

M.D. assigned to Decision to Admit: 160 Minutes (median)

• M.D. assigned to Discharge Order: 120 Minutes (median)

Patient satisfaction for "Doctors Overall": Goal 50% of Top Box Score

Document Submitted to Legal for Review:	Х	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:	Х	Yes		No
Budgeted Item:		Yes	N/A	No

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Team Physicians of Southern California Medical Group for Emergency Medicine Physician and Allied Health Coverage for a term of 24 months, beginning June 1, 2018 and ending May 31, 2020.



# Tri-City Medical Center Professional Affairs Committee Meeting Open Session Minutes April 12, 2018

Members Present: Director Leigh Anne Grass, Director Laura Mitchell, Director Larry Schallock, Dr. Contardo, Dr. Souza, Dr. Johnson and Dr. Ma.

Non-Voting Members Present: Steve Dietlin, CEO, Scott Livingstone, COO, Sharon Schultz, CNE/ Sr. VP, Susan Bond, general legal Counsel and Marcia Cavanaugh, Sr. Director for Risk Management.

Others Present: Oska Lawrence, Merebeth Richins, Candice Parras, Eva Froyd, Joy Melhado, Lisa Mattia, Patricia Guerra and Karren Hertz.

Members Absent: Carlos Cruz, Chief Compliance Officer.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:07 PM in Assembly Room 1.	100 100 100 100 100 100 100 100 100 100	Director Grass
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Schallock and seconded by Dr. Souza	Director Grass
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Grass read the paragraph regarding comments from members of the public.		Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of March 2018.	Director Grass called for a motion to approve the minutes from March 8, 2018.	Director Schallock approved and Dr. Souza seconded the motion to approve the minutes from March 2018.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures  Patient Care Services			
Abbreviations, Use of	There was a question on the use of abbereviation "qhs". Patricia Guerra will check and review into how this word is being used in CERNER.	ACTION: The Patient Care policies and procedures were approved. Dr. Souza moved and Director Schallock seconded the	Patricia Guerra
Automatic Stop Orders     Policy	Dr. Johnson made a small clarification on the automatic stop orders policy; it was noted that this policy provide the guidelines for discontinuing narcotics, antibiotics, chemotherapeutic agents and all other agents.	motion to approve the policies moving forward for Board approval.	
3. Continuous Ambulatory Peritoneal Dialysis Procedure – tracked changes Continuous Ambulatory Peritoneal Dialysis Procedure – clean copy	There was no discussion on this policy.		
Emergency Department     Standardized     Procedure	There was no discussion on this policy.		

	Торіс	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
5.	Fall Risk Procedure and Score Tool Procedure	There was no discussion on this policy.		
6.	Infusion Pump Syringe or PCA Module System with Guardrails Procedure	There was no discussion on this policy.		
7.	Infusion Pumps, Intravenous Therapy Policy	There was no discussion on this policy.		
8.	Point of Care Testing Competency Assessment Procedure	There was no discussion on this policy.		
9.	Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	It was noted that the power injection is still being in use mostly in IR in conjunction with a special PICC line.		
Admi	inistrative			
	Non-Beneficial Treatment 399	Director Schallock asked the committee if the situation of providing non-beneficial treatment happens frequently in the hospital. Currently, Tri-City still deals with this kind of scenario. Unrepresented seeks hospital treatment; some cases are brought out for discussion and review in the Bioethics Committee. And then, the Interdisciplinary areas meet to make sure that patient is discharged with a sustainable treatment plan.	ACTION: The Administrative policy was approved. Director Schallock moved and Director Mitchell seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific			
Behavioral Health Services			
AMA Discharges	There was no discussion on this policy.	ACTION: The Behavioral Health policies were approved. Director	Patricia Guerra
Managing the Medical     Record for ED visits	There was no discussion on this policy.	Mitchell moved and Dr. Souza seconded the motion to approve the policy moving forward for	
Notification of MediCal     Beneficiary of Denial of     Benefits	This policy is being pulled out as it needs further review and clarification.	Board approval.	
Notification of Responsible     Persons	There was no discussion on this policy.		
5. One to One Observation of Patients	There was no discussion on this policy.		
6. One to One Patient Supervision	There was no discussion on this policy.		
7. Orientation of New Patients	There was no discusson on this policy.		
	There was a brief discussion the volunteer chaplains. Since BHU is a special unit with a specific population, chaplains needs to be oriented thoroughly giving special attention to safety issues.		
9. Patient Belongings	There was no discussion on this policy.		
_ ,,	This policy addresses patients who want to leave the hospital without having completed their treatment.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
11. Patient Responsibilities	Joy stated that for the most part, BHU patients comply with the rules in the unit such as participating in groups and other activities requiring patient participation.		
12.Patient Satisfaction Surveys	There was no discussion on this policy.		
13. Psychiatric Advanced Directive	There was no discussion on this policy.		
14. Release of Information	There was no discussion on this policy.		
15. Role of Medical Staff Leadership in Behavioral Health Services	There was no discussion on this policy.		
16. Scabies Lice Fleas in the BHU	There was no discussion on this policy.		
17. Scope of Service - Behavioral Health Unit	There was no discussion on this policy.		
18. Smoking Guidelines for Behavioral Health Unit	There was no discussion on this policy.		
19. Solicitation of Patients/Referrals to Self	There was no discussion on this policy.		
20. Telephone Use	It was noted that there are no cell phones allowed in the Behavioral Health unit.		
21. Treatment of Patients	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
22. Unit Staff Meetings	The minutes for the staff meetings are distributed to the people who were not able to attend to make sure they are all aware of the changes and other important things pertaining to the department.		
23. Utilization Management	There was no discussion on this policy.		
24. Visiting in Behavioral Health Unit	Joy stated that BHU patients get mail and they do have the ability to write somebody if they want to.		
25. Vital Signs	There is no discussion on this policy.		
26. Washer Dryer Use	This poliy is being pulled out for futher review and clarification.		
Infection Control  1. Department Specific Infection Control Behavioral Health Services - IC 7	There is no discussion on this policy.	ACTION: The Infection Control policy was approved. Director Mitchell moved and Director Schallock seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Women & Newborn Services  1. Breast Milk, Pumping, Handling and Storage of  2. Formula Feeding Procedure  3. Infant Feedings – tracked changes	It was clarified to the committee that the hospital continues to participate in the	ACTION: The WNS policies were approved. Director Mitchell moved and Director Schallock seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Infant Feedings – clean copy  Formulary Requests	program to have exclusive breastfeeding for newborns. Currently, we are at 54.5 % percentile for infant feedings and in Path 2 Category for being baby-friendly hospital in the county.		
<ul> <li>Albuterol/Ipratropium inhaler</li> <li>Bupropion</li> <li>Combivir</li> <li>Darunavir</li> <li>Droperidol</li> <li>Exparel</li> <li>Fluticasone inhaler</li> <li>Fluticasone/Salmeterol inhaler</li> <li>Genvoya</li> <li>Ipratropium inhaler</li> <li>Lansoprazole solu-tabs</li> <li>Medium chain triglycerides</li> <li>Mepivacaine</li> <li>Nitroglycerin 0.3 mg and 0.6 mg sublingual tablets</li> <li>Nitroglycerin 0.4 mg spray</li> <li>Raltegravir</li> <li>Salmeterol inhale</li> <li>Tivicay</li> <li>Verapamil SR</li> </ul>	*It was noted that patients can bring in their Albuterol from home. In addition, the inhaler and nebulizer are placed in the patient's bedside because the RT/ RP are the ones taling care of these medications thus reducing the inventory for the Pharmacy.  *Droperidol manufacturer has no plans to resume production in the future.  *The drug Exparel is the medication that is given to Peri-op patients at the beginning of the case.  *Fluticasone is being changed to Symbicort while admitted as inpatient at the hospital since it does the same job.  *Oska had reported that there is a fair amount of HIV patients that come to the hospital so the drug Tivicay has been added to the formulary.	ACTION: The formulary rquests changes were approved. Director Mitchell moved and Director Schallock seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Schallock moved, Dr. Souza seconded and it was	Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		unanimously approved to go into closed session at 12:40 PM.	
8. Return to Open Session	The Committee return to Open Session at 1;45 PM.		Director Grass
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Grass
10. Comments from Members of the Committee	No comments.		Director Grass
11. Adjournment	Meeting adjourned at 1:48PM.		Director Grass

### PROFESSIONAL AFFAIRS COMMITTEE April 12<sup>th</sup>, 2018

**CONTACT: Sharon Schultz, CNE** 

		1. Sharon Schultz, GNE
Policies and Procedures	Reason	Recommendations
Patient Care Services		UUS ink
Abbreviations, Use of	3 Year Review	Forward To BOD For Approval
2. Automatic Stop Orders Policy	3 Year Review, Practice Change	Forward To BOD For Approval
<ol> <li>Continuous Ambulatory Peritoneal         Dialysis Procedure – tracked changes</li> <li>Continuous Ambulatory Peritoneal         Dialysis Procedure – clean copy</li> </ol>	3 Year Review, Practice Change	Forward To BOD For Approval
<ol><li>Emergency Department Standardized Procedure</li></ol>	Practice Change	Forward To BOD For Approval with Revisions
<ol><li>Fall Risk Procedure and Score Tool Procedure</li></ol>	Practice Change	Forward To BOD For Approval
7. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	3 Year Review	Forward To BOD For Approval
Infusion Pumps, Intravenous Therapy     Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Point of Care Testing Competency     Assessment Procedure	3 Year Review	Forward To BOD For Approval
10. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
\		
Administrative		
Non-Beneficial Treatment 399	NEW	Forward To BOD For Approval
11-14-0		
Unit Specific		
Behavioral Health Services		
1. AMA Discharges	DELETE	Forward To BOD For Approval
Managing the Medical Record for ED visits	3 Year Review, Practice Change	Forward To BOD For Approval
Notification of MediCal Beneficiary of Denial of Benefits	3 Year Review	Pulled for Further Review
4. Notification of Responsible Persons	3 Year Review, Practice Change	Forward To BOD For Approval
5. One to One Observation of Patients	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
6. One to One Patient Supervision	DELETE	Forward To BOD For Approval
7. Orientation of New Patients	3 Year Review, Practice Change	Forward To BOD For Approval
8. Pastoral Care	3 Year Review, Practice Change	Forward To BOD For Approval
9. Patient Belongings	3 Year Review, Practice Change	Forward To BOD For Approval
10. Patient Discharge Types	3 Year Review	Forward To BOD For Approval
1. Patient Responsibilities	3 Year Review	Forward To BOD For Approval
12. Patient Satisfaction Surveys	3 Year Review, Practice Change	Forward To BOD For Approval

### PROFESSIONAL AFFAIRS COMMITTEE April 12<sup>th</sup>, 2018

**CONTACT: Sharon Schultz, CNE** 

	CONTACT: Sharon Schultz, CNE		
Policies and Procedures	Reason	Recommendations	
13. Psychiatric Advanced Directive	3 Year Review	Forward To BOD For Approval	
14. Release of Information	3 Year Review	Forward To BOD For Approval	
<ol> <li>Role of Medical Staff Leadership in Behavioral Health Services</li> </ol>	3 Year Review, Practice	Forward To BOD For Approval	
	Change	Forward To BOD For Assessed	
16. Scabies Lice Fleas in the BHU	DELETE	Forward To BOD For Approval	
17. Scope of Service - Behavioral Health Unit	3 Year Review, Practice Change	Forward To BOD For Approval	
<ol> <li>Smoking Guidelines for Behavioral Health Unit</li> </ol>	3 Year Review, Practice Change	Forward To BOD For Approval	
19. Solicitation of Patients_Referrals to self	3 Year Review	Forward To BOD For Approval	
20. Telephone Use	3 Year Review	Forward To BOD For Approval	
21. Treatment of Patients	3 Year Review, Practice Change	Forward To BOD For Approval	
22. Unit Staff Meetings	3 Year Review, Practice Change	Forward To BOD For Approval	
23. Utilization Management	3 Year Review, Practice Change	Forward To BOD For Approval	
24. Visiting in Behavioral Health Unit	3 Year Review, Practice Change	Forward To BOD For Approval	
25. Vital Signs	3 Year Review, Practice Change	Forward To BOD For Approval	
∠6. Washer Dryer Use	3 Year Review, Practice Change	Pulled for Further Review	
Infection Control			
Department Specific Infection Control     Behavioral Health Services - IC 7	3 Year Review, Practice Change	Forward To BOD For Approval	
Women & Newborn Services			
Breast Milk, Pumping, Handling and     Storage of	DELETE	Forward To BOD For Approval	
Formula Feeding Procedure	DELETE	Forward To BOD For Approval	
Infant Feedings – tracked changes     Infant Feedings – clean copy	3 Year Review, Practice Change	Forward To BOD For Approval	
Formulary Requests			
Albuterol/Ipratropium inhaler	Modification to Formulary Status	Forward To BOD For Approval	
Bupropion	Remove from Formulary	Forward To BOD For Approval with Revisions	
Combivir	Remove from Formulary	Forward To BOD For Approval	
Darunavir	Addition to Formulary	Forward To BOD For Approval	
Droperidol	Remove from Formulary	Forward To BOD For Approval	
xparel	Modification to Formulary Status	Forward To BOD For Approval	
Fluticasone inhaler	Remove from Formulary	Forward To BOD For Approval	
Fluticasone/Salmeterol inhaler	Remove from Formulary	Forward To BOD For Approval	

### PROFESSIONAL AFFAIRS COMMITTEE April 12<sup>th</sup>, 2018

**CONTACT: Sharon Schultz, CNE** 

Policies and Procedures	Reason	Recommendations
Genvoya	Addition to Formulary	Forward To BOD For Approval
Ipratropium inhaler	Modification to Formulary Status	Forward To BOD For Approval
Lansoprazole solu-tabs	Remove from Formulary	Forward To BOD For Approval
Medium chain triglycerides	Remove from Formulary	Forward To BOD For Approval
Mepivacaine	Remove from Formulary	Forward To BOD For Approval
Nitroglycerin 0.3 mg and 0.6 mg sublingual tablets	Remove from Formulary	Forward To BOD For Approval
Nitroglycerin 0.4 mg spray	Remove from Formulary	Forward To BOD For Approval
Raltegravir	Remove from Formulary	Forward To BOD For Approval
Salmeterol inhale	Modification to Formulary Status	Forward To BOD For Approval
Tivicay	Addition to Formulary	Forward To BOD For Approval
Verapamil SR	Remove from Formulary	Forward To BOD For Approval

#### **PATIENT CARE SERVICES**

**ISSUE DATE:** 

03/97

SUBJECT: Use of Abbreviations, Use of

REVISION DATE: 5/02, 12/02, 5/03, 12/03, 3/04, 4/06,

08/06. 07/09

**Department Approval:** 

02/18

Clinical Policies & Procedures Committee Approval:

04/1503/18

**Nurse Executive Committee Approval:** 

04/1503/18

Pharmacy and Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

<del>05/15</del>03/18 06/1504/18

**Professional Affairs Committee Approval:** 

**Board of Directors Approval:** 

06/15

#### A. **PURPOSE:**

To provide optimal safety for patients and clear understanding of written medical communication by eliminating the use of potentially dangerous abbreviations and dose designations.

#### В. **POLICY:**

- Tri-City Medical Center (TCMC) has adopted the Neil-Davis Med Abbreviations (Neil-Davis-Med Abbreviations for abbreviations.
  - In addition, Pharmacy has adopted the Institute for Safe Medication Practices (ISMP)'s Error-Prone Abbreviations, Symbols, and Dose Designations for medication orders.
- 2. Abbreviations identified as "Do Not Use Abbreviations" by the Joint Commission are prohibited for use in all orders and medication-related documentation that is handwritten (including freetext computer entry) or on pre-printed orders.
- 3. Medication orders
  - If an unapproved abbreviation is used on a medication order or other written communication for patient care, the ordering physician shall be contacted by the nurse or pharmacist for clarification. The clarified order shall be documented in the medical record.
  - b. Medication orders containing unapproved abbreviations shall not be dispensed by pharmacy or administered by the nurse until clarified and the medication order re-
- 4. Changes to abbreviation references will be approved by the Pharmacy and Therapeutics Committee (P&T), the Medical Executive Committee and the Board of Directors.

#### C. RELATED DOCUMENTS:

- ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (20152013) 1.
- 2. Joint Commission "Do Not Use" List (20172014)

#### D. **EXTERNAL LINK(S):**

Neil-Davis Medical Abbreviation - MedAbbrev.com http://www.medabbrev.com/

#### **REFERENCES:** E.

The Joint Commission (June 20172014). Facts about the Official "Do Not Use" List. Retrieved from www.jointcommission.org on March 7th, 2018April 6, 2015. https://www.jointcommission.org/facts about do\_not use list/ http://www.jointco mmission.org/assets/1/18/Do-Not-Use List.pdf

## ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (2015<del>2013</del>)

Institute for Safe Medication Practices

# ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when commu-

nicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

Abbreviations	Intended Meaning	Hisioterpretation	Corresion
pp minimum	Microgram	Mistaken es "mg"	lise 'mcg"
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	lise "right ear," "left ear," or "each ear"
OD, OS, OU	Right eyè, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	like "right eye," "left eye," or "each eye
MARKET BT	Bedäme	Mistaken as "BID" (twice daily)	llse "hedtime"
cc	Cubic centimeters	Mistaken as "u" (units)	lise "ml"
DIC	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	Use "discharge" and "discontinue"
The Lates of the L	Injection	Mistaken as "IV" or "intrajugular"	Use "injection"
N N N N N N N N N N N N N N N N N N N	Intranasal	Mistaken as "IM" or "IV"	the "intrascal" or "NAS"
HS	Half-strength	Mistaken as bedtime	lke "half-strength" or "bedtime"
		Brat & K. K. a. all	STATE OF STA
ha	At hedtime, hours of sleep	Mistaken as half-strength	
- Alberta Company	International unit	Mistaken as IV (intravenous) or 10 (ten)	Use "units"
OD to Ja.o	Once delly	Mistaken as "right eye" (OD-oculus dexter), leading to craf liquid medications administered in the eye	Use "daily"
OJ	Orange juice	Nistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Ilse "etange juice"
Per es Per	By mouth, orally	The "os" can be mistaken as "left eye" (OS-oculus sinister)	Use "PO," "by mouth," or "orally"
q.d., or QD**	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i"	lise "daily"
THE REAL PROPERTY.	Highly at bedtime	Mistaken as "qhr" or every hour	lise "nightly"
to the second	Nightly or at bedtime	Mistaken as "qh" (every hour)	lize "nightly" or "at bedlime"
q.o.d. or QOD**	Every other day	Mistakea as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written	itse "every other day"
SECTION AND DESCRIPTION OF	Daily	Mistaken as q.i.d. (four times daily)	tise "daily"
g6PM, elc.	Every evening at 6 PM	Mistakea as every 6 hours	Use "daily at 6 PM" or "6 PM daily"
SC, SQ, sub q	Subcutzmenus	SC mistaken as St (sublingual); SO mistaken as "5 every;" the "q" in "sub q" has been mistaken as "every" (e.g., a heparin dose ordered "sub q 2 hours before surgery" missunderstood as every 2 hours before surgery and every 2 hours before surgery)	lise "subcut" or "subcutaneously"
s	Sliding scale (insulin) or 1/2 (apolhecary)	Mistaken as "55"	Spell out "sliding scale;" use "one-half"
SSRI	Sliding scale regular insulm	Mistaken as selective-serotonin reuptake inhibitor	Spell out "sliding scale (insulin)"
SSI	Sliding scale Insulio	Mistaken as Strong Solution of Iodine (Lugal's)	
SECTION CONTRACT	One daily	Mistaken as "tid"	lise "I daily"
TIW or liw	3 times a week	Mistaken as "3 times a day" or "twice in a week"	Use "I times weekly"
U ne m <sup>an</sup>	Bail	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 40 seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	lke "unit"
UD	As directed ("ut dictum")	Mistaken as unit dose (e.g., diltiazem 125 mg IV infusion "UD" misin- terpreted as meaning to give the entire infusion as a unit (bolus) dose)	lise "as directed"
Die e Designations and Other Information	Interaled Meaning	Desinterpretation	Derredien
Trailing zero after decimal point (e.g., 10 mg)**	l mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
"Haked" decimal point (e.g., 5 mg)"	0.5 mg	Mistaken as 5 mg if the decimal point is not seen Use zero before a deci doso is less than a who	
Abbreviations such as mg. or mL. with a period following the abbreviation	mg ml	The period is unnecessary and could be mistaken as the number 1 if written pourly	Use mg, mL, etc. without a terminal period

#### Institute for Safe Medication Practices

## ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (continued)

Dose Designations and Other Information	Intended Misming	Misinterpretation	Correction
Orno name and dese roo	I Indetal 40 mg	Mistaken as Inderal 140 mg	Place adequate space between the drog
logather (especially problematic for drug names that end in "!" such as Indom!40 mg; Tograto!300 mg)	Tegretal 300 mg	Mistaken as Tegrelol 1300 mg	name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 100 mL)	10 mg	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate space between the dose at unit of measure
Large doses without properly placed commes (e.g., 100000 miles; 1000000 enits)	1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 10000000 has been mistaken as 100,000	Use commax for doxing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability
Drug Name Abbreviations	Introded Meaning	Misicrespretation	(Apression
To avoid confusion, do not	t abbreviate drug names when co	mmunicating medical information. Examples of drug name abbrevial	tions involved in medication errors include:
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	Use complete drug name
AZT	zidovudine (Retrovir)	Mistaken as azathioprine or aztreonam	lise complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlororomazine	Lise complete drug name
DPT	Demerol-Phenergan-Thorazine	Mistaken as diphtheria-pertussis-telanus (vaccine)	Use complete drug name
DTO	Diluted lincture of opium, or deodorized lincture of opium (Paregoric)	Histaken as lincture of opium	Use complete drug name
HCI	kydrochleric acid or kydrochleride	Mistaken as polassium chloride (The "H" is misinterpreted as "K")	Use complete drug name unless expressed as a salt of a drug
HCT HOW	hydrocortisone	Mistaken as hydrochlorothiazide	Use complete drug name
HCTZ.	lrydrochlorothiazide	Mistaken as hydrocortisone (seen as HCT250 mg)	Use complete drug name
MgS04**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MS04**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methorexale	Mistaken as mitoxantrone	Use complete drug name
HeAC	novel/new oral anticoagulant	No anticoagulant	tise complete drug name
PEA	proceinamide	Mistaken as patient controlled analyssia	Use complete drug name
PTU	propylhicoracil	Mistaken as mercaptopurine	Use complete drug name
T	Tylenol with codeine No. 3	Mistaken as fothyronine	Use complete drug name
TAC	Irlam cinclone	Mistaken as tetracaine, Adrenalin, cocaine	Use complete drug name
TNK	THKese	Mistaken as "TPA"	Use complete drug name
TPA or tPA	tissue plusminagen activator, Activase (alteplase)	Mistaken as TNKese (tenecteplese), or less often as another tissue plasminogen activator, Relavase (retoplase)	Use complete drug names
ZnSO4	zinc sullale	Mistaken as morphine sulfate	Use complete drug name
Stennoed Doug Names	late tated Meaning	Misinformatation	(Laggarious)
"Nitro" drip	nitroglyceria infusion	Histaken as sodium nitroprusside infusion	Use complete drug name
"Norflex"	notfloxacin	Mistaken as Horflex	Use complete drug name
"IV Vanc"	intravenous vancomycip	Mistaken as Invanz	Use complete drug game
Syrrants	intended Montring	Measterpretation	Correstion
3	Dram	Symbol for dram mistaken as "3"	Use the metric system
my	Minim	Sumbal for minimum intolory on fig.10	
x3d	For three days	Symbol for minim mistaken as "m2" Mistaken as "3 doses"	Use "for three days"
> 831 <	More than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "more than" or "less than"
/ (slash mark)	Separates two doses or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" misread as "25 units and 110" units)	Use "per" rather than a slash mark to separate doses
@	Al and the second	Mistaken as "2"	Use "al"
8	And	Histaken as "?"	Use "and"
	Pies or and	Histaken as "4"	Ike 'and'
•	Hour	Mistaken as a zero (e.g., q2° seen as q 20)	Use "lu," "li," or "hour"
COMPONED INCOME	CONTRACTOR OF THE PARTY OF THE		Use C or zero,
Фига	Zero, null sign	Mistaken as numerals 4, 6, 0, and 9	or describe intent using whole words

<sup>\*\*</sup>These abbreviations are included on The Joint Commission's "minimum list" of dangerous abbreviations, according, and symbols that must be included on an organization's "Do Not Use" list, effective Jacuary 1, 2004. Visit provided commission requirement.

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# ISMP's List of *Error-Prone Abbreviations*, *Symbols*, and *Dose Designations*

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when commu-

nicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

Abbreviations	Intended Meaning	Missinfer predation		Contertion
Maria Maria	Alicrogram	Mistaken as "mg"	Use "moj"	
AD, AS, AU	Right ear, left ear, each ear	Mislaken as OD, OS, OU (right eye, left eye, each eye)	Use "right o	ear," "left ear," or "each ear
QD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use "right"	ye," "left eye," or "each eye
BT	Bedtime	Mistaken as "BID" (twice daily)	Use "bedime"	
CC	Cubic centimeters	Mistaken as "u" (units)	lke "ml"	The second second
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	lka "discha	rge" and "discontinue"
N STATE	Injection	Mistaken as "IV" or "intrajugular"	lke "injecti	un"
MARCON IN LOCAL DE	Intranasal	Mistaken as "IM" or "IV"	lise 'intran	esal" or "HAS"
HS	Half-strength	Mistaken as bedtime	Use Thatf-si	rength" or "bedlime"
	As I. Mar. I am at all as	Mission of Kanasak	<b>100</b>	Line Park
ha	At bedtime, hours of sleep	Mistaken as half strength	Part of the second	Mark Commence
10**	International unit	Mistaken as FV (intravenous) or 10 (ten)	Use "units"	AND THE PARTY OF
O.d. or OD	Once daily	Mictalon et "right eur" (NR neules derter), leading to mel liquid	lke dale	75636363
0.1	8 0			ulce"
		DELETE		STREET STREET, STREET
Per es		DELETE	/ mouth," or "orally"	
a.d. or OD**				
	AND PRODUCED VIOLATION AND IN	the 'q' is mismonstanou as an 'T'	vortices high	
qhs qhs	Nightly at bedtime	Mistaken as "qhr" or every hour	Use "nightly	
deste p Aces	Niglaly or at bedtime	Mistaken as "qh" (every hour)	Use "nightly	" or "at bedtime"
q.a.d. or QOD**	Every other day	Mistaken as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written	Use "every other day"	
q1d	Daily	Mistaken as q.l.d. (four times daily)	Use "daily"	
qGPM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use "daily at 6 PM" or "6 PM daily"	
SC, SQ, sub q	Subcutaneous	SC mistaken as SL (sublingual); SQ mistaken as "5 every," the "q" in "sub q" has been mistaken as "every" (e.g., a beparin dese ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery.	lkse "subcut" or "subcutaneously"	
8	Sliding scale (insulin) or ½ (apolhecary)	Mistaken as "55"	Spell out "z	iding scale;" use "one-half"
SSRI	Sliding scale regular Jasulin	Mistaken as selective-serotonin reuptake inhibitor	Spell out 's	iding scale (insulin)"
001	No. 1	Mill to the state of the	5.00	
SSI SSI	Stiding scale Insulin	Mistaken as Strong Solution of Iodine (Lugol's)	44 - 44 - 4 4	Mary as a research
years III Francis	One daily	Mistaken as "tid"	Use "I daily	The second secon
TIW or liw	I times a week	Mistaken as "I times a day" or "twice in a week"	Use 7 time	s weekly"
n ot n <sub>ov</sub>	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 40 seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	Use "unil"	
VD	As directed ("ut dictum")	Mistaken as unit dose (e.g., diltiazem 125 mg IV infusion "UD" misin- terpreted as meaning to give the entire infusion as a unit (bolos) dose)	Uka "as directed"	
Dose Designations and Other Information	Intended Meaning	Maxintospeciation		Correction
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	On not use trailing zeros for doses expressed in whole numbers	
"Naked" decimal point (e.g., 5 mg)"	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when dose is less than a whole unit	
Abbreviations such as mg or mt. with a period following the abbreviation	mg mt	The period is unnecessary and could be mistaken as the number 1 if writen poorly	lise mg, mL period	, etc. wilkout a terminal



## ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (continued)

Date (legipations and Other Information	Intended Meaning	Mointerprotation	U	miceloin
Orug name and dose run	Inderal 40 mg	Mistaken as Inderal 140 mg	Place adequate so	ace between the drug
together (especially problematic for drug names that and in "I" such as Inderal40 mg; Togratol300 mg)	Tegretal 300 mg	Mistaken as Tegretol 1300 mg		
Numerical desa and unit of measure run tegether (e.g., 10mg, 100ml.)	10 mg 100 mL	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate sp unit of measure	ace between the dose a
Large doses without properly placed corress (e.g., 100000 anits; 1000000 units)	100,000 units (1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for d 1,000, or use word or 1 "million" to in	osing units at or above is such as 100 "thousan inprove readability
Ding Name Albreviations	Intended Misining	Micatterpretation		errection
To avoid confusion, do not	abbreviate drug names when co	mmunicating medical information. Examples of drug name abbrevia	tions involved in med	ication errors include:
APAP	acetaminophen	Hot recognized as acetaminophen	lise complete drug	name
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	lise complete drug	name
AZT AZTA	zidavudine (Retravir)	Mistaken as azathioprine or aztreonam	Use complete drug	name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpromazine	Use complete drug	name
DPT SASTA	Demeral-Pheneryan-Thorazine	Mistaken as diphtheria-pertussis-tetanus (vaccine)	Use complete drug	name
UTO	Diluted tincture of opium, or deadarized lincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name	
HCI	kydrochloric acid or kydrochloride	Mistaken as potassium chloride (The "H" is misinterpreted as "K")	Use complete drug as a salt of a drug	name unless expresse
HCT	byd			ame
HCTZ HCTZ	byd			ame
MgSO4**	mag	DELETE		ame
MS, MS04**	mar			ame .
NTX	met			ame
PCA PCA	procainamide	Mistaken as patient controlled analgesia	Use complete drug	natne
PTU ACCOUNT	propylthiouracil	Mistaken as mercaptopurine	Use complete drug	name sman
B Barrier B	Tylenal with cadeine Ho. 3	Mistaken as liothyronine	Use complete drug	matte
TAC	Trismcinolone	Mistaken as tetracaine, Adrenalin, cocaine	like complete drug	Rame
TNK	THKase	Mistaken as "TPA"	Use complete drug	hame
ZnS04	zinc sullale	Mistaken as morphine sulfate	tise complete drug	Raine
Stemmed Hung Hanney	Interpled Meaning	Mointerprotetions	C	of textians
"Nito" dip	nitroglycerin infusion	Mistaken as sodium nitroprosside infusion	Use complete drug	name
"Nortlex"	norfloxacio	Mistaken as Horflex	Use complete drug	name
"IV Vanc"	intravenous vancomycin	Mistaken as Invanz	Use complete drug	name
Symbols	Intended Meaning	Manterpretation	E	armediani
5 m	Oram Minim	Symbol for dram mistaken as "3"  Symbol for minim mistaken as "ml."	Use the metric syst	
x3d	For three days	Mistaken as "3 doses"	Use "for three days"	
>ani<	Greater than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "greater than" or "less than"	
/ (slash mark)	Separates two doces or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" micread as "25 units and 110" units)	Use "per" rather than a shish mark to separate doces	
Ð	A STATE OF THE STA	Mistaken as "2"	Use "al"	
Market & Canada and	And	Mistaken as "2"	Use "and"	
KAZANI THOMAS	Plus or and	Mistaken as "4"	lise "and"	
THE ALLESS OF	How	Mistaken as a zero (e.g., q2° seen as q 20)	llse "hr," "h," or "?	our"
Фига	zero, null sign	Mistaken as numerals 4, 6, 8, and 9	Use O or zero, or describe intent u	sing whole words

<sup>&</sup>quot;These abbreviations are included on The Joint Commission's "minimum list" of dangerous abbreviations, acronyms, and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. Visit

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# Facts about the Official "Do Not Use" List of Abbreviations June 9, 2017

The Joint Commission's "Do Not Use" List is part of the Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

#### Official "Do Not Use" List1

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod(every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO₄ and MgSO₄	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

<sup>&</sup>lt;sup>1</sup>Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

#### Development of the "Do Not Use" List

In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01. For more information, contact the Standards Interpretation Group at 630-792-5900 or complete the Standards Online Question Submission Form.

https://www.jointcommission.org/facts\_about\_do\_not\_use\_list/ Retrieved March 7, 2018

<sup>\*</sup>Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

#### Joint-Commission "Do Not Use" List (2014)



#### Facts about the Official "Do Not Use" List

In 2001, The Joint Commission Issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "do not use" list of abbreviations (see below) as part of the requirements for meeting that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

Currently, this requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols, and dose designations from the software.

#### Official "Do Not Use" List1

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the	Write "unit"
IU (International		_
Q.D., QD, q.d., qd	DELET	ſΕ
Q.O.D., QOD, q.o.		
(every other day)	"I" and the "O" mistaken for "I	
Trailing zero (X.0 mg)*	Decimal point is missed	Write X mg
Lack of leading zero (X mg)		Write 0.X mg
MS	Can mean morphine sulfate or	Write "morphine sulfate"
	magnesium sulfate	Write "magnesium sulfate"
MSO <sub>4</sub> and MgSO <sub>4</sub>	Confused for one another	

Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

#### The National Summit on Medical Abbreviations

Participants at the November 2004 National Summit on Medical Abbreviations supported the "do not use" list. Summit conclusions were posted on the Joint Commission website for public comment. During the four-week comment period, the Joint Commission received 5,227 responses, including 15,485 comments. More than 80 percent of the respondents supported the creation and adoption of a "do not use" list. This special one-day Summit brought together representatives of more than 70 professional societies and associations and special interest groups to discuss medical errors related to the misuse and misinterpretation of abbreviations, acronyms, and symbols. The objective of the Summit was to reach consensus on the scope and implications of this serious and complex problem and to find reasonable solutions using all of the evidence at hand and in the most dispassionate way possible.

The National Summit on Medical Abbreviations was hosted by The Joint Commission with its coconveners American College of Physicians, American College of Surgeons, American Dental Association,

<sup>\*</sup>Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Patient Care Services Use of Abbreviations Page 8 of 8

American Hospital Association, American Medical Association, American Society of Health-System Pharmacists, Institute for Safe Medication Practices, and United States Pharmacopeia. Approximately 50 professional societies and associations and selected interest groups participated in the Summit representing every perspective.

#### For more information

Contact the Standards Interpretation Group at (630) 792-5900, or complete the Standards Online Question Submission Form at <a href="http://www.jointcommission.org/Standards/OnlineQuestionForm/">http://www.jointcommission.org/Standards/OnlineQuestionForm/</a>.

6/14

## DELETE



#### **PATIENT CARE SERVICES**

ISSUE DATE: 01/03 SUBJECT: Automatic Stop Orders

REVISION DATE: 06/03, 07/09, 03/14 POLICY-NUMBER: IV.I.5

Department ReviewApproval: 01/18

Clinical Policies & Procedures Committee Approval: 01/1402/18

Nurse Executive Council Approval: 01/1403/18

Pharmacy and Therapeutic Committee 01/1403/18

Medical Executive Committee Approval: 02/1403/18

Professional Affairs Committee Approval: 03/1404/18

Board of Directors Approval: 03/14

### A. PURPOSE:

1. To provide guidelines for discontinuing narcotics, antibiotics, chemotherapeutic agents, and all other drugs.

#### B. POLICY:

- In the absence of a specific physician/Allied Healthcare Professional (AHP)'s order indicating the desired duration of therapy, automatic medication expiration is as follows:
  - a. Narcotics-Opioids and benzodiazepines seven (7) days
  - b. Antibiotics seven (7) days
  - c. Ghemotherapeutic agents 1-time order (unless oral route-and written for nonchemotherapeutic indication i.e. methotroxate for rheumatoid-arthritis)
  - d.c. Intravenous (IV) acetaminophen- 24 hours (not to exceed 72 hours)
  - e.d. Ketorolac- five (5) days
  - f. Meperidine 4 days
  - g.e. Paralytic agents (i.e. cisatracurium, rocuronium, pancuronium, vecuronium)- 48 hours
  - f. Albumin- 24 hours (exceptions: status post Cardiac-Coronary Artery Bypass Graft, hypotension during dialysis, hepatorenal syndrome, spontaneous bacterial peritonitis; not to exceed 14 continuous days)
  - g. Mannitol seven (7) days
  - h. Phytonadione (Vitamin K) seven (7) days
  - i. Iron sucrose maximum cumulative dose 1,000 mg within 14 day period
  - h.j. All other medications 30 days
  - i.k. All medication written to be given for "duration of stay" shall be interpreted as the physician requesting therapy for the entire inpatient stay unless otherwise stated.
- 2. The expiration date(s) of these medications shall be monitored via the Pharmnet Pharmacy System.
- 3. The ordering physician/AHP will receive a renewal notice in their inbox to renew the medication electronically via computerized physician order entry (CPOE).
- 4. If medication order is not renewed within two days before the medication is stopped, Medication Renewal Forms shall be printed to the nursing units for placement in patient's medical chart by nursing personnel. Nursing-personnel shall place a "Please Sign and Date Renewal Flag" on the renewal form and the form shall be placed in patient's chart.
- 5. If the physician desires to renew the medication listed on the Medication Renewal Form a check mark shall be placed in the renewal box located next to the medication order on the renewal form. The Physician shall sign, date and time the renewal order form in an area located at the bettem of the form.

- If no action-is-taken, the Medication Renewal Form shall-print in pharmacy the day of medication expiration for pharmacist-follow-up with physician to determine if the medication is to be renewed or discontinued.
- 7.4. Medications that are not renewed shall not be given after the renewal date noted on the renewal form for each medication.
- 8-5. Any medications put on "hold" by the physician/AHP shall automatically be discontinued by the nurse or pharmacist and must be reordered by the physician/AHP if and when the medication is resumed.
- 9. A-pharmacist shall call the physician if an order-form is received without a signature by the physician. The pharmacist shall clarify with the physician if the medications appearing on the form are to be continued.

(e)			Tracked Changes	
Tri-City Me	Tri-City Medical Center			
PROCEDURE:	CONTINUOUS AMBULATORY PROCESSION CONTINUOUS CYCLERCYCLIC			
Purpose:	To outline nursing responsibilities in, trouble shooting and disconnecting a patient that has a Liberty Newton IQ® Cycler (CCPD), and responsibilities in CAPD exchanges, trouble shooting and disconnecting a patient that has a Fresenius Stay Safe CAPD exChange exchange Safe-Lock ® Premier ™ Plus exchange (8 Preng CAPD Manifold Set) or a Premier ™ Double Bag with Del-Clamp™ and Snap (One time CAPD exchange).			
Supportive Data:	: To maintain aseptic technique when disconnecting patients from a CAPD or CCPD device in addition to maintaining the CAPD and CCPD treatment for the patient when San Diego Dialysis, Inc nurses are not available within the facility.			
Equipment:	Mask, Gloves, Del Clamps™, IV Pole (CAPD), Spring Scale (CAPD), Chux Pad, Blue plastic hemostats			

#### A. **POLICY:**

- 1. Tri-City Medical CenterHealthcare District (TCHD) has contracted San Diego Dialysis Services, Inc. to administer peritoneal dialysishemodialysis on 4 Pavilion in room 476 including set up and support for inpatients receiving peritoneal dialysis as needed in our main hospital.
- 2. The responsibility of the San Diego Dialysis Services, Inc., per their contract, will be to:
  - a. Prep, connect, monitor and disconnect patients requiring <del>hemodialysis and peritoneal dialysis.</del>
  - b. Administer medications as ordered by privileged TCMCHD physicians during continuous ambulatory peritoneal dialysis (CAPD) and automated peritoneal dialysis (APD) treatments.
- 3. The CAPD and continuous cycler peritoneal dialysis (CCPD) trained nurses who are trained in CAPD a CCPDand APD, will be responsible for trouble shooting alarmsand clamping and unclamping for night-CAPD-exchanges when Safe-Lock ® Premier ™ Plus exchange (8 Preng APD Manifold Set) is used and the San-Diego-Dialysis Services, Inc.'s dialysis nurses are not on the Liberty cycler.site.
- 4. Nurses who are trained in CAPD or CCPD trained nurses, may also be required to disconnect peritoneal dialysis patients from the Liberty Cycler® Stay Safe ®APD for the Liberty-Cycler® Safe-Lock ® Premier ™ Plus exchange (8 Preng APD Manifold-Set) and Premier ™ Double Bag with-Del Clamp™ and Snap (One time APD exchange), when the San Diego Dialysis Services, Inc.'s dialysis nurses are unable to disconnect patients due to immediate proceduresetaffing shortages or time constraints related to in house hemodialysis patients. Nurses working in 3 Pavilien may be utilized as resources.
- 5. Emergency equipment shall be readily available at patient's bedside in case offor emergency disconnection for both CAPDAPD and CCPD patients includes:
  - a. 2 Masks (nurse and patient)
  - b. Gloves
  - c. Chux
  - d. 1 Stay Safe® Cap
  - e. 1 Stay Safe® Organizer
  - a. 2 blue Del-Clamps™ (if-tubing-does-not-have the Stay Safe® patient connectors)
  - d.f. Blue plastic hemostats (if patient's catheter does not have a clamp)

#### B. **PROCEDURE:**

CCPDAPD for the Liberty Cycler®:

) IL	Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
	04/06, 06/12, 1 <b>2/1</b> 7	07/12, <b>02/18</b>	08/12 <b>, 03/18</b>	n/a	08/12 <b>, 03/18</b>	09/12 <b>, 04/18</b>	09/12

- a. Trouble-Shooting:
  - i. Refer to the Peritoneal Dialysis Manual located in 3 Pavilion-to trouble shoot any alarms on Libertythe Newton IQ® Cycler.
  - ii. If unable to trouble shoot alarms on the APD for the Liberty Cycler®: by using the Peritoneal Dialysis Manual, contact the on call Dialysis nurse at 1-855-726-9720858-627-3506.
- b. Disconnect using tubing other than the Newton IQ 4 Lead Set with Stay Safe® patient connectors:
  - i. Have the following supplies:
    - 1. - Mask
    - 2. Gleves
    - 3. Chux
  - ii. When the Newton-IQ®-Cyclor-roads "Completed" on the display screen the CCPD has finished and the patient can be disconnected.
  - iii. Close-all clamps including the clamp closest to the patient.
  - iv. Close-window/doors and turn off fans to minimize environmental contaminants.
  - v. Apply mask-to-self, patient, and others in the room.
  - vi. Thoroughly wash-hands and don gloves.
  - vii. Place a Chux under the disconnecting area of the Transfer Set.
  - viii. Follow the disconnecting policy by turning the blue-pin-trigger of the Stay safe connector of the Liberty Cycler tubing, pushing in the pin-trigger to set the pin into the patient's transfer set, then placing the Stay Safe connection into the Organizer before placing the new Stay Safe cap.
  - ix. Document-the APD-output from the Records screen at the end of the treatment where it reads Total-UF. Document-in-Cerner the color, clarity and volume at the end of treatment.
  - x. If patient is to be discharged after-CCPD-is-completed, an assessment by the San Diego Dialysis Services, Inc.'s-dialysis nurse must be done on the patient prior-to-discharge.
- b. Disconnecting with the Liberty CyclerNewton IQ 4 Lead Set with Stay Safe® Patient Connectors:
  - i. Place a new Stay Safe® Cap in the notch on the Organizer.
  - ii. Turn the blue end of the Patient Connector clockwise until it stops.
  - Push in the blue end of the Patient connector until it stops.
  - iv. Close the clamp on the Extension Set.
  - v. Insert the Patient Connector into the Organizer.
  - vi. Remove the protective cover from the new Stay Safe® Cap.
  - vii. Unscrew the Extension Set from the Patient Connector.
  - viii. Connect the Extension Set to the new Stay Safe® Cap and remove from Organizer.
  - ix. Connect the protective cover on the used Patient Connector...
  - xi. Disconnect cycler set from the drain line. Drain-line may be emptied, stored, and reused. If reusing drain line, place protective cap on end during storage.
  - x. Document the CCPD output, (located in the right hand corner of the Newton IQ® Gycler-screen), color, and clarity of fluid using the I&O form in Cerner. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
  - xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

#### C. PROCEDURE:

- 2.1. CAPD Stay Safe single exchange
  - a. The following supplies are needed to perform the Fresenius Stay Safe CAPD Exchange Procedure:

b.

C.

d.

i. Bag of Stay Safe Delflex solution with appropriate dextrose percent (%), as ordered by the physician ii. Stay Safe® Organizer iii. Stay Safe® Cap(s) iv. Masks for everyone in the room Personal protective equipment (PPE) for (Sstaff), (Ppatient/Ccaregiver as v. instructed by dialysisHT Nnurse) vi. Liquid antimicrobial soap and/or alcohol based hand sanitizergel vii. Intravenous (IV) pole viii. Spring scale (optional) Organizer holder (optional) Apply masks to all persons in the room; staff applies remaining PPE except gloves. Wash hands with liquid antimicrobial-soap and water per Procedure: Hand Hygiene, FMS-CS-IC-II-155-090C. Apply non-sterile gloves (staff). Apply masks to all persons in the room; staff applies remaining PPE except gloves. Wash hands with liquid antimicrobial soap and water per Infection Control Procedure: Hand Hygiene – IC 8, FMS-CS-IC-II-155-090C. Apply non-sterile gloves (staff). Place a new Stay Safe® Cap in the notch on the Organizer. SAFE LOCK @ PREMIER THE PLUS EXCHANGE (8 PRONG APD MANIFOLD SET) AND PREMIER ™ DOUBLE BAG WITH DEL CLAMP™ ® AND SNAP (ONE TIME APD EXCHANGE). Trouble-Shooting: Contact the on-call Dialysis nurse at 760-509-8341. San-Diege-Dialysis-Services, Inc.'s dialysis nurses will set up and connect-all-APD patients to the above-APD-sets. Check the physician's peritoneal dialysis order with the dialysate that has been set up by the San Diego Dialysis-Services, Inc. nurse. Ensure the dialysate and its contents (medications) coincide with the physicians order before performing an APD exchange on a patient. Verify dwell times for the dialysate-solution. Don mask, place mask on patient then wash hands and don gloves Drain (When San Diego Dialysis-Services, Inc.'s dialysis nurses are not available) ii. Unclamp patient's catheter and Turn the blue end of the Patient Connector clockwise until it stops. iii. Push in the blue end of the Patient connector until it stops. iv. Close the clamp on the Extension Set. i.v. Insert the Patient Connector Premier-tubing and any other clamps that drain directly into the Organizerdrainage-bag. When drain is complete, clamp the drain line. Fill Unclamp the fill-line and allow the patient-to-fill-When fill is complete, clamp the fill line Disconnocting: Have the protective coverfollowing supplies: Mask (2) Glove Chux Del-Clamps™ (blue)

After the last fill is complete and all lines are clamped, close window/doors and

turn off fans to-minimize-environmental contaminants.

- iii. Thoroughly wash-hands and-don-gloves.
- iv. Apply mask to self, patient, and others in the room.
- v. Place-Chux under the disconnecting area of the Snap disconnects extension-set.
- ii.vi. Attach one Del-Clamp ™ to each side of the Snap-discennect-extension set (on the soft part of the tubing) that is the most distalRemove the protective cover from the new Stay Safe® Cap.patient (the Snap discennect extension set has two-Snap-discennects).
- vii. UnscrewEnsure that the Extension Set fromtubing is correctly positioned in the Patient Connector.
- iii-viii. ConnectDel-Clamp™ closure by pressing the Extension Set totubing-firmly into the new Stay Safe® Cap and remove from OrganizerDel-Clamp™ tubing guides.
- vi. Close and lock both Del-Clamps™.
- vii. Carefully-bend-the-protective-cover-onSnap disconnect that is between the two Del-Clamps™ te-break-the-patient-line.
- iv.ix. Weigh-drain-bags-using-the-spring-scale. Subtract the drain-bag volume from the amount of dialysate that was during the APD fill. Connect the protective cover on used Patient Connector.

Example:

6900-mL-of-total fluid from drain bag(s).

- -6000 mL of dialysate used during the fill process of the APD procedure.
- = 900 is the APD output.
- v.x. Document the CCPDAPD output, color, and clarity of fluid using the I&O form in Gernerthe medical record. All CCPDAPD patients mustshall have the CCPDAPD output recorded after every completed CCPDAPD exchange.
- xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.
- viii. Notify the San Diego Dialysis Services, Inc.'s dialysis nurse to dispose of drain bags.

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

1. Infection Control Procedure: Hand Hygiene - IC 8

#### C.E. REFERENCE(S):

- Fresenius Liberty Cycler Termination of TreatmentSafe Lock Premier Plus APD Exchange Procedure FMS-CS-iiHI-I-530-110C4 18-DEC-2013215-015A-June 1, 2007
- Fresenius Stay Safe CAPD Exchange Procedure FMS-IS-IICS-HI-I-530-082C 18 DEC-2013215-010A June 1, 2007
- Fresenius Peritoneal Dialysis Procedure Manual-Clinical Services 1-200-0001-SD
- Fresenius Snap-Disconnect-Exchange Procedure FMS-CS-HT-L 215 0001A June 1, 2007
- 4. Newton IQ 4 Lead Cycler-Set-with Stay Safe patient Connectors package insert

	Tri-City Medical Center		Patient Care Services	Clean Copy	
			DITONEAL DIALVOID (C	ARRY EVOLUNOE:	
	PROCEDURE:	CONTINUOUS AMBULATORY PE CONTINUOUS CYCLER PERITOR			
Purpose:  To outline nursing responsibilities in, trouble shooting and disconnecting a patient that has a Liberty ® Cycler (CCPD), and responsibilities in CAPD exchanges, trouble shooting and disconnecting a patient that has a Fresenius Stay Safe CAPD exchange					
	Supportive Data:	To maintain aseptic technique whe device in addition to maintaining the San Diego Dialysis, Inc nurses are	e CAPD and CCPD treatn	nent for the patient when	
	Equipment:	Mask, Gloves, Del Clamps™, IV Poplastic hemostats	ole (CAPD), Spring Scale	(CAPD), Chux Pad, Blue	

### A. POLICY:

- Tri-City Healthcare District (TCHD) has contracted San Diego Dialysis Services, Inc. to administer peritoneal dialysis including set up and support for inpatients receiving peritoneal dialysis as needed.
- 2. The responsibility of the San Diego Dialysis Services, Inc., per their contract, will be to:
  - a. Prep, connect, monitor and disconnect patients requiring peritoneal dialysis.
  - b. Administer medications as ordered by privileged TCHD physicians during continuous ambulatory peritoneal dialysis (CAPD) and automated peritoneal dialysis (APD) treatments.
- The CAPD and continuous cycler peritoneal dialysis (CCPD) trained nurses will be responsible for trouble shooting alarms on the Liberty cycler.
- 4. CAPD or CCPD trained nurses may also be required to disconnect peritoneal dialysis patients from the Liberty Cycler® Stay Safe ® when the San Diego Dialysis Services, Inc.'s dialysis nurses are unable to disconnect patients due to immediate procedures or time constraints related to in house hemodialysis patients.
- 5. Emergency equipment shall be readily available at patient's bedside for emergency disconnection for both CAPD and CCPD patients includes:
  - a. 2 Masks (nurse and patient)
  - b. Gloves
  - c. Chux
  - d. 1 Stav Safe® Cap
  - e. 1 Stay Safe® Organizer
  - f. Blue plastic hemostats (if patient's catheter does not have a clamp)

## B. PROCEDURE:

- CCPD for the Liberty Cycler®:
  - a. Trouble-Shooting:
    - i. Refer to the Peritoneal Dialysis Manual to trouble shoot any alarms on Liberty® Cycler.
    - ii. If unable to trouble shoot alarms on the APD for the Liberty Cycler®: by using the Peritoneal Dialysis Manual, contact the on call Dialysis nurse at 1-855-726-9720
  - b. Disconnecting with the Liberty Cycler with Stay Safe® Patient Connectors:
    - i. Place a new Stay Safe® Cap in the notch on the Organizer.
    - ii. Turn the blue end of the Patient Connector clockwise until it stops.
    - iii. Push in the blue end of the Patient connector until it stops.
    - iv. Close the clamp on the Extension Set.
    - v. Insert the Patient Connector into the Organizer.
    - vi. Remove the protective cover from the new Stay Safe® Cap.
    - vii. Unscrew the Extension Set from the Patient Connector.
    - viii. Connect the Extension Set to the new Stay Safe® Cap and remove from

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors	
04/06, 06/12,	07/12. 02/18	08/12. 03/18	n/a	08/12, 03/18	09/12, 04/18	09/12	72

Organizer.

- ix. Connect the protective cover on the used Patient Connector.
- x. Document the CCPD output, color, and clarity of fluid using the I&O form in Cerner. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
- xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

#### C. PROCEDURE:

- CAPD Stay Safe single exchange
  - a. The following supplies are needed to perform the Fresenius Stay Safe CAPD Exchange Procedure:
    - Bag of Stay Safe Delflex solution with appropriate dextrose percent (%), as ordered by the physician
    - ii. Stay Safe® Organizer
    - iii. Stay Safe® Cap(s)
    - iv. Masks for everyone in the room
    - v. Personal protective equipment (PPE) for staff, patient/caregiver as instructed by dialysis nurse
    - vi. Liquid antimicrobial soap and/or alcohol based hand sanitizer
    - vii. Intravenous (IV) pole
    - viii. Spring scale (optional)
    - ix. Organizer holder (optional)
  - b. Apply masks to all persons in the room; staff applies remaining PPE except gloves.
  - Wash hands with liquid antimicrobial soap and water per Infection Control Procedure: Hand Hygiene.
  - d. Apply non-sterile gloves (staff).
    - i. Place a new Stay Safe® Cap in the notch on the Organizer.
    - ii. Turn the blue end of the Patient Connector clockwise until it stops.
    - iii. Push in the blue end of the Patient connector until it stops.
    - iv. Close the clamp on the Extension Set.
    - v. Insert the Patient Connector into the Organizer.
    - vi. Remove the protective cover from the new Stay Safe® Cap.
    - vii. Unscrew the Extension Set from the Patient Connector.
    - viii. Connect the Extension Set to the new Stay Safe® Cap and remove from Organizer.
    - ix. Connect the protective cover on used Patient Connector.
    - x. Document the CCPD output, color, and clarity of fluid in the medical record. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
    - xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

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

Infection Control Procedure: Hand Hygiene - IC 8

### E. REFERENCE(S):

- Fresenius Liberty Cycler Termination of Treatment Procedure FMS-CS-ii-I-530-110C4 18-DEC-2013
- 2. Fresenius Stay Safe CAPD Exchange Procedure FMS-IS-II-I-530-082C 18 DEC-2013
- Fresenius Peritoneal Dialysis Procedure Manual-Clinical Services 1-200-0001-SD



#### PATIENT CARE SERVICESSTANDARDIZED PROCEDURES MANUAL

#### STANDARDIZED PROCEDURE: EMERGENCY DEPARTMENT

#### I. POLICY:

- A. Function: To define appropriate utilization of specific orders and order sets, otherwise referred to as standardized procedures.
- B. Circumstances:
  - 1. Setting: Tri-City Medical Center, Emergency Department (ED)
  - Supervision: An Emergency Services Physician will be available for consultation.
     Registered Nurses will immediately contact the physician for any patient who is critical in nature or unstable. Physician contact will not be delayed in order to initiate or complete Standardized Procedures.
  - Patient contraindications: None
- C. Documentation:
  - 1. The Registered Nurse (RN) will document all interventions performed into the electronic health record (EHR).
  - 2. The RN will enter all orders performed per the standardized procedure in the EHR.

#### II. PROCEDURE:

- A. Abdominal Pain between the ages of 10 25 :
  - 1. In patients who present to the ED with abdominal pain, the RN shall order the following:
    - a. Labs:
      - i. CBCE
      - ii. Metabolic Panel, Comprehensive
      - iii. Jic Blue
      - iv. Serum HCG in females
    - b. Nurse Orders:
      - Routine urinalysis with reflex culture
    - c. Medications:
      - Ondansetron (Zofran) 8 mg oral disintegrating tablet (ODT) times one (1), prn for nausea in patients 16 years of age and older.
- B. Abdominal Pain, ages 26 and older:
  - 1. In patients who present to the ED with abdominal pain, the RN shall order the following:
    - a. Labs:
      - i. CBCD
      - ii. Metabolic Panel, Comprehensive
      - iii. Jic Blue
      - iv. Serum HCG in females aged 26 to 55
    - b. Nurse Orders:
      - i. Routine urinalysis with reflex culture
    - c. Medications:
      - Ondansetron (Zofran) 8mg ODT times one (1), PRN for nausea, in patients 16 years or older.
    - d. Additional orders if patient presents with upper abdominal pain (above umbilicus or abdominal pain of unknown location) to rule out cardiac conditions:
      - i. Cardiology:
        - 1) EKG STAT
          - a) Print old EKG if available

Revision Dates	Clinical Policies & Procedures	Nursing Executive Committee	Department of Emergency Medicine	Pharmacy and Therapeutics	Inter- disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/04, 03/06, 08/08, 07/09, 06/11, 06/14	01/11, 11/13, 10/14, 01/15, 12/16	01/11, 11/13, 10/14, 02/15, 03/17	06/11, 12/14, 05/17	06/11, 11/13, 01/15, 07/17	06/11, 02/14, 06/15, 10/17	06/11, 02/14, 06/15, 03/18	06/15, 04/18	06/11, 02/14, 07/15

- b) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to ED physician to rule out ST-elevation Myocardial Infarction (STEMI)
- ii. Labs:
  - 1) Creatine Kinase (CPK)
  - 2) CK, Mb Fraction (CKMB) if CK elevated
  - 3) Cardiac Troponin (Troponin I)
  - 4) Lipase level
- C. <u>Asthma with Wheezing:</u>
  - 1. In patients who present to ED with wheezing and a stated history of asthma, the RN shall order the following:
    - a. Nursing Orders:
      - i. Pulse oximetry monitoring
    - b. Medications:
      - Albuterol 5 mg nebulized times one (1) with Ipratropium 0.5 mg nebulized times one (1) per Respiratory Therapy, in patients who are greater than 11 years of age.
- D. <u>Chest Discomfort in Patients over 30 years of age:</u>
  - In patients who present to the ED with chest pain, pressure, squeezing, shortness of breath, pain or discomfort in other parts of the body including one or both arms or shoulders, upper back, neck, jaw, abdomen, or female, elderly or diabetic patients with atypical symptom suspicious for acute coronary syndrome (ACS) such as diaphoresis, nausea, dizziness, altered level of consciousness the Registered Nurse (RN) shall order the following:
    - a. Cardiology:
      - i. EKG STAT
        - Print old EKG if available
        - STAT ED EKG's will be completed with the goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.
    - b. Labs:
      - CBCD
      - ii. Metabolic Panel, Comprehensive
      - iii. Creatine Kinase (CPK)
      - iv. CK, Mb Fraction (CKMB) if CPK elevatedabove normal
      - v. Cardiac Troponin (Troponin I)
    - c. Nurse Orders:
      - Bring patient to first available bed
      - ii. Initiate at least one peripheral intravenous (IV) saline lock
      - iii. Initiate cardiac monitor
      - iv. Initiate oxygen 2 liters per minute (LPM) per nasal cannula (NC) to maintain oxygen saturation by pulse oximetry (SPO2) greater than 92%
    - d. Medications:
      - i. Aspirin 325 mg one (1) tablet by mouth (PO) chewed times one (1) if not already administered
      - ii. Nitroglycerin (NTG) 0.4 mg sublingually, every five (5) minutes times three (3) doses for ongoing chest pain
    - e. Radiology:
      - X-Ray Chest 2 View
        - 1) If patient is female and under 55, shield pelvis
- E. Dysuria:
  - In patients who present to the ED with dysuria, hematuria, urgency, or frequency, the RN shall order:

- a. Nurse Orders:
  - i. Routine urinalysis with reflex culture
  - ii. Urine HCG for females age 10-55

### F. <u>Extremity Trauma:</u>

- Notify physician STAT for open fractures, dislocations, or neurological or vascular compromise.
- Consult physician for x-ray orders for back, skull, facial bones, chest, pelvis, hips, and ribs.
- In patients who present to ED with injuries that are suspicious for fracture, the RN shall order the following:
  - a. Medications:
    - i. Acetaminophen
      - 1) For ages 3 months-11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
        - a) Maximum 2600mg/day
        - b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
      - For 12 years and older, acetaminophen 650mg PO or PR times one
        - a) Maximum 3000mg/day
        - b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
  - b. Radiology:
    - Acromioclavicular Joints
    - ii. Ankle complete 4 views left
    - iii. Ankle complete 4 views right
    - iv. Heel left OS Calcis
    - v. Heel right OS Calcis
    - vi. Clavicle left
    - vii. Clavicle right
    - viii. Elbow left
    - ix. Elbow right
    - x. Femur left
    - xi. Femur right
    - xii. Finger left
    - xiii. Finger right
    - xiv. Foot 4 views left
    - xv. Foot 4 views right
    - xvi. Forearm left
    - xvii. Forearm right
    - xviii. Hand 4 views left
    - xix. Hand 4 views right
    - xx. Hip Left, with AP Pelvis
    - xxi. Hip Right with AP Pelvis
    - xxii. Humerus left
    - xxiii. Humerus right
    - xxiv. Knee left
    - xxv. Knee right
    - xxvi. Shoulder left
    - xxvii. Shoulder right
    - xxviii. Tibia/Fibula left
    - xxix. Tibia/Fibula right
    - xxx. Wrist 4 views left
    - xxxi. Wrist 4 views right

#### xxxii. X-ray extremity wound site if suspect foreign body

- G. Fever in children under 3 months of age:
  - 1. In patients who are under 3 months of age and who present to ED with rectal temperature of 38°C (100.4°F) or greater, assign an emergency severity index (ESI) level 2 and arrange for immediate placement in the treatment area. The RN shall order the following:
    - a. Labs:
      - i. CBCD
      - ii. Metabolic Panel, Basic
      - iii. C-Reactive Protein (CRP)
      - iv. Blood Culture (only one required for less than 3 months of age)
    - b. Nurse Orders:
      - i. Routine urinalysis, catheter specimen
      - ii. Urine culture
      - iii. Pulse oximetry monitoring
      - iv. Initiate intravenous (IV) saline lock
    - c. Medications:
      - Acetaminophen 15 mg/kg PO or PR times one (1)
        - 1) Maximum 2600mg/day
        - Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
    - d. Radiology:
      - i. X-Ray: Chest 2 View PA and LAT
- H. Fever in patients older than 3 months of age:
  - In patients who present to the ED with fever, the RN shall order:
    - a. Medications:
      - i. Acetaminophen
        - For ages 3 months 11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
          - a) Maximum 2600mg/day
          - b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
        - For 12 years and older, acetaminophen 325mg PO or PR times one (1)
          - a) Maximum 3000mg/day
          - Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
      - ii. Ibuprofen
        - 1) For ages 6 months to 11 years, ibuprofen 10mg/kg PO times one (1), round to nearest 5mg
          - a) Maximum 40mg/kg/day
          - b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.
        - 2) For 12 years and older, ibuprofen 400mg PO times one (1)
          - a) Maximum 3200mg/day
          - b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.
- Generalized Weakness, Syncope, Dizziness or Altered Mental Status
  - In patients who present to ED with generalized weakness, syncope, or dizziness, the RN shall order the following:
    - Cardiology:
      - i. STAT EKG
        - Print old EKG if available

- STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.
- b. Labs:
  - i. CBCD
  - ii. Metabolic Panel, Comprehensive
  - iii. Creatine Kinase (CPK)
  - iv. CK, Mb Fraction (CKMB) if CK elevated
  - v. Cardiac Troponin (Troponin I)
- c. Nurse Orders:
  - i. Routine urinalysis, clean catch
  - ii. Urine culture, clean catch
  - iii. Serum Urine-HCG if female and 10 55 years of age
- d. Radiology:
  - . Chest X-ray 2 View PA and LAT
    - 1) If patient female and under 50 years of age, shield pelvis
- J. Gastro Intestinal (GI) Bleed
  - In patients who present to ED with the complaint of blood in the stool, vomiting of blood or coffee ground emesis, and a systolic blood pressure (SBP) less than or equal to 90 mmHg, the RN shall order the following:
    - a. Nurse Orders:
      - Initiate two 16 gauge (if possible) peripheral IVs
    - b. Medications:
      - Administer 500 ml 0.9 NaCl IV fluid bolus times one (1), infuse over 30 minutes
    - c. Labs:
      - Type and Screen
      - ii. Check capillary bloodBedside glucose
      - iii. CBCD
      - iv. Metabolic Panel, Comprehensive
- K. Psychiatric Evaluation
  - Patients who present to the ED with suicidal ideation, hallucinations, delusions, or who
    are an immediate safety risk to self or others will be assigned an Emergency Severity
    Index (ESI) Level 2 and moved to the treatment area as soon as possible. If immediate
    bed placement is not possible for psychiatric patients at risk, security should be notified
    for direct observation while bed placement is arranged.
  - In patients who present to the ED with the above complaints the RN shall order the following:
    - a. Labs:
      - i. CBCD
      - Metabolic Panel, Comprehensive
      - iii. Ethanol, Serum (Blood Alcohol Level)
      - iv. Urine toxicology screen
      - v. Cannabinoid level
      - vi. TSH level
      - vii. Serum HCG if female age 10 to 55
    - b. Nurse Orders:
      - Urinalysis, routine with reflex culture
- L. Sepsis
  - I. If patient presents to triage with signs/symptoms of SEPSIS including:
    - a. Temperature >38.3 or <36 (or history of recent fever/ infection)
    - b. Plus heart rate above 90 and/or respiratory rate above 20 and or Systolic Blood Pressure Below 90
  - 2. The Nurse shall order the following:

- a. Laboratory:
  - i. CBCD
  - ii. Metabolic Panel, Comprehensive
  - iii. Blood Cultures times 2
  - iv. Lactate with repeat lactate
  - v. JIC Blood Bank
  - vi. Urinalysis with reflex to culture
  - vii. Serum HCG if female and 10 to 55 years of age
- b. Radiology: Chest Xray
- c. Cardiology: Stat EKG
- d. Nursing:
  - i. Start 18 gauge IV
  - A.ii. Fluid Bolus 500 mL Normal Saline

#### LM. Vaginal Bleeding, Known Pregnancy:

- In patients who present to the ED with vaginal bleeding, and who are pregnant the RN shall order the following:
  - a. Labs:
    - i. CBCD
    - ii. ABORh Type
    - iii. Beta HCG, Quantitative
  - b. Nurse Orders:
    - If heart rate is greater than 120 BPM or the systolic blood pressure is less than 90 mmHg:
      - 1) Immediately notify physician of patient's condition
      - 2) Initiate two 16 gauge (if possible) peripheral IV's
      - 3) Set up for pelvic exam and notify physician
      - 4) Routine urinalysis with reflux culture, catheter specimen
  - c. Medications:
    - Administer 500 ml 0.9 NaCl IV fluid bolus times one, infuse over 30 minutes

#### M-N. Vomiting, Diarrhea, Dehydration:

- 1. In patients who present to the ED with vomiting, diarrhea and or dehydration the RN shall order the following:
  - a. Nurse orders:
    - Initiate peripheral IV for severe vomiting
  - b. Medications:
    - Adults (16 years of age and older):
      - 1) Ondansetron 8 mg ODT times one (1)
      - 2) Ondansetron 4 mg IVP times one (1) for severe vomiting.
    - ii. Pediatrics (0 to 15 years of age):
      - 1) Ondansetron 2 mg ODT times one (1) in patients less than 15 kg
      - 2) Ondansetron 4 mg ODT times one (1) in patients greater than 15 kg

### III. REQUIREMENTS FOR RN:

- A. Excellent customer service communication
- B. Education: Successful completion of Standardized Procedure training
- C. Initial Evaluation: Demonstrated competency
- D. Ongoing Evaluation: Annual skills lab.

### IV. <u>DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:</u>

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration. New standardized procedures or additions to existing

Patient Care Services
Standardized Procedure: Emergency Department Admission
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standardized procedures will be approved by the Department of Emergency Medicine, Pharmacy and Therapeutics (if medications are involved) and the TCMC Board of Directors.

B. Review: Every two (2) years

## V. <u>CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:</u>

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Emergency Department Standardized Procedure.

Tri-City Medical Center		Patient Care Services	
PROCEDURE:	FALL RISK PROCEDURE AND S	CORE TOOL	
Purpose:	To provide a comprehensive fall risk assessment on all patients each shift and implement appropriate fall risk interventions based upon the patient's identified fall risk factors.		
Supportive Data:	Inclusive of all inpatient areas. Requires a Registered Nurse (RN) to evaluate and identify risk factors for falls, develop an appropriate plan of care for prevention, perform a comprehensive evaluation of falls that occur, and revise the plan of care as appropriate for fall prevention.		
Equipment:	Fall Risk Score Tool		

#### A. PROCEDURE:

- The registered nurse (RN) completes the Morse Fall Risk Assessment on every patient, including visually assessing and interviewing the patient, to determine the patient's fall risk score and secondary risk factors:
  - a. Upon admission to the hospital
  - b. Upon admission or transfer to another level of care-area
  - c. Once a shift
  - d. After any fall occurs
  - e. When there is a change in the patient's status (physiological, functional, or cognitive)
- 2. Review the patient's medications for any that may alter the patient's ambulatory stability (see Medication Fall Alert Reference Text).
- 3. All patients receive the following Universal Fall Precautions as appropriate:
  - a. Adequate lighting
  - b. Assistive devices within easy reach
  - c. Bed in low position
  - d. Bed wheels and wheelchair brakes locked
  - e. Assure call light and possessions are within easy reach
  - f. Clean and dry surfaces
  - g. Hand rails and grab bars accessible
  - h. Hourly rounding
  - i. Non-skid slippers or footwear are worn during ambulation
  - j. Orient patients to their bed area, unit facilities, and how to get assistance
  - k. Patient/family fall prevention education (uses the Patient and Family Guide and review Fall Prevention section).
  - I. Review Partnering for Fall Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.
    - i. Excluding patients in Behavioral Health Services, Progressive Care Unit and Women and Newborn Services
  - I-m. Rooms free of clutter
  - m.n. Side rails up times two (2)
- 4. The patient's primary RN shall implement an individual Interdisciplinary Plan of Care (IPOC) for fall risks identified. Appropriate interventions based on the patient's fall risk score shall be selected and documented on the IPOCInterdisciplinary Plan of Care. These include but are not limited to:
  - a. Low Risk Patients (equals = 0 35 total score):
    - i. Reinforce use of grab bars near toilets.
    - Reinforce possible medication side effects that could increase risk of falling.
    - iii. Limit administration of combinations of medications that may increase fall risk when possible.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 1/08, 6/09, 09/15, 04/16, 09/17	11/11, 10/15, 06/16 <b>, 03/18</b>	11/11, 10/15, 7/16, 03/18	n/a	11/15, 11/16, 03/18	2/12, 01/16, 01/17, 04/18	2/12, 1/16, 01/17

- iv. Select suitable chairs with armrests that are an appropriate height for rising and sitting.
- v. Encourage patient to move/change position slowly.
- vi. Place patients with urgency near toilets or use commodes.
- vii. Instruct male patients prone to dizziness to sit while voiding.
- b. Moderate Risk Patients (equals = 36 44 total score):
  - i. Implement Universal and Low Risk interventions.
  - ii. Ambulate patients with assistance.
  - iii. Re-orient confused patients.
  - iv. Move confused patients close to nurse's station.
  - v. Encourage family members to sit with confused patients.
  - vi. Use bed exit alarms.
  - vii. Use chair alarms.
  - viii. Teach activity limits to patient and family.
  - ix. Large fall risk sign shall be placed at the head of the bed for moderate risk patients.
  - x. A fall risk magnet shall be placed on the patient's doorframe with the designated bed indicated on the magnet.
  - xi.— Review-Partnering for Fall-Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.
- c. High Risk Patients (equals= 45 or more+ total score) require:
  - i. Implement Universal, Low, and Moderate Risk interventions.
  - ii. Place fall risk wristband on patient.
    - a. High Risk Rounding: strongly encourage patient to use the bathroom or Bedside Commode at least every four (4) to- six (6) hours while awake if they have not gone when offered during hourly rounding (does not include patients with indwelling urinary catheter such as Foleys).
  - iii. Remain with patient while toileting or showering-if-appropriate.
    - b.a. Document if patient refuses.
  - iii-iv. Ensure commode is available at bedside if patient is unable to ambulate to the bathroom with assistance.
- d. Responsibilities:
  - i. Fall Risk Armbands:
    - a. The RN or Designee is responsible for placing the armbands on the wrist of patients identified as high risk (45 or more+).
    - b. The RN or Ddesignee is responsible for removing the armband upon change in Ffall Rrisk Sscore or upon discharge.
  - ii. Large Fall Risk Laminates:
    - The RN or Ddesignee is responsible for placing, updating, and/or removing the large Fall Risk laminates over the head of the patient's bed.
  - iii. Fall risk magnets:
    - a. The RN or Designee is responsible for placing, updating, and/or removing the fall risk magnet on the patient's doorframe with the designated bed indicated on the magnet.
  - iv. The Assistant Nurse Manager (ANM)/charge nurse shall check for appropriateness of signage during rounds.
- e. The primary RN shall reassess the patient every shift for needs and change in status.
  - i. When patient is reassessed and has a change in risk level, interventions are added or discontinued as indicated.
- f. The primary RN shall note and document the availability of family/friends to stay with the patient. The care plan shall be revised with any patient status change or the absence of family.

- g. The patient's fall risk status and family presence shall be reported during <del>communication</del> hand-offs communication.
- h. If a patient falls, the ANM or designee shall conduct an immediate educational debriefing for all staff involved.
  - An incident report-Quality-Review-Report (QRR) and Post Fall Huddle shall be completed by the Assistant-Nursing ManagerANM or designee.
  - ii. The QRR-incident report and Post Fall Huddle shall be reviewed by the Director/Manager and Risk Management.
- i. Each outpatient care area and Emergency Department will assess the risk for falls based on their own unit specific guidelines, and intervene as appropriate.

#### B. SPECIAL CONSIDERATIONS:

- Intensive Care Unit (ICU) Specific Fall Precautions:
  - a. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:
    - i. Stoplight magnets and overhead laminates are not required.
    - ii. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.
  - b. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team Technician assistance with getting out of bed (requires physician order).
- 2. Peri-Anesthesia Nursing Services (PANS) Specific Fall Precautions and Labor and Delivery Unit specific fall precautions:
  - All patients in PANS area and Labor and Delivery Unit are considered high fall risk due to post anesthesia-/-sedation status.
  - Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.
    - i. PlaceIncluding call light within reach of bedside.
    - ii. Patients-shall-be-aAssisted patients to bathroom and ambulated wearing shoes or non-slip socks.
    - iii. RN, Advance Care Tech, Peri-Operative Aide or family member must be in attendance behind curtain to assist out-patient while dressing prior to discharge.
  - c. Fall Risk magnets and overhead laminates are not required.
- 3. Emergency Department (ED) Sspecific Ffall Pprecautions:
  - Patients seen in the ED are scored for falls using KINDER1 Falls Scale, which is an
    evidenced based best practice tool developed specifically for Emergency
    DepartmentsED.
  - b. Fall risk assessment is performed by an RN upon initial assessment.
    - The patient is deemed not at risk.
    - ii. The patient is deemed at risk if there is a yes answer to any question.
  - c. Reassessments are performed with any change of condition.
  - d. If a patient falls in the ED the patient automatically becomes an at risk for falls patient.
  - e. The following interventions are instituted based on the patient's risk value:
    - i. Universal Falls precautions are initiated on all patients in the Emergency DepartmentED.
    - ii. At risk for falls precautions (include but not limited to):
      - a. Encourage family to remain with patient
      - b. Encourage patient to change position slowly
      - c. Increase intervals of nursing observation
      - d. Patients shall be assisted to bathroom and with ambulation
      - e. Fall Risk armband placed on patient
- 4. Imaging Services:
  - a. See Imaging Services: General Safety Management 128 Policy for Unit Specific Interventions
- C. FORM(S):

Patient Care Services Fall Risk Procedure & Scoring Tool Page 4 of 10

- Morse Fall Scale Sample <del>5.</del>1.
- Partnering for Fall Prevention- My Safety Plan-Sample <del>6.</del>2.
- <del>7.</del>3. Post Fall Huddle - Sample

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

- 1. Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions
- 2.
- Fall Risk Algorithm
  Medication Fall Alert Reference Text 3.

## Morse Fail Scale - Sample

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	0 15 30	
4. Intravenous therapy/heparin lock	No 0 Yes 20	
5. Gait Normal/bedrest/wheelchair Weak* Impaired <sup>†</sup>	0 10 20	
6. Mental status Oriented to own ability Overestimates/forgets limitations	0 15	
Total Score <sup>‡</sup> : Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		

<sup>\*</sup> Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

<sup>&</sup>lt;sup>†</sup> Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

furniture, support person, or walking aid to walk.

\* Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, , Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

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## Partnering for Fall Prevention - My Safety Plan

Directions: This is a tool to partner with the patient and family for education of the patient's fall risk factors and strategies to reduce risk of falls and keep the patient safe.

Partnering for Fall Prevention- My Safety Plan - Sample

Partnering for Fall Prevention - OurMy Safety Plan for You We care about you and your safety. We want to partner with you and your family to prevent falls. Your medical assessment shows you tomay be at risk for falls.



You are considered at risk for falls or injury for one or more of the following itemsreasons because:

☐ You are unsteady when you walk

☐ You may bleed easily if you fall.
You are taking medications that may make you fall more easily.
☐ Your medical history shows an increased risk for broken bones, due to:
☐ Recent surgeries or procedures put you at risk for falling, such as:
☐ Medical equipment (sequential devices, foot pumps, etc.)
☐ Other:
You and your family can do to help us keep you safe by doing the following:
☐ Show I know how to use my call light
☐ RN: Patient demonstrated correct use of call light to notify nursing staff
<ul> <li>I will always use the call light to contact the nurse. I promise to stay in bed and call my nurse for help.</li> <li>Whenever I need to get up</li> <li>Whenever I need help reaching something that is out of my reach</li> <li>Whenever I am feeling dizzy or sleepy from medications</li> </ul>
I will always call the nurse and not ask family for help getting out of bed
☐ I will wear my skid-proof slipper socks and yellow wrist band
I have a bed alarm that is active at all times. It will alert nursing staff when I am out of bed. I will not turn off the alarm.
☐ I will not use the over-bed table to help me stand; it is on rollers and may cause me to fall if I lean on it.
□ RN: Reviewed falls prevention plan with patient and family
☐ Patient unable to sign the form
☐ Patient refuses to sign the form
atient Initials/Date/Time: N Signature/Date/Time:

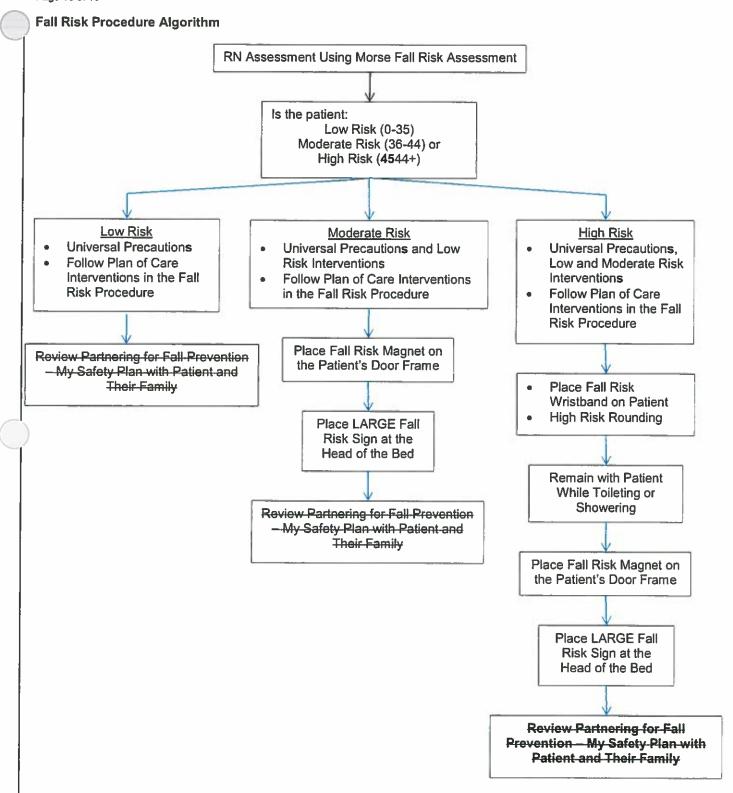
## Post Fall Huddle - Sample

Date: _/_/ Time:		
Setting: FIN #: Entered By:		
Reason for Audit. To involve front line staff in identifying problems and solutions, and it and learn building among team members. To promote a positive Cutture of Safety without	n creating change in their work	k environment. To promote trust
Instructions:		
1. Hold the Huddle as soon as possible and after every fall. 2. Involve the patient, staff involved in the care of patient or fall, and assistant nurse mane 3. Meeting is organized by primary RN and is brief.	ger or manager.	
* Indicates that an answer is required.		
2013 Post Fall Huddle/ After /	Action Review	
2013 Post Fall Huddle	Answer	Comments
1.* What was the lastest Fall Risk Score for the patient?		
2.° How did you find out that this patient fell?		
I saw the patient fall	<u> </u>	
Alarm went of	[	[
Patient/witness called		-
Heard noise/found patient on floor	[]	7
Other	[]	<del>-</del>
3.* What was the patient doing at the time of the fall?		
1 don't know	П	
Rolled out of bed	1	
Getting in/out of bed to go to BR/commode/urinal	l	
Trying to reach/pick up something	[]	
Trying to get in/out of bed for another reason	[]	
Trying to get on/off toilet/bedside commode	[]	
Trying to use the sink/shower	[]	
Other	[]	<u></u>
4.* Prior to the patient fall, what was the activity level?		
Up ad lib	[]	
Ambulate with assistance	[]	7
Bedrest	[]	7
Up in chair with assistance	[]	
Other	[]	
5.* Prior to the fall, was the patient assisted by staff to the mechanism that led to the fall?	Yes   No	i
(Example-Did staff assist the patient to the toilet and then left the patient alone?)		

6.* Why do you think the patient fell?		
I do not know	0	
Confusion	<del></del>	
Catastrophic event (stroke, arrhythmia)	[]	
Arms or legs got weak	[]	
Became lightheadeded, dizzy, or blacked out	n	
Tried to sit but missed	[]	
Secondary gain (seeking attention)	[]	
Got tangled in equipment	1)	
Low blood sugar	[]	
Slipped or tripped (not in equipment)	11	
Lost balance	[]	
Medication	[]	
Other	[]	
7.* Prior to the fall, identify the ancillary walking aid the patient had available in the room.		
None	[]	
Cane	[]	
Walker		
Wheelchair	[]	
Other	[]	
NA NA	[]	
8.* Did you do hourly rounding?	Yes ] No	
9. The last time you did hourly rounding, did you ask any questions pertaining to:		
Pain	[1]	
Potty	[]	
Position	[]	
Possessions	[]	
10.* What could you have done to prevent this fall?		
11.* What will you do differently in the future?		
12.* Post Fall Checklist		
RL Completed	[]	
IPOC Post Fall Initiated	[]	
Physician Notified	[]	
Documentation in the Medical Record (event, phys exam, intervention)		
Morse Fall Risk Score Updated	[]	
13.* RN : Patient Ratio (1 :)		
Please fill in the number of patients the RN was assigned to		
14.* Did you feel as though your patient assignment was appropriate?	Yes   No	

## POST FALL HUDDLE/AFTER ACTION REVIEW - Sample

Date: / /Time: Setting: FIN #: Entered By:	9000000 TO 1	
Reason for Audit: To involve frontline staff in identifying problems and solutions, and in c and team building among team members. To promote a positive Culture of Safety without in	creating change in their edividual blame.	work environment. To promote trus
Instructions: 1. Hold the Huddle as seen as possible and after every fall. 2. Involve the patient, staff involved in the care of patient or fall, and assistant nurse manage manager, 3. Meeting is organized by primary RN and is brief.	<del>If Of</del>	
* Indicates that an answer is required.		
2013 Post Fall Huddle/ After /	Action Review	¥
2013 Post Fall Huddle	Answer	Comments
1.* Why did this patient fall? Ask the group "why" 3 times to find the root cause. Example: Why did this patient fall? The patient got out of bed alone because he had to go to the bathroom.		Lessons Learned
2.* Why did "answer to question 1" happen?  Example: Why did the patient get out of bed alone? The patient get out of bed alone because he did not know where his call light was.	5. TE SEGRE	Lessons-Learned
3.* Why did "answer to question 2" happen?  Example: Why did he not know where his call light was? The call light was not within-reach-of-the-patient.		Lessons Learned
4.*-What-was-the-latest-Fall-Risk-Score-for-the-patient?		
Were the appropriate interventions in place?	Yes   No	What accounted for the difference?
6.* How could the same outcome be avoided next time?		Lossons Loarned
7.* What is the follow up plan?		Follow-up-Plan
8. Patient's account (if able to share)		Patient's Account
9. Agreement-with-patient-for safety (Promise-to-use-call bell; return demo how to use-call bell)		Safety Agreement
O.* Type of Fall?  Definitions for Type of Falls Accidental falls—Slipping, tripping, person making errors of judgement Anticipated physiological falls—Related to age and functional ability, Disease(e), Provious Fall(s), Weak or impaired gait, Lack of realistic assessment of their own ability, Person making errors of judgment.  Unanticipated physiologic falls—Attributed to physiological causes but created by conditions that cannot be predicted Behavioral falls—Patient who has behavioral issues and voluntarily positions his/her body from a higher level to a lower level.		
Accidental Fall	H	
Anticipated Physiological Fall	H	
Unanticipated Physiological Fall	H	
Behavioral (Intentional) Fall	H	
1.* Post Fall Checklist		
RL Completed	H	
IPOC Post Fall Initiated	H	
Physician Notified	H	
Documentation in the Medical Record (event, phys exam, intervention)	The state of the s	
Morse Fall Risk Score Updated	H	



#### **Medication Fall Alert Reference Text**

# Medication Fall Alert Below are Medications That May Affect Patients' Fall Risk Level

# \*Denotes individual drugs associated with highest risk of dizziness or falls in each category Category One

- 1. Antihistamines
  - a. Chlortrimeton (Chlorpheniramine Maleate)
  - b. \*Benadryl (Diphenhydramine Hydrochloride)
  - c. Dramamine (Dimenhydrinate)
  - d. Vistaril (Hydroxyzine)
  - e. Antivert (Meclizine)
- 2. Cardiac Drugs
  - a. Tenormin (Atenolol)
  - b. Capoten (Captopril)
  - c. Cardizem (Diltiazem)
  - d. Vasotec (Enalapril)
  - e. Zestril (Lisinopril)
  - f. Lopressor (Metoprolol)
  - g. \*Procardia (Nifedipine)
  - h. Inderal (Propranolol)
- 3. Hypotensive Agents
  - a. Catapres (Clonidine)
  - b. Apresoline (Hydralazine)
  - c. Trandate (Labetalol)
  - d. \*Minipress (Prazosin) (Especially first dose syncope)
  - e. \*Hytrin (Terazosin)
  - f. \*Cardura (Doxazosin)

#### **Category Two**

- 1. Neurotoxic Chemotherapeutic Drugs
  - a. Ifex (Ifosfamide)
  - b. Vincasar (Vincristine)
  - c. Platinol (Cisplatin)
  - d. Methotrexate
  - e. Cytosar-U (Cytarabine)
  - f. Adrucil (5-fluorouracil)
  - g. Taxol (Paclitaxel)
- Vasodilating Agents
  - a. Isordil (Isosorbide Dinitrate)
  - b. \*Nitrostat (Nitroglycerin)
- Opiate Agonists
  - a. Codeine (Includes cough syrups and Tylenol #3)
  - b. Vicodin (Hydrocodone)
  - c. \*Morphine
  - d. Percocet (Oxycodone)
- Anticonvulsants
  - a. Phenobarbital
  - b. \*Valium (Diazepam)
  - c. Dilantin (Phenytoin)
  - d. Tegretol (Carbamazepine)

Category Three

- Psychotherapeutic Agents
  - a. \*Anafranil (Clomipramine)
  - b. \* Elavil (Amitriptyline)
  - c. \*Sinequan (Doxepin)
  - d. Zoloft (Sertraline)
  - e. Desyrel (Trazodone)
  - f. \*Tofranil (Imipramine)
  - g. \*Surmontil (Trimipramine)
- 2. Antipsychotic Agents
  - a. \*Serentii (Mesoridazine)
  - b. \*Thorazine (Chlorpromazine)
  - c. \*Clozaril (Clozapine)
  - d. \*Mellaril (Thioridazine)
- 3. Benzodiazepines
  - a. Xanax (Alprazolam)
  - b. \*Librium (Chlordiazepoxide)
  - c. \*Dalmane (Flurazepam)
  - d. Ativan (Lorazepam)
  - e. Restoril (Temazepam)
  - f. Halcion (Triazolam)
- 4. Diuretics
  - a. Lasix Furosemide (Lasix Furosemide)
  - b. Bumex Bumetanide (Bumex Bumetanide)
  - c. Demadex <del>Torsemide</del> (<del>Demadex</del> Torsemide)
- 5. Miscellaneous Anxiolytics, Sedatives & Hypnotics
  - a. Equanil (Meprobamate)

Tri-City Medical Center		Patient Care Services			
PROCEDURE: INFUSION PUMP - SYRINGE OR PATIENT CONTROLLED ANALGESIC (POMODULE INFUSION SYSTEM WITH GUARDRAILS					
Purpose:	To regulate intravenous (IV) infusion using an electronic control device.				
Supportive Data: The Alaris Intravenous Infusion Pump with Guardrails System provides medical					
	prevention software to protect patients at the point of infusion delivery.				
Equipment:	Alaris administration set				
	2. Primary IV solution				
	Pump programmer point of care (POC)				
	4. Pump Syringe Module or Patient Controlled Analgesic (PCA) Module				

### A. PROCEDURE:

- Syringe Module:
  - a. Prior to the start of an infusion program, confirm syringe type and size. The system will provide a prompt for the programmer to select both the syringe type and size.
    - i. Selecting the incorrect syringe type and size may cause under-infusion or overinfusion of solutions or medications to patient.
  - b. Priming the Alaris Syringe Module:
    - Prime tubing prior to attaching system to patient with normal saline.
    - ii. Attach administration set to syringe and prime tubing with the medication that is ordered.
    - iii. Once set is primed, close slide clamp.
  - c. Loading the Alaris Syringe Module:
    - i. Prior to loading syringe, close roller tubing clamp to prevent uncontrolled flow.
    - ii. Open syringe barrel clamp until it clears syringe chamber.
    - iii. Twist gripper control clockwise and raise device head to fully extended position.
    - iv. Insert syringe barrel flange between barrel flange grippers.
    - v. Lock syringe in place by closing barrel clamp.
    - vi. Twist gripper control clockwise then lower drive head.
    - vii. Lock plunger in place with plunger grippers.
  - d. Programming Guardrails:
    - d-i. -sSee Patient Care Services Procedure: Infusion Pump:- Infusion System with Guardrails-Procedure
  - e. Removing the Alaris Syringe Module:
    - i. Silence alarm.
    - ii. Close roller tubing clamp.
    - Open plunger grippers and syringe barrel clamp.
    - Remove syringe by applying downward pressure to remove disc.
  - f. Near End of Infusion:
    - The system will alternate between Near End and remaining volume to be infused (VTBI).
    - ii. The audio prompt requires being silenced just once and will not reoccur following initial silencing.
- 2. PCA Syringe Module:
  - Select syringe type and size.
  - b. Prime tubing prior to attaching tubing to patient:
    - i. Option One: Manually express air from the administration tubing set by:
      - 1) Prime tubing prior to attaching system to patient with normal saline.
      - 2) Attach administration set to syringe and prime tubing with the medication that is ordered.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/08, 04/09, <b>01/18</b>	07/11, 03/15, <b>02/18</b>	08/11,03/15	0 <b>5</b> /15 <b>, 03/18</b>	10/11, 06/15, <b>03/18</b>	11/11, 07/15, <b>04/18</b>	11/11, 07/15

- 3) Once set is primed, close slide clamp.
- ii. Option Two: Prime tubing using Alaris PCA Module.
- iii. The tubing may be primed from the Infusion Mode Screen prior to programming the PCA Module:
  - Select Options key.
  - Press Prime Set with Syringe.
  - Press and hold Prime key to prime tubing.
  - Press Exit when prime is complete.
- c. After priming tubing, close slide clamp.
- Initial Set-Up:
  - Label syringe per the Patient Care Services Policy: Patient Controlled Analgesia (PCA) Policy.
  - b. Load syringe with administration set attached.
  - c. Press System On key.
  - Select Yes or No to New Patient.
  - e. Select appropriate profile.
  - f. Press Channel Select key.
  - g. Set key to Program position.
  - h. Press Confirm time setting.
  - i. Choose correct syringe type and size.
    - Selecting the incorrect syringe type and size may cause under-infusion or overinfusion of solutions or medications to patient.
  - j. Select correct medication and concentration.
  - k. Enter the dose and time limits.
  - I. Enter the total dosage patient may receive as ordered.
  - m. Responds to appropriate clinical advisory.
  - n. Close and lock door.
  - o. Attach administration set tubing set to patient.
  - Verify entered prescription with a second Registered Nurse (RN).
  - q. Press Start to begin PCA Module.
  - r. Document in the medical record per the Patient Care Services Policy: Patient Controlled Analgesia (PCA)Policy.
- Changing Syringe:
  - a. Press Pause.
  - b. Close roller tubing clamp.
  - c. Unlock door and remove old syringe.
  - d. Press Silence.
  - e. Date and time new syringe and attach to tubing.
  - f. Load new syringe.
  - g. Set key to Program position, close door.
  - h. Press Channel Select.
  - i. Select correct syringe type and size.
  - j. Press Confirm.
  - k. Press Restore.
  - Verify entered drug, concentration, and settings.
  - m. Lock door and open roller tubing clamp.
  - n. Press Start.
- 5. Administering a Bolus:
  - Press Channel Select.
  - b. Set key to Program position and enter authorization code.
  - Enter bolus dose amount and lock door.
  - d. Press Confirm.
  - e. Confirm settings and press Start.
  - f. Document bolus in the medical record.

- 6. Reviewing History:
  - Review patient history at the beginning of the shift and every four hours.
  - b. Press Channel Select Key.
  - c. Press Options.
  - d. Press Patient History.
  - e. Review drug totals.
  - f. Press Zoom key to review time intervals.
  - g. Press Detail to collect average dose per hour.
  - h. Press Main History.
  - To clear patient history, press Clear History and select Yes.
    - Clear patient history every four hours and prior to transferring a patient to another nursing unit.
  - To view 24 hours totals, select 24 h Totals.
  - k. Press Exit after viewing history.
  - Press Start to return to program.
  - m. Document patient history every four (4) hours in the patient's electronic medical record (EMR).
- 7. Documentation:
  - Document the start and change of syringes in the medical-recordEMR.
  - b. A second RN must verify for accuracy the initiation, change in dosage or any boluses and document it in the electronic medication administration record (eMAR).

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

- 1. Patient Care Services Policy: Patient Controlled Analgesia (PCA)
- 2. Patient Care Services Procedure: Infusion Pump- Infusion System with Guardrails

#### B.C. REFERENCE(S):

- Cardinal Health. (2010-2014). Alaris syringe module v8: Quick reference guide. Retrieved from <a href="http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf">http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf</a>
- 2. Cardinal Health. (2010-2014). Alaris pca module v8: Quick reference guide. Retrieved from <a href="http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf">http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf</a>

#### **PATIENT CARE SERVICES**

ISSUE DATE: 06/05 SUBJECT: Infusion Pumps, Intravenous (IV)

Therapy

REVISION DATE: 04/07, 03/11 POLICY NUMBER: - IV.EE

Department Approval: 01/18

Clinical Policies & Procedures Committee Approval: 03/1502/18

Nursing Executive Committee Approval: 03/1503/18
Pharmacy & Therapeutics Committee Approval: 05/4503/18

Medical Executive Committee Approval: 06/1503/18
Professional Affairs Committee Approval: 07/1504/18

Board of Directors Approval: 07/15

### A. PURPOSE:

1. To establish standards at Tri-City Medical-CenterHealthcare District (TCHD) for the management of intravenous (IV) administration sets, solutions, and medications in order to decrease the incidence of infections, complications, and errors.

#### B. <u>DEFINITION(S):</u>

- Back flushing A means to prime a secondary administration set in order to flush the secondary set of residual medication and/or to flush secondary tubing between the deliveries of incompatible medications.
- 2. Channel The module attached to the programming module for the delivery of IV fluids or medications.
- Channel Labels Provides a hospital- defined list of labels, which can be displayed in the channel message display allowing the user to identify the channel with the solution being infused (i.e., blood or chemotherapy), or the catheter location (i.e., pulmonary artery or intraperitoneal).
- 4. Drug Library A drug dataset defines a list of up to 1500 drugs and concentrations appropriate for each Profile<sup>™</sup>. Programming via the drug dataset automates programming steps, including the drug name, drug amount and diluent volume, and represents established best practice Guardrails<sup>™</sup> limit checking.
- 5. Epidural Analgesia infusion delivered via the epidural space.
- 6. Flush solution A solution used to provide a flush between or at the end of IV medications. The flush solution shall be compatible with the medications delivered.
- 7. Guardrails<sup>TM</sup> The programming software within the Alaris Medley infusion system designed to help prevent programming errors by:
  - a. Providing an advisory prompt if an out-of-limit entry is made at the time the device is programmed to infuse medications defined in the drug library
  - b. Comparing user programming with the hospital-defined best practice guidelines
  - c. Customizing device configurable settings to meet the need of the selected patient population
- 8. Intrathecal Analgesia infusion delivered through the intrathecal space.
- 9. Point of Care (POC)/Programming Module The module of the Alaris Medley medication safety system that contains the drug library and pump configurations. This module controls all of the solutions and medications delivered through the pumping modules. The programming module cannot deliver any medication without a pumping module. Each programming module has the ability to control four pumping modules.

- 10. Priming Volume The amount of fluid used to clear the administration set of air. The amount of priming volume varies by administration set. The amount of priming volume can be found on the administration set package.
- 11. Profile<sup>TM</sup> Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population.

#### C. <u>INTRAVENOUS (IV) INFUSIONS:</u>

- All solutions and medications administered via an IV route shall be administered using an IV infusion device except in the following situations:
  - a. IV push administration.
  - b. Surgery, under the direct supervision of an anesthesiologist.
  - c. Emergent situations, under the direct supervision of the Registered Nurse (RN).
  - d. Identified research studies when the research RN is present to monitor the infusion.
  - e. High census, if there is a shortage of infusion pumps; plain solutions (without additives) at rates less than or equal to 75 mL/hour may be infused without an infusion pump.
- 2. Staff must utilize both the appropriate Profile<sup>TM</sup> with Guardrails<sup>TM</sup> features and the channel labels when programming the Alaris infusion system to enhance the safe delivery of intravenous IV medications and solutions.
  - a. Intensive Care Unit (ICU)/Emergency Department (ERD)/Operating Room (OR) shall be used by ICU, Post Anesthesia Care Unit (PACU), Cardiac Catheterization Lab, Interventional Radiology, and Emergency Department (ED), Surgery.
  - b. IMC4/Telemetry shall be used by Telemetry and Progressive Care UnitFerensies.
  - c. Acute Care shall be used by 1North, Acute Rehab, 2Pavilion, 3Pavilion, 4Pavilion, and the Forensic Unit.
  - d. Neonatal Intensive Care Unit (NICU) shall be used by Neonatal Intensive Care Unit (NICU) and ED.
  - e. Peds4 shall be used for pediatric patientsby, ED, and PACU.
  - f. WNS (formerly WCS) shall be used by Labor &and Delivery and Mother Baby.
  - g. Oncology
- 3. Profiles and Channel Labels shall be checked by the licensed nurse at the beginning of each shift.
- 4. Profiles <sup>™</sup> shall be checked and changed as needed when a patient is transferred to another patient care unit. The receiving unit RN shall be responsible to check and change the patient profile.
- 5. Channel labels shall be utilized for medications and/or solutions that are not a part of the drug data set.

#### D. PRIMING AND FLUSHING:

- The priming volume shall be subtracted from the volume to be infused in order to ensure the medication and/or solution is infused over the prescribed rate as appropriate in NICU and Pediatrics.
- To clear residual medication volume from the IV administration set, the back flushing technique shall be utilized. Approximately 20 mL of medication shall be flushed back into the empty bag or bottle. The flush solution is then infused at the same rate as the original rate of the medication.

#### E. <u>SMART SITE PORTS:</u>

- 1. Smart Site injection sites on the IV tubing are accessed only with a luer lock syringe.
  - 1.a. Note: Using a needle or blunt tip syringe will damage the valve and result in leaking. The valve may be secured by attaching a Smart Site valve cap.

#### F. CARE AND CLEANING:

1. One POC and channel shall be left in the patient's room at discharge and cleaned by Environmental Services (EVS). Extra POCs and channels shall be stored in a designated area on the unit or in the Sterile Processing Department (SPD).

- The tubing and IV bag shall be removed and discarded by the unit's RN prior to EVS cleaning pump.
- b. EVS shall not clean pump if tubing and/or IV bag have not been removed.
- c. EVS shall attempt to locate the Assistant Nurse Manager (ANM) shift supervisor/designee and request the tubing and IV bag be removed. If the ANM, shift supervisor/designee cannot be located, or the tubing/IV bag is not removed in a timely manner, cleaning the pump shall be nursing's responsibility.
- Cleaned infusion pumps shall be covered with a plastic bag.
- 3. Cleaning needs of the Infusion Pump during patient care shall be the responsibility of the RN caring for the patient.
  - a. They shall be wiped down with a hospital- approved disinfectant weekly and when visibly soiled. (Refer to Infection Control Policy-Manual, IC-9r: Cleaning and Disinfection, IC 9)
  - b. To avoid damage to the connectivity points never spray cleaning solutions directly onto the pump.
  - c. Spray cleaning solution onto a cloth and wipe the pump with the moistened cloth.
- 4. Greater than 70% alcohol solutions are damaging to equipment surface, and shall not be used.
- 5. Infusion pumps shall be kept plugged into an electrical outlet at all times.
  - Cleaned infusion pumps not in use shall be stored in the patient's room or designated storage area.
  - **b.** Sterile Processing (SPD) shall make rounds (Monday-Friday) to maintain a minimum supply in SPD.
    - b.i. (Exception: Forensic Unit)

#### G. RELATED DOCUMENTS

Infection Control Policy:-Manual IC 9r Cleaning and Disinfection IC 9

Tri-City Medical Center		Patient Care Services				
PROCEDUR	RE: POINT OF CARE TESTING COM	MPETENCY ASSESSMENT				
Purpose:	To outline the mandatory Point of	Care testing personnel competency requirements.				
Supportive D	Data: To meet regulatory requirements.	To meet regulatory requirements, to include but not limited to College of American				
	Pathology and Joint Commission	Pathology and Joint Commission				
Equipment:	POC Competency Forms (located	POC-Competency Forms (located on Intranet)				

#### A. POLICY:

- Point of Care Testing (POCT) includes analytical patient tests performed outside the clinical facilities of the main laboratory. All POCT is covered under the Laboratory's Clinical Lab Improvements Amendments license, and is subject to the same regulations. The College of American Pathologist (CAP) personnel competency requirements for POCT includes:
  - a. Evidence testing personnel have adequate, specific training to ensure competence.
  - b. A list delineating the specific tests each POCT personnel is authorized to perform.
  - c. A documented program ensuring each person performing POCT maintains satisfactory levels of competence.
- 2. Joint Commission requires competency to be assessed using at least two (2) of the following methods per person per test:
  - Performance of a test on a blind specimen.
  - b. Periodic observation of routine work by the supervisor or qualified designee.
  - c. Monitoring of each user's quality control performance.
  - d. Use of written test specific to the test assessed.
- 3. Competency for waived testing shall be evaluated upon hire and annually thereafter.

  Competency for non-waived testing shall be evaluated upon hire, semi-annually during the first year, and annually thereafter. Competency shall be reassessed at any time when problems are identified with employee performance.
- 4. The records must make it possible for the Inspector to determine what skills were assessed and how those skills were measured. Some elements of competency include, but are not limited to:
  - Direct observations of routine patient test performance, including, as applicable, patient identification and preparation; and specimen collection, handling, processing and testing.
  - Monitoring the recording and reporting of test results, including, as applicable, reporting critical results.
  - c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventative maintenance records.
  - Direct observation of performance of instrument maintenance and function checks, as applicable.
  - e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples.
  - f. Evaluation of problem solving skills.
- 5. For non-waived (moderate-complexity) tests, all of the above six (6) elements must be assessed annually. For waived tests, it is not necessary to assess all elements at each assessment. Ongoing supervisory review is an acceptable method of assessing competency.
- Personnel will not be allowed to perform POC testing without completion of the competency requirements.

#### B. PROCEDURE:

 The Laboratory Medical Director authorizes personnel to perform testing. Authorization is determined by job description and is specific to nursing unit and job title. Refer to the Laboratory Point of Care Coordinator and Quality Management Manual for any clarification.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/10, 06/11, 06/14 <b>, 10/17</b>	04/11, 06/14, 11/17	05/11, 06/14, <b>12/17</b>	08/14	n/a	n/a	06/11, 10/14, <b>04/18</b>	06/11, 11/14

- 2. Evidence of training and competency shall be documented and records shall be maintained in the Employee file.
- 3. Management is responsible to ensure all testing personnel within their department have completed the required competencies.
- If an individual fails to complete competency assessment by the due date, they will not be allowed to perform POC testing until the competency is completed.
- 5. Return all completed competencies to the Education department.
  - Blank forms are found on the TCMC Intranet.

## C. FORM(S):

b.1. Point of Care Competency Form

## C.D. REFERENCE(S):

- College of American Pathology. (2014) Point of Care Testing Checklist.
- 4-2. e-dition.jcrinc.com WT.03.01.01. Retrieved on May 11, 2011.
- 2-3. The Joint Commission (2017). Hospital Accreditation Standards. Illinois: Joint Commission Resources.

Tri-City Me	dical Center	Patient Care Services			
PROCEDURE:	POWER INJECTION PROCEDURE FOR PERIPHERALLY INSERTED CENTRAL CATHETER (PICC)				
Purpose:	To outline the Registered Nurse's (RN's) responsibility when attaching and disconnecting a Power Injectable Peripherally Inserted Central Catheter with the Contrast Power Injector. Maintain compliance with state and manufacturers guidelines.				
Supportive Data:	ort or long term peripheral access to the central capy and power injection of contrast media. For blood a 5 French or larger catheter. The maximum liliter/sec for power injection of contrast media. The cors used with the Power Injectable CT PICC may not				
Equipment:	exceed 250 psi.  Power Injectable CT PICC, Power Injector, Computerized Axial Tomography Scanner-/magnetic resonance imaging (MRI) Scanner.  1. Non-sterile gloves. 2. 3 alcohol swabs. 3. Sterile field (may use 4x4 sterile gauze). 4. 10mL or more Sterile Normal Saline filled syringe. 5. 1 Anti-reflux valve for each lumen.				

#### A. POLICY:

- 1. Use only lumens marked "Power Injectable" for power injection of contrast media.
  - a. Warning: Use of lumens not marked "Power Injectable" for power injection of contrast media may cause failure of the catheter.
- 2. Confirm injection flow rate does not exceed capacity of 5 French double lumen **peripherally** inserted central catheter (PICC) line with technologist.
  - a. Warning: Exceeding the maximum flow rate of 4 mL/sec may result in catheter failure and/or catheter tip displacement.

#### B. PROCEDURE PERFORMED BY A REGISTERED NURSE:

- Perform hand hygiene.
- 2. Don clean non-sterile gloves.
- 3. Clamp both PICC ports and suspend all Intravenous (IV) meds and Total Parenteral Nutrition (TPN).
- Select port to be used and ensure patency.
  - a. Warning: Failure to ensure patency of the catheter prior to power injection studies may result in catheter failure.
  - b. Cleanse catheter tip thoroughly with three (3) alcohol swabs and allow to air dry.
  - c. Attach a 10 mL or larger syringe filled with sterile normal saline.
  - d. Unclamp and aspirate for adequate blood return and flush the catheter with the full 10 mL or more of sterile normal saline.
- Detach syringe.
- 6. Attach the IV tubing from the power injector syringe directly to the PICC with the anti-reflux valve attached.
- 7. Keep PICC to be used for power injection unclamped while keeping secondary catheter lumen not connected to power injection system clamped.
- 8. Notify technologist that the system is connected.
- 9. Monitor PICC and injection site while the injection is under way. Immediately notify technologist if of any abnormal infiltration, leaking or catheter failure.

Department Review	Clinical Policies & Procedures  Nurse Executive Committee		Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors	
11/06, 06/08, 11/09 <b>, 01/18</b>	11/09, 03/15, <b>02/18</b>	12/09, 03/15, <b>03/18</b>	05/15 <b>, 03/18</b>	06/15, <b>03/18</b>	02/10, 07/15, <b>04/18</b>	02/10, 07/15	

Patient Care Services
Power Injection Procedure for Peripherally Inserted Central Catheter (PICC)
Page 2 of 2

- 10. Exit the room upon request of the technologist to avoid any exposure to radiation. Technologist will give a 10 second warning announcement.
- 11. After imaging is complete, disconnect the power injection tubing.
- 12. Flush the Power PICC with 10 mL of sterile normal saline, using a 10 mL or larger syringe.
- 13. Resume previous IV fluids or clamp unused port.

## C. RELATED DOCUMENT(S):

- Infection Control Policy IC8 Hand Hygiene
- 2. Patient Care Services Central Venous Access Procedure

#### D. <u>REFERENCE(S):</u>

- Angiodynamics, Inc. Morpheus CT PICC Insertion Kit, http://www.angiodynamics.com/products/morpheus-smart-picc2014.
- 2. Bard Access Systems Power PICC. Polyurethane Radiology Catheters with Microintroducer Set, Instructions for Use. http://powerpicc.com/clinician-info.php 2014



## Administrative Policy Patient Care

**ISSUE DATE:** 

**NEW** 

**SUBJECT: Non-Beneficial Treatment** 

**REVISION DATE(S):** 

POLICY NUMBER: 8610-399

**Department Approval:** 

02/18

**Administrative Policies and Procedures Committee Approval:** 

02/18

Medical Executive Committee Approval:

03/18

**Professional Affairs Committee Approval:** 

04/18

**Board of Directors Approval:** 

## A. PURPOSE:

 The purpose of this policy is to outline a process for physicians to follow when a patient or his/her designated decision maker has requested treatment that in the best judgment of the patient's physician is non-beneficial in compliance with the relevant California statutes regarding health care decisions.

#### B. POLICY:

- 1. Tri-City Medical-CenterHealthcare District and physicians of the Tri-City-Medical CenterTCHD's Medical Staff are not obligated to provide a patient with medical treatment that, in the physician's best judgment, will not be beneficial. This policy applies to all patients regardless of race, color, national origin, religion, disability, age, sex, marital/familial status, socioeconomic status or sexual orientation. Disagreements concerning this issue between doctors, patients, family members, surrogates, conservators, nurses and other health care personnel will be addressed in the following manner:
  - a. Preempt conflict. Attempt to promote understanding among the involved parties in advance.
  - b. Negotiate solutions to disagreements using available hospital resources including the Ethics Committee, palliative care services, and chaplaincy services.
  - c. An effort should be made to contact the patient's outpatient primary care physician if available.
  - d. If disagreement persists, seek consultation from another physician.
  - e. If the consulting physician disagrees with the attending physician, consider transfer of the patient's care to another physician.
  - f. If both physicians agree, but there is still disagreement with the patient, family, conservator, or surrogate, consultation from the hospital Ethics Committee should be requested.
  - g. If the Ethics Committee review disagrees with the recommendation of the two physicians, help with transfer of the patient to another physician or institution should be provided. Until such transfer can occur, the current physician remains ethically and legally responsible for the care of the patient.
  - h. If the Ethics Committee review concludes that the proposed treatments are nonbeneficial but there is still failure to reach consensus with the patient, family, conservator, or surrogate, the following steps should be taken:
    - i. Risk Management and Administration of the hospital must be notified.
      - 1) Inform the patient or designated decision maker of the decision of the medical team. Document this discussion in the patient's health record.

- 2) The patient or the designated health care decision maker for the patient should be promptly notified in writing that the non-beneficial treatment will not be provided. A letter must be issued to the patient or designated health care decision maker on hospital stationery and signed by the patient's Attending Physician and the hospital's Chief Medical Executive, or their designees, documenting this decision. The letter will be hand delivered, if possible.—2
- ii. Discuss the option of transfer to an appropriate care setting. It is the responsibility of the patient, family, conservator, or surrogate to find an acceptable medical practitioner or institution and arrange the transfer of the patient. Reasonable efforts will be made to assist in the transfer of the patient.
- iii. Recognize the opportunity of the patient or designated decision maker to seek a judicial mandate to continue the treatments in question. Continuing care will be provided to the patient until a transfer can be accomplished or it appears that transfer cannot be accomplished. No new treatment, which has been determined to be non-beneficial, will be initiated unless court ordered.
- i. If the patient has not been transferred or a judicial mandate has not been issued within a reasonable period of time, not to exceed ten (10) days from the issuance of the letter, the treatment in question may be withheld or withdrawn.

#### C. RELATED DOCUMENT(S):

j-1. Non-Beneficial Treatment Patient Letter

#### C.D. REFERENCE(S):

California Probate Code sections 4735, 4736 and 4740



To: [Name of patient/surrogate] [Address]

[Date]

#### Re: Medical care of patient, [Name and MRN] at Tri-City Healthcare District

Dear [Name of patient/Surrogate],

We have been caring for your [relationship to patient], [Patient's Name], during his/her current hospitalization at Tri-City Healthcare District. We have been asked by you to provide treatments for [Patient's Name] which includes treatments like [Name each treatment deemed to be non-beneficial]. We understand why you are requesting this care and have carefully considered your reasons for requesting this care. Our goal in caring for our patients is to provide them with medical treatments most appropriate for their condition. We have consulted with our colleagues and we have evaluated the potential outcomes of the treatment requested. We have also consulted our hospital ethics committee and they agree that the treatments mentioned above would not be beneficial to [Patient's Name] and would not be appropriate. After careful review and discussion, we do not believe that the requested treatments would be beneficial under the circumstances.

We are providing you with this written notice of our decision in compliance with the hospital's policy and the California Probate Code that addresses requests for medical treatments which physicians believe are non-beneficial. We have also asked our Chief Medical Executive to sign this letter. He has reviewed this matter and his signature indicates the hospital's support of our decision.

We recognize that making treatment decisions for gravely ill persons is challenging for everyone involved. If you disagree with our decision, you may seek out another physician and institution willing to accept [Patient's Name] for transfer and provide the care you are seeking. Although you are responsible for locating alternative providers, we will make reasonable efforts to assist you. You may also seek a court order that directs our hospital to continue the treatment in question. You must carry out these alternatives within 1 - 10 days of this notice. After that time, we will not continue to provide the non-beneficial treatments.

We do recognize how difficult this time is for the patient, clinicians, and family. We will continue to provide the current medical treatment to [Patient's Name], and continue to work with you to develop a mutually acceptable plan of care.

Sincerely,

[Name], MD [Name], MD Attending Physician Chief Medical Executive



## Tri-City Medical Center Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

DELETE – incorporated into Patient Care Services Policy: Discharge of Patients and Discharge Against Medical Advice (AMA)

SUBJECT:

**AMA Discharges** 

**POLICY NUMBER:** 

100

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

06/1603/18

**Division of Psychiatry Approval:** 

-n/a04/18

Pharmacy and Therapeutics Approval:

n/a n/a

Medical Executive Committee Approval:

**Professional Affairs Committee Approval:** 

**Board of Directors Approval:** 

#### \. <u>PURPOSE:</u>

To help provide a process whereby a patient-is advised of the risks associated with leaving the Behavioral Health Unit-or Crisis Stabilization Unit against medical advice (AMA) and guidelines for action when a patient elects to leave AMA.

### B. POLICY:

- A voluntary patient may leave the hospital at any time by giving notice to any member of the hospital-staff on his/hor-desire to leave and by completing usual discharge processes.
- 2. A Conservatee may leave in a like manner if the patient's Conservator gives notice.
- 3. If a voluntary patient cannot be persuaded to continue his or her hospitalization, cannot be safely discharged, and meets criteria for involuntary hospitalization, an appropriately credentialed-clinician will initiate a 72 hour hold and the patient will not be permitted to leave the unit.

#### PROCEDURE:

#### Definitions

- a. <u>Against Medical Advice (AMA):</u> Terminating-treatment-without a discharge-from the attending-psychiatrist or his/her-designee or terminating treatment against the attending psychiatrist's advice or his/her-designee.
- <u>Discharge:</u> Absolute unconditional release of a patient from the hospital by action of the hospital or court.
- 5. <u>Elepement:</u> The unauthorized leave of a patient who has been admitted and leave the hospital without permission.
- d. <u>Conservator:</u> A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or developmentally disabled.
- If a voluntary patient requests to terminate treatment, cannot be persuaded to stay, and does not meet 5150 criteria the staff will:
  - a. Notify the attending psychiatrist or his/her designee after making a clinical determination regarding the safety of allowing the patient to leave.
  - b. Provide the patient with discharge instructions, medication reconciliation paperwork and other discharge information
  - . Ask the patient to complete a Termination of Treatment Against Medical Advice form
  - Document in the medical record the patient's response to discussion including:

- Risks to health associated with leaving AMA
- ii. How the patient left
- iii. With whom and at what time the patient left
- iv. Persons notified and actions taken by-them
- v. Any-instructions given to the patient-regarding follow-up treatment
- 3. If a voluntary patient requests to terminate treatment, cannot be persuaded to stay and meets 5150 criteria the staff-will:
  - a. Notify the attending psychiatrist or his/her designee
  - b. Ask a credentialed-clinician to independently evaluate the patient and, as appropriate, initiate a 72-hour hold.
  - Decument the details of the occurrence in the medical record.
  - d. Explain to the patient the reasons he/she will not be permitted to leave the unit
  - e. Complete 72 hour hold advisement, give patient original and place copy in medical record behind the original 72 hour hold form.



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

Managing the Medical Record When-afor BHU Patient Goes toin the Emergency

Department for Treatment While-Hospitalized

**POLICY NUMBER:** 

303

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: Professional Affairs Committee Approval:

n/a n/a

n/a 04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

To provide continuity in the medical record.

#### B. POLICY:

 Patients who require emergency medical interventions while hospitalized on the Inpatient Behavioral Health Unit (BHU) will not be discharged from the unit.

#### C. <u>PROCEDURE:</u>

- When a nurse is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will contact the operator by dialing "66." The operator will announce "Rapid Response Team to Room..." three (3) times overhead. Once notified, the Rapid Response Team (RRT) member will simultaneously respond to that room/location within five (5) minutes.-[Refer-to-Patient Care Services Manual Policy-IV.L.: Rapid-Response Team and Condition Help (H)]
- When an individual who is being treated on the inpatient Behavioral-Health-UnitBHU develops a
  medical symptom or complaint the nurse will assess the need for immediacy in addressing that
  symptom or complaint and will report the results of that assessment to the attending psychiatrist
  and hospitalist.
  - a. If possible, a consultation will be initiated for the physician/Allied Health Professional (AHP) specialty that addresses the presenting complaint or to the internist who performed the initial history and physical examination.
  - b. When the condition is emergent or potentially emergent, the nurse will ensure that the patient is transported to the Emergency Department (ED) for immediate intervention.
    - The attending psychiatrist and hospitalist will be notified.
    - ii. The Emergency departmentED will be notified and given clinical information.
    - iii. A staff member from the BHU will accompany the patient by either wheelchair or stretcher as the condition warrants.
    - iv. A Security staff member may accompany the patient and staff member if it is clinically indicated.
    - v. The BHU record will be sent with the patient.
- 3. The patient will not be discharged from the Behavioral Health-UnitBHU.
- 4. The patient will be issued a new encounter for the emergency-departmentED visit to allow that patient to be entered into the Firstnet system.

- 5. When the patient returns to the BHU, the original encounter remains intact and the Emergency DepartmentED encounter will be discharged. The patient's BHU medical record will be returned to the BHU with the patient.
- 6. The accounts will be combined at the time of patient discharge.
- 7. If the patient is sent, from the Emergency DepartmentED, to a medical or surgical unit for treatment of the complaint, the patient will be discharged from the BHU.

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

8-1. Patient Care Services Policy: Rapid Response Team and Condition Help



#### **Behavioral Health Services** Inpatient Behavioral Health Unit **Crisis Stabilization Unit**

SUBJECT:

**Notification of Responsible Persons** 

**POLICY NUMBER:** 

710

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

06/1609/17

**Division of Psychiatry Approval:** Pharmacy and Therapeutics Approval:

n/a

**Medical Executive Committee Approval:** 

n/a n/a

**Professional Affairs Committee Approval:** 

04/18

**Board of Directors Approval:** 

#### A. **PURPOSE:**

To ensure that appropriate notification will occur if/when a patient experiences a significant change in physical or mental status while hospitalized inen the Inpatient Behavioral Health Unit (BHU), or the Crisis Stabilization Unit (CSU).

#### **POLICY:** B.

In the event that a patient experiences a significant change in either physical or mental status, 1. appropriate notification will occur in accordance with patient consent and all HIPAA regulatory standards.

#### C. PROCEDURE:

- When a patient experiences an acute or serious change in physical status the following individuals will be notified:
  - The attending Psychiatrist a.
  - b. Attending medical dectorphysician/Allied Health Professional (AHP) if one has been identified
  - Immediate family or legal conservator C.
  - Program Manager
- 2. When a patient experiences an acute or serious change in mental status the following individuals will be notified:
  - The attending Psychiatrist a.
  - Immediate family or legal conservator b.
  - Program Manager
- 3. In the event that the patient is relocated to another unit within the hospital or to another facility, the patient's family and or legal conservator is notified.

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

- 1. Behavioral Health Services Policy: Confidentiality
- 4.2. Behavioral Health Services Policy: Family Involvement in Treatment



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

One to One Observation of Patients

**POLICY NUMBER:** 

711

**ISSUE DATE:** 

03/08

REVISION DATE(S): 08/09, 03/13

**Department Approval:** 

<del>06/16</del>09/17

Division of Psychiatry Approval:
Pharmacy and Therapeutics Approval:
Medical Executive Committee Approval:

n/a n/a

Medical Executive Committee Approval:
Professional Affairs Committee Approval:

n/a 04/18

**Board of Directors Approval:** 

#### A. <u>PURPOSE:</u>

1. To provide guidelines for intensive patient monitoring to assure the safety of the patient and the environment.

#### B. POLICY:

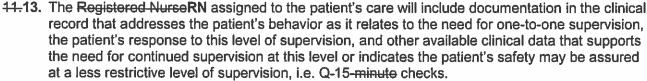
1. When a patient displays behavior that places his safety, the safety of others, or the safety of the environment in immediate risk, the patient will be closely observed by a clinical staff member who will be assigned specifically to provide that monitoring.

#### C. PROCEDURE:

- Criteria for assigning one-to-one supervision:
  - a. The patient has expressed intent to inflict serious injury to him/herself in the immediate future, is unable to contract for safety, and is unable to adequately control impulses to carry out the intent such that every 15 minutes (Q-15)-minute checks do not assure his or her safety.
  - b. The patient has displayed behavior either immediately prior to admission or while on the unit that is indicative of his or her intent to inflict serious injury to self.
  - c. The patient has expressed intent to inflict serious injury on another or others in the milieu and may not be able to control impulses to carry out the intent such that Q-15 minute checks to do assure his or her safety.
  - d. The patient has displayed behavior, either immediately prior to admission or while on the unit, that is indicative of intent to harm others and/or the patient has displayed or is reported to have recently displayed poor control of impulses to act on this intent.
  - e. The patient's reality testing or level of symptoms is such that he or she has been determined to be at risk for acting out in a manner that puts the environment at serious risk.
  - f. The patient has a medical condition that puts him or her at immediate high risk for falls such that it is not safe to leave the patient unattended.
  - g. The patient has a medical condition (such as dressings, open wounds, etc.) that would put that patient or others in the environment at risk if the patient was unable to comply with treatment, and it has been determined that Q-15 minute checks do not assure his or her safety or protection.
  - h. The patient is placed in four-limb restraints.

- 2. When it becomes necessary to assign the patient to one-to-one supervision the **registered nurse** (RN) and/or Psychiatrist will explain the nature and purpose of this level of observation to the patient/family and answer questions as indicated.
- 3. When a patient is placed on one-to-one supervision, the patient will be restricted to the Behavioral Health Unit (BHU) except to receive emergency medical care.
  - 3.a. If the patient must leave the unit, a member of the BHU clinical staff and a Security Officer will escort the patient.
- 4. The patient will continue to exercise all patient rights (i.e. clothing, visitors, telephone) while on one-to-one supervision unless there are indications specific to each right to impose a limitation.
- 4.5. A registered nurseRN may initiate one-to one observation when, in his or her judgment, it is clinically warranted to assure the safety of the patient or the environment. After doing so, the RN will obtain a written physician order for this level of observation as soon as is practicable.
- 5.6. The Psychiatrist will be responsible for writing an order to discontinue one-to-one observation when, in his or her clinical judgment, the reason for initiating this level of supervision no longer exists. A registered-nurseRN may not discontinue one-to-one supervision without a physician order.
- 6-7. The staff member who is assigned to provide one-to-one supervision will not have an additional clinical assignment and will be expected to provide observation and care to only one patient.
  - a. The staff-member-assigned will be provided with relief at regularly scheduled intervals at least every 2 hours, for fifteen-minute breaks and for-meals. If a break is needed contact the Assisted Nurse Manager (ANM)/Charge RN on the unit so proper coverage can be obtained during your absence.
  - b. The staff member will not leave the assignment until a relief person presents him or herself to take over.
  - c. All clinical staff who provide one-to-one observation will possess the necessary competencies to adequately provide this level of care including but not limited to:
    - i. Knowledge of indicators for suicidal risk
    - ii. Knowledge of indicators for elopement risk
    - iii. Knowledge of indicators of escalation of aggression
    - iv. Verbal de-escalation skills
    - v. Restraint and seclusion
    - vi. Therapeutic communication skills
- 7.8. The staff member who is assigned to provide one-to-one observation will remain at close proximity (arm's length) to the patient at all times. This includes:
  - Bathing and toileting
  - b. Meals
  - c. Smoking breaks
  - d. Sleep
- d.9. The assigned staff member will document-give report of significant observations about the patient at least once every hour-and-more frequently as indicated on a form provided for this purpose to assigned RN.
- a.10. Information may include approaches that have been helpful, triggers, patient preferences, patient concerns, and observations that will assist others to better understand and treat the patient.
  - b.This-content-of-this-documentation will be reviewed by the assigned RN-and will-be communicated between care-givers and at change of shift but will-not-become a part of the patient's permanent-medical record.
- 9.11. The staff member who is assigned to provide one-to-one observation will interact with the patient in a therapeutic manner and will refrain from engaging in personal conversation, reading, use of cellular phones, watching television, or other activities that might provide a distraction from the intent of the assignment-.
- 40.12. The Registered NurseRN assigned to the patient's care will assess the patient's condition throughout the shift and provide professional nursing care as indicated.

Behavioral Health Unit Inpatient One to One Observation of Patients Page 3 of 3



42.14. One-to-one observation, because of its restrictive nature, will be discontinued as soon as the attending psychiatrist, with input from clinical staff, determines that the patient's safety can be assured with Q-15-minute monitoring. Once discontinued, one-to-one supervision may be resumed if clinical justification exists. If it is resumed by the RN, he or she will obtain a new physician order for this level of observation as soon as is practicable.



#### **BEHAVIORAL HEALTH SERVICES**

**DELETE- Duplicate Policy** of Inpatient Behavioral Health Services: One-to-One Observation of **Patients** 

SUBJECT:

One to One Patient Supervision

**POLICY NUMBER:** 

6340-015

**ISSUE DATE:** 

5/83

REVISION DATE(S): 7/85, 4/87, 5/91, 8/94, 5/97 6/99, 3/00,

4/03, 12/04, 4/05, 3/13

**Department Approval:** 

09/17

**Division of Psychiatry Approval:** 

n/a

Pharmacy and Therapeutics Approval:

n/a

**Medical Executive Committee Approval:** 

n/a

**Professional Affairs Committee Approval:** 

04/18

**Board of Directors Approval:** 

#### One-to-One Patient Supervision:

- Staff-must-be at arm's length from the patient at all times. This includes trips to the bathroom, shower, meals, patio, and sleep hours.
- Patient is restricted to the Behavioral-Health Unit except for emergent Medical care.
- Staff providing one-to-one supervision are to-have no other patient assignments. Relief is provided every 2 hours for the staff member, for 15-minute breaks.
- Patient on one-to-one-supervision required a daily Progress Note every-shift-addressing the requirement for one-to-one-and the patient's progress to be completed by assigned RN.
- A-nurse can order one-te-one supervision status-if-in-nurse's clinical judgment, the patient would benefit-from-one-to-one supervision. Attending physician-must be notified for a physician order. as soon as possible.
- Removal-from-one-to-one supervision-status requires a physician's order. This decision-is-made between a Physician-and ANM/Charge-Nurse.



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

**Orientation of New Patients** 

**POLICY NUMBER:** 

712

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

<del>06/16</del>09/17

Division of Psychiatry Approval:
Pharmacy and Therapeutics Approval:
Medical Executive Committee Approval:

n/a n/a

Medical Executive Committee Approval: Professional Affairs Committee Approval:

n/a 04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

To identify the process of patient orientation to the linpatient <del>psychiatric-Behavioral Health u</del>Unit (BHU).

#### B. **POLICY:**

- Each patient will receive an orientation to the Inpatient-Behavioral Health UnitBHU by the admitting Registered Nurse (RN) or designee. Orientation information will be presented in a manner that maximizes the patient's understanding of the information.
- 2. Orientation information will be presented in both verbal and written formats.

#### C. PROCEDURE:

- Each patient who is admitted to the-unitBHU will be given a copy of the Unit Rules with the
  instruction that they are expected to read them and ask for clarification if there are items they do
  not understand. Rules will be briefly reviewed with the patient.
- 2. Patients will be given a tour of the unit including smeking areas, their room, day room, dining room and other common areas. They will be oriented to the use of the laundry, telephone, and shown where information is located regarding patient rights, patient grievances, interpreters, daily therapy schedule, nurse assignment and community resource information.
- 3. Patients will be informed of visiting hours,-and where visitors may and may not visit, and what visitors may and may not bring.
- 4. Patients will be shown where their belongings will be kept and how they are to request access to them. They will be told what items they may and may not keep with them.
- 5. Patients will be informed about how and where to procure clean linen and to dispose of used linens.
- 6. Patients will be informed of their rights and responsibilities and voluntary patients will be asked to sign consent forms at the time of admission.
- 7. Patients will be introduced to other staff and to other patients.
- 8. Each patient's orientation will be adapted to the patient's clinical presentation. When the patient's symptoms are of such severity that it is deemed either unsafe or impractical to orient the patient, the orientation will be given as soon as the patient's condition is such that it is deemed safe and practical.

## D. RELATED DOCUMENT(S):

1. Behavioral Health Services Policy: Patient Belongings

Behavioral Health Unit Inpatient **Orientation of New Patients** Page 2 of 2



- Behavioral Health Services Policy Patient Responsibilities 2.
- <del>9.</del>3.
- Behavioral Health Services Policy: Patient Rights
  Behavioral Health Services Policy: Consent Related to Mental Health Treatment

# Behavioral Health Services Inpatient Behavioral Health Unit Crisis Stabilization Unit

SUBJECT:

**Pastoral Care** 

POLICY NUMBER:

713

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

Department Approval:

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: Professional Affairs Committee Approval: n/a n/a

n/a 04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

1. To define availability of pastoral care, religious consultation and education to patients.

#### B. POLICY:

 Recognizing that spiritual values and issues may affect patient response to treatment, patients will have access to clergy while they are hospitalized on the linpatient Behavioral Health Unit (BHU) or Crisis Stabilization Unit (CSU).

#### C. PROCEDURE:

- 1. Patients' spiritual needs are assessed as part of the Psychosocial Assessment.
- 2. Identified problems are discussed in the Interdisciplinary Treatment Planning meeting and a plan is developed to address identified problems.
- 3. When a patient requests pastoral assistance or consultation the program staff will contact the Chaplain's office to arrange for such consultation.
- 4. The patient may contact a clergy person of his or her choice to visit during the hospitalization.
- 5. If clergy visits the patient, private space will be provided to accommodate the consultation. The patient may visit with clergy outside of regularly scheduled visiting hours with prior approval by the attending psychiatrist.
- 6. Staff will maintain a supportive and unbiased relationship with patients regarding religious issues and patients' secular needs will be referred to clergy.



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

**Patient Belongings** 

**POLICY NUMBER:** 

402

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 06/11, 03/13** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: n/a n/a

Professional Affairs Committee Approval:

n/a

**Board of Directors Approval:** 

04/18

#### A. PURPOSE:

In order to provide and maintain a safe and secure environment for all patients and hospital
personnel, a patient's personal belongings/room may be searched for dangerous objects and/or
drugs. Patients are requested to be present during the search of their personal
belongings/room.

## B. <u>DEFINITION(S):</u>

- Contraband: for the purpose of this policy, contraband is defined as materials or articles not authorized to remain in the possession of patients while admitted to Tri-City Healthcare District (TCMCHD). Contraband includes, but may not be limited to:
  - a. Weapons (firearms, knives or other objects that are easily used or adapted to cause personal injury, including any item identified as a weapon in the California Cal. Penal Code § 12276 that might be used as weapons).
  - b. Recording devices, cell phones, and cameras.
  - a.c. Alcohol, cigarettes and other tobacco products, illicit drugs or Food and Drug
    Administration (FDA)- approved drugs, and any other unauthorized substances meant
    to be inhaled, ingested or taken into the body and not prescribed or permitted by the
    patient's physician(s)/Allied Health Professional (AHP) for use while the patient is
    under the care of the facility
    - i. Note: Medication permitted under policy Patient Care Services Policy: IV.DD, "Medications Brought in by the Patient" are not contraband when handled in accordance with that policy.
      - i-1) Patients will be encouraged to send all medications home with a family member.
      - ii-2) Other medications will be sent to pharmacy for safe-keeping. A list will be kept in the patient's medical record and the medications will be returned to the patient at the time of discharge from the unit.
      - iii.3) Patients will be informed that illicit drugs will not be returned to them upon discharge if taken into possession by the hospital. Security will be notified for proper disposal
    - iv. Patients will be informed that prescription opioids, barbiturates, narcotics, and other controlled substances will not be returned to them upon discharge if taken into possession by the hospital-pharmacy.

- e.d. Drug paraphernalia as defined in §Section 863 of Title 21 of the United States Code, which includes equipments or materials of any kind meant for use in planting, growing, harvesting, manufacturing, compounding, producing, processing, preparing, packaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance.
- 2. Illegal Contraband: for the purposes of this policy, illegal contraband is defined as that subset of materials or articles that meet the definition of contraband, above, and addition, are normally illegal for individuals to possess or use in public places under the laws of the United States and/or California.
- 3. Restricted Items: restricted items or other items in addition to contraband which could be used for injury to self or others and are, therefore, not allowed to be in the possession of patients on a locked unit. Some examples include: scissors, glass items, drug paraphernalia, blades or safety razors, aerosol cans, mirrors, ropes, shoe laces, soda cans, model glue, plastic bags, unpackaged food and silverware. Other items may be considered restricted at the discretion of the staff.
- 3.4. Safety Assessment: a procedure, not involving a search of the person by which an attempt is made to find potentially harmful objects and restrict them from the unit milieu.

#### C. POLICY:

- Patients are entitled to receive, possess, and use personal property while hospitalized, under the conditions and exceptions set forth in this policy. TCMGHD Behavioral Health Unit (BHU) is committed to maintaining a safe and therapeutic environment for patients, visitors, and staff. Possession of contraband, as defined above, by patients, and visitors is not authorized while on TCMGHD In-patient BHU premises.
- 2. On the BHU, patients and visitors will be informed through some combination of verbal instruction, written materials and posted signs of unit rules regarding articles which may not be held in their possession.
- 3. If contraband is noted anywhere on the BHU, employees are authorized to take appropriate action to secure the items. Security is available to assist as necessary with materials or articles suspected to be Illegal Contraband. Security will secure the items and will be responsible for seeing that items of Illegal Contraband are turned over to local law enforcement authorities. Articles of contraband that are not Illegal contraband will be retained by TCMCHD security pursuant to Security Policy: 232 Property CustodyTCMC policies-applicable to patient valuables (Administrative Policy Manual: Policy 8610-217).

#### D. PROCEDURE:

- 1. Clothing and Personal Items:
  - i.a. On admission, all patients will be informed of the reason and rationale for inspecting personal property, and the prohibition of specific items that are not allowed on the PICUBHU and main unit (both lecked).
  - ii.b. On admission each patient's belongings will be searched and inventoried, in the presence of the patient or witnessed by another staff member if the patient is unable to be present.
  - iii-c. All patients will be transported from the Emergency Department (ED) to the BHU in a hospital gown and will have their clothing searched in the ED for contraband or restricted items, prior to entering the BHU.
  - iv-d. All patients who are admitted directly to the unitBHU and who arrive in street clothing will be asked to change into a hospital gown in a private room, and will have their clothing searched for contraband or restricted items.
  - v.e. Staff will check patient luggage, bags, billfolds and/or purses for contraband or restricted items.
  - vi.f. Each patient will have a closet/locker in his or her room for the storage of clothing and some personal belongings.

- vii-g. Certain personal property will not be kept in patient rooms because of their potential for inducing injury. Secure storage will be provided for each patient with his/her name on it for the safe keeping of belongings that are not permitted in patient rooms. Contents will include items that will be collected after their use and those for which the patient may require one to one supervision during their use.
- viii.h. Patients will have access to the times at 0800 hours each day
- ix.i. Patients may use the articles from their storage with supervision or independently as is clinically indicated.
- x.j. The patient will be permitted to inspect personal property at reasonable times.
- xi.k. Examples of items kept in secured storage include the following:
  - 1-i. All glass items including, but not limited to, mirrors, perfume, and make-up bottles.
  - ii. Any clothing with drawstrings: sweatpants, running shorts, hoodies, pajamas, etc.
  - iii. Tobacco items, lighters, or matches.
  - 2.iv. Razor blades and non-electric razors. (Disposable razors are supplied by the unit and their-use is supervised)
  - 3.v. Battery operated or cordless electric razors.
  - 4.vi. Belts, neckties, scarves, long jewelry, pins.
  - 5.vii. Nail files, metal combs, metal hair picks, necklaces.
  - 6-viii. Needlework equipment, long strands of yarn, needles, knitting needles, crochet hooks.
  - 7-ix. Certain projects made in craft's groups.
  - 8.x. Spray cans (hairspray).
  - 9-xi. Toxic substances such as hair dye or permanent wave solutions.
  - 40.xii. Pencil and make up sharpeners.
  - 41-xiii. Plastic bags.
  - 12-xiv. Recording devices, pagers, cell phones, cameras.
  - 13.xv. Money in excess of ten dollar (\$10), checkbooks, credit cards.
  - 14-xvi. Walkman, earphones, headphones (with supervision)
  - 15.xvii. Other items that, in the nurse's judgment, should not be kept in the patient's room.
- When personal items are taken into possession by the hospital, the patient and a designated individual are provided a copy of the "Receipt for Belongings taken-into Possession" Property Custody Record form that lists these items. A copy of this form is to be placed on the medical record. If the designated individual is not present, a copy of the form may be mailed to that individual upon the request of the patient.
  - i.a. The items will all be returned to the patient at the time of discharge.
  - ii.b. Whenever possible, items that will not be used during the hospital stay will be sent home with the patient's family.
- 3. Food:
  - i-a. Food items will not be allowed in patient rooms due to the possibility of insect infestation.
  - ii.b. Dietary trays will be permitted in the dining room and patio. Dietary trays are to contain plastic-ware only, excluding plastic knives. Plastic forks will be given out, upon request, and collected by staff after meals.
  - iii.c. Visitors will be asked to check with staff before bringing in food and beverages to the patient. Food and drinks from outside of the hospital will not be allowed.
  - iv-d. No beverages with caffeine will be permitted en the unit-except with a written order by the physician/AHP.
  - v.e. The kitchen will be kept locked when not in use.
  - vi.f. Snacks will be available between meals and in the evening at scheduled times.
  - vii.g. No cans will be permitted on the unit.

- 4. If the patient refuses to have contraband or restricted items placed in secure storage per TCMC BHU policy, the Registered Nurse (RN) will implement a denial of rights per the Behavioral health Servicespatient rights Policy: (BHU 6340-614) Patient Rights.
- 4.5. The MDphysician/AHP or RN will write an order in the patient's medical record documenting the item removed from the patient and the circumstance requiring removal of the item, i.e. patient may not have belt on the unit due to active suicidal ideation.
- 5.6. The denial of right order to remove patient's clothing or belongings must be reviewed on a daily basis by the RN and the treatment team and will be removed when the circumstances that justified the denial of right cease to exist.
- 6.7. In accordance with Cal.ifernia Code Title 9 § 865.1 the notification of the removal of rights must address the following:
  - •a. Date and time the right was denied
  - b. Specific right denied
  - •c. Good cause for the denial of right
  - Date of review if denial was extended beyond 30 days
  - •e. Signature of the professional person in charge of the facility or his designee authorizing the denial of right
- 7.8. The notification can be done at admission by MDphysician/AHP or RN, as designated by the professional person in charge of the facility.
- 8.9. The RN will document the denial of right in the patient's electronic medical record (Cerner ad hoc form), and on the Patients' Rights Denial- Monthly Tally hard copy form placed in the back of the medical record.
- 9-10. The following items must be inventoried and checked in by staff, but may be retained by the patient with complete responsibility for safeguarding his or her valuables:
  - i.a. Toothbrushes, toothpaste tubes, and other non-medication tubes of similar kind.
  - ii.b. Combs, hairbrushes, rollers
  - iii-c. Emery boards, lipstick, mascara and eye shadow that are not in containers with glass mirrors
  - iv.d. Wallets, and personal papers
  - v.e. Jewelry except long or heavy necklaces or pins
  - vi.f. Eyeglasses and saline solution for contact lenses
  - g. Other items that, in the nurse's judgment will not be injurious to the patient or to other patients on the unit.

#### E. FORM(S):

vii.1. Property Custody Record

#### F. RELATED DOCUMENT(S):

- 1. Administrative Policy: 217 Disposal of Drugs and Drug Paraphernalia
- viii-2. Behavioral health Services Policy: Patient Rights
- 3. Patient Care Services Policy: Medications Brought in by the Patient
- 4. Security Policy: 232 Property Custody

#### E.G. REFERENCE-LIST(S):

- 2.1. Cal. Code Reg. Title 9 § 865.1
- 2. Cal. Penal Code § 12276
- 3. Consent Manual: The Industry Resource for Consent and Related Health Care Law, 38<sup>th</sup> Ed., 2011.
- 4. Drug Paraphernalia Title 21 U.S. Code § 863

## **Property Custody Record**

## Tri-City Medical Center Security Department

## **Property Custody Record**

Notice to Property Owner: Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

Department. Any items not picked up within thirty(30) days will be destroyed.											
Officer Receiving Property:							Date Received:	Time R	eceived;		
Property Received from:  q Owner:					Location / Reason Property Obtained:						
q Othe	r:			<del></del>	q Property Received for Safekeeping						
Item #	Qty	Description	/ Condit	ion:	SN / Tag :				/ Tag #		
	Property Disposition:										
	q Property Returned to Owner q Property Returned to Other Reason:										
	q Property Destroyed After Thirty(30) Days q Property Destroyed Before Thirty(30) Days Reason:										
Property	Return	ed By:				Property Rece	eived Bv:				
Officer		,	Badge:	Date:		Signature:			Date		

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt



## Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

**Patient Discharge Types** 

**POLICY NUMBER:** 

704

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval:

n/a n/a

Professional Affairs Committee Approval:

n/a 04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

 To establish guidelines for the determination of discharge criteria and their application to the discharge process.

#### B. POLICY:

1. Each individual receiving treatment will be evaluated by applying established severity of illness criteria and in accordance with standards for clinical pertinence. Discharges from the inpatient unit may be of either a clinical or administrative nature. All administrative discharges must be approved by the attending psychiatrist and will be reviewed by the program director.

#### C. PROCEDURE:

- A patient may be discharged from treatment when it is determined that those goals defined in the treatment plan have been successfully achieved and the patient no longer meets the severity of illness continued stay criteria for the inpatient level of service.
  - a. The treatment team will meet daily to discuss the patient's progress toward goal achievement. Each specific patient's treatment plan will be reviewed at least once every week and more frequently as is clinically indicated.
  - b. The discharge planners will actively work with patients and their support systems to formulate a viable discharge plan that will be enacted when treatment goals in the inpatient level of service have been met.
- 2. A patient may be discharged from treatment when, based upon clinical presentation, it is determined that another level of service would better meet the patient's needs.
- 3. A voluntary patient may be discharged if they are unable or unwilling to continue in treatment.
  - When a patient requests a discharge against medical advice the clinical staff will attempt to ascertain the patient's reason for wanting to leave the program and will encourage the patient to complete his or her course of treatment.
  - b. The attending psychiatrist will be notified when a patient requests to leave the program against medical advice.
  - c. When a patient requests an **Against Medical Advice** (AMA) discharge, the clinical staff will continue to work with the patient to assure the best possible discharge plan that includes medications and an appointment for follow-up treatment.
  - d. When a voluntary patient asks to leave the program and, in the opinion of the clinical staff, that patient is assessed to be either a danger to self or others, or unable to provide for basic needs, (gravely disabled); the patient may be placed on a 72-hour hold for

- further assessment. When this occurs, all applicable forms and advisements will be completed in accordance to the **Patient Care Services** Policy: "72- Hour Holds, **Evaluation and Treatment of the Involuntary Patient**."
- e. In the event a patient is placed on a 72-hour hold, the patient will be informed of the reason(s) he/she will not be permitted to leave the unit.
- 4. A patient may be discharged or transferred to another unit or facility if, during the course of treatment they meet exclusionary criteria and therefore present a great health risk to self, other patients, or staff by their continued presence.
  - a. When a patient develops an acute medical or surgical condition while on the inpatient psychiatric unit, a medical consult will be completed and the patient may be discharged from the program and admitted to an appropriate medical/surgical unit within the hospital.
  - b. When an emergent medical or surgical condition occurs, the patient may be transported to the Emergency Department (ED) for immediate evaluation, treatment, and/or disposition.
    - i. In this event, the BHU medical record is kept active until such time as it is ascertained that the patient will not immediately return to the Inpatient psychiatric unitBHU.
    - ii. (If a BHU patient is taken to the Emergency DepartmentED for assessment, is treated, and returns to the BHU, the original BHU record is continued since it is not necessary that the patient is discharged and readmitted to the unit.)

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

1. Patient Care Services Policy: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient



#### **Behavioral Health Services** Inpatient Behavioral Health Unit **Crisis Stabilization Unit**

SUBJECT:

Patient Responsibilities

**POLICY NUMBER:** 

513

**ISSUE DATE:** 

3/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval: Division of Psychiatry Approval:** Pharmacy and Therapeutics Approval: **Medical Executive Committee Approval:** 

**Professional Affairs Committee Approval:** 

**Board of Directors Approval:** 

09/17 n/a

n/a

03/13

n/a 04/18<del>03/13</del>

#### A.

In order to provide safe delivery of care, treatment, and services, the Behavioral Health Unit (BHU) is entitled to reasonable behavior on the part of patients, within their capabilities, and their families.

#### В. POLICY:

- It is the policy of BHU to assure each patient is a partner in the health care process as appropriate to his or her abilities.
- 2. Upon admission, each patient will be given a copy of the Unit Rules and Patient Responsibilities. The Patient Responsibilities are listed below:
  - As a patient of the BHU, you have the responsibility to:
    - Provide accurate information. To the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications must be provided. You also must report perceived risks in your care and unexpected changes in your condition.
    - Ask questions. When you do not understand your care, treatment, and service, or ii. what you are expected to do, you must ask questions.
    - iii. Follow instructions. You must follow the care, treatment, and service developed. Express any concerns about your ability to follow the proposed care plan.
    - Accept consequences. You are responsible for the outcomes if you do not follow iv. the plan of care, treatment, or service.
    - Follow the rules. V.
    - Participate to the best of your ability in the unit groups and activities. Becoming vi. involved in the therapeutic milieu and mingling with your peers is part of
    - vii. Report to a staff member immediately if you feel unsafe or if you feel you might harm yourself, another patient, or a staff member.
    - viii. Show respect and consideration. You must be considerate of the BHU staff and property, as well as other patients and their property.
    - ix. Meet your financial commitments. You should promptly meet any financial obligation agreed to with the hospital.

Behavioral Health Unit Inpatient Patient Responsibilities Page 2 of 2



- The Clinical Staff will be responsible for interpreting patients' responsibilities to them and for assisting patients to meet their responsibilities to the best of their ability.
- 2. Additional information on patient rights and patient responsibilities will be made available to patients upon request.

#### Behavioral Health Services Inpatient Behavioral Health Unit Crisis Stabilization Unit

SUBJECT:

**Patient Satisfaction Surveys** 

**POLICY NUMBER:** 

106

**ISSUE DATE:** 

03/08, 03/13

**REVISION DATE(S):** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: Professional Affairs Committee Approval:

n/a n/a

04/18

n/a

**Board of Directors Approval:** 

#### A. PURPOSE:

1. To maintain high quality and consumer responsive care for patients through the application of feedback obtained through the use of patient satisfaction surveys.

#### B. POLICY:

 Patient satisfaction surveys will be conducted at the time of the patient discharge using valid sampling standards.

#### C. **PROCEDURE**:

- A written satisfaction survey will be made available to all patients at the time of prior to their discharge from the inpatientBehavioral Health Unit (BHU) or Crisis Stabilization Unit (CSU). psychiatric unit.
- Surveys will be deposited and kept in a secured locked box such that patient confidentiality is maintained.
- 3. Results of the survey process will be aggregated monthly and shared at monthly staff meetings.
- 4. The Clinical Nurse Manager will review patient satisfaction survey results and identify areas for improvement thatand the The minimal overall-acceptable standard is equal to or greater than 85% patient satisfaction. If patient satisfaction falls below 85% the department will implement a performance improvement initiative that addresses the area(s) of concern.



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

**Psychiatric Advance Directive** 

POLICY NUMBER: 719

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

<del>06/16</del>09/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval:

n/a n/a n/a

**Professional Affairs Committee Approval:** 

04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

1. To provide opportunities for patients to have input into the treatment they will receive if they require emergency psychiatric interventions related to out-of-control or aggressive behaviors.

2. To ensure that patients' physical disability and history of abuse are considered when interventions are enacted in response to aggressive behaviors.

#### B. POLICY:

Upon admission, or as soon thereafter as possible, each patient will be asked to provide information about situations that may cause their behavior to escalate, their preferences for intervention should escalation occur and any factors that may help the clinical staff determine the safest and most humane manner in which to respond to problematic behaviors.

#### C. PROCEDURE:

- 1. All clinical staff will be required to attend an eight (8) hour course on Nnon-vViolent physical eCrisis lintervention for the purpose of gaining an understanding of the cycle of aggression, verbal de-escalation interventions, and the team approach for managing out of control aggressive or destructive patient behaviors. The class must be completed upon hire, and every year for a four (4) hour renewal course, thereafter. In alternate years the clinical staff will complete a NetLearning module to independently review the course material.
- 2. Upon admission, as part of the Initial Nursing Assessment, the patient will be asked questions to ascertain the following information:
  - a. History of physical or sexual abuse or trauma
  - b. Physical or medical limitations or co-morbidities
  - c. Events or situations that have caused him or her to become angry, agitated, or violent in the past (triggers)
  - d. De-escalation techniques that have been successful in reestablishing control and calm in the past
  - e. Preferences for interventions, e.g. quiet time in patient's room, space to pace outside, early use of prn (as needed) medication, use of the quiet room for brief periods, shower, phone call to family member, etc.
- 3. The information obtained in this assessment will become part of the patient's treatment plan and preferences will be taken into consideration in the event the patient experiences an escalation of aggression.



#### **Behavioral Health Services** Inpatient Behavioral Health Unit **Crisis Stabilization Unit**

SUBJECT:

Release of Information

**POLICY NUMBER:** 

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: **Medical Executive Committee Approval:** 

n/a n/a

**Professional Affairs Committee Approval:** 

n/a 04/18

**Board of Directors Approval:** 

#### A. **PURPOSE:**

1. To identify those circumstances that necessitate a consent for release of information.

2. To identify how a patient consents to the release of information.

#### B. **POLICY:**

A separate and individual Patient Consent Visitation and/or Phone Calls FormConsent for Release-of-Information will be used to obtain copies of clinical records from any of the patient's previous treatment providers. A Patient Consent Visitation and/or Phone Calls FormConsent for Release-of-Information will also be used with each significant individual involved in continuity of care with whom staff members have verbal contact unless information is being shared between two caregivers engaged in the ongoing treatment of the patient. Although obtaining records is not the goal in this instance, consent for the purpose of open communication regarding different aspects of the patient's care is necessary. Patient Consent Visitation and/or Phone Calls FormPatient Consent for Release of Information does not deny the patient his or her right to confidentiality.

#### C. **PROCEDURE:**

- The patient will be told what information will be requested and to whom it will be released. The patient will be afforded an opportunity to discuss the release. The decision to consent must be
- 2. The patient will be informed that they have the right to revoke the release with a written request.
- 3. If the patient is under conservatorship, the signature of the conservator will be obtained for the purpose of the Consent to Treat and for the administration of Receive Psychotropic Medications.
- 4. The patient will be told that provision of treatment is not based on the consent to release information unless the physician/Allied Health Professional (AHP) indicates that it is necessary for treatment.
- 5. The patient will be asked to read the authorization form or will have the form read to him or her and asked if there are questions. The staff member will make a good-faith effort to answer all questions.
- 6. On each form the specific record(s) to be released will be indicated and the specific purpose of the disclosure will also be provided.
- 7. The patient will be asked to sign the form and date it indicating the release's expiration date.
- 8. A witness will sign name, date, and indicate title.

Behavioral Health Services Inpatient Release of Information Page 2 of 5



## D. FORM(S):

- 40.1. Patient Consent Visitation and/or Phone Calls
- 44-2. Consent to Receive Psychotropic Medication 6340-1001

tient Co	nsent Vi	sitation and/or	Phone Calls					
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f signed by	y a person	other than the patie	ent, indicate relationship	to patient:	Evample	s: Spouse, Partner, I	acal Guardian	
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144.54								

#### Consent to Receive Psychotropic Medication 6340-1001

#### CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION

INSTRUCTIONS TO PATIENT: The form describes information your physician will provide to you regarding your treatment with Antipsychotic, Psychotropic or Neuroleptic medications. Please read the form thoroughly before you sign it and if you have any questions, ask your physician. This is a two-sided form.

My physician has advised me that psychotropic medications are necessary for my treatment and has discussed the following information with me:

Category of Medication and Name of Medication:	
Anti-Depressant	☐ Mood-Stabilizer
Anti-Anxiety	Anti-Psychotic
☐ Hypnotic	Other
1. My physician discussed the nature of my medica	condition with me.

- 2. My physician has given me the reason for taking such medications including the likelihood of improving or not improving without such medications and has informed me that my consent can be withdrawn at any time by telling either my physician or member of my treatment team.
- 3. My physician has told me of any reasonable alternative treatments available, if there are any.
- My physician has informed me of the type of medications he/she will prescribed for me; how often, in what amount, for how long and by what route (by mouth or injection).
- 5. My physician has told me of common side effects that may occur when taking these medications, and especially those that I may have because of factors personal to me.
- 6. My physician has discussed with me any possible side effects, which may occur to patients taking certain categories of medications. Such side effects may include persistent involuntary movement of the face of mouth and might at times, include similar movements of the hands and feet, and that these symptoms are potentially irreversible and may appear after the medications have been discontinued. These medications may also cause restlessness, increased muscle tone, elevated blood sugar, lipids. and weight gain.
- 7. The general side effect profile(s) of the above medications have been reviewed with me and could include some specifically from the list below. This is not a complete list of all the possible side effects. I consent to the use of the prescribed medication (s). I understand that I can withdraw this consent at any time by informing my physician.

Cardiac conduction changes	Elevated cholesterol/triglycerides	Motor changes/EPS
Changes in blood count	Glaucoma	Nausea/vomiting
Confusion	Headaches	Renal impairment
Diabetes/elevated glucose	Hypothyroidism	Sedation/stimulation
Diarrhea/constipation	Insomnia	Seizures
Elevated blood pressure	Liver inflammation	Stroke
		Weight gain/loss

While I have a right as a patient to refuse to accept these medications, my physician may, in an emergency, order that I be given these medications without my consent. Such an emergency is defined when there is a sudden marked change in my condition leading to a need to protect my life or prevent serious bodily harm to me or to others.



Affix Patient Label





Page 1 of 2

<ol> <li>Having been advised and inf medications as my physician</li> </ol>		bove by my physician, I cor	nsent to receiving these
PATIENT'S SIGNATURE	DATE/TIME	PHYSICIAN'S SIGNATURE	DATE/TIME
	· · · · · · · · · · · · · · · · · · ·		
these medications as I presc	ribe them. However,	the patient chooses not to	sign this consent form.
i. Patient has been advised of, these medications as I presc  PHYSICIAN'S SIGNATURE  II. Patient willing to take medica understand and sign.	DATE/TIME	the patient chooses not to RN WITNESS	sign this consent form.  DATE/TIME



CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION



Page 2 of 2

Affix Patient Label



SUBJECT:

Role of Medical Staff Leadership in Behavioral Health Services

**POLICY NUMBER:** 

003

**ISSUE DATE:** 

07/85

REVISION DATE(S): 02/87, 05/91, 06/94, 06/97, 07/00, 04/02,

07/03, 04/05, 03/13

**Department Approval:** 

06/1609/17

**Division of Psychiatry Approval:** Pharmacy and Therapeutics Approval: **Medical Executive Committee Approval:** 

n/a n/a

n/a

**Professional Affairs Committee Approval:** 

04/18

**Board of Directors Approval:** 

#### A. POLICY:

In the Behavioral Health Unit-Service (BHS) Line, the Medical Director and Psychiatric Division Chief will provide medical leadership and care of psychiatric patients.

#### B. **PSYCHIATRIC DIVISION CHIEF:**

- Availability
  - The Division Chief is available to the Clinical Nurse Manager and nursing staff via direct communication or an as needed basis.
- 2. Responsibility
  - The Division Chief shall have responsibility in assisting with standards development/approval, problem identification/solving in patient care issues and in conflict resolution with specific physicians.

#### C. **MEDICAL DIRECTOR:**

- Existence/Availability
  - The Behavioral Health Unit (BHU) Medical Director has an annually negotiated contract for services with Tri-City Medical CenterHealthcare District (TCHD). The Medical Director's responsibilities include:
    - i. Providing psychiatric medical leadership for attending/consulting physicians/Allied Health Professionals (AHP) and the multi-disciplinary staff.
    - ii. Conflict resolution that is intradepartmental or interdepartmental.
    - iii. Working collaboratively with the Clinical Nurse Manager to insure all necessary compliance with Lanterman-Petris-Short Act (LPS), Joint Commission (JCHAO), Title 22, and State of California/Tri-City-Medical-CenterTCHD regulations.
    - Monitoring bed utilization. iv.
    - Staff development. ٧.
    - vi. Participating in Quality Assurance/Performance Improvement activities, including standards of development/approval.
    - vii. Policy implementation.

Behavioral Health Services Inpatient Role of Medical Staff Leadership in Behavioral Health Services Page 2 of 2

#### D. <u>HOSPITALIST:</u>

- Availability
  - a. The Medical Director is responsible for oversight of the hospitalist and is available to the nursing staff as needed. They provide medical care to the supervising physician's/AHP's patients under the direction of the physician/AHP.
- 2. Responsibility
  - The responsibilities of the hospitalist include:
    - i. Make daily rounds.
    - ii. Record initial history and physical and pertinent progress of the patient on the chart.
    - iii. Schedule diagnostic procedures, laboratory studies, x-rays, electrocardiograms, consultations, and transmit verbal orders of the supervising physician (to be countersigned by the physician/AHP within 24 hours).
  - Questions on any orders are to be confirmed by the nurse directly with the physician/AHP.



## Tri-City Medical Center Oceanside, California

DELETE – incorporated into Infection Control Policy: Scabies and Lice

#### Behavioral Health Services Inpatient Behavioral Health Unit Crisis Stabilization Unit

SUBJECT:

Scabies, Lice, and Fleas in the BHU/CSU

POLICY NUMBER: 40

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

Department Approval:

06/1609/1703/18

Division of Psychiatry Approval:
Pharmacy and Therapeutics Approval:
Medical Executive Committee Approval:

n/a n/a n/a

Professional Affairs Committee Approval:

04/18

**Board of Directors Approval:** 

#### ---PURPOSE:

To-ensure the provision-of-treatment and to-prevent the transmission of infestation in the event
of patient and/or-staff exposure to scabios, lice and/or fleas in the Behavioral-Health Unit (BHU)
or Crisis Stabilization Unit (CSU).

#### B. POLICY:

- 1. Patients who are infested with scabies, lice and or fleas will be treated in accordance with established hospital Infection Control Policy: Scabies and Lice policy (AP&P 400).
- Transmission:
  - a: Scabies is a parasitic disease (infestation) of the skin-caused by the human-itch mite, Sarcoptes scabiei. Scabies is generally transmitted to by direct skin-to-skin centact with an infested patient. Activities such as performing physical-assessments or, bathing and changing a patient's soiled linen are conducive to transmission-because physical-centact is often prolonged. The mite can only survive for a few-hours on inanimate objects such as dry surfaces, clothing or bedding.
  - Lice-are-ectoparasites, which infest head and body and may result severe itching. Lice
    are host specific and those of animals do-not infest humans. Transmission requires
    direct-contact with an infested person and objects used by them (for example, shared
    elothing and headgear).
  - Fleas are external parasites are generally-found on or in the skin and are important pests-because they bite or anney both humans and their pets. Fleas are small (1/16"), dark, reddish-brown, wingless, blood sucking insects. Their bedies are laterally compressed, (i.e., flattened side to side) permitting easy-movement through the hairs on the host's body. Their-logs are long and well-adapted for jumping. They are known to jump 7-8 inches vertically and 14-15 inches horizontally. The flea body is hard, polished, and covered with many hairs and short spines directed backward. The mouthparts of an adult flea are adapted for sucking blood from a host.

#### 3. Infestation:

a. Scabies: Following an incubation period of 2 days to 6 weeks, the infested person will complain of itching, which intensifies at bed-time under the warmth of blankets. In previously infested persons, itching may-be noticeable as soon as 48 hours following infestation. In typical scabies, the rash is generally characterized as red, raised bumps

- (papules). Skin lesions are generally seen on the hands, wrists, elbows, and folds of armpits, female breasts or the male genitals.
- Lice: Under optimal conditions, eggs hatch within 7- 10 days. Body and head lice survive for a week without feeding off the hest, crab lice only 2 days. Nymphs survive only 24 hours without feed.
- c. Fleas: Fleas vary in life cycles from 2 weeks to 2 years. Fleas lay eggs while on the hest, then the eggs drop off into carpet, bedding, furniture, or onto the fleor. After a few days, the eggs hatch into very small, legless larvae. Partly digested blood that flakes continuously from a flea infestation patients/pets is the main food source for larvae. The bites can cause intense itching often resulting in secondary infection. The usual flea bite has a small red spot where the flea has inserted its mouthparts. Around the spot there is a red halo with very little swelling.

#### PROCEDURE:

- Standard Precautions should prevent the transmission of most cases of scables, lice and fleas.
  If an exposure to a patient with scables, lice and/or fleas occurs before Contact Presautions are applied and the patient is treated the employee should:
  - Report and document exposure of staff as per Infection Control Policy: Scabies and LiceAP & P 400.
  - Follow all treatment guidelines.
- Contact the patient's physician/Allied Health Professional (AHP) to specific treatment orders for the patient.
- Employees who are symptomatic will be referred to Work Partners for treatment. In this
  instance, all caregivers will be treated even if they are not symptomatic. Employees and their
  patients should be treated at the same time.
- Follow-up treatments are not necessary unless re-exposure or symptoms persist.
- A clinical note will be made in the patient's chart documenting interventions, treatments and response.
- Treatment of the BHU environment may follow the common guidelines. Place the patient in a single room as soon as possible. Isolate the patient as much as possible from other patients and staff to minimize transmission. Housekeeping should be contacted for a deep cleaning.
  - a. Scabies: While scabies is readily transmissible with skin to skin centact, the mite can only survive in the environment for 48 hours without a human host. The bedding and clothing of the patient may centain viable mites, but exposure to a human host must occur within a short period of time for transmission to occur. Vacuuming and general cleanliness should previde adequate environmental centrol. Furnigation is not necessary; furniture should not be discarded. Clething or bedding used by the patient during should be laundered and dried with the hot cycle. Items that cannot be laundered or dry cleaned should be placed in a plastic bag and sealed for seven days to allow time for mites and eggs to die. Isolate patient until treatment has been completed.
  - b. Lice: While the majority of head lice are transmitted directly from person to person, to central any head lice that are temporarily surviving off of a human hest, you should: Wash bedding in hot water and dry in a het dryer or iron with a het iron. Wash and dry recently worn clothing (including coats, caps and scarves) in het temperatures. Clothing or bedding that cannot be washed may be dry cleaned or scaled in a plastic bag for two weeks (the plastic bags contain the lice until they are dead, and prevent head lice from temperarily infesting these items again while the treatment process is taking place. Clean floors, carpeting and furniture by thorough vacuuming. Cleaning efforts should occur on the day of the first head lice treatment, and subsequently whenever live lice are found on the patient's head during the daily inspections.
  - Fleas: These flakes will turn rod when moisture is applied to them. Frequent, rigorous vacuuming and disrupting of flea breeding sites can help greatly in indeer flea centrel. Vacuum under furniture, cushions, chairs, beds, and along the edges of walls, this is a favorite flea breeding site. Be sure to discard your vacuum cleaner bag or dump the

Behavioral Health Services Inpatient Scabies, Lice, and Fleas in the BHU/CSU Page 3 of 3

container contents immediately-after cleaning. Fleas-can develop inside a vacuum cleaner bag and can-re-infest the area.

## RELATED DOCUMENT(S):

d. Infection-Control Policy: Scabies and Lice

#### D. REFERENCE(S):

- 1. Control of Communicable Diseases Manual, D.L. Heymann, Ed. 18th edition, 2004
- 2.1. APIC Text of Infection Control and Epidemiology, revised edition, 2005



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

Scope of Service - Behavioral Health Unit

**ISSUE DATE:** 

10/11

**REVISION DATE(S): 11/13, 03/13** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval:

n/a n/a

Medical Executive Committee Approval: Professional Affairs Committee Approval:

n/a 04/18

**Board of Directors Approval:** 

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#### A. GOAL(S):

- 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 multi-disciplinary care by working closely with other disciplines.
- 5. To provide individualized treatment to promote mental health and substance use recovery.
- 6. Patients will be given the opportunity to increase their involvement in the therapeutic milieu and to discuss their issues and concerns in a daily meeting that includes other patients and members of the treatment team.

#### B. BRIEF DESCRIPTION OF SERVICE:

The inpatient service offers psychiatric treatment for a variety of acute states of mental illness with 24 hour care. An eighteen (18)-29 bed intensive care unit accommodate patients with an immediate need for acute psychiatric services. Admission to the unit is typically via-the-Medical CenterTri-City Healthcare District's (TCHD) Emergency Department (ED) or by physician/Allied Health Professional (AHP) referral. The Behavioral Health Unit (BHU) staff includes a multi-disciplinary team of psychiatrists, psychologists, licensed marriage and family therapists (MFT), licensed clinical social workers, registered nurses, recreational therapists, licensed psychiatric technicians, mental health workers, and supervised MFT interns and trainees who collaborate to help individuals achieve recovery goals.

#### C. METHODS USED TO ASSESS PATIENTS' NEEDS:

- Treatment is planned, implemented and evaluated by an interdisciplinary team comprised of mental health clinicians, the patient, and the patient's family or legal representative. All patients will receive whatever treatment and care his or her condition requires for the full period that he or she is hospitalized. Patients receive treatment in the least restrictive environment based on assessment of the clinical needs. The program maintains mechanisms by which patients move between the available levels of service within the department and in the community.
  - a. All patients who are admitted to the program will routinely have an admission psychiatric assessment, physical assessment, nursing assessment, psychosocial assessment, and activity therapy assessment.
  - b. Patients are considered members of the treatment team and will be asked to provide information regarding their concerns, needs, limitations, physical health needs, preexisting conditions and preferences as part of the assessment process.

- c. Information from all assessments, including input from the patient, will be used in the formulation of the patient's individualized treatment plan that includes provision for ensuring the patient's safety when there are co-morbid medical conditions, physical limitations, or other safety issues.
- d. The interdisciplinary treatment plan is formulated and altered based on the assessment data collected by each member of the treatment team.
- e. The clinician will use all available clinical resources to gather assessment data including but not limited to the patient's subjective report, objective observations, written information from laboratory and diagnostic testing, past medical record information, and information from family and significant others.

#### D. SCOPE AND COMPLEXITY OF SERVICES:

- Mental health practitioners who are licensed and registered in accordance with their discipline specific requirements will provide clinical treatment. The Behavioral-Health-DepartmentBHU will develop and implement competency standards to insure that clinicians have the requisite skill, knowledge, experience and education to provide services. The department will maintain a description of its scope of care, services provided, type of individuals served and the important aspects of care. Patients will be treated in the least restrictive environment; treatment intensity will be determined on the basis of the severity of the patient's symptoms and the assessment of the patient's treatment needs.
- 2. An interdisciplinary team led by the psychiatrist and comprised of members of other disciplines including but not limited to psychologists, registered nurses, licensed psychiatric technician, recreational therapists, licensed clinical social workers, marriage and family therapists (MFT), mental health workers, and supervised MFT interns and trainees will deliver services. The patient and his or her family, conservator, significant other and or primary care giver will be considered vital members of the team and will be included in the assessment, treatment planning and evaluation processes.
- 3. Treatment will occur within the context of a therapeutic milieu in which activities are purposefully planned and executed to meet the needs of patients. Biweekly clinical collaboration meetings reflect one form of information exchange between disciplines and interdisciplinary care. Team conferences are also scheduled on an individual basis as needed. Types of treatment available include but are not limited to:
  - a. Individual Psychotherapy
  - b. Group Psychotherapy
  - c. Family Psychotherapy
  - d. Psychopharmacology

#### E. ADMISSION CRITERIA-TYPE AND AGES OF PATIENTS SERVICED:

- 1. Adults who are referred for admission to the Inpatient Behavioral Health unitBHU must meet DSM V-IV-R Severity of Illness criteria, have a primary psychiatric diagnosis, and be able to derive benefit from the therapeutic milieu. Patients will be considered inappropriate for admission if they meet any of the following exclusionary criteria:
  - a. Under age eighteen (18).
  - b. Primary Substance abuse diagnosis.
  - Primary dementia diagnoses.
  - d. Co-existing medical condition(s) requiring care by nursing staff with specific medical surgical nursing competencies including but not limited to:
    - i. Intravenous (IV) Medication
    - ii. Indwelling Catheter
    - iii. Tracheostomy
  - e. Individuals with developmental disabilities of such a degree that they are unable to participate in daily unit activities.
    - Unstable medical condition, i.e. chest pain, acute infectious disease, uncontrolled hypertension or blood glucose levels.

## F. STAFFING AND THE AVAILABILITY OF STAFF:

 The unitBHU is staffed with a clinical nurse manager, two assistant nurse managers (ANM), registered nurses (RN), a licensed psychiatric technician, licensed clinical social workers, marriage family therapistsMFTs, recreation therapists, and mental health workers. The clinical nurse manager has 24-hour responsibility for patient care and unit management Staff work 8hour and 12-hour shifts.

#### G. SCOPE OF SERVICE:

- The Assistant Nurse Manager (ANM) or Charge RN 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 6 patients. The Clinical Nurse Manager/ANM will confer if additional staff is needed based on acuity.
  - a. BLS, Non Violent Crisis Intervention or equivalent managing aggressive behavior (MAB) training are required of all nursing personnel working on the unit. Initial and annual competency requirements for staff are defined and updated on a yearly basis at Skills Lab and unit based training. Competency requirements for 5150 designee or faceto-face one hour assessment for the specially trained RN is done annually at Skills Lab and unit based training.

#### H. **ASSESSING DEPARTMENT SERVICES:**

 The unit is a 24-hour, 7-day-a-week service. If a patient needs a higher level of care, physicians/AHPs and nursing staff coordinate the transfer to an appropriate facility with assistance of case management as appropriate.

## I. THE EXTENT TO WHICH THE DEPARTMENT'S LEVEL OF CARE/SERVICE MEET PATIENT NEEDS:

The level of care provided by the Acute Inpatient Behavioral Health UnitBHU 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.

#### J. PERFORMANCE IMPROVEMENT:

In order to improve patient care, the inpatient behavioral-health-unitBHU has implemented a
performance improvement (PI) committee that will address high risk indicators and research
quality measures to improve overall safety and patient care outcomes.

#### K. STANDARDS USED BY THE DEPARTMENT IN THE CARE OF PATIENTS:

 The nursing service abides by regulations by California Title XXII Standards: Psychiatric Unit General Requirements, Comprehensive Accreditation Manual for Psychiatric Health Care, The Joint Commission, Centers for Medicare and Medicaid Services (HCFACMS) Regulations, CMS, Welfare and Institutions Code § 5150, and California Board of Registered Nurses (BRN).

#### L. <u>MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT:</u>

 Medications, general and narcotics, are dispensed via the Pyxis system. Daily patient doses are stored and dispensed from the locked profile machine. Medications requiring refrigeration are stored at the appropriate temperatures. Nurses assess and document the administration/effectiveness/side effects of medication.



SUBJECT:

**Non-Smoking Environment** 

**POLICY NUMBER:** 

406

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

Department Approval:

02/1609/17

Division of Psychiatry Approval:
Pharmacy and Therapeutics Approval:
Medical Executive Committee Approval:

n/a n/a

Professional Affairs Committee Approval:

n/a 04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

 To communicate the prohibition of smoking, offer Nicotine Replacement Therapy for patients to decrease or stop nicotine intake, and implement a smoke free environment at Tri-City Healthcare District (TCHD) Behavioral Health Unit (BHU) and Crisis Stabilization Unit (CSU). All patients, work associates, families and visitors are expected to comply with the smoking regulations.

#### B. <u>DEFINITION(S):</u>

 Smoking: any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, cigarette, chewing tobacco, snuff, electronic cigarettes, in any form.

#### C. POLICY:

- As part of Tri-CityTCHD's commitment to provide a healthy environment for patients and work associates, smoking is prohibited indoors and on the Behavioral Health Services (BHS) patios owned or operated by Tri-CityTCHD Behavioral Health ServicesBHS for all persons, including patients, staff, and visitors.
- Adherence to this policy is the responsibility of all individuals working, visiting, or receiving care within the BHU or CSUInpatient Behavior Health Unit. Compliance with this policy is mandatory and will be strictly enforced. Findings will be reported as needed to clinical managers, Assistant Nurse Managers (ANMs), charge nurse, or the hospital safety committee to develop strategies to eliminate the incidence of policy violations.
- As part of each patient's individual assessment by the attending provider, the various options for helping that patient avoid the distraction and discomfort of smoking cessation will be addressed. This will allow the patient to better focus on the primary psychiatric reason for their hospitalization.
- 4. When each patient is admitted, the patient should be educated by the admitting nurse on the **Administrative Policy: 205** ne-Smokinge-Free Environmentpolicy, the Nicotine Replacement Therapy, and health information about smoking.
- 5. All patients will be requested to turn in their smoking materials upon admission; these are considered contraband and will be returned at discharge. Any materials found on the unit will be confiscated by staff and returned to the patient at discharge.

- 6. Visitors are not to bring in cigarettes or other tobacco products. Patients, visitors, and any other guests who fail to comply with this policy may result in termination of visiting privileges and will be reminded that Inpatient BHU is a smoke-free department and will be advised of resources available to assist with compliance while they are on the unit.
- 7. Smoke breaks are being replaced with healthy breaks, outdoor scheduled activities per unit schedule under direct staff supervision.

## D. RELATED DOCUMENT(S):

- 1. Administrative Policy: 205 Smoke-Free Environment
- 2. Administrative Policy: 234 Security Department Incident Notification
- 3. Administrative Policy: 424 Coaching and Counseling for Work Performance

#### D.E. REFERENCE-LIST(S):

- 1---- Administrative Policy 8610-205: Smoke-Free Environment
- 2. Administrative-Policy 424: Coaching and Counseling for Work Performance Improvement
- 3. Administrative-Policy 234: Security-Department-Incident Notification
- 4-1. Centers for Disease Control and Prevention. Healthy Workforce Initiative: Implementing a Tobacco-Free Campus Initiative United States 2004. Available at: www.cdc.gov/nccdphp/dnpa/hwi/toolkits/tobacco/index.htm



SUBJECT:

Solicitation of Patients/Referrals to Self

POLICY NUMBER:

518

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: Professional Affairs Committee Approval:

n/a n/a 04/18

n/a

Board of Directors Approval:

#### A. PURPOSE:

To specify parameters with respect to the solicitation of patients or referrals to self.

#### B. POLICY:

- Tri-City Medical-CenterHealthcare District (TCHD) employees and contracted employees will
  not refer patients, directly or indirectly to their private practices.
- 2. Tri-City Medical CenterTCHD employees and contracted employees will not, directly or indirectly, approach, solicit or suggest to any patient or patient's representative that the patient should or must see such employee on any basis outside the program for additional care or therapy, with the exception of those patients who were seen in a therapist's private practice prior to the patient's admission. In such cases, referrals back to the therapist's private practice are acceptable, if deemed clinically appropriate.



SUBJECT:

**Telephone Use** 

**POLICY NUMBER:** 

519

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

Department Approval:

06/4609/17

Division of Psychiatry Approval:
Pharmacy and Therapeutics Approval:
Medical Executive Committee Approval:

n/a n/a n/a

Professional Affairs Committee Approval:

04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

1. To provide guidelines that describes patient access to the telephone during inpatient hospitalization or admission to the Crisis Stabilization Unit (CSU).

#### B. POLICY:

1. Patients are entitled to unimpeded private and uncensored communication with others by telephone. Telephone communication may be restricted if warranted by documented circumstances.

#### C. PROCEDURE:

- Patients will be informed of all rights related to telephone use upon their admission to the unit.
- 2. Telephones will be available for patient use. Patient telephones are cordless, rechargeable phones. Posted times for telephone calls will be in all telephone areas and on bulletin boards. Patients may use the telephone outside of these times with the permission of the treatment team, depending upon the prevailing circumstances.
- 3. Patients will have unlimited access to the telephone within the posted hours.
- 4. Upon request from a patient in seclusion or restraint, staff may make at least **two** (2) telephone calls a day on behalf of the patient.
- 5. The clinical staff will insure that the use of the telephone does not interfere with a patient's treatment. Problems observed will be directed first to the patient's assigned nurse and then to the assistant nurse manager (ANM) for resolution.
- 6. The patient's right to communicate by telephone will not be limited except as authorized in the patient's treatment plan. The rationale for any limitation will be documented. A limitation on telephone use may be imposed as follows:
  - To prevent violation of the law.
  - b. To prevent substantial and/or serious physical or mental harm to the patient or others.
  - c. To prevent reasonably expected future telephone harassment by a patient or an individual previously harassed and who has complained. A limitation to prevent harassment will require a written request from the victim of the harassment to limit the patient's telephone use. The written request will also describe the frequency or content of past calls that were considered harassment.
  - d. When excessive use of the telephone prevents the patient from participating in therapeutic programming.

- 7. A patient will be promptly informed of any telephone use limitation and a limitation of rights form will be completed in the Denial of Rights Right of Behavioral Health Patients Form (per Behavioral Health Services Policy: 6340-614: Patient Rights). On request, the patient will be informed of the purpose a limitation is intended to achieve, the persons or entities involved and additional information as deemed appropriate.
- 8. The treatment team will review limitations on a daily basis.
- 9. A limitation on telephone rights will not apply between a patient and an attorney or a court or between a patient and other individuals if the communication involves matters that are or may be the subject of legal inquiry.
- 10. The patient may appeal any limitation to the Patient Advocate's office.
- D. FORM(S):
  - 11.1. Right of Behavioral Health Patients 8340-1007
- E. RELATED DOCUMENT(S):
  - 42.1. Behavioral Health Services Policy: Patient Rights

## Right of Behavioral Health Patients 8340-1007

Each patient, resident or client in this facility has the following rights:

- (a) To wear his own clothes; to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.
- (b) To have access to individual storage space for his private use.
- (c) To see visitors each day.
- (d) To have reasonable access to telephones, both to make and receive confidential calls.
- (e) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
- (f) To refuse convulsion treatment including, but not limited to, any electroconvulsive treatment, any treatment of the mental condition which depends on induction of a convulsion by any means, and insulin coma treatment.
- (g) To refuse psychosurgery.
- (h) To refuse antipsychotic medication.
- (i) Other rights as specified by regulation. (Section 5325, W & I Code)

The professional person in charge of the facility or his designee may, for good cause, deny any of the rights under (a) to (e), inclusive. If you believe that one of your rights was denied without a good reason, you may call the Patients' Advocate who must respond to your complaint within two working days.

Patient Advocacy Program	(619) 282-1134 or 1 (800) 479-2233	24 hours
Name	Phone	Hours

You may call collect from North County.

It is his responsibility to investigate and resolve your complaint to your satisfaction. If he is unable to do so, the complaint must be referred by him to the local mental health director. After that, if the problem is still not resolved, it must be referred to the Patients' Rights Specialist, State Department of Health, Sacramento. If you are unable to locate a Patients' Advocate, you may contact:

California Office of Patients' Rights
1831 K Street • Sacramento, CA 95811
Telephone: 916-575-1610 • Fax: 916-575-1613
COPRinforequest@disabilityrightsca.org

(This notice must be posted, as well as distributed to each mental patient admitted in state hospitals, health facilities and community care facilities.)

No person may be presumed incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether voluntarily or involuntarily received. (5331 W. I Code). I understand the Patient's Rights as stated above.

Patient Signature	Printed Name	Date	Time	
Witness Signature	Printed Name	Date	Time	
(e)		Affix Patier	t Label	



62/306 · OA · 52030



RIGHT OF BEHAVIORAL HEALTH PATIENTS

White - Chart Yellow - Patient



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

**Treatment of Patients** 

POLICY NUMBER: 7

**ISSUE DATE:** 

03/08

REVISION DATE(S): 08/09, 03/13, 06/16

**Department Approval:** 

<del>06/16</del>09/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval: Professional Affairs Committee Approval:

n/a n/a 04/18

n/a

**Board of Directors Approval:** 

#### A. PURPOSE:

1. To ensure that the treatment of patients is conducted in compliance with all applicable guidelines and standards.

#### B. **POLICY:**

Treatment is planned, implemented, and evaluated by an interdisciplinary team comprised of mental health clinicians, the patient, and the patient's family or legal representative. All patients will receive whatever treatment and care his or her condition requires for the full period that he or she is hospitalized. Patients receive treatment in the least restrictive environment based on assessment of the clinical needs. The program maintains mechanisms by which patients move between the available levels of service within the department and in the community.

#### C. PROCEDURE:

- 1. Mental health practitioners who are licensed and registered in accordance with their discipline specific requirements will provide clinical treatment.
- 2. The Behavioral Health DepartmentUnit (BHU) will develop and implement competency standards to insure that clinicians have the requisite skill, knowledge, experience, and education to provide services.
- 3. The departmentBHU will maintain a description of its scope of care, services provided, types of individuals served, and the important aspects of care.
- 4. Patients will be treated in the least restrictive environment; treatment intensity will be determined on the basis of the severity of the patient's symptoms and the assessment of the patient's treatment needs.
- 5. An interdisciplinary team led by the psychiatrist and comprised of members of other disciplines will deliver services. The patient and his or her family, conservator, significant other and or primary care giver will be considered vital members of the team and will be included in the assessment, treatment planning, and evaluation processes.
- 6. Treatment will occur within the context of a therapeutic milieu in which activities are purposefully planned and executed to meet the needs of patients.
- 7. Types of treatment available include but are not limited to:
  - a. Individual Psychotherapy
  - b. Group Psychotherapy
  - c. Family Psychotherapy
  - d. Psychopharmacology

- e. Diagnostic Evaluation
- f. Milieu Therapy
- g. Psychoeducation
- h. Activity Therapy
- i. Life Skills Management
- 8. The clinical team includes but is not limited to:
  - a. Psychiatrists
  - b. Psychologists
  - c. Nurse Practitioners
  - e.d. Social Workers
  - d.e. Marriage and Family Therapists (MFT)
  - e.f. MFT Interns and Trainees
  - f.g. Registered Nurses (RN)
  - g.h. Recreational Therapist
  - h.i. Psychiatric Liaisons
  - i.j. Mental Health Workers
- 9. Patients may make transitions from one level of care to another based on the severity of their symptoms and clinical needs. When an internal transfer occurs between the inpatient unit and the intensive outpatient program:
  - a. The decision will be made collaboratively by the treatment team and will include the patient and significant other in the decision making process.
  - b. Clinical information will be shared between the sending and receiving program by:
    - i. Telephonic Report
    - ii. Faxed Assessments and Most Recent Treatment Data
    - iii. Completed Transfer Packet with Pertinent Information
    - iv. Completed Problem List
    - v. Medication Reconciliation Reports
  - c. In some instances the patient will be more formally referred to another service. In these instances a designated staff member from the receiving program will meet with the patient and significant other and review clinical data before making a decision about acceptance. The decision will be made on the basis of program admission criteria (including exclusion criteria) and the patient's willingness/desire to participate in the program
  - Documentation in the medical record will include the clinical justification for the transition.
- Patients may be discharged to an outside agency based upon clinical need.
  - At the time of discharge the patient and/or significant other will be given referral
    information including appointment times and contact persons.
  - b. Patients will be discharged or transferred to other agencies in keeping with established policy addressing such items as transportation arrangements, completion of transfer summaries, and notifications to receiving agency, medication reconciliation, insurance information, and authorization information.
- 11. Staff members will maintain therapeutic boundaries in all relationships with patients.
  - a. Relationships will be patient-centered and based upon the identified needs of the patient.
  - b. Staff members will not engage in personal, social, or sexual relationships with patients who are on the unit.
  - c. Staff members will be discouraged from establishing personal, social, or sexual relationships with patients after their discharge from the unit.
  - d. Staff members will not share information with patients about their personal problems, seek advice from patients, or otherwise engage in interactions that are focused on the needs of the staff member rather than the needs of the patient.
  - e. In the event that a patient with whom a staff member currently has or has had a personal, social or sexual relationship is admitted to the unit, the staff member will be

Behavioral Health Unit Inpatient Treatment of Patients Page 3 of 3

responsible for disclosing the existence of that relationship to his or her immediate supervisor as soon as it is discovered:

- i. The staff member may be floated to another area of the hospital for the duration of the patient's hospitalization to preserve the patient's right to privacy and confidentiality and to avoid real or perceived conflicts of interest.
- ii. This will include but is not limited to spouses/ significant others, children, siblings, other relatives, friends or acquaintances.
- iii. This will not include patients with whom the staff member has had a therapeutic relationship with in another treatment setting.



SUBJECT:

**Unit Staff Meetings** 

**POLICY NUMBER:** 

104

**ISSUE DATE:** 

03/08

REVISION DATE(S): 08/09, 03/10, 03/13, 06/16

Department Approval: n/a

06/1609/17

Division of Psychiatry Approval:
Pharmacy and Therapeutics Approval:
Medical Executive Committee Approval:
Professional Affairs Committee Approval

n/a n/a n/a

Professional Affairs Committee Approval:

04/18

**Board of Directors Approval:** 

#### A. PURPOSE:

To establish guidelines for the program staff meetings

#### B. POLICY:

 The Inpatient Behavioral Health Unit (BHU), Crisis Stabilization Unit (CSU), and Psychiatric Liaison Team will have staff meetings and clinical problem solving meetings at least every two (2) months; or semimonthly menthly, and more frequently as are indicated.

#### C. **GUIDELINES:**

- The Clinical Nurse Manager of Behavioral Health Services (BHS) will conduct general staff meetings once per month. All staff members are expected to attend or call in to the conference telephone.
  - a. The purposes of the general staff meetings are:
    - To give staff the opportunity to discuss program administrative issues and day-today operations.
    - To encourage staff to participate in decision-making.
    - iii. To provide information.
    - iv. To provide educational updates and roll-outs.
    - iv.v. To keep communication lines open between clinical staff and administration.
    - vi. To discuss ongoing program performance, improvements, and quality improvement measures.
    - y.vii. To invite guest speakers and in-service training related to new medications, community resources, or other related services.
  - b. Staff will be encouraged to submit agenda items prior to the meeting.
  - c. BHU Safety representative will submit agenda items and share applicable info from hospital safety meetings.
  - d. Minutes will be taken and circulated to those who were unable to attend within ten (10) days of staff meeting. Past minutes will be kept on file, in a binder in the administrative assistant office. Monthly minutes will be posted in the staff lounge.
- The Clinical Nurse Manager will facilitate Assistant Nurse Manager (ANM) meetings biweekly.
  - a. The purposes of the Assistant Nurse ManagerANM meetings are:
    - To provide encouragement and support to Assistant Nurse Managers ANM.
    - ii. To encourage team-building, information sharing and communication.

- iii. To encourage consistency between shifts and within shifts.
- iv. To develop leadership and management skills.
- v. To review employee/patient rounding, and-stop-light report progress related issues.
- vi. To review patient related issues.
- vii. To review RL Solutions.
- b. All Assistant Nurse ManagerANMs are encouraged to attend each meeting.
- Minutes will be taken and circulated by the administrative assistant to Clinical Nurse Manager and Assistant-Nurse Managers.
- c. The Assistant-Nurse ManagerANM will meet prior to the monthly general staff meeting to preview the agenda and make suggestions. The administrative assistant will coordinate the agenda items between the Clinical Nurse Manager, the Psychiatric Liaison Supervisor, Assistant Nurse ManagerANMs, and the Clinical Educator via email.
- 3. Shared Governance Committee Professional Nursing Governance Committee (PNGC):
  - a. Professional Practice and Development Council (PPDC):
    - The purposes of this meeting are to maintain BHU educational standards that promote nursing professional development and ongoing clinical competency and quality.
    - To establish and promote relationships and partnerships among all types of community organizations, such as NAMI Walk, Meeting of the Minds and Depression screenings.
    - iii. To encourage communication of best practices, improvement, and evidencebased nursing practice (EBP) by participating and attending educational activities and Journal Club.
    - iv. To act as a resource for other communities of practice.
    - v. To encourage and provide educational advancement to all staff including mental health workers (MHW), recreational therapists (RT), social workers (SW), and marriage family therapists (MFT).
    - vi. Promote continuous improvement in the quality of patient care
    - vii. Develop, implement, and evaluate BHU and service performance improvement efforts.
    - viii. To ensure evidence-based practice (EBP)
    - v.ix. To communicate performance improvement findings, recommendations, and collaborate with the other councils to ensure dissemination of comprehensive quality data to direct-care staff personnel.
  - b. Nursing Leadership/Quality Council (NLQC)::
    - i. The purposes of this meeting are to encourage the professional development of nurses at all levels to empower them to contribute to the decision-making process related to practice in strategic planning, advocacy and influence, visibility, and communication.
    - ii. To facilitate excellence and promote positive patient outcomes.
    - iii. To support and guide changes in work environment and patient care based on input and collaboration with nurses at every level.
  - c. Nursing Practice (NP):Practice CommitteeNursing Informatics Council (NIC):
    - The purposes of this meeting are to ensure consistency in standards of nursing practice.
    - ii. To assure nursing practice and standards are evidence-based and consistent with current research and national standards of nursing practice.
    - iii. To integrate care delivery systems within the professional practice models to promote and support delivery of nursing care.
  - d. Nursing Performance Improvement/Quality (NPIQ): Performance Improvement Quality
    Committee
  - i. The purposes of this meeting are to promote continuous improvement in the quality of patient care

- ii. To develop, implement, and evaluate BHU-and service performance-improvement efforts.
- iii. To ensure evidence based practice (EBP)
- iv. To communicate performance improvement findings, recommendations, and collaborate with the other councils to ensure dissemination of comprehensive quality data to direct-care-staff personnel.
- 4. Clinical Program Meetings:
  - a. The Clinical Nurse Manager will facilitate a bi-annual (twice a year) meeting of senior clinical staff including representatives from social work, recreational therapy, nursing, psychiatric liaisons, marriage family therapists/interns and nursing education
  - b. The purposes of the meeting are:
    - i. To assess clinical programming and group schedule.
    - ii. To develop new program components.
    - iii. To share ideas for improving patient care.
    - To encourage team-building among clinical staff.
  - c. Information discussed at the Clinical Leadership Meetings will be included on the general staff meeting agenda.
- 5. Psychiatric Liaison/Crisis-Stabilization UnitCSU, BHU-Emergency Department- Meetings:
  - a. The Psychiatric Liaison Supervisor will facilitate a monthly staff meeting. All CSU staff and psychiatric liaison team memberss are expected to attend or access conference telephone. The BHU Clinical Nurse Manager and ED Manager/DirectorANMs will also attend to provide leadership and support to the psychiatric liaison team.
  - b. The purposes of the meeting are:
    - To give the staff opportunity to discuss day-to-day operations.
    - ii. To provide information.
    - iii. To provide education updates and roll-outs.
    - iii-iv. To review clinical cases for the benefit of training and education.
    - iv-v. To encourage team building, information sharing and communication.



#### Behavioral Health Services Inpatient Behavioral Health Unit

SUBJECT:

**Utilization Management** 

POLICY NUMBER:

107

**ISSUE DATE:** 

03/08

REVISION DATE(S): 08/09, 03/10, 03/13

Department Approval:

<del>06/16</del>09/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval:

n/a n/a

Professional Affairs Committee Approval:

n/a 04/18

**Board of Directors Approval:** 

## A. PURPOSE:

To provide a system and processes that enable qualified professionals to systematically review medical records to ensure that quality of care standards are maintained and that the intensity of care services available at the Inpatient and-outpatient levelBehavioral Health Unit (BHU) are to provided exclusively to those individuals who meet the accepted industry severity of illness criteria for those levels.

#### B. <u>POLICY:</u>

1. A systematic and routine review of medical record documentation will be conducted in the Behavioral Health ServiceBHU on an ongoing basis to ensure that patients are receiving care at the appropriate level of intensity in relation to the acuity of their symptoms.

#### C. PROCEDUREGUIDELINES

- 1. Authorization to Perform Utilization Review: will be
  - 4.a. Limited to assigned M.D.physician/Allied Health Professional (AHP), nurse practitioner, registered nurse (RN), marriage and family therapist (MFT), case manager, social worker or psychologist who have training in documentation review and knowledge of the relationship between severity of illness and intensity of service criteria.
  - a.b. Behavioral Health Department Utilization Review:
    - i. If a denial is received, the reviewer staff will immediately notify the attending physician/AHP and will attempt to provide the attending physician/AHP with the payer's contact person's name (preferably their physician advisor) and phone number, should she/he choose to immediately appeal the denial.
    - ii. In all cases, the decision to discharge a patient is solely in the purview of the attending physician/AHP.
  - c. Retrospective Review:
    - b.i. -mMay be performed in the following circumstances:
      - i-1) Problem cases not identified by concurrent review mechanism.
      - ii.2) Random sampling of cases to pick up situations that are new,
      - iii-3) To address cases of inappropriate utilization,
      - iv.4) Review of cases for which third-party payers question or deny care, and/or
      - **v.5)** When required by a third-party payer.
  - d. Focused Review:

- i. A focus review is review of known or suspected specific problems.
- e.ii. The Utilization Review Committee may initiate focused review of records and approve sampling the methods. The focused review will apply to all patients regardless of payment source and may be based on diagnosis, procedure, admission, duration of stay, physician/AHP or ancillary services furnished, Diagnostic Related Groups, delay of services, and all professional services performed on the hospital premises with respect to the medical necessity for these services. Cases denied for payment by third-party payers are also included. Activities as such will be reported to the Quality Assurance Committee.
- d.e. The Utilization Review staff may identify cases that are associated with unusually high costs or excessive services, or identify classes of admission wherein patterns of care are found to be questionable. Patterns of resource utilization may be evaluated on a retrospective basis as a part of the overall evaluation of the utilization
- 1. Reporting to Hospital Utilization Review Committee: A-member-of the Department Utilization Review will be appointed to attend the Hospital Utilization Review Committee on a regular basis. The member will communicate relevant studies, ongoing concerns, and progress toward-assuring appropriate utilization of services.
  - 2. Conflict of Interest:
    - a. A physician/AHP may not participate in the review of any case in which he/she has been or anticipates being professionally involved. Physicians/AHPs having either a direct or indirect financial interest in the case(s) being reviewed may not participate except to furnish additional information as may be requested by the Chairman.
  - 3. Confidentiality:
    - a. The proceedings of the Utilization Review Committee-and, its derivative documents, findings, and minutes are all confidential and are protected from discoverability under Section 1157 of the California Evidence Code. Members of the Committee have a duty to preserve this confidentiality.
    - b. To ensure confidentiality, patient references will be only as medical record numbers, and the physician references will be only as an assigned code number.
    - c. The Utilization Review Committee must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient's medical information.
    - a.d. Documentation of Utilization Review Committee activities shall not be incorporated into the patient's chart.
  - 4. Review Activities:
    - The medical director of the Behavioral Health UnitBHU will be responsible for secondary review of all cases referred by staff reviewers and will make a determination regarding the appropriateness of the documentation of severity of illness criteria as they relate to the intensity of services being provided.
      - a-i. When the medical director determines that documentation does not substantiate continued care at the current level, he will contact the attending physician/AHP to discuss the case further. In those instances where there exists a significant divergence of opinion between the medical director and the attending physician/AHP, the Hospital Utilization Review Committee Chairman may be consulted so that resolution of the dispute may be mediated
    - b. The Utilization Review professional(s) within the <del>Department of Behavioral HealthBHU</del> will perform the following activities:
      - Concurrent Review
        - i-1) aReview at periodic intervals in accordance with provider requirements, utilizing continued stay SI/IS criteria. Concurrent review includes admission review and continued stay review, and focuses on the medical necessity for admission and continued hospital stay for all patients. The source of payment is not the sole determinant in identifying patients for concurrent review. All patients are screened and case priority determined by factors including the hospital's case load, identified problems, and

specific practitioners with known or suspected patterns of inappropriate utilization.

#### ii. Admission Review

- ii.1) Pis-performed at time of the patient's presentation for behavioral health services to assure admission to the appropriate level of service. The admission review must be completed and documented, in all cases, within 48 hours of admission following admission. Admission review is an assessment of the medical necessity for a patient's admission to the program.
  - 4)a) If the admission meets criteria and is considered appropriate by the psychiatric liaison, the reviewer will monitor the admission and assign a continued stay review date based on the medical record information.
  - 2)b) If the admission does not meet the screening criteria for medical necessity, the reviewer will contact the attending physician to discuss the case

#### iii. Continued Stay Review is the

- iii-1) Assessment of the medical necessity of a patient's need for continued stay at the designated level of care. The continued stay review date is assigned by the admission reviewer based on the patient's principal diagnosis, severity of illness, intensity of service, as established by-the DepartmentBHU. Justification for continued stay is based on the professional staff and attending physician's documentation in the medical record. If a case meets criteria for continued stay, the reviewer will assign the next review date.
  - 4-)a) Cases which do not meet the criteria for continued stay will be referred to the physician advisor for review. The physician advisor uses clinical judgment as well as screening criteria as the basis for decision. If an adverse decision is considered, the attending physician/AHP will be given an opportunity to present his/her views before a determination is made.
  - 2)b) In cases of a dispute between the attending physician and the physician advisor, a second physician advisor in the same or related specialty as the attending physician may be consulted whenever possible.
  - 3)c) If a decision is made that further stay is not medically necessary, the attending physician/AHP is afforded an opportunity to appeal the decision as set forth under Section XII, Appeals Process in the Hospital Utilization Review Plan. Should the adverse determination be upheld, the Hospital Utilization Review/DRG Committee will provide written notification to the patient or his/her representative, the attending physician, Business Office, peer review organization (PRO) and Medical Records Department
- iv. Periodic open chart review and notification of physician and other documenting professionals when current documentation does not support continued stay in relation to SI/IS criteria.
- v. Collaboration with social work staff to integrate discharge planning into the treatment plan at time of admission to facilitate timely discharge.

## 5. Case Management is a

a. Methodology for moving a patient from admission to discharge with outcomes that are determined by quality standards, within a designated time frame, with patient and family participation and the control and careful use and coordination of systems and resources. Case Management integrates the utilization review/management, discharge planning and quality improvement functions.

- b. The scope of case management in the behavioral-health-populationBHU entails the initial review and determination, based on SI/IS criteria, of appropriate placement, ongoing review for continued stay, and discharge planning. The goals of case management activities are to reduce length of stay, prevent barrier days, and improve resource utilization with emphasis on cost-effective and cost-efficient strategies that maximize quality delivery systems. The case management function, in Behavioral Health ServicesBHU is integrated into the professional duties of the psychiatric liaison and social work staff and is overseen by the clinical nurse manager of the Inpatient and Outpatient Services within the DepartmentBHU.
- c. Discharge planning is an integral part of case management process and must be initiated as early as possible, including prior to admission, to facilitate timely discharge. Departmental discharge planning activity shall include placement in alternative care facilities, and arrangements for appropriate community resources to improve or maintain the patient's health status on an outpatient basis. The members of the health care team collaborate in an interdisciplinary approach to facilitate discharge planning. The patient and his/her family or caregiver network are included in team membership.
- 6. Approval of Department Utilization Review Plan:
  - 5.a. The Behavioral Health DepartmentBHU Utilization Review Plan will be reviewed as revised, in accordance with Hospital Standard for Plan reviews. Revisions will be submitted to the Tri-City Medical CenterHealthcare District Utilization Review for approval.



SUBJECT:

Visiting in Behavioral Health Services

**POLICY NUMBER:** 

520

**ISSUE DATE:** 

03/08

**REVISION DATE(S): 08/09, 03/13** 

Department Approval:

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: Medical Executive Committee Approval:

n/a n/a n/a

Professional Affairs Committee Approval:

04/18

**Board of Directors Approval:** 

#### A. <u>DEFINITION(S)</u>:

 To provide guidelines for patients to have access to visiting with family and significant others during their hospitalization.

## B. POLICY:

1. The patient is entitled to visit with persons of his or her choice during the hospital stay.

#### C. PROCEDURE:

- Visitors will be restricted from visiting patients in the Crisis Stabilization Unit due to the level of acuity and nature of treatment reserved for patients in crisis.
- 2.1. Visitors will be allowed to visit patients in the Inpatient Behavioral Health Unit (BHU) and the Crisis Stabilization Unit (CSU) with the following restrictions:
  - a. Family and significant others may visit patients during the times that are posted in the Behavioral Health UnitBHU and the CSU.
    - i. Visiting hours are posted on entry to the unit and at other areas of the unit.
    - i-ii. Visiting hours are reviewed and outlined in daily community meeting.
    - ii-iii. Visiting outside of regularly posted hours may be arranged by the patient with the physician/Allied Health Professional (AHP) and/or nursing staff.
  - b. The staff will ensure that visiting hours do not interfere with a patient's treatment.
  - c. Visits will be limited to two (2) visitors per patient at any time in the BHU and one (1) visitor per patient in the CSU. If there are more than two (2) visitors, it will be explained to them that they may share the visiting time.
    - i. Clergy members are not counted as one of the two visitors permitted to each patient.
    - ii. Visiting by clergy will be permitted outside of regular visiting hours if the patient so wishes as long as it does not interfere with the patient's treatment program
  - d. The units will have designated visiting areas. Visitors will not be permitted to visit in patient rooms.
  - e. All packages and belongings intended for patients brought to the units by visitors will be checked and inventoried by nursing personnel in the presence of the patient and/or visitor prior to being given to the patient.
  - f. Visitors may not bring food or drinks onto the units.

- g. Visitors will be encouraged to refrain from bringing personal items such as purses and backpacks to the unit. When a visitor arrives with such items they will be instructed to leave them in the provided lockers in the visitor's waiting room. Tri-City Healthcare District (TCHD) is not responsible for lost or stolen valuables.
- No cellular telephones, cameras, or video recording devices are permitted on the units.
- i. In the event that a visitor exhibits inappropriate behavior (e.g. is under the influence of drugs or alcohol, becomes verbally or physically abusive) staff will insist that the visit is terminated. If the visitor refuses to leave the unit, security will be called to escort the visitor out of the building.
- j. Visitors are asked to wear a "Visitor" identification badge upon entering the units.
  - i. Unauthorized visitors will be asked to leave the building without seeing the patient.
  - ii. At all times staff will interact with visitors employing service excellence skills.
  - iii. Staff will identify all persons entering the building and will not permit any individual to have access to either unit until the nature of their presence has been clarified.
- 3.2. The patient will be informed of all rights and units' rules related to visiting upon admission and will be provided with a written copy of the rules that include the unit visiting hours and policy.
- 4-3. Problems observed during visiting will be directed to the Assistant Nurse Manager (ANM) for disposition and reported to the patient's attending psychiatrist.
- 5.4. Patients have the right to refuse visits from designated individuals.
  - a. Patients will be afforded an opportunity to indicate, in writing, those individuals they would welcome as visitors and those they do not wish to visit.
  - The written list will be included in the patient's medical record.
- 6.5. Staff must be aware of the whereabouts of visitors at all times.
- 7.6. The patient's right to visitation will not be limited except as authorized in the patient's treatment plan in accordance with the **Behavioral Health Services** Policy: "Patient Rights." A limitation may be imposed:
  - a. To prevent violation of the law.
  - b. To prevent substantial and or serious physical or mental harm to the patient or others.
    - i. Mental harm may include a visit that, in the opinion of the clinical staff, would substantially upset the patient and interfere with ongoing treatment. A visit may be limited or prohibited to prevent mental harm only if the person and the limitation are specifically identified in the plan of treatment.
    - ii. Physical harm may include a visit that, in the opinion of clinical staff, would pose a risk to the patient, another visitor, or staff and interfere with ongoing treatment. Examples include visitors with whom there is a recent history of domestic violence, visitors against whom there is a restraining order, etc. A visit may be limited or prohibited to prevent physical harm only if the person and the limitation are specifically identified in the plan of treatment.
- 8.7. A patient will be promptly informed of any visitation limitation and a limitation of rights form will be completed. In addition, the patient will be informed of the purpose that the limitation is intended to achieve, the persons involved, and additional information as is deemed appropriate.
- 9-8. Limitations will be reviewed daily by the treatment team and when a limitation is removed it will be noted in the patient record as the right having been restored.
- 40.9. Visits from a patient's private physician or a mental health professional, a court, a patient's attorney, or other person when communication involves matters which are or may be the subject of legal inquiry will not be limited except that non-emergency visits of a private physical or a mental health professional may be limited to reasonable times. A time is reasonable if a visit does not seriously tax the effective functioning of the unit. A limitation upon visitation rights will not apply between a patient and attorney or court; or between a patient and other individuals if the communication involves matters that are or may be the subject of legal inquiry. The attending physician/AHP will be notified of a patient's request to talk to an attorney or other individual regarding a legal matter.

Behavioral Health Unit Inpatient Visiting in the Behavioral Health Unit Page 3 of 3

- **11.10.** The patient may appeal any limitation to the patient advocate through the established grievance procedure.
- 42.11. Children under the age of 16 will not be permitted to visit the Behavioral Health Unit.BHU. Patients with young children may be permitted to visit in the unit lobby or front office if, in the opinion of the clinical staff, it is deemed safe for them to do so.
  - a. Off unit visits will not be permitted if the patient is on a 1:1 or is high risk for elopement.
  - b. Off unit visits will not be permitted if the patient, as assessed by the clinical staff, is too ill to manage the visit outside of the unit.

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

6.1. Behavioral Health Services Policy: Patient Rights



#### **Behavioral Health Services** Inpatient Behavioral Health Unit

SUBJECT:

**Vital Signs** 

**POLICY NUMBER:** 

**ISSUE DATE:** 

03/08

REVISION DATE(S): 08/09, 03/13

**Department Approval:** 

06/1609/17

Division of Psychiatry Approval: Pharmacy and Therapeutics Approval: n/a n/a

**Medical Executive Committee Approval:** 

n/a

**Professional Affairs Committee Approval:** 

04/18

**Board of Directors Approval:** 

#### **PURPOSE:** A.

Holistic care of patients in a Behavioral Health Unit (BHU) requires attention to their physical well-being as well as their illnesses requiring inpatient treatment. Therefore, routine vital signs are done on all patients.

#### B. POLICY:

- Vital signs are to be taken on admission, in the morning and in the evening, when a patient has a change in health status (e.g. after a fall) or reports symptoms such as chest pain, feeling hot, or faints, and any other time a physician/Allied Health Professional (AHP) has ordered or the nurse believes is clinically appropriate. Vital signs will be measured-and-recorded on each patient on admission, twice once daily, and as needed.
- 2. Vital signs include temperature, respiration, heart rate, blood pressure, and pain rating.
- 3. Any member of the nursing staff, licensed or unlicensed, may take vital signs.
- 3.Patients-participating-in research trials will have vitals-measured and recorded according to research protocols.

#### PROCEDURE:

- Any-member-of-the nursing staff, licensed or unlicensed, may take vital signs.
- 4-Vital signs are to be taken in the morning, after a fall, and any other time a physician has ordered or the nurse believes is clinically appropriate. Vital-signs are to be taken on admission, in the morning-and in the evening, when a patient-has a change in health status (e.g. after a fall) or reports symptoms such as chest-pain, feeling hot, or faints, and any other time-a-physician has ordered or the nurse believes is clinically appropriate.



#### Infection Control Policy-Manual

**ISSUE DATE:** 

09/01

SUBJECT: Department Specific: Behavioral

Health UnitServices (BHS)

REVISION DATE: 07/03, 07/07, 07/10, 06/14

POLICY NUMBER: IC.7.1

Department Approval:

**Infection Control Committee Approval:** 

Pharmacy and Therapeutics Approval: Medical Executive Committee Approval:

**Professional Affairs Committee Approval:** 

**Board of Directors Approval:** 

09/17

<del>07/07, 07/10, 04/14</del>10/17

07/10, 05/1401/18

04/18

<del>07/10,</del> 06/14

#### A. **POLICY:**

Patients with mental illness may be at increased risk for infection because of impaired judgement, poor impulse control, reduced self-care, irregular or poor medication compliance, lack of personal hygiene or dental care. The unique practices of the various treatment settings in the Behavioral Health UnitServices (BHS), as well as the behaviors of the clients themselves, can lead to a heightened risk for transmission to other clients and staff. Infection Prevention in behavioral healthBHS requires application of recommended prevention strategies to the extent possible. The unique behavioral traits of some clients may pose an obstacle to traditional methods. The goal is to identify infections and utilize strategies to prevent transmission in this at risk population. The Behavioral Health Unit is a unique setting-staffed by a multidisciplinary group. The purpose of the service is to provide for the treatment and management of mental illness with a limited use of-invasive-procedures. Rather than treatment-of-physical-illness, the focus is on decreased mental suffering. Treatment is designed to change behaviors and permit increased outpatient societal functioning. Patient movement might be broad and far ranging and the interaction with other patients and staff is close, continuing with a purposefully directed component of care and recovery. The patient may not be a reliable medical historian. The pathophysiology of the mental illness-may-present-behavior that could result in-infection-to-self-or others. For example, during hospitalization, patients may be sexually active and expose themselves or others to sexually transmitted-diseases. Inadequate hygiene, nutrition, and hydration as well as psychetropic medications, increase-susceptibility to infection. Medications-designed to moderate the mental illness-may mimic early signs and symptoms of infection. Staff will consult with appropriate physicians for the treatment of infected patients and the need to transfer to a medical floor.

#### В. PREVENTION STRATEGIES:

- Standard Precautions are implemented for every patient in BHUBHS regardless of their diagnosis. Hand hygiene and cough etiquette is encouraged among staff and patients. Hand hygiene and personal hygiene reinforced daily during community meetings. Staff and patients perform hand hygiene prior to eating meals.
- 3.2. The Behavioral Health UnitBHS does not have negative pressure rooms. Patients requiring Airborne Precautions for infectious tuberculosis, measles, or varicella (chickenpox or disseminated herpes zoster) shall be transferred to an appropriate medical bed within the hospital.
- 4.3. A patient requiring Contact Precautions for conditions other than multi-drug-resistant organisms (e.g. MRSA and VRE) or Droplet Precautions may remain on the unit if the psychiatrist deems this necessary. Patients requiring Droplet precautions will be asked to wear a surgical

- mask as tolerated (if patient presents as a danger to self, consideration of one-on-one observation will be considered).
- 5.4. If a patient is diagnosed in cases of patients with a multi-drug-resistant organisms (e.g. MRSA and VRE) the individual patient's clinical situation, hygiene practices and facility resources will be considered in deciding whether to implement Contact Precautions with that patient.
- 6-5. Clean linen is kept covered and stored inside a clean supply room. Dirty utility rooms are locked
- 7.6. The cleanliness of the kitchen is the responsibility of the staff. Patients will be instructed, assisted and menitored with safe food preparation and handling.
- 8.7. Each patient will be assigned a closet for personal clothes and belongings.
- 9.8. Patients will be instructed on the use of laundry facilities. Patients are to wash only their own clothes andwith direct staff superivision-will assist as needed. Staff is responsible for the cleanliness of the laundry area. Family members can be asked to take heavily soiled clothing home for washing.
- 40.9. Housekeeping performs sanitizing, disinfecting, and general cleaning tasks such as but not limited to trash/recycling removal, dusting, vacuuming, polishing, and mopping.
- 11.10. BathtubShower area is to be cleaned by the environmental services staff assigned to the Behavioral Health area is to be cleaned by the environmental services staff assigned to the Behavioral Health Unit BHS after each patient use.
- 11. Sharps boxes will not be kept in patient rooms for safety reasons.
- 12. Staff to wipe off reusable equipment with hospital approved disinfectant wipes in between patient use.

#### C. RELATED DOCUMENT(S):

- 1. Administrative-Policy-#401 Injury Prevention-Program
- 2. BHU- MRSA -- Contact-precautions Modifications for Patients-on-behavioral health units
- 13.1. Employee Health & Wellness Services Policy: Injury Illness Prevention Program
- 14.2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC.11
- 3. Infection Control: Cleaning and Disinfection IC.9
- 15.4. Infection Control: Hand Hygiene IC.8
- 16.5. Infection Control: Philosophy IC 1.2
- 47.6. Infection Control: Standard and Transmission Based Precautions IC.5
- 18. Participation-of-Staff in the Infection Control-Program IC.7

## B.D. REFERENCE(S):

- 1. APIC Text of Infection Control and Epidemiology 4th edition 2014-Chapter 49 Behavioral Health; Larysa M. Fedoriw, MPH.
- 1. Hatch, R, Mental-Health in APIC Text of Infection-Control and Epidemiology. Wash: DC, 2000.
- 2. Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee Management of Multi-drug-Resistant Organisms in Healthcare Settings, 2006-HICPAC

Tri-City Medica	al Center	Distribution:	Women's & Children's Services,
PROCEDURE:	BREAST MILK, PUMPIN	G, HANDLING,	AND STORAGE OF
			llection storage and handling of maternal
	breast milk in the hospital	setting.	DELETE: replace with Elsevier Online
Supportive Data:	Methers giving their babie	s-pumped milk	Skills: Breastmilk: Collection,
1	program that hospitals sup		Storage and Administration
	baby-occur then the staff i		
	pumping, handling and sto	oring of human	TIBIN.

#### A. <u>CRITERIA FOR BREAST MILK STORAGE:</u>

- 1. Gloves should be worn when preparing breast milk or when spillage may occur. General guidelines for determining which breast milk to use, unless otherwise ordered:
  - a. Milk-in chronological-order
  - Fresh-expressed milk
  - c. Rofrigorated milk
- At all times, all containers shall be labeled with patient identification label including mother or infant's name, medical record number, date and time.

#### B. BREAST-MILK STORAGE GUIDELINES:

1. Breast milk shall be stored as follows in a designated refrigerator/freezer:

Breast Milk Storage-Guidelines					
Pre-Term or					
<del>Method</del>	<del>Term Infant</del>	Sick-Infant			
Room temperature less than or equal to 25° C (77° F)	6-8 hours	4-hours			
Refrigeration of Fresh-Milk less than or equal to 4° C (39° F)	3-5 days	96 hours			

#### C.—PROCEDURE:

- 1. Collection
  - Provide-instruction to MOB-on "Pumping, Storing & Transporting-Breast Milk for hospitalized-infants. Parent information sheet given-by lactation consultant.
  - b. Direct-parent to a pump rental-facility and use of in-house pump when-parent is at hospital
    with baby.
  - c. -- Instruct mother of baby in hand expression and manual pumping as alternative-ways of collecting milk.
  - d. Provide individualized labels with the mether's name and medical record number, containers and lids, and NICU will provide infant labels on initial NICU visit.
  - e. When giving or receiving milk from the refrigerator the identification band will be checked with the milk-label.
  - f. -- Instruct mother to write the date and time of collection-
  - g. Instruct mother in-hand washing before and after pumping.
  - h. Instruct mether in cleaning collection-bottles and flange.
  - i. Educate-mother in how to store-breast milk in small volumes to minimize waste.

#### Hospital Pump-Care:

- a. Breast-pumps shall be wiped-down with a hospital approved germicide as follows:
  - ——Prior to each use in the NICU.
  - ii. Prior to each-new-patient use in areas other than NICU-
  - iii. If a spill occurs.
- b. If internal contamination is noted, take the pump out-of-service and send to-Biemed for deep cleaning.

Review/Revision Date	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/03, 05/06, 06/07, 05/08, 04/09, 06/11, 12/14, 09/15 <b>, 01/</b> 18	08/07, 06/15 <b>, 02/18</b>	n/a	08/07, 08/15 <b>, 03/18</b>	09/07, 06/09, 09/15, 04/18	09/07, 06/09, 09/15

Women &Newborn Services Breast Milk, Pumping, Handling, and Storage of Page 2 of 2

#### D. DOCUMENTATION:

Document parent education-in-patient record.

#### E. <u>CROSS-REFERENCE:</u>

1. See Breast Milk Misadministration procedure

#### F. REFERENCES:

- Human Milk-Banking Association of North America, Inc. Best Practice for Expressing, Stering and Handling Human-Milk in Hospitals, Homes and Child Care Settings. 2005. Raleigh, NC: HIMBANA.
- Infant Feedings: Guidelines for Preparation of Fermula and Breast milk in Health Care-Facilities.
   American Dietetic Association. Copyright 2004
- Meirer, P.P. (1997). Professional Guide to Breastfeeding Premature Infants. Ross Products
  Division, Abbett Laboratories.
- 4. Pardou, A., et al. (1994) Human-Milk-Banking: Influence of storage process and of bacterial contamination on some milk constituents. <u>Biol Neonate</u>; 65; 302-309.
- 5. Pierce, K.Y. & Tully M.R. (1992). Mother's Won Milk: Guidelines for storage and handling. Journal of Human-Lactation; 8 (3); 159-160.
- 6.— The Academy of Breastfeeding-Medicine Protocol-Committee; Caroline J. Cantry, MD, FABM; Cynthia R. Heward, MD, MPH, FABM. Protocol-#7: Model Breastfeeding Policy.—Approved 2/20/2004.
- 7.1. Lawrence, Ruth & Lawrence Robert (2005). Breastfeeding— A Guide for the Medical Profession. Elsevier Mosby. 761-778, 1081 1093.

Tri-City Me	dical Center	Distribution: WOMEN AND NEWBORN SERVICES	
PROCEDURE:	FORMULA FEEDING PROCEDUP	RE	
Purposo:	To outline an alternative method of meeting an infant's nutritional needs.		
Supportive Data:	Use of commercially prepared, iron-fortified for neonatal nutrition. Use of formula is indicated net to breastfeed, or when the mether or the		
Equipment:	bottle-feeding with formula-or-pump  1. Appropriate commercially prepared.		
	2.1. Appropriate type of sterile n		

### A. PROCEDURE:

- 1. Porform-hand-hygione
- 2. Verify-type of formula-to-feed newborn. Formula may be given at room temperature.
- 3. Assess-newborn's-physiologic readiness (behavioral cues) for initiation of feedings by assessing:
  - a. Vital signs
  - b. Activity exhibiting rooting, sucking, or crying behaviors
  - c. Muscle tone
- 4. Change diaper if necessary and wrap infant in-blankets—perform hand-hygiene after diapering and-prior to-feeding.
- 5. Newborn-should-be-held-during feedings in a semi-upright position (45 degree angle) with-close physical-contact and-contingent responsiveness (nurturance). Do-not prop bettles or use products that hold a bettle-in-a-newborn's mouth.
  - a. Propping the bettle for feeding has been associated with reflux of milk into the Eustachian tubes
- 5. Insert-nipple-into newborn's mouth, keeping the nipple-full-of-formula-in-order-te-decrease swallowing of air.
  - Assess if infant-initiates and sustains suck and swallow-coordination
  - b. Assess-if-color-and respiratory effort remain stable throughout-feeding
- 7. Burp newborn after-every-half ounce (15 mL) or halfway through the feeding.
- 3. Allow 20 minutes for a feeding-and-feed-on demand, or at least every four hours, or as ordered by physician.
  - a. Normal infant feeding-is:
    - i. 1<sup>st</sup> 24 hours: 2-10-ml/food
    - ii. 24-48 hours 5-15 ml/foed
    - iii. 48-72 hours 15-30-ml/feed
    - iv. 72-96 hours 30-60-ml/feed
- 9. Discard any formula remaining in the feeding-bettle-
- 10. Assess for signs of formula intolerance:
  - a: Encourage parents to be alert-for-signs/symptoms-prior to and after discharge, signs include:
    - . Constipation
    - ii. Fussiness
    - iii. Abdominal-cramps
    - iv. Excessive-spit-up or vomiting
    - Notify-pediatrician for signs of intolerance (formula-type-or-brand alternative)

### B. DOCUMENTATION:

- Document-type and amount of formula for each feeding on newborn patient care record.
- Document any abnormal events associated with this procedure in nurse's notes.

Review/Revision Date	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/03, 07/09, <b>01/18</b>	n/a	08/09, 03/15, <b>02/18</b>	n/a	05/13, 04/15 <b>,</b> 03/18	06/13, 05/15 <b>,</b> <b>04/18</b>	06/13, 05/15

Women and Newborn Services (WNS) Formula Feeding Procedure Page 2 of 2

### C. REFERENCES:

- 1. The Academy of Breastfeeding Medicine Protocol Committee. Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2009.
- 2. Mattson, S., & Smith, J.E. (Eds.) (2011) Core-Curriculum for Maternal-Newborn-Nursing (4<sup>th</sup> Ed.) Philadelphia: Saunders.
- 3.1. Simpson, K., & Creehan, P. (2014). Perinatal Nursing (4thEd). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Lippincett Williams and Wilkins, PA



### WOMEN'S AND CHILDREN'S SERVICES POLICY MANUAL

ISSUE DATE: 10/94 SUBJECT: INFANT FEEDINGS

REVISION DATE(S): 01/00, 06/03, 12/09, 04/10, 06/14

Department Approval: 01/18

Department of Pediatrics Approval: 05/1302/18

Pharmacy and Therapeutics Approval: n/a

Medical Executive Committee Approval: 05/1403/18
Professional Affairs Committee Approval: 06/1404/18

Board of Directors Approval: 06/14

### A. **DEFINITION(S)**:

1. BFHI: Baby-Friendly-Hospital Initiative

2. EBM: Expressed Breastmilk

3. WHO: World Health Organization

- 4. Exclusive Breastfeeding: The optimal-practice of feeding infants no food or drink other than human-milk-unless another food is determined to be medically necessary.
- 5.1. Skin to Skin (STS): Direct physical contact between the newborn infant and mother. After birth, the healthy term infant should be completely dried and placed naked against the mother's naked chest. The infant may wear a diaper and/or hat, but no other clothing should be between the mother's and infant's bodies. The infant and mother are then covered with a warmed blanket, keeping the infant's head uncovered. STS contact should continue, uninterrupted, until the completion of the first feeding (or for at least 1 hour if the mother is not breastfeeding). STS contact should be encouraged beyond the first hours and into the first days after birth. Another adult may hold the infant STS if/when the mother is not available.

### B. POLICY:

- 1. To promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this maternal infant process.
- 2. To assist families choosing to breastfeed with initiating and developing a successful and satisfying experience.
- 3. This policy is adapted from the Academy of Breastfeeding Medicine (AMB): AMB Clinical Protocol # 7: Model Breastfeeding Policy (2010) which is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization (WHO), and the American Dietetic Association.
- 4. This policy is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family-Physicians, the World Health Organization, the American Dietetic Association, and the Academy of Breastfeeding Medicine, and the UNICEFWHO evidence based "Ten Stops to Successful Breastfeeding".
- 5. This policy encompasses the UNICEF/WHO evidence-based Ten Steps to Successful Breastfeeding; practices that have been shown to increase breastfeeding initiation and duration.
- 4.6. Tri-City Medical Center complies with the WHO International Code of Marketing of Breastmilk Substitutes.

### C. PROCEDURE:

- 1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
  - a. Tri-City Medical Center staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary team comprised of physicians, midwives, nursing, lactation consultants, dietary, and outpatient providers shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. This group will evaluate data relevant to breastfeeding support services and formulate, along with administrators, a plan of action to implement needed changes.
  - b. Tri-City Medical Center upholds the WHO International Code of Marketing of Breastmilk Substitutes by offering education and materials that promote human milk rather than other infant food or drink, and by refusing to accept or distribute free or subsidized supplies of breastmilk substitutes, nipples, and other feeding devices. Mothers will be protected from the promotion of breastmilk substitutes and other efforts that undermine an informed feeding choice.
  - c. This written breastfeeding policy will be communicated to all health care staff members. It will be reviewed and updated every 2 years (per medical center policy) or as needed using current research as an evidence-based guide.
  - d. All new Women and Newborn Services' staff and care providers will be oriented to the policy during their initial orientation. The orientation process is different for type of hire and is detailed in the Women and Newborn Services Lactation Education Checklist (see Attachment B). Staff and care providers will be expected to read and sign the policy.
  - e. This policy will be readily available to all areas of Tri-City Medical Center that potentially interact with childbearing women and infants so that they may promote, protect, and support breastfeeding in all departments. Other department's polices will support, and will not countermand the medical center's infant feeding policy.
- 2. Train all health care staff in the skills necessary to implement this policy.
  - a. The nursing leadership team will ensure that all staff working in the Women and Newborn Services department (excluding the NICU) will receive a minimum of 20 hours of education, including at least 5 hours of supervised clinical training, on the topics specified by the BFHI (see Attachment A). For new employees, this training will be completed within 6 months of hire. Details for the execution of the training are specified in a separate training plan: Baby Friendly Training Requirements (Attachment B).
  - b. Upon completion of training for new employees, the staff preceptor will supervise and verify the clinical competency of the new staff member. This will be documented in the orientation checklist and maintained in the employee file. Staff will receive adequate training and mentorship to attain competence in:
    - i. Counseling the feeding decision
    - ii. Skin to skin (STS) in the immediate postpartum period
    - iii. Comfortable and effective positioning and attachment at the breast
    - iv. Assessing and documenting a latch score
    - v. Maintenance of exclusive breastfeeding
    - vi. Feeding cues
    - vii. Rooming-in
    - viii. Hand expression
    - ix. Formula preparation and feeding when necessary
    - x. Finding support upon discharge
  - c. Documentation of all training will be maintained by the Lactation Supervisor and/or appropriate CNS on the BFHI Staff Training Documentation Checklist.
  - d. Providers with privileges for labor, delivery, maternity, anesthesia, and/or newborn care will have a minimum of 3 hours of breastfeeding management education pertinent to their role. Education will be verified by successful completion of the First Latch module and a certificate of completion will be verified and maintained by a provider coordinator.

- e. The content and number of hours of training for other staff will be developed based on job description and workplace exposure to breastfeeding couplets.
- 3. Inform all pregnant women about the benefits and management of breastfeeding.
  - a. Physicians, midwives, and nurses providing prenatal services are responsible for educating pregnant women and their support people about breastfeeding. Education will cover the importance of exclusive breastfeeding, non-pharmacologic pain relief methods for labor, the importance of early STS contact, early initiation of breastfeeding, rooming-in, feeding on demand, frequent feeding to help assure optimal milk production, effective positioning and attachment, exclusive breastfeeding for the first 6 months, and that breastfeeding continues to be important after 6 months even after other foods are introduced. Contraindications to breastfeeding and other special medical conditions will be discussed as indicated. Education will be documented in the prenatal record.
  - b. Exclusive breastfeeding is defined as providing breastmilk as the sole source of nutrition to infants. Exclusively breastfed infants receive no other liquids or solids unless medically indicated. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. The planned feeding method will be documented in the prenatal record.
  - c. Tri-City Medical Center does not distribute educational materials in which the use of formula or infant feeding bottles is discussed routinely.
  - a.d. Tri-City Medical Center offers no group education on the use of infant formula or feeding bottles.
  - e. Breastfeeding classes are offered by Tri-City Medical Center. Pregnant women who receive services at Tri-City Medical Center will receive written information regarding the benefits of breastfeeding as well as an explanation of practices implemented in the Women and Newborn Services department that support successful breastfeeding.
  - f. Tri-City Medical Center fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages.
  - g. Tri-City Medical Center provides organizations that offer prenatal services curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding.
  - h. Members of the staff at Tri-City Medical Center participate in the local breastfeeding coalition.
- 4. Help mothers initiate breastfeeding within one hour of birth.
  - a. Immediately after delivery, all term infants, regardless of feeding preference, will be placed STS with the mother as long as the infant and mother are stable and it is not medically contraindicated.
  - b. STS contact including any reasons for delaying STS will be documented in the infant's medical record.
  - c. Preterm or unstable infants or infants having required resuscitation will be placed STS as soon as possible after medical stability has been established.
  - d. The nursing staff present at the delivery has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding. This encompasses placing the infant STS with mother immediately after birth (including cesarean deliveries if possible), assisting the mother in recognizing infant signs of feeding readiness, and allowing the infant the opportunity to self-attach to the breast. Vaginal delivery mother/infant couplets will be given the opportunity to initiate breastfeeding within 1 hour of birth. Cesarean delivery mother/infant couplets will be given the opportunity to initiate breastfeeding as soon as possible.
  - e. Time of initiation of STS contact as well as the time this contact ends will be documented in the medical record.
  - f. During the initial period of STS contact, routine newborn procedures will be postponed (up to 2 hours) until the first breastfeeding has been completed.

Assessments and procedures (including the administration of vitamin K and erythromycin eye ointment) should be performed while the infant is still STS with the mother.

- g. After 24 hours of life, the stable infant may receive a bath upon parent's request.
  - i. Earlier bathing may be considered in the instances of specific parental request, meconium stained infant, or malodorous amniotic fluid.
  - ii. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after the delivery.
  - iii. Education is provided to parents about delayed bathing to include the importance of initial bonding, STS, and establishment of breastfeeding.
- STS contact will be encouraged throughout the hospital stay.
- 5. Show mothers how to breastfeed and how to maintain lactation even if separated from their infants.
  - a. The nurse will assess the mother's breastfeeding techniques and, if needed, will demonstrate appropriate breastfeeding positioning and attachment, optimally within 3 hours, and no later than 6 hours after birth.
  - b. Breastfeeding assessment, teaching, and documentation will be done on each shift and whenever possible during each staff contact with the mother. After each feeding, staff will document information about the feeding in the infant's medical record. This documentation may include the latch, position, and any problems encountered. For feedings not directly observed, maternal report may be used. Every shift, a direct observation of the infant's position and latch during feeding will be performed and documented. If the LATCH score is < 7, the nurse will document any interventions and the infant's response to those interventions. The LATCH score will be repeated with the next feed.
  - c. Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and the newborn channel as appropriate. If clinically indicated, the provider or nurse will make a referral to a lactation consultant. The mother will be given a breastfeeding log book and shown how to monitor feedings and diapers, as well as information about breastfeeding support groups.
  - d. Parents will be taught that breastfeeding infants, including cesarean-birth infants, should be put to breast at least 8 to 12 times in 24 hours. Infant feeding cues (such as increased alertness, activity, mouthing, or rooting) will be used as indicators of the infant's readiness for feeding. Breastfeeding mothers will be instructed about breastfeeding and the following principles and skills reviewed before discharge:
    - i. Importance of exclusive breastfeeding
    - ii. How to maintain lactation for exclusive breastfeeding for up to 6 months
    - iii. Proper positioning and latch
    - iv. Nutritive sucking and swallowing
    - v. Milk production and release
    - vi. Frequency of feeding/feeding cues
    - vii. How to manually express, pump, handle, and store breastmilk
    - viii. How to assess if the infant is adequately nourished
    - ix. Reasons to contact the provider
    - x. How to sustain lactation if separated from the infant or if not exclusively breastfeeding after discharge
  - e. Time limits for breastfeeding on each side will be avoided. Infants may be offered both breasts at each feeding but may be interested in feeding on only one side early on.
  - f. When a mother must be separated from her infant, the staff will instruct the mother to begin expressing her breastmilk within 3 hours of the separation. The mother will be taught how frequently to express her milk as well as proper storage and handling. The EBM (expressed breastmilk) will be given to the infant as soon as the infant is medically stable. The mother's EBM will be used before any supplementation with breastmilk substitutes unless otherwise contraindicated.

- g. A mother discharged home without her infant due to illness or prematurity will be seen by a lactation consultant before discharge and will be given a discharge pumping plan and appropriate education:
  - i. Instruction on hand expression and the electric breast pump:
    - Expression/pumping at least 8 times per day, approximately every 3 hours for 15 minutes or until milk flow stops.
    - 2) The importance of continuing to pump throughout the night.
    - 3) For mothers who will be separated from their infants for an extended period of time, instruct to pump 6 times a day once milk supply is established.
  - ii. Encouraged to breastfeed on demand as soon as the infant's condition permits.
  - iii. Encouraged to practice daily STS when the infant is medically stable.
  - iv. Instruction on proper storage and labeling of breastmilk.
  - v. Assistance in obtaining a double set up electric breast pump prior to going home.
- h. The mother who chooses to feed her infant a breastmilk substitute will be given written and verbal information regarding appropriate hygiene, preparation, storage, handling, and feeding of the substitute. This education will be documented in the medical record.
  - i. Ready to feed formula or liquid concentrate is recommended for the first 2 months of life.
  - ii. Families with WIC or those who will be using powdered formula will be given information regarding safe preparation. (see WHO Guidelines: How to Prepare Formula for Bottle-Feeding at Home):
    - 1) Powdered formula is not sterile.
    - 2) Mix powder with hot water (158 degrees F/70 degrees C).
    - 3) Allow formula to cool prior to feeding to the infant.
- 6. Give infants no food or drink other than breastmilk, unless medically indicated.
  - a. For healthy term infants, no supplemental water or glucose water will be given.
  - b. For healthy term infants, no breastmilk substitute will be given unless by a provider's order or standardized procedure. Note: Breastmilk substitutes should not be used as a prophylactic measure for anticipated weight loss, jaundice, etc.
  - c. Infants who are receiving supplemental nutrition will be offered alternative feeding methods to avoid the use of bottles and nipples if acceptable to the mother and achievable according to staff. These methods include:
    - i. Supplemental Nursing System (SNS)
    - ii. Finger Feeding
    - iii. Cup feeding
      - In breastfeeding infants that require supplementation, the supplementation should be given by a Supplemental Nursing System (SNS), finger feeding, or cup feeding as follows:
  - d. EBM, if available, will be given prior to supplementation with a breastmilk substitute. If EBM is not immediately available, it will be given as soon as it is available.
  - e. Each day the provider will be consulted regarding the volume and type of supplement.
  - f. If formula supplementation is medically indicated, an order is needed and the nurse must document initial reason(s) and ongoing indications.
  - g. If a mother requests her infant be supplemented with a breastmilk substitute, staff will explore and address the mother's concerns. The mother will be given the Risks of Formula Supplementation handout for review. If the mother's request for formula persists, the provider will be called for an order for formula. The education to the risks of formula and informed decision of the patient will be documented. The mother will be given supplies and education (refer to Mosby's Skills Formula Feeding Education Maternal Newborn).
  - h. Assessment for clinical signs of hypoglycemia and dehydration will be ongoing. Routine glucose monitoring of full term (AGA, non IDM) infants is not indicated.

- a-i. Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into a spoon or the infant's mouth during feeding attempts. STS contact will be encouraged. Parents will be instructed to watch closely for feeding cues, and when observed, to feed the infant. If the infant continues to feed poorly, hand expression and/or an electric breast pump (and pumping with breast massage) will be introduced and maintained approximately every 3 hours, or a minimum of 8 times per day. Any expressed colostrum or mother's milk will be fed to the infant by SNS, finger feeding, or cup feeding. The mother will be educated that it is normal not to obtain much milk or even any milk the first few times she pumps her breasts. The lactation consultant or specialist should also be consulted for these cases.
- i.j. Breastfeeding is contraindicated for:
  - ii.i. Mothers who are HIV-positive.
  - iii-ii. Mothers who abuse illicit drugs or alcohol.
  - iv-iii. Mothers who are taking certain high risk medications. (Most prescribed and over-the-counter medications are safe for the breastfeeding infant, however some may be contraindicated while breastfeeding.)
  - y.iv. Mothers who have active, untreated tuberculosis (infant may safely receive EBM).
  - vi.v. Infants who have galactosemia, maple syrup disease, or phenylketonuria.
  - vii.vi. Mothers with active herpetic lesions on the breast(s). (The Infectious Disease Department should be consulted for any problematic infectious disease issues regarding safety of STS, direct breastfeeding, and/or EBM.)
  - i-vii. Mothers with varicella that is determined to be infectious to the infant.
  - ii.viii. Mothers with HTLV1 (human T-cell leukemia virus type 1)
- 7. Practice rooming-in allow mothers and infants to remain together 24 hours a day.
  - a. Mother/infant couplets (regardless of maternal feeding preference) will begin rooming-in immediately after delivery and will not be separated during hospitalization as long as both are medically stable and mother/family are able to care for infant.
  - b. Routine newborn procedures will be done at the mother's bedside.
  - c. Infants can only be admitted to couplet care or the NICU.
  - d. If an infant needs to be separated from its mother, documentation of the location, reason, and the expected time period will be recorded.
  - e. The infant will be reunited with the mother as soon as possible. If an infant and mother are separated, the staff will support exclusivity of breastfeeding.
  - a.f. If a mother requests that her infant be taken out of the room, staff will explore the mother's reason for the request, will educate her on the benefits of continuing to room in, and will document as appropriate.
- 8. Encourage breastfeeding on demand.
  - a. All mothers will be taught to feed their infant when the infant exhibits signs of feeding readiness. Mothers will be taught to recognize these feeding cues in the infant.
  - b. Mothers will be informed of normal newborn feeding behaviors such as cluster feeding, feeding through the night, and a normal feeding schedule of at least 8-12 feedings in a 24 hour period.
  - c. No limitations will be taught to mothers regarding length or number of feedings.
  - 5.d. Parents will be taught that both physical contact and nourishment are important parts of the feeding process.
- a.9. Give no pacifiers or artificial nipples to breastfeeding infants.
  - Pacifiers will not be given to healthy, full-term breastfeeding infants.
  - b. Preterm infants in the NICU or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.
  - c. Infants undergoing painful procedures may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mother with the pacifier.

- d. Pain management interventions during uncomfortable or distressing procedures will be used whenever possible. This may include breastfeeding during a heel stick procedure for infant blood tests.
- e. If a parent requests a pacifier, artificial nipples, or feeding bottles they will be educated regarding possible negative consequences as it relates to breastfeeding and this education will be documented.
- f. Any supplementation should be given by SNS, finger feeding, or cup feeding before introduction of an artificial nipple or bottle.
- 6.g. A nipple shield may be given by the RN or lactation consultant to manage latch problems, or sore or cracked nipples. The RN or lactation consultant will document why the nipple shield was given and the infant's response to the intervention.

  Mothers using nipple shields will be followed by a lactation consultant.
- 10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.
  - a. Infants that are not feeding well should not be discharged home.
  - b. Before leaving the hospital breastfeeding mothers should be able to:
    - i. Position and latch the infant correctly at the breast with no/minimal discomfort during feeding.
    - ii. Recognize when the infant is swallowing milk.
    - iii. State that the infant should be breastfed approximately 8 to 12 times in 24 hours.
    - iv. State an age-appropriate elimination pattern at least 6 voids and 3 to 4 stools per day by the fourth day of life.
    - v. List indications for calling the provider.
    - a.vi. Manually express milk from her breasts.
  - b.c. Prior to going home, mothers will be given the names and telephone numbers of community resources to contact for help with breastfeeding including the Tri-City Medical Center breastfeeding clinic and support group.
  - d. All infants should be seen for follow-up within the first few days after discharge. This visit should be with a pediatrician or other qualified health care practitioner for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice, and age-appropriate elimination.

#### D. BREASTFED NEWBORN INPUT AND OUPUT NORMS

Age in hours	Milk volume per feeding	# feeds	# voids	# stools
0-24	0-5 mls / drops	6-8	≥1	≥1
24-48	5-10 mls / 1 tsp	≥ 8	≥ 2	≥ 2
48-72	10-20 mls / 1 tbsp	≥ 8	≥ 3	≥ 3
72-96	20-30 mls / 1 oz	≥ 8	≥ 4	≥ 4
> 96	> 30 mls / > 1 oz	≥ 8	≥ 5-12	≥ 5-12

- 1. Infant has 24 hours to void and 48 hours to stool after birth.
- There may be a lull in stooling after meconium is cleared while baby waits for milk to come in.
- 3. Infants may feed VERY frequently before the milk comes in; even hourly for the first few nights.

### E. MEDICAL INDICATIONS FOR SUPPLEMENTATION

- When making the decision to start supplementation, it is necessary to look at all the factors involved. Weight loss alone does not imply the need for supplementation. Breastfeeding assessment, assistance, and education should be done prior to starting supplementation.
- 2. Possible medical indications for supplementation include:
  - a. Infant risk factors:
    - i. Asymptomatic Hypoglycemia unresponsive to appropriate, frequent breastfeeding

- ii. Inadequate intake as evidenced by:
  - 1) Clinical or laboratory evidence of clinical dehydration (high sodium, poor feeding, lethargy) that is not improved after skilled assessment and proper management of breastfeeding.
  - 2) Excessive weight loss (≥ 10%):
    - a) Note that excessive newborn weight loss is correlated with positive maternal intravenous fluid balance and may not be directly indicative of breastfeeding success or failure.
    - b) Number of voids and stools should be taken into consideration.
  - 3) Delayed bowel movements: < 4 stools on DOL 4, or continued meconium stools on DOL 5.
- iii. Hyperbilirubinemia
  - With ongoing weight loss, limited stooling, and voiding with uric acid crystals.
    - With Bili-level-20-25mg/dL
- iv. Inborn errors of metabolism
- b. Maternal risk factors:
  - i. Delayed secretory activation.
  - ii. Primary glandular insufficiency as evidenced by:
    - 1) Abnormal breast shape
    - 2) Poor breast growth during pregnancy
    - 3) Prior breast surgery resulting in poor milk production
  - iii. Intolerable pain during feedings unrelieved by interventions.

### F. SUPPLEMENTAL NURSING SYSTEMS (SNS) AND NIPPLE SHIELDS

- Supplemental Nursing System (SNS):
  - a. Assemble the SNS tubing with a syringe or container; considered a single-use piece of equipment.
  - b. Gently tape the tubing to the mother's breast with the end of the tubing extending about ¼ inch beyond the end of her nipple.
  - c. Assist the mother in latching the infant to the breast and tubing as needed.
    - i. Sucking from the infant creates a siphon effect and allows supplementation from the reservoir of the syringe or SNS container kit.
  - d. Supplementation should be monitored accordingly.
    - Amounts of EBM or breastmilk substitute should be measured to meet the infant's needs.
    - ii. 10-15 ml of EBM or breastmilk substitute is considered adequate intake for the newborn infant. It is important not to overfeed. Cue-based infant feeding should be utilized.
- 2. Nipple shield:
  - a. Application of the nipple shield:
    - Assess both mother and infant to choose the correct size nipple shield.
       Sizing a nipple shield is dependent on both the size of the infant's mouth and the size of the mother's nipple.
    - ii. The nipple shield may be placed under very warm water to increase pliability and enhance adherence to the breast. Colostrum or lanolin cream may also be used to help with adherence.
    - iii. Handle the shield by the rim. Place the shield over the breast with the nipple centered inside the nipple portion of the shield. Support the breast with a "C" hold. Place the thumb on both the top of the breast and the top part of the shield and place the fingers below, underneath the areola.
  - b. Latching the infant to the breast with a nipple shield:
    - i. Guide the mother to stroke the infant's lower lip with the shield. When the infant's mouth opens wide, bring the infant directly onto the shield allowing the infant to take as much of the areola as possible into the mouth.

- ii. Allow the infant to breastfeed on one breast as long s/he likes. Repeat on the other breast if infant shows a desire to continue breastfeeding.
- c. Cleaning and care of the nipple shield:
  - i. Instruct the mother to wash her hands and the nipple shield in warm, soapy water, rinsing well before each use.
  - ii. Store the shield with the nipple facing upward, and keep in a clean and dry covered container.
- d. Reportable conditions and referral to a lactation consultant:
  - i. Continued inability to sustain latch.
  - ii. Absence of audible swallow after several minutes of sucking.
  - iii. Infant weight loss greater than 7% below birth weight.
  - 7.iv. Signs of dehydration or anemia.
- 3. Follow-up:
  - a. If a mother is still using a breastfeeding aid (SNS or nipple shield) at the time of discharge, she will be referred to lactation services to schedule a follow-up outpatient lactation clinic appointment within a few days of discharge.
  - b. It is not uncommon for a mother to use a breastfeeding aid for up to 6 months for the following conditions:
    - i. Nipple abnormalities (e.g., flat, inverted, fibrous).
    - iii. Premature infant.

G. SUPPLEMENTATION FREQUENCY AND QUANTITY

	Fraguency	Quantity
	Frequency	Quantity
Term Infant (≥	DOL 1: 8 attempts (usually 4-5	DOL 1: 5-10 ml per feeding
37.0 weeks)	successful feedings)	➤ DOL 2: 10-20 ml per feeding
	➢ DOL 2: 8-12 times	DOL 3: 20-30 ml per feeding
	DOL 3 & 4: 8-12 times	DOL 4: 30-40 ml per feeding
		➤ DOL 5: 40-50 ml per feeding
		> DOL 6: 50-60 ml per feeding
		DOL 7 – 1 <sup>st</sup> month: 60-90 ml
		per feeding
		*Volumes may yang dapanding
		*Volumes may vary depending
		on infant's weight
Late Preterm	At least every 3 hours, more	➤ DOL 1: 5-10 ml per feeding
Infant (≥ 35.0 –	often based on infant feeding	➤ DOL 2: 10-20 ml per feeding
36.6)	cues.	DOL 3: 20-30 ml per feeding
	Limit total feeding time to 30	➤ DOL 4: 30-40 ml per feeding
	minutes in order to minimize	➤ DOL 5: 40-50 ml per feeding
	fatigue and conserve energy.	DOL 6: 50-60 ml per feeding
	0	> DOL 7 – 1 <sup>st</sup> month: 60-90 ml
	*Late preterm have immature	per feeding
	feeding capabilities, increased	'
	calorie needs, low metabolic	*May do better with smaller
	stores, and are high risk for	volumes
	hyperbilirubinemia.	

### H. <u>OTHER CONSIDERATIONS</u>

- 1. Drugs to specifically suppress lactation will not be given to any postpartum mother.
- 2. It is recommended that mothers wait 6 weeks postpartum to receive Depo-Provera, unless the OB team feels it is indicated earlier.
- 3. Prior to administration of any drugs that may inhibit milk production, mothers will be counseled as to the risks.
- 4. Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch technique and will be instructed to apply expressed

colostrum or breast milk to the areola after each feeding. Lanolin cream may be used if medically indicated.

### I. <u>COMPLIANCE WITH THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES</u>

- 1. Employees of manufactures or distributers of breastmilk substitutes, bottles, nipples, or pacifiers have no direct communication with pregnant women or delivered mothers.
- 2. Tri-City Medical Center does not receive free gifts, non-scientific literature, material, equipment, money, or support for breastfeeding education or events from manufactures of breastmilk substitutes, bottles, nipples, or pacifiers.
- 3. No pregnant women, delivered mothers, or families are given marketing materials, samples, or gift packs by the facility that contain breastmilk substitutes, bottles, nipples, pacifiers, or any other infant feeding equipment or coupons for the above items.
- 4. All educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drink other than breastmilk.

### B.— PROCEDURE:

- 1. Tri-City Medical Center WCS staff will-actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary, culturally appropriate team comprising physician and nursing-staff, lactation-consultants and specialists, nutrition staff, and other appropriate staff shall-be-established and-maintained to identify and eliminate institutional barriers to breastfeeding support services and formulate, along with the administrators, a plan-of-action to implement needed changes.
- 2. Written breastfeeding procedures will be in place and communicated to all health care staff. The Tri-City Medical Center Lactation Services policy and breastfeeding procedures will be reviewed and updated routinely (biannually) using current research as an evidence based guide.
- All-pregnant women and their support people, as appropriate, will-be provided with information on breastfeeding and counseled on the benefits of breastfeeding, contraindications to breastfeeding, and risk of formula feeding.
- The woman's desire to breastfeed will be documented in her medical record.
- 5. Mothers will be supported in their-choice to exclusively-breastfeed unless-medically contraindicated. The method of feeding will be documented in the medical record of every infant. Exclusive breastfeeding is defined as providing breast-milk as the sole source of nutrition. Exclusively breastfed-babies receive no other liquids or solids.
- 6. Supplementation-criteria include:
  - a.- Infant weight-less> 10% and maternal milk volume judged to be insufficient.
  - b. Baby with extreme hunger cues ("frantic", excessive weight loss, signs/symptoms of dehydration, hyperbilirubinemia-judged to be secondary to poor intake) and maternal-milk volume judged to be insufficient.
  - c. Infant more-than 24 hours old and unable to latch and/or suck.
  - d. Hypoglycemia-after breastfeeding (see hypoglycemia-policy)
  - e. Late preterm (>37 weeks)/low-birth-weight/IUGR infant-
  - f. Maternal insistence after education.
  - Infant separation from mether such that breastfeeding is not possible: Breast pump to be set up and initiated within 3 hours. Mether of baby to receive bedside education.
- 7. At birth or soon-thereafter all newborns, if baby and-mother are stable, will be placed-skin to-skin with the mother. Skin to-skin contact involves placing the naked (with diaper and hat) baby prone on the mother's bare chest. Methor/infant couples will be given the opportunity to initiate breastfeeding within 1 hour of birth. Post cesarean birth babies will be encouraged to breastfeed as-soon as possible. The administration of vitamin K and prophylactic antibiotics to prevent ophthalmia neonatorum-may be delayed for the first 1-2 hours after birth to allow uninterrupted methor infant contact and breastfeeding.
- Breastfeeding mether-infant couples will be encouraged to remain together throughout their hospital stay. Skin-to-skin contact will be encouraged as much as possible.

- Breastfeeding assessment, teaching, and decumentation will be done on each shift and
  whenever possible with each staff contact with the mether. After each feeding, staff will decument
  information—about the feeding in the infant's medical record. This decumentation may include:
  - a. Latch,
  - Position
  - Any problems encountered.
  - For feedings not directly observed, maternal-report may be used.
  - A direct observation of the baby's position and latch on during feeding will be performed and documented as a LATCH score at least once a shift.
- Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and video presentations, as appropriate. If clinically indicated, the pediatrician/neonatologist or nurse will make a referral to a lactation consultant. (Refer to A.4.)
- Breastfeeding methers will be instructed about breastfeeding and the skills reviewed before discharge:
  - Proper positioning and latch on.
  - b. Nutritive suckling and swallowing.
  - Milk production and-release.
  - d. Frequency of feeding/feeding cues.
  - Expression of breast milk and use of a pump if indicated.
  - f. How to assess if infant is adequately nourished.
  - Reasons for contacting the clinician.
- 12. Parents will be encouraged to breastfeed their infants, including cesarean-birth babies, 8 or more times each 24-hours. Infant feeding cues (such as increased alertness or activity, mouthing, or rooting,) will be used as indicators of the baby's readiness for feeding. Breastfeeding babies will be breastfed at night.
- 13. Time limits for breastfeeding on each side will be avoided. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side at a feeding during the early days.
- 14. Ne supplemental water, glucose water, or formula will be given unless medically indicated or by the methor's documented and informed request. Prior to non-medically indicated supplementation, methors will be informed of the risks of supplementing. The supplement should be fed to the baby by SNS or sup. (see WCS policy on Supplementation/Alternative Feeding Methods for Newborns). Bettles will not be placed in a breastfeeding infant's crib or room.
- Those parents who, after appropriate counseling, choose to formula feed their infants will be provided individual instruction.
- Preterm infants in the Neonatal Intensive Care Unit or infants with specific medical conditions may be given pacifiers for non-nutritive sucking. Newborns undergoing painful procedures (eg. Circumcision) may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mether with the pacifier. Tri City Medical Center encourages "pain free newborn care", which may include breastfeeding during the heel stick procedure for the newborn metabolic screening tests. Pacifiers are not recommended in the first 3-4 weeks until breastfeeding is well established in healthy newborns.
- Routine blood glucose monitoring of full term healthy appropriate for gestational age (AGA)
  infants of methers who are not diabetic is not indicated. Assessment for clinical signs of
  hypoglycemia and dehydration will be engoing. (Refer to PCS Standardized Precedure: Newborn
  Hypoglycemia).
- 18. Drugs to specifically suppress lactation will not be given to any postpartum mether. It is recommended that methers wait 6 weeks postpartum to receive Depo-Prevera, unless the OB team feels it is indicated earlier.
- 19. Routine-use of nipple creams, eintments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch-on techniques and will be instructed to apply expressed colestrum or breast milk to the arcola after each feeding.
- 20. Soft pliable nipple shields may be initiated by RNs or lactation consultants, to cover a mother's nipple to treat latch on problems or for sore or cracked nipples and/or for mother's flat or inverted nipples. The use of breastfeeding aids will be followed by the lactation consulting team.

- 21. Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin broast massage and hand expression of colestrum into the baby's mouth during feeding attempts. Skin to skin contact will be encouraged. (Parents will be instructed to watch closely for feeding cues and whenever these are observed to awaken and feed the infant.) If the baby continues to feed peerly, pumping with skilled hand expression or an electric breast pump will be initiated and maintained approximately every 3 hours or a minimum of eight times per day during wakeful hours. Any expressed solestrum or mother's milk will be fed to the baby by an alternative method. The mother will be reminded that she may not obtain much milk or even any milk the first few times she pumps her breasts. Until the mother's milk is available, a collaborative decision should be made among the methor, nurse, and her pediatrician regarding the need to supplement the baby. In cases of problem feeding, the lactation consultant or specialist will be consulted when available.
- 22. Infants that are not latching on or feeding well should not be discharged home. If, after assessment with the Lactation and the medical team a safe home discharge plan is agreed upon, this may allow early discharge.
- 23. All babies should be seen for follow up within the first few days after discharge and/or as determined by the physician. This visit should be with a pediatrician or other qualified health care provider for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice and age appropriate elimination.
- 24. Mothers who are separated from their sick or premature infants will be seen by a lactation consultant before maternal discharge, and given a discharge pumping plan, assurance of proper pumping equipment, cooler for milk transport, and appropriate education. (Refer to WCS/NICU Procedure: Breast Milk, Pumping, Handling, and Storage of).
  - a. Instructed on how to use skilled hand expression or the electric breast pump; instructions will include expression at least eight times per day or approximately every 3 hours for 15 minutes (or until milk flow stops, whichever is greater) around the clock and the importance of not missing a pumping session during the night.
  - Encouraged to breastfeed on demand as seen as the infant's condition permits.
  - Taught proper storage and labeling of human milk; and assisted in learning skilled hand expression or obtaining a double set up electric breast pump prior to going home.
- Before leaving the hospital-breastfeeding mothers should be able to:
  - a. Position the baby correctly at the broast with no pain during the feeding.
  - b. Latch the baby to breast properly.
  - State when the baby is swallowing milk.
  - State that the baby should be nursed approximately 8 to 12 times every 24 hours until satisfy
  - State age-appropriate elimination patterns (at least six urinations per day and three to four stools per day by the fourth day of life).
  - f.— List indications for calling a clinician.
  - Manual expression of milk from their breasts.
- 26. Prior to going home, mothers will be given contact name(s) and the telephone number of TCMC's lactation community outpatient clinic to contact for help with breastfeeding.
- Tri-City Medical Center health-professionals will attend educational sessions on lactation
  management and breastfeeding promotion to ensure that correct, current, and consistent
  information is provided to all methers wishing to breastfeed.
- Breastfeeding is contraindicated in the following situations:
  - HIV-positive mother.
  - Mother using illicit drugs (for example, cocaine, heroin) unless specifically approved by the infant's health care provider on a case-by-case basis.
  - A mother taking certain medications. Although most prescribed and over-the-counter drugs are safe for the breastfeeding infant, some medications may make it necessary to interrupt breastfeeding. These include radioactive isotopes, antimetabolites, cancer chemotherapy, and a small number of other medications.
  - Mother has active, untreated tuberculosis.
  - e. Infant has galactosomia.

- f. Mether has active herpetic lesions on her breast(s)—breastfeeding can be recommended on the unaffected-breast (the Infectious Disease-Service will-be consulted for problematic infectious disease issues).
- g. Mother with varicella that is determined to be infectious to the infant.
- n. Mother has HTLV1 (human-T-cell-loukemia-virus type 1).
- 29. Nursing will follow the Ten Steps to Success Breastfeeding that include:
  - a. Have a written breastfeeding policy that is routinely communicated to all health care staff.
  - b. Train all health care staff in skills necessary to implement this policy.
  - s. Inform-all-prognant women about the benefits-and-management of breastfeeding.
  - Help methers initiate breastfeeding within 1 hour of birth.
  - e. Show mothers how to breastfeed and how to maintain-lastation, even-if-they are separated from their infants.
  - f. Give newborn-infants no-food-or-drink other than breast milk, unless-medically-indicated.

    (A hospital must pay-fair-market-price for all formula and infant feeding supplies that it uses and cannot accept free or heavily-discounted formula and supplies)
  - g. Practice rooming in allow mothers and infants to remain together 24 hours a day.
  - h.——Encourage breastfeeding on demand.
  - i. Give-no artificial teats or pacifiers to breastfeeding-infants.
  - j.a. Foster the establishment of breastfeeding support groups-and-refer-methers to them, on discharge from the hospital-or-clinic.

### C.J. FORM(S):

- Risks of Formula Supplementation
- 2. Lactation Education Handout
- Delayed Newborn Bathing

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

- 1. Women and Newborn Services: Standards of Care Newborns
- 2. Formula Feeding Education Maternal Newborn (Mosby's Skills)

### E.L. EXTERNAL LINK(S):

www.newbornchannel.com

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Mesbys Online - OB (Tri-City Medical Center Intranet): Breastfeeding: Patient Teaching; Breast Pump.

		Objectives	Content	Method of Education
	1	Discuss the rationale for professional, government, and international policies that promote, protect, and support breastfeeding in the United States.	The BFHI: A Part of the Global Strategy The Global Strategy for Infant and Young Child Feeding and how it fits with other activities How the BFHI can assist health care facilities to implement evidence-based practice, improve quality of care, and deliver continuity of care	✓ First Latch Module
	2	Demonstrate the ability to communicate effectively about breastfeeding.	Communication Skills  Listening and learning  Skills to build confidence and give support  Arranging follow-up and support suitable to the mother's situation	✓ First Latch Module ✓ 1:1 time with lactation consultant
	3	Describe the anatomy and physiology of lactation and the process of breastfeeding.	How Milk Gets from the Breast to the Infant  The parts of the breast involved in lactation  Breastmilk production  The infant's role in milk transfer  Breast care	✓ First Latch Module
	4	Identify teaching points appropriate for prenatal classes and interactions with pregnant women.	Promoting Breastfeeding During Pregnancy  > Discussing breastfeeding with pregnant women  > Why breastfeeding is important  > Antenatal breast and nipple preparation  > Identifying women who need extra attention	✓ First Latch Module ✓ 1:1 time with lactation consultant
	5	Discuss hospital birthing policies and procedures that support exclusive breastfeeding.	Birth Practices and Breastfeeding  Labor and birth practices to support early breastfeeding  The importance of early STS contact  Helping with initiation of breastfeeding  Ways to support breastfeeding after cesarean  BFHI practices for women who are not breastfeeding	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>
	6	Demonstrate the ability to identify the hallmarks of milk transfer and optimal breastfeeding.	Helping the Mother Breastfeed  > How to assess breastfeeding  > When to assist with breastfeeding  > Identify optimal positioning and latch  > Help mothers learn to position and latch her infant  > Positioning for comfortable breastfeeding  > Identifying the infant who has difficulty attaching to the breast	<ul> <li>✓ First Latch Module</li> <li>✓ 1:1 time with a lactation consultant</li> </ul>
	7	Discuss hospital postpartum management policies and procedure that support exclusive breastfeeding.	Practices that Promote Breastfeeding  > Rooming-in  > STS  > Recognizing feeding cues, feeding on demand  > Management of sleepy or fussy infants  > Avoiding unnecessary supplementation  > Avoiding artificial nipples and pacifiers	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>
	8	Discuss methods that may increase milk production in a variety of circumstances.	Milk supply  Addressing mother's concerns about "not enough milk"  Normal growth patterns of infants  Improving milk intake and milk production	<ul> <li>✓ First Latch Module</li> <li>✓ 1:1 time with a lactation consultant</li> </ul>
)	9	Identify teaching points to include when educating or counseling parents who are using bottles and/or formula.	Supporting the non-breastfeeding mother and infant  Counseling the formula choice: a pediatric responsibility  Teaching/assuring safe formula preparation in the postpartum period  Safe bottle feeding; issues with overfeeding and underfeeding	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>

- 1				
	10	Discuss contraindications to breastfeeding in the United States as well as commonly encountered areas of concern for breastfeeding mothers and their infants.	Infants and Mothers with Special Needs  > Breastfeeding infants who are preterm, low birth weight, and/or ill  > Breastfeeding more than one infant  > Prevention and management of common clinical concerns  > Medical reasons for breast milk substitutes  > Nutritional needs of breastfeeding women  > Breastfeeding and birth control  > Breastfeeding management when the mother is ill  > Medications and breastfeeding  > Contraindications to breastfeeding	<ul> <li>✓ First Latch Module</li> <li>✓ 1:1 time with a lactation consultant</li> <li>✓ Review policies and procedures</li> </ul>
	11	Describe interventions for breast and nipple problems.	Breast and Nipple Concerns  Examination of the mother's breasts and nipples  Engorgement, blocked ducts, and mastitis  Sore nipples	✓ First Latch module
	12	Identify acceptable medical indications for supplementation of breast fed infants according to national and international authorities.	If the Infant Cannot Feed at the Breast  Learning to hand express  Use of donor milk  Feeding EBM to the infant	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>
	13	Describe essential components of support for mothers to continue breastfeeding beyond the early weeks.	Ongoing Support for Mothers  > Preparing a mother for discharge > Follow-up and support after discharge > Protecting breastfeeding for employed women > Sustained breastfeeding beyond one year	<ul> <li>✓ First Latch Module</li> <li>✓ Learn about breastfeeding support group during orientation</li> <li>✓ San Diego County Breastfeeding Coalition resource guide</li> </ul>
	14	Describe strategies that protect breastfeeding as a public health goal.	Protecting Breastfeeding  The effects of marketing on infant feeding practices  The International Code of Marketing of Breastmilk Substitutes  How health care workers can protect families from marketing  How to respond to marketing practices  Donor milk in emergency situations  The role of breastfeeding in emergencies	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> </ul>
	15	Identify both the barriers and the solutions to implementing the Ten Steps to Successful Breastfeeding.	Making Your Hospital or Birth Center Baby Friendly  The Ten Steps to Successful Breastfeeding  What "Baby Friendly" practices are  The process of becoming a "Baby Friendly" hospital or birth center	✓ First Latch Module

Baby Friendly 1	Training	Requirements
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Position	Training Required
Registered Nurses	First Latch Module - BFHI General Healthcare: 15 hours
Lactation Consultants	First Latch Module – BFHI General Healthcare: 15 hours
Dieticians	First Latch Module – BFHI General Healthcare: 15 hours
Occupational Therapists	First Latch Module – BFHI General Healthcare: 15 hours
Pediatricians	First Latch Module - BFHI Provider Training: 3 hours
Neonatologists	First Latch Module - BFHI Provider Training: 3 hours
Obstetricians	First Latch Module - BFHI Provider Training: 3 hours
Anesthesiologists	First Latch Module - BFHI Provider Training: 3 hours
Midwives	First Latch Module – BFHI Provider Training: 3 hours
PAs	First Latch Module – BFHI Provider Training: 3 hours
NNPs	First Latch Module – BFHI Provider Training: 3 hours
OB Techs	First Latch Module – BFHI Ancillary Training: 3 hours
Advanced Care Technicians (ACT)	First Latch Module – BFHI Ancillary Training: 3 hours
Hearing Screeners	First Latch Module – BFHI Ancillary Training: 3 hours
Social Workers	First Latch Module – BFHI Ancillary Training: 3 hours
Environmental Services (EVS)	Review and sign Ten Steps for Successful Breastfeeding
Unit Secretaries	Review and sign Ten Steps for Successful Breastfeeding
Peri Operative Aides	Review and sign Ten Steps for Successful Breastfeeding
Birth Clerks	Review and sign Ten Steps for Successful Breastfeeding
Respiratory Therapists	Review and sign Ten Steps for Successful Breastfeeding
Case Managers	Review and sign Ten Steps for Successful Breastfeeding
Newborn Photographers	Review and sign Ten Steps for Successful Breastfeeding



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### **WOMEN'S AND CHILDREN'S SERVICES**

ISSUE DATE: 10/94 SUBJECT: INFANT FEEDINGS

REVISION DATE(S): 01/00, 06/03, 12/09, 04/10, 06/14

Department Approval:

Department of Pediatrics Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

01/18

02/18

03/18

### A. <u>DEFINITION(S):</u>

Skin to Skin (STS): Direct physical contact between the newborn infant and mother. After birth, the healthy term infant should be completely dried and placed naked against the mother's naked chest. The infant may wear a diaper and/or hat, but no other clothing should be between the mother's and infant's bodies. The infant and mother are then covered with a warmed blanket, keeping the infant's head uncovered. STS contact should continue, uninterrupted, until the completion of the first feeding (or for at least 1 hour if the mother is not breastfeeding). STS contact should be encouraged beyond the first hours and into the first days after birth. Another adult may hold the infant STS if/when the mother is not available.

### B. **POLICY**:

- To promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this maternal infant process.
- 2. To assist families choosing to breastfeed with initiating and developing a successful and satisfying experience.
- 3. This policy is adapted from the Academy of Breastfeeding Medicine (AMB): AMB Clinical Protocol # 7: Model Breastfeeding Policy (2010) which is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization (WHO), and the American Dietetic Association.

4.

- 5. This policy encompasses the UNICEF/WHO evidence-based Ten Steps to Successful Breastfeeding; practices that have been shown to increase breastfeeding initiation and duration.
- 6. Tri-City Medical Center complies with the WHO International Code of Marketing of Breastmilk Substitutes.

### C. PROCEDURE:

- Have a written breastfeeding policy that is routinely communicated to all health care staff.
  - a. Tri-City Medical Center staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary team comprised of physicians, midwives, nursing, lactation consultants, dietary, and outpatient providers shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. This group will evaluate data relevant to breastfeeding support services and formulate, along with administrators, a plan of action to implement needed changes.
  - b. Tri-City Medical Center upholds the WHO International Code of Marketing of Breastmilk Substitutes by offering education and materials that promote human milk rather than other infant food or drink, and by refusing to accept or distribute free or subsidized supplies of breastmilk substitutes, nipples, and other feeding devices. Mothers will be protected from

- the promotion of breastmilk substitutes and other efforts that undermine an informed feeding choice.
- c. This written breastfeeding policy will be communicated to all health care staff members. It will be reviewed and updated every 2 years (per medical center policy) or as needed using current research as an evidence-based guide.
- d. All new Women and Newborn Services' staff and care providers will be oriented to the policy during their initial orientation. The orientation process is different for type of hire and is detailed in the Women and Newborn Services Lactation Education Checklist (see Attachment B). Staff and care providers will be expected to read and sign the policy.
- e. This policy will be readily available to all areas of Tri-City Medical Center that potentially interact with childbearing women and infants so that they may promote, protect, and support breastfeeding in all departments. Other department's polices will support, and will not countermand the medical center's infant feeding policy.
- 2. Train all health care staff in the skills necessary to implement this policy.
  - a. The nursing leadership team will ensure that all staff working in the Women and Newborn Services department (excluding the NICU) will receive a minimum of 20 hours of education, including at least 5 hours of supervised clinical training, on the topics specified by the BFHI (see Attachment A). For new employees, this training will be completed within 6 months of hire. Details for the execution of the training are specified in a separate training plan: Baby Friendly Training Requirements (Attachment B).
  - b. Upon completion of training for new employees, the staff preceptor will supervise and verify the clinical competency of the new staff member. This will be documented in the orientation checklist and maintained in the employee file. Staff will receive adequate training and mentorship to attain competence in:
    - i. Counseling the feeding decision
    - ii. Skin to skin (STS) in the immediate postpartum period
    - iii. Comfortable and effective positioning and attachment at the breast
    - iv. Assessing and documenting a latch score
    - v. Maintenance of exclusive breastfeeding
    - vi. Feeding cues
    - vii. Rooming-in
    - viii. Hand expression
    - ix. Formula preparation and feeding when necessary
    - x. Finding support upon discharge
  - c. Documentation of all training will be maintained by the Lactation Supervisor and/or appropriate CNS on the BFHI Staff Training Documentation Checklist.
  - d. Providers with privileges for labor, delivery, maternity, anesthesia, and/or newborn care will have a minimum of 3 hours of breastfeeding management education pertinent to their role. Education will be verified by successful completion of the First Latch module and a certificate of completion will be verified and maintained by a provider coordinator.
  - e. The content and number of hours of training for other staff will be developed based on job description and workplace exposure to breastfeeding couplets.
- 3. Inform all pregnant women about the benefits and management of breastfeeding.
  - a. Physicians, midwives, and nurses providing prenatal services are responsible for educating pregnant women and their support people about breastfeeding. Education will cover the importance of exclusive breastfeeding, non-pharmacologic pain relief methods for labor, the importance of early STS contact, early initiation of breastfeeding, rooming-in, feeding on demand, frequent feeding to help assure optimal milk production, effective positioning and attachment, exclusive breastfeeding for the first 6 months, and that breastfeeding continues to be important after 6 months even after other foods are introduced. Contraindications to breastfeeding and other special medical conditions will be discussed as indicated. Education will be documented in the prenatal record.
  - b. Exclusive breastfeeding is defined as providing breastmilk as the sole source of nutrition to infants. Exclusively breastfed infants receive no other liquids or solids unless medically indicated. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. The planned feeding method will be documented in the prenatal record.

- c. Tri-City Medical Center does not distribute educational materials in which the use of formula or infant feeding bottles is discussed routinely.
- d. Tri-City Medical Center offers no group education on the use of infant formula or feeding bottles.
- e. Breastfeeding classes are offered by Tri-City Medical Center. Pregnant women who receive services at Tri-City Medical Center will receive written information regarding the benefits of breastfeeding as well as an explanation of practices implemented in the Women and Newborn Services department that support successful breastfeeding.
- f. Tri-City Medical Center fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages.
- g. Tri-City Medical Center provides organizations that offer prenatal services curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding.
- h. Members of the staff at Tri-City Medical Center participate in the local breastfeeding coalition.
- 4. Help mothers initiate breastfeeding within one hour of birth.
  - Immediately after delivery, all term infants, regardless of feeding preference, will be placed STS with the mother as long as the infant and mother are stable and it is not medically contraindicated.
  - b. STS contact including any reasons for delaying STS will be documented in the infant's medical record.
  - c. Preterm or unstable infants or infants having required resuscitation will be placed STS as soon as possible after medical stability has been established.
  - d. The nursing staff present at the delivery has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding. This encompasses placing the infant STS with mother immediately after birth (including cesarean deliveries if possible), assisting the mother in recognizing infant signs of feeding readiness, and allowing the infant the opportunity to self-attach to the breast. Vaginal delivery mother/infant couplets will be given the opportunity to initiate breastfeeding within 1 hour of birth. Cesarean delivery mother/infant couplets will be given the opportunity to initiate breastfeeding as soon as possible.
  - e. Time of initiation of STS contact as well as the time this contact ends will be documented in the medical record.
  - f. During the initial period of STS contact, routine newborn procedures will be postponed (up to 2 hours) until the first breastfeeding has been completed. Assessments and procedures (including the administration of vitamin K and erythromycin eye ointment) should be performed while the infant is still STS with the mother.
  - g. After 24 hours of life, the stable infant may receive a bath upon parent's request.
    - i. Earlier bathing may be considered in the instances of specific parental request, meconium stained infant, or malodorous amniotic fluid.
    - ii. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after the delivery.
    - Education is provided to parents about delayed bathing to include the importance of initial bonding, STS, and establishment of breastfeeding.
  - STS contact will be encouraged throughout the hospital stay.
- 5. Show mothers how to breastfeed and how to maintain lactation even if separated from their infants.
  - a. The nurse will assess the mother's breastfeeding techniques and, if needed, will demonstrate appropriate breastfeeding positioning and attachment, optimally within 3 hours, and no later than 6 hours after birth.
  - b. Breastfeeding assessment, teaching, and documentation will be done on each shift and whenever possible during each staff contact with the mother. After each feeding, staff will document information about the feeding in the infant's medical record. This documentation may include the latch, position, and any problems encountered. For feedings not directly observed, maternal report may be used. Every shift, a direct observation of the infant's

- position and latch during feeding will be performed and documented. If the LATCH score is < 7, the nurse will document any interventions and the infant's response to those interventions. The LATCH score will be repeated with the next feed.
- c. Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and the newborn channel as appropriate. If clinically indicated, the provider or nurse will make a referral to a lactation consultant. The mother will be given a breastfeeding log book and shown how to monitor feedings and diapers, as well as information about breastfeeding support groups.
- d. Parents will be taught that breastfeeding infants, including cesarean-birth infants, should be put to breast at least 8 to 12 times in 24 hours. Infant feeding cues (such as increased alertness, activity, mouthing, or rooting) will be used as indicators of the infant's readiness for feeding. Breastfeeding mothers will be instructed about breastfeeding and the following principles and skills reviewed before discharge:
  - i. Importance of exclusive breastfeeding
  - ii. How to maintain lactation for exclusive breastfeeding for up to 6 months
  - iii. Proper positioning and latch
  - iv. Nutritive sucking and swallowing
  - v. Milk production and release
  - vi. Frequency of feeding/feeding cues
  - vii. How to manually express, pump, handle, and store breastmilk
  - viii. How to assess if the infant is adequately nourished
  - ix. Reasons to contact the provider
  - x. How to sustain lactation if separated from the infant or if not exclusively breastfeeding after discharge
- e. Time limits for breastfeeding on each side will be avoided. Infants may be offered both breasts at each feeding but may be interested in feeding on only one side early on.
- f. When a mother must be separated from her infant, the staff will instruct the mother to begin expressing her breastmilk within 3 hours of the separation. The mother will be taught how frequently to express her milk as well as proper storage and handling. The EBM (expressed breastmilk) will be given to the infant as soon as the infant is medically stable. The mother's EBM will be used before any supplementation with breastmilk substitutes unless otherwise contraindicated.
- g. A mother discharged home without her infant due to illness or prematurity will be seen by a lactation consultant before discharge and will be given a discharge pumping plan and appropriate education:
  - i. Instruction on hand expression and the electric breast pump:
    - Expression/pumping at least 8 times per day, approximately every 3 hours for 15 minutes or until milk flow stops.
    - 2) The importance of continuing to pump throughout the night.
    - 3) For mothers who will be separated from their infants for an extended period of time, instruct to pump 6 times a day once milk supply is established.
  - ii. Encouraged to breastfeed on demand as soon as the infant's condition permits.
  - iii. Encouraged to practice daily STS when the infant is medically stable.
  - iv. Instruction on proper storage and labeling of breastmilk.
  - Assistance in obtaining a double set up electric breast pump prior to going home.
- h. The mother who chooses to feed her infant a breastmilk substitute will be given written and verbal information regarding appropriate hygiene, preparation, storage, handling, and feeding of the substitute. This education will be documented in the medical record.
  - Ready to feed formula or liquid concentrate is recommended for the first 2 months
    of life.
  - ii. Families with WIC or those who will be using powdered formula will be given information regarding safe preparation. (see WHO Guidelines: How to Prepare Formula for Bottle-Feeding at Home):
    - 1) Powdered formula is not sterile.
    - 2) Mix powder with hot water (158 degrees F/70 degrees C).
    - 3) Allow formula to cool prior to feeding to the infant.

- 6. Give infants no food or drink other than breastmilk, unless medically indicated.
  - a. For healthy term infants, no supplemental water or glucose water will be given.
  - For healthy term infants, no breastmilk substitute will be given unless by a provider's order or standardized procedure. Note: Breastmilk substitutes should not be used as a prophylactic measure for anticipated weight loss, jaundice, etc.
  - c. Infants who are receiving supplemental nutrition will be offered alternative feeding methods to avoid the use of bottles and nipples if acceptable to the mother and achievable according to staff. These methods include:
    - i. Supplemental Nursing System (SNS)
    - ii. Finger Feeding
    - iii. Cup feeding
  - d. EBM, if available, will be given prior to supplementation with a breastmilk substitute. If EBM is not immediately available, it will be given as soon as it is available.
  - e. Each day the provider will be consulted regarding the volume and type of supplement.
  - f. If formula supplementation is medically indicated, an order is needed and the nurse must document initial reason(s) and ongoing indications.
  - g. If a mother requests her infant be supplemented with a breastmilk substitute, staff will explore and address the mother's concerns. The mother will be given the Risks of Formula Supplementation handout for review. If the mother's request for formula persists, the provider will be called for an order for formula. The education to the risks of formula and informed decision of the patient will be documented. The mother will be given supplies and education (refer to Mosby's Skills – Formula Feeding Education Maternal Newborn).
  - Assessment for clinical signs of hypoglycemia and dehydration will be ongoing. Routine glucose monitoring of full term (AGA, non IDM) infants is not indicated.
  - i. Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into a spoon or the infant's mouth during feeding attempts. STS contact will be encouraged. Parents will be instructed to watch closely for feeding cues, and when observed, to feed the infant. If the infant continues to feed poorly, hand expression and/or an electric breast pump (and pumping with breast massage) will be introduced and maintained approximately every 3 hours, or a minimum of 8 times per day. Any expressed colostrum or mother's milk will be fed to the infant by SNS, finger feeding, or cup feeding. The mother will be educated that it is normal not to obtain much milk or even any milk the first few times she pumps her breasts. The lactation consultant or specialist should also be consulted for these cases.
  - Breastfeeding is contraindicated for:
    - i. Mothers who are HIV-positive.
    - ii. Mothers who abuse illicit drugs or alcohol.
    - iii. Mothers who are taking certain high risk medications. (Most prescribed and overthe-counter medications are safe for the breastfeeding infant, however some may be contraindicated while breastfeeding.)
    - iv. Mothers who have active, untreated tuberculosis (infant may safely receive EBM).
    - v. Infants who have galactosemia, maple syrup disease, or phenylketonuria.
    - vi. Mothers with active herpetic lesions on the breast(s). (The Infectious Disease Department should be consulted for any problematic infectious disease issues regarding safety of STS, direct breastfeeding, and/or EBM.)
    - vii. Mothers with varicella that is determined to be infectious to the infant.
    - viii. Mothers with HTLV1 (human T-cell leukemia virus type 1)
- 7. Practice rooming-in allow mothers and infants to remain together 24 hours a day.
  - a. Mother/infant couplets (regardless of maternal feeding preference) will begin rooming-in immediately after delivery and will not be separated during hospitalization as long as both are medically stable and mother/family are able to care for infant.
  - b. Routine newborn procedures will be done at the mother's bedside.
  - c. Infants can only be admitted to couplet care or the NICU.
  - d. If an infant needs to be separated from its mother, documentation of the location, reason, and the expected time period will be recorded.

- e. The infant will be reunited with the mother as soon as possible. If an infant and mother are separated, the staff will support exclusivity of breastfeeding.
- f. If a mother requests that her infant be taken out of the room, staff will explore the mother's reason for the request, will educate her on the benefits of continuing to room in, and will document as appropriate.

### 8. Encourage breastfeeding on demand.

- a. All mothers will be taught to feed their infant when the infant exhibits signs of feeding readiness. Mothers will be taught to recognize these feeding cues in the infant.
- b. Mothers will be informed of normal newborn feeding behaviors such as cluster feeding, feeding through the night, and a normal feeding schedule of at least 8-12 feedings in a 24 hour period.
- c. No limitations will be taught to mothers regarding length or number of feedings.
- d. Parents will be taught that both physical contact and nourishment are important parts of the feeding process.

### 9. Give no pacifiers or artificial nipples to breastfeeding infants.

- Pacifiers will not be given to healthy, full-term breastfeeding infants.
- b. Preterm infants in the NICU or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.
- c. Infants undergoing painful procedures may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mother with the pacifier.
- d. Pain management interventions during uncomfortable or distressing procedures will be used whenever possible. This may include breastfeeding during a heel stick procedure for infant blood tests.
- e. If a parent requests a pacifier, artificial nipples, or feeding bottles they will be educated regarding possible negative consequences as it relates to breastfeeding and this education will be documented.
- f. Any supplementation should be given by SNS, finger feeding, or cup feeding before introduction of an artificial nipple or bottle.
- g. A nipple shield may be given by the RN or lactation consultant to manage latch problems, or sore or cracked nipples. The RN or lactation consultant will document why the nipple shield was given and the infant's response to the intervention. Mothers using nipple shields will be followed by a lactation consultant.

## 10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

- Infants that are not feeding well should not be discharged home.
- b. Before leaving the hospital breastfeeding mothers should be able to:
  - i. Position and latch the infant correctly at the breast with no/minimal discomfort during feeding.
  - ii. Recognize when the infant is swallowing milk.
  - iii. State that the infant should be breastfed approximately 8 to 12 times in 24 hours.
  - iv. State an age-appropriate elimination pattern at least 6 voids and 3 to 4 stools per day by the fourth day of life.
  - v. List indications for calling the provider.
  - vi. Manually express milk from her breasts.
- c. Prior to going home, mothers will be given the names and telephone numbers of community resources to contact for help with breastfeeding including the Tri-City Medical Center breastfeeding clinic and support group.
- d. All infants should be seen for follow-up within the first few days after discharge. This visit should be with a pediatrician or other qualified health care practitioner for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice, and age-appropriate elimination.

### D. <u>BREASTFED NEWBORN INPUT AND OUPUT NORMS</u>

Age in hours	Milk volume per feeding	# feeds	# voids	# stools
0-24	0-5 mLs / drops	6-8	≥1	≥1
24-48	5-10 mLs / 1 tsp	≥ 8	≥ 2	≥2
48-72	10-20 mLs / 1 tbsp	≥ 8	≥ 3	≥ 3
72-96	20-30 mLs / 1 oz	≥8	≥ 4	≥ 4
> 96	> 30 mLs / > 1 oz	≥ 8	≥ 5-12	≥ 5-12

- 1. Infant has 24 hours to void and 48 hours to stool after birth.
- 2. There may be a lull in stooling after meconium is cleared while baby waits for milk to come in.
- 3. Infants may feed VERY frequently before the milk comes in; even hourly for the first few nights.

### E. <u>MEDICAL INDICATIONS FOR SUPPLEMENTATION</u>

- When making the decision to start supplementation, it is necessary to look at all the factors involved. Weight loss alone does not imply the need for supplementation. Breastfeeding assessment, assistance, and education should be done prior to starting supplementation.
- 2. Possible medical indications for supplementation include:
  - Infant risk factors:
    - i. Asymptomatic Hypoglycemia unresponsive to appropriate, frequent breastfeeding
    - ii. Inadequate intake as evidenced by:
      - Clinical or laboratory evidence of clinical dehydration (high sodium, poor feeding, lethargy) that is not improved after skilled assessment and proper management of breastfeeding.
      - 2) Excessive weight loss (≥ 10%):
        - a) Note that excessive newborn weight loss is correlated with positive maternal intravenous fluid balance and may not be directly indicative of breastfeeding success or failure.
        - b) Number of voids and stools should be taken into consideration.
      - 3) Delayed bowel movements: < 4 stools on DOL 4, or continued meconium stools on DOL 5.
    - iii. Hyperbilirubinemia
      - 1) With ongoing weight loss, limited stooling, and voiding with uric acid crystals.
    - iv. Inborn errors of metabolism
  - b. Maternal risk factors:
    - i. Delayed secretory activation.
    - ii. Primary glandular insufficiency as evidenced by:
      - 1) Abnormal breast shape
      - 2) Poor breast growth during pregnancy
      - 3) Prior breast surgery resulting in poor milk production
    - iii. Intolerable pain during feedings unrelieved by interventions.

### F. <u>SUPPLEMENTAL NURSING SYSTEMS (SNS) AND NIPPLE SHIELDS</u>

- Supplemental Nursing System (SNS):
  - a. Assemble the SNS tubing with a syringe or container; considered a single-use piece of equipment.
  - b. Gently tape the tubing to the mother's breast with the end of the tubing extending about 1/4 inch beyond the end of her nipple.
  - c. Assist the mother in latching the infant to the breast and tubing as needed.
    - i. Sucking from the infant creates a siphon effect and allows supplementation from the reservoir of the syringe or SNS container kit.
  - d. Supplementation should be monitored accordingly.
    - Amounts of EBM or breastmilk substitute should be measured to meet the infant's needs.

- 10-15 ml of EBM or breastmilk substitute is considered adequate intake for the newborn infant. It is important not to overfeed. Cue-based infant feeding should be utilized.
- 2. Nipple shield:
  - a. Application of the nipple shield:
    - i. Assess both mother and infant to choose the correct size nipple shield. Sizing a nipple shield is dependent on both the size of the infant's mouth and the size of the mother's nipple.
    - ii. The nipple shield may be placed under very warm water to increase pliability and enhance adherence to the breast. Colostrum or lanolin cream may also be used to help with adherence.
    - iii. Handle the shield by the rim. Place the shield over the breast with the nipple centered inside the nipple portion of the shield. Support the breast with a "C" hold. Place the thumb on both the top of the breast and the top part of the shield and place the fingers below, underneath the areola.
  - b. Latching the infant to the breast with a nipple shield:
    - Guide the mother to stroke the infant's lower lip with the shield. When the infant's mouth opens wide, bring the infant directly onto the shield allowing the infant to take as much of the areola as possible into the mouth.
    - ii. Allow the infant to breastfeed on one breast as long s/he likes. Repeat on the other breast if infant shows a desire to continue breastfeeding.
  - c. Cleaning and care of the nipple shield:
    - i. Instruct the mother to wash her hands and the nipple shield in warm, soapy water, rinsing well before each use.
    - ii. Store the shield with the nipple facing upward, and keep in a clean and dry covered container.
  - Reportable conditions and referral to a lactation consultant:
    - i. Continued inability to sustain latch.
    - ii. Absence of audible swallow after several minutes of sucking.
    - iii. Infant weight loss greater than 7% below birth weight.
    - iv. Signs of dehydration or anemia.
- Follow-up:
  - a. If a mother is still using a breastfeeding aid (SNS or nipple shield) at the time of discharge, she will be referred to lactation services to schedule a follow-up outpatient lactation clinic appointment within a few days of discharge.
  - b. It is not uncommon for a mother to use a breastfeeding aid for up to 6 months for the following conditions:
    - i. Nipple abnormalities (e.g., flat, inverted, fibrous).
    - ii. Premature infant.

### G. SUPPLEMENTATION FREQUENCY AND QUANTITY

	Frequency	Quantity
Term Infant (≥ 37.0 weeks)	<ul> <li>DOL 1: 8 attempts (usually 4-5 successful feedings)</li> <li>DOL 2: 8-12 times</li> <li>DOL 3 &amp; 4: 8-12 times</li> </ul>	<ul> <li>DOL 1: 5-10 ml per feeding</li> <li>DOL 2: 10-20 ml per feeding</li> <li>DOL 3: 20-30 ml per feeding</li> <li>DOL 4: 30-40 ml per feeding</li> <li>DOL 5: 40-50 ml per feeding</li> <li>DOL 6: 50-60 ml per feeding</li> <li>DOL 7 − 1<sup>st</sup> month: 60-90 ml per feeding</li> </ul>
		*Volumes may vary depending on infant's weight
Late Preterm Infant (≥ 35.0 – 36.6)	At least every 3 hours, more often based on infant feeding cues.	<ul> <li>DOL 1: 5-10 ml per feeding</li> <li>DOL 2: 10-20 ml per feeding</li> <li>DOL 3: 20-30 ml per feeding</li> </ul>

Limit total feeding time to 30 minutes in order to minimize	<ul> <li>DOL 4: 30-40 ml per feeding</li> <li>DOL 5: 40-50 ml per feeding</li> </ul>
fatigue and conserve energy.	DOL 6: 50-60 ml per feeding
	DOL 7 – 1 <sup>st</sup> month: 60-90 ml
*Late preterm have immature	per feeding
feeding capabilities, increased	, ,
calorie needs, low metabolic stores,	*May do better with smaller
and are high risk for	volumes
hyperbilirubinemia.	

### H. OTHER CONSIDERATIONS

- Drugs to specifically suppress lactation will not be given to any postpartum mother.
- 2. It is recommended that mothers wait 6 weeks postpartum to receive Depo-Provera, unless the OB team feels it is indicated earlier.
- 3. Prior to administration of any drugs that may inhibit milk production, mothers will be counseled as to the risks.
- 4. Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch technique and will be instructed to apply expressed colostrum or breast milk to the areola after each feeding. Lanolin cream may be used if medically indicated.

### I. <u>COMPLIANCE WITH THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES</u>

- 1. Employees of manufactures or distributers of breastmilk substitutes, bottles, nipples, or pacifiers have no direct communication with pregnant women or delivered mothers.
- Tri-City Medical Center does not receive free gifts, non-scientific literature, material, equipment, money, or support for breastfeeding education or events from manufactures of breastmilk substitutes, bottles, nipples, or pacifiers.
- 3. No pregnant women, delivered mothers, or families are given marketing materials, samples, or gift packs by the facility that contain breastmilk substitutes, bottles, nipples, pacifiers, or any other infant feeding equipment or coupons for the above items.
- 4. All educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drink other than breastmilk.

### J. FORM(S):

- Risks of Formula Supplementation
- 2. Lactation Education Handout
- 3. Delayed Newborn Bathing

### K. RELATED DOCUMENT(S):

- 1. Women and Newborn Services: Standards of Care Newborns
- 2. Formula Feeding Education Maternal Newborn (Mosby's Skills)

### L. EXTERNAL LINK(S):

1. www.newbornchannel.com

#### M. REFERENCE(S):

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)	Objectives	Content	Method of Education
1	Discuss the rationale for professional, government, and international policies that promote, protect, and support breastfeeding in the United States.	<ul> <li>The BFHI: A Part of the Global Strategy</li> <li>The Global Strategy for Infant and Young Child Feeding and how it fits with other activities</li> <li>How the BFHI can assist health care facilities to implement evidence-based practice, improve quality of care, and deliver continuity of care</li> </ul>	✓ First Latch Module
2	Demonstrate the ability to communicate effectively about breastfeeding.	Communication Skills  Listening and learning  Skills to build confidence and give support  Arranging follow-up and support suitable to the mother's situation	<ul> <li>✓ First Latch Module</li> <li>✓ 1:1 time with lactation consultant</li> </ul>
3	Describe the anatomy and physiology of lactation and the process of breastfeeding.	How Milk Gets from the Breast to the Infant  The parts of the breast involved in lactation  Breastmilk production  The infant's role in milk transfer  Breast care	✓ First Latch Module
4	Identify teaching points appropriate for prenatal classes and interactions with pregnant women.	Promoting Breastfeeding During Pregnancy  > Discussing breastfeeding with pregnant women  > Why breastfeeding is important  > Antenatal breast and nipple preparation  > Identifying women who need extra attention	First Latch Module  1:1 time with lactation consultant
5	Discuss hospital birthing policies and procedures that support exclusive breastfeeding.	Birth Practices and Breastfeeding  > Labor and birth practices to support early breastfeeding  > The importance of early STS contact  > Helping with initiation of breastfeeding  > Ways to support breastfeeding after cesarean  > BFHI practices for women who are not breastfeeding	First Latch Module Review policies and procedures 1:1 time with lactation consultant
6	Demonstrate the ability to identify the hallmarks of milk transfer and optimal breastfeeding.	Helping the Mother Breastfeed  > How to assess breastfeeding  > When to assist with breastfeeding  > Identify optimal positioning and latch  > Help mothers learn to position and latch her infant  > Positioning for comfortable breastfeeding  > Identifying the infant who has difficulty attaching to the breast	<ul> <li>✓ First Latch Module</li> <li>✓ 1:1 time with a lactation consultant</li> </ul>
7	Discuss hospital postpartum management policies and procedure that support exclusive breastfeeding.	Practices that Promote Breastfeeding  > Rooming-in  > STS  > Recognizing feeding cues, feeding on demand  > Management of sleepy or fussy infants  > Avoiding unnecessary supplementation  > Avoiding artificial nipples and pacifiers	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>
8	Discuss methods that may increase milk production in a variety of circumstances.	Milk supply  > Addressing mother's concerns about "not enough milk"  > Normal growth patterns of infants  > Improving milk intake and milk production	First Latch Module 1:1 time with a lactation consultant
9	Identify teaching points to include when educating or counseling parents who are using bottles and/or formula.	Supporting the non-breastfeeding mother and infant  Counseling the formula choice: a pediatric responsibility  Teaching/assuring safe formula preparation in the postpartum period  Safe bottle feeding; issues with overfeeding and underfeeding	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>

- 1				
	10	Discuss contraindications to breastfeeding in the United States as well as commonly encountered areas of concern for breastfeeding mothers and their infants.	Infants and Mothers with Special Needs  > Breastfeeding infants who are preterm, low birth weight, and/or ill  > Breastfeeding more than one infant  > Prevention and management of common clinical concerns  > Medical reasons for breast milk substitutes  > Nutritional needs of breastfeeding women  > Breastfeeding and birth control  > Breastfeeding management when the mother is ill  > Medications and breastfeeding  > Contraindications to breastfeeding	<ul> <li>✓ First Latch Module</li> <li>✓ 1:1 time with a lactation consultant</li> <li>✓ Review policies and procedures</li> </ul>
	11	Describe interventions for breast and nipple problems.	Breast and Nipple Concerns  Examination of the mother's breasts and nipples  Engorgement, blocked ducts, and mastitis  Sore nipples	✓ First Latch module
	12	Identify acceptable medical indications for supplementation of breast fed infants according to national and international authorities.	If the Infant Cannot Feed at the Breast  Learning to hand express  Use of donor milk  Feeding EBM to the infant	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> <li>✓ 1:1 time with lactation consultant</li> </ul>
	13	Describe essential components of support for mothers to continue breastfeeding beyond the early weeks.	Ongoing Support for Mothers  > Preparing a mother for discharge  > Follow-up and support after discharge  > Protecting breastfeeding for employed women  > Sustained breastfeeding beyond one year	<ul> <li>✓ First Latch Module</li> <li>✓ Learn about breastfeeding support group during orientation</li> <li>✓ San Diego County Breastfeeding Coalition resource guide</li> </ul>
	14	Describe strategies that protect breastfeeding as a public health goal.	Protecting Breastfeeding  The effects of marketing on infant feeding practices  The International Code of Marketing of Breastmilk Substitutes  How health care workers can protect families from marketing  How to respond to marketing practices  Donor milk in emergency situations  The role of breastfeeding in emergencies	<ul> <li>✓ First Latch Module</li> <li>✓ Review policies and procedures</li> </ul>
	15	Identify both the barriers and the solutions to implementing the Ten Steps to Successful Breastfeeding.	Making Your Hospital or Birth Center Baby Friendly  The Ten Steps to Successful Breastfeeding  What "Baby Friendly" practices are  The process of becoming a "Baby Friendly" hospital or birth center	✓ First Latch Module

### **Baby Friendly Training Requirements**

Position	Training Required
Registered Nurses	First Latch Module – BFHI General Healthcare: 15 hours
Lactation Consultants	First Latch Module - BFHI General Healthcare: 15 hours
Dieticians	First Latch Module - BFHI General Healthcare: 15 hours
Occupational Therapists	First Latch Module – BFHI General Healthcare: 15 hours
Pediatricians	First Latch Module - BFHI Provider Training: 3 hours
Neonatologists	First Latch Module - BFHI Provider Training: 3 hours
Obstetricians	First Latch Module – BFHI Provider Training: 3 hours
Anesthesiologists	First Latch Module - BFHI Provider Training: 3 hours
Midwives	First Latch Module - BFHI Provider Training: 3 hours
PAs	First Latch Module – BFHI Provider Training: 3 hours
NNPs	First Latch Module – BFHI Provider Training: 3 hours
OB Techs	First Latch Module - BFHI Ancillary Training: 3 hours
Advanced Care Technicians (ACT)	First Latch Module – BFHI Ancillary Training: 3 hours
Hearing Screeners	First Latch Module – BFHI Ancillary Training: 3 hours
Social Workers	First Latch Module – BFHI Ancillary Training: 3 hours
Environmental Services (EVS)	Review and sign Ten Steps for Successful Breastfeeding
Unit Secretaries	Review and sign Ten Steps for Successful Breastfeeding
Peri Operative Aides	Review and sign Ten Steps for Successful Breastfeeding
Birth Clerks	Review and sign Ten Steps for Successful Breastfeeding
Respiratory Therapists	Review and sign Ten Steps for Successful Breastfeeding
Case Managers	Review and sign Ten Steps for Successful Breastfeeding
Newborn Photographers	Review and sign Ten Steps for Successful Breastfeeding



# Albuterol/Ipratropium (Combivent Respimat): Recommendation for formulary restriction

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Albuterol ipratropium (Combivent) is a combination long acting antimuscarinic/beta agonist used for the chronic management of asthma and COPD

<u>Background:</u> Combivent is offered as a "respimat" inhaler device which administers a fine mist that is inhaled twice daily. The medication may not be shared between patients nor can it be sent home with the patient upon discharge.

### **Assessment:**

- Each Combivent device costs \$291
- A therapeutically equivalent medication, albuterol/ipratropium nebulized solution costs \$0.29 per dose
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of Combivent to an equipotent dose of albuterol/ipratropium nebulized solution
- A conversion from Combivent to albuterol/ipratropium nebulized solution would save TCMC approximately \$12,000 annually

### Recommendation(s):

- P&T Committee approved the Pharmacy Service recommendation that all orders for Combivent be restricted to Pulmonologists only.
  - Per this agreement, Pharmacy will not routinely stock this inhaler with the understanding that therapy would be delayed until the next day when the inhaler could be ordered and delivered. Nebulized albuterol/ipratropium solution would be administered in the interim
- All other orders for Comibvent will be converted to an equivalent dose of albuterol/ipratropium nebulized solution as per the Automatic Therapeutic Interchange Policy
- Both recommendations above were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)



# Bupropion SR-XL (Wellbutrin SRXL): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

<u>Situation:</u> Bupropion is an antidepressant indicated for the treatment of major depressive disorder and smoking cessation assistance

<u>Background:</u> Bupropion is available as an immediate release tablet, a sustained-release tablet, and as an extended-release tablet.

### Assessment:

- Having two long-acting formulations (XL and SR) is not cost-effective and has resulted in medication errors at TCMC
- Bupropion SR is less expensive than bupropion XL
- There is no therapeutic advantage in using one long-acting agent over the other.
   In the outpatient setting, using the once-daily XL formulation may assist with compliance
- The Pharmacy Service has recommended an update to the Automatic Therapeutic Interchange policy which includes an automatic conversion from bupropion XL to an equivalent daily dosage of bupropion SR

### Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that all strengths of bupropion XL be removed from the TCMC formulary at this time given automatic conversion process to a therapeutic equivalent
- All future orders for bupropion XL will be converted to bupropion SR as per the Automatic Therapeutic Interchange Policy

# Combivir (lamivudine and zidovudine) tablet: Recommendation for formulary removal

Requestor: Manuel Escobar, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Combivir (lamivudine and zidovudine) is a combination tablet that is no longer commonly prescribed for the treatment of HIV-1 infection

<u>Background:</u> Combivir (lamivudine and zidovudine) is an oral HIV Nucleoside reverse transcriptase inhibitor combination tablet used with other antiretroviral agents for the treatment of HIV-1 infection. Other products in this class considered better tolerated are available to replace Combivir (lamivudine and zidovudine).

<u>Assessment:</u> Combivir (lamivudine and zidovudine) is no longer commonly prescribed for the treatment of HIV-1 infection given the availability of new options in this drug class. TCMC formulary includes the individual components of this tablet if needed.

### Recommendation(s):

 P&T Committee approved the Pharmacy and ID Service recommendation for removal of Combivir (lamivudine and zidovudine) from the hospital formulary to reduce drug costs and waste

#### Prezista (Darunavir): Recommendation for formulary addition

Requestor: Manuel Escobar, PharmD, Infectious Diseases Pharmacist

Declared conflicts of interest: None

Situation: Darunavir is an protease inhibitor

<u>Background:</u> Darunavir is FDA approved to be used in with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients 3 years of age or older

Dosing Recommendations: Treatment-naïve and treatment-experienced adult patients with no darunavir resistance associated substitution: 800 mg taken with ritonavir 100 mg once daily

Treatment-experienced adult patients with at least one darunavir resistance associated substitution: 600 mg taken with ritonavir 100 mg twice daily

#### **Assessment:**

- Darunavir is a commonly prescribed anti-retroviral in the outpatient setting. In order to provide continuity of care, the drug has been purchased for use frequently on a non-formulary basis
- Efficacy has been demonstrated in treatment-naïve and treatment experienced patients receiving darunavir plus ritonavir in combination with tenofovir/emtricitabine.
- FDA Black Box warnings: None
- Cost impact: 600 mg & 800 mg tablets (\$1,377 per #30 count bottle)

- The Pharmacy Service in cooperation with the ID Service recommended addition of darunavir to the formulary with the following criteria for use:
  - Restricted to patients already taking darunavir for continuity of outpatient care during admission
  - Restricted to ID physicians for new starts
- The P&T Committee approved the above recommendations and criteria for use. Per discussion by Committee members, including Dr. Smith (Infectious Diseases), darunavir would not be routinely stocked but ordered when needed for qualifying patients.



#### **Droperidol Recommendation for formulary removal**

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

<u>Situation:</u> Droperidol injection has been on continued shortage since 2015 and product has never been available for purchase in that time. There are no plans from manufacturers to resume production at this time

**Background:** Droperidol is an anesthetic adjunct and antiemetic.

#### **Assessment:**

- In 2015, Hospira cited lack of raw materials as the reason for the shortage
- Given the complete lack of product, even in small quantities it is unlikely that droperidol will return to the market
- Due to its formulary status, droperidol is ordered with some regularity due to its inclusion in Power Plans resulting in phone calls from Pharmacists to providers requesting permission to discontinue the order. Nurses are also required to conduct annual competency training on a droperidol standardized procedure for which there is little benefit given the lack of drug availability.

#### Recommendation(s):

 The P&T Committee approved the Pharmacy Service recommendation that droperidol be removed from the TCMC formulary due to current and anticipated future unavailability. Formulary status may be reassessed at a future date if this drug ever becomes available on the market again



## Exparel (liposomal bupivacaine): Expansion of approved indication and ordering privileges

Requestor: Dr. Seif/Dr. Gandhi

**Declared conflicts of interest: None** 

<u>Situation:</u> Exparel is liposomal formulation of bupivacaine which is an amide-type anesthetic.

<u>Background:</u> Exparel is a long-acting formulation of bupivacaine. Exparel is not recommended for epidural, intrathecal, intravascular, or intra-articular administration. Use for regional nerve blocks is also not recommended.

Exparel was approved by the P&T Committee in 2017 for use by CT Surgery during VATS procedures to eliminate the need for epidural placements. No other indications or provider groups have been approved to order this drug to date.

The Anesthesia and Surgery Services requested that liposomal Exparel be approved for the indication of TAP (transverse abdominis plane) blocks in the setting of minimally invasive robotic colorectal procedures. The request is part of more comprehensive approach to pain management and quicker post-operative recovery being put together by a collaborative group of physicians, nurses, and pharmacists (Peri-Surgical Home Model).

#### **Assessment:**

- Exparel has established efficacy in a prospective randomized controlled trial and a retrospective analysis when administered as a TAP block, reducing opioid use and maintaining lower pain scores in the first 24-48 hours post-surgery
- Cost Impact
  - Exparel 10 mL vial (\$157), 20 mL vial (\$315). Comparator arm is epidural placement which is estimated at ~\$400 per case
  - Peri-Surgical Home Model pilot program estimates patients to be discharged from the hospital 1-2 days earlier when compared against current practice. A value estimated to \$3,000 saved per admission-free day

- The P&T Committee approved the request to expand Exparel's approved indications to include TAP block placement during minimally-invasive colorectal surgery as part of the Peri-Surgical Home Model pilot program
- Per the requestors, ordering privileges for this indication are to be restricted to Dr. Fierer, Dr. Gandhi, and Dr. Hannah

#### Fluticasone Inhaler (Flovent): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Inhaled corticosteroids are used for the chronic management of asthma and COPD

<u>Background:</u> Several inhaled corticosteroids are currently on the TCMC formulary including beclomethasone (QVAR) and two strengths of fluticasone (Flovent).

#### **Assessment:**

- It is not cost effective to carry multiple inhaled corticosteroids on the formulary as they are equally effective at equipotent doses
- Beclomethasone (QVAR) is currently the lowest cost option at \$191 per inhaler
  - Fluticasone 110 mcg is \$217 per inhaler
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of all ordered inhaled corticosteroids to an equipotent dose of inhaled beclomethasone

- The P&T Committee approved the Pharmacy Service recommendation that fluticasone inhalers be removed from the TCMC formulary at this time and that beclomethasone remain as the formulary preferred product
- All future inpatient orders for fluticasone inhalers will be converted to an equivalent dose of inhaled beclomethasone 40 mcg as per the Automatic Therapeutic Interchange Policy
- All recommendations were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)



## Fluticasone/Salmeterol (Advair Diskus): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Fluticasone/salmeterol is a combination beta-agonist/inhaled corticosteroid used for the chronic management of COPD and asthma.

<u>Background:</u> Fluticasone/salmeterol is supplied as a "diskus" device which dispenses a dry powder that is inhaled twice daily. Devices may not be shared between patients and may not be sent home with the patient upon discharge.

#### Assessment:

- Each fluticasone/salmeterol device costs approximately \$130
- The Pharmacy Service has recommended an update to the Automatic Therapeutic Interchange policy which includes an automatic conversion from fluticasone/salmeterol to an equivalent daily dosage of budesonide/formoterol (Symbicort)
- The estimated cost savings associated with a conversion of all fluticasone/salmeterol patients to budesonide/formoterol is approximately \$49,000 annually

- The P&T Committee approved the Pharmacy Service recommendation that all strengths of fluticasone/salmeterol (100 mcg/50 mcg, 250 mcg/50 mcg, 500 mcg/50 mcg) be removed from the TCMC formulary at this time
- All future orders for fluticasone/salmeterol will be converted to budesonide/formoterol as per the Automatic Therapeutic Interchange Policy
- All recommendations were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)



## Genvoya (emtricitabine, tenofovir, elvitegravir, cobicistat) Recommendation for formulary addition

Requestor: Manuel Escobar, PharmD, Infectious Diseases Pharmacist

**Declared conflicts of interest: None** 

<u>Situation:</u> Genvoya is a combination antiretroviral product consisting of 2 HIV nucleoside reverse transcriptase inhibitors, a HIV integrase inhibitor, and a cytochrome P450 inhibitor.

<u>Background:</u> Genvoya is a complete regimen for treatment of HIV-1 infection for adults and pediatric patients (at least 25 kg) who are treatment-naïve or to replace a current, stable (meaning the patient had been taking the regimen for at least 6 months) antiretroviral regimen in a virologically-suppressed patient (HIV-1 RNA less than 50 copies per milliliter) without a history of treatment failure or mutations that confer resistance to any of the individual agents of Genvoya.

Dose: 1 tablet PO daily with food

#### **Assessment:**

- Combination HIV anti-retroviral treatment has become a more standardized approach to treatment in the community. When patients prescribed these medications are admitted to the hospital, it is not possible to substitute with alternative agents
- FDA Black Box warnings: Genvoya has a boxed warning for severe, acute exacerbations of hepatitis B. This risk is for patients co-infected with both HIV and hepatitis B and applies if they discontinue products containing emtricitabine and tenofovir (either tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide).
- Cost impact: \$2,591 for #30 count bottle

- The Pharmacy Service in cooperation with the ID Service recommended addition of Genvoya to the formulary with the following criteria for use:
  - Restricted to patients already taking Genvoya (or comparable agent Stribild) for continuity of outpatient care during admission
  - Restricted to ID physicians for new starts
- The P&T Committee approved the above recommendations and criteria for use.
   Per discussion by Committee members, including Dr. Smith (Infectious Diseases), Genvoya would not be routinely stocked but ordered when needed for qualifying patients.



## Ipratropium Metered Dose Inhaler (Atrovent): Recommendation for formulary restriction

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Ipratropium is a short-acting antimuscarinic used for the chronic management of COPD and asthma exacerbations

<u>Background:</u> Ipratropium is offered as a metered dose inhaler (MDI) device which administers a fine mist that is inhaled up to 12 times daily. The medication may not be shared between patients nor can it be sent home with the patient upon discharge.

#### Assessment:

- Each ipratropium MDI costs \$338
- A therapeutically equivalent medication, ipratropium 0.02% nebulized solution costs \$0.13 per dose
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of ipratropium MDI to an equipotent dose of ipratropium 0.02% nebulized solution
- A conversion from ipratropium MDI to ipratropium nebulized solution would save TCMC approximately \$9,400 annually

- The P&T Committee approved the Pharmacy Service recommendation that all orders for Atrovent be restricted to Pulmonologists only.
  - Per this agreement, Pharmacy will not routinely stock this inhaler with the understanding that therapy would be delayed until the next day when the inhaler could be ordered and delivered. Nebulized ipratropium solution would be administered in the interim
- All other orders for Atrovent will be converted to an equivalent dose of ipratropium nebulized solution as per the Automatic Therapeutic Interchange Policy
- Both recommendations above were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)



#### Lansoprazole solu-tab: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

<u>Situation:</u> Lansoprazole solu-tabs are no longer on contract through the hospital GPO Vizient and now costs \$130 per tablet

<u>Background:</u> Lansoprazole is a proton pump inhibitor (PPI). The solu-tab formulation was added to the formulary in an effort to reduce drug costs by converting patients on intravenous pantoprazole to an oral formulation which could be administered via gastric tube. Oral pantoprazole is not an option for gastric tube administration as it cannot be crushed.

#### Assessment:

- Intravenous pantoprazole costs \$3 for a standard 40 mg dose. The conversion from IV pantoprazole to lansoprazole solu-tab via gastric tube is no longer a cost effective process
- There is no therapeutic advantage to converting patients from IV pantoprazole to an oral PPI. The only benefit was cost, therefore it is appropriate to delay any conversion until the patient can tolerate oral pantoprazole given PPI therapy is still warranted
- >90% of orders for lansoprazole were placed by Pharmacists as part of the Automatic IV to PO policy in an effort to reduce drug costs in qualifying patients

- The P&T Committee approved the Pharmacy Service recommendation that lansoprazole solu-tabs be removed from the TCMC formulary due to current and anticipated future unavailability
- The P&T Committee approved the Pharmacy Service recommendation to work on amending the Pharmacy Automatic IV to PO protocol to remove the recommended conversion from IV pantoprazole or PO lansoprazole solu-tabs

#### Medium Chain Triglycerides: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

<u>Situation:</u> Medium chain triglyceride (MCT) oil is a nutritional supplement. It has not been ordered/dispensed in over 3 years

<u>Background:</u> MCT oil was primarily utilized by neonatologists as a nutritional supplement in the NICU population

#### Assessment:

- Dr. Movahhedian (Chief, Neonatology) has indicated that this supplement is not currently needed given other nutritional supplements on formulary
- Current supply currently expires on the shelf on a routine basis (\$65/bottle)

#### Recommendation(s):

 The P&T Committee approved the Pharmacy Service recommendation that MCT oil be removed from the TCMC formulary at this time



#### Mepivacaine Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

**Situation:** A substantial supply of mepivacaine expired in late 2017.

<u>Background:</u> Mepivacaine is an amide anesthetic used as a nerve block for pain procedures

#### **Assessment:**

- Mepivacaine 1.5% (30 mL) vials and mepivacine 3% (1.7 mL cartridges) are on the TCMC formulary
- Neither product has been dispensed for at least 2 years and were stocked only in the Surgery department
- The Anesthesia Service acknowledged that the product is not necessary for daily patient care and feels that it could be removed from the formulary

#### Recommendation(s):

 The P&T Committee approved the Pharmacy Service recommendation that mepivacaine in all strengths and formulations be removed from the TCMC formulary due to lack of use and agreement from the Anesthesia Service



## Nitroglycerin 0.3 mg/0.6 mg tablets: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

<u>Situation:</u> Nitroglycerin sublingual tablets are currently stocked in three strengths: 0.3 mg, 0.4 mg, 0.6 mg

<u>Background:</u> When nitroglycerin was historically added to the TCMC formulary, no stipulation was made on the specific doses that would be stocked

#### **Assessment:**

- Nitroglycerin 0.4 mg is the gold standard dose for this medication when administered sublingually
- Nitroglycerin 0.3 mg and 0.6 mg tablets routinely expire on the shelf due to nonuse

- The P&T Committee approved the Pharmacy Service recommendation that nitroglycerin 0.3 mg and 0.6 mg sublingual tablets be removed from the TCMC formulary at this time
- Sublingual nitroglycerin 0.4 mg tablets remain available for use on the formulary

#### Nitroglycerin 0.4 mg Spray: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Nitroglycerin spray has increased in price to \$100 per bottle. For regulatory reasons, bottles cannot be shared between patients

Background: Nitroglycerin spray is stocked in STEMI kits, ED, and Cath Lab

#### **Assessment:**

- Nitroglycerin when administered as a spray has no documented clinical advantage when compared to the standard sublingual tablet
- The use of sublingual tablets is the gold standard in ambulatory and emergency settings and is often the only formulation carried by most hospitals
- Nitroglycerin 0.4 mg tablets cost \$0.28 each
- The Cardiology Service and Emergency Department where this formulation is used supported this formulary recommendation

- The P&T Committee approved the Pharmacy Service recommendation that nitroglycerin 0.4 mg spray be removed from the TCMC formulary at this time
- Sublingual nitroglycerin 0.4 mg tablets remain available for use on the formulary

#### Raltegravir (Isentress) tablet: Recommendation for formulary removal

Requestor: Manuel Escobar, PharmD

**Declared conflicts of interest: None** 

**Situation:** Dolutegravir (Tivicay) has been recommended for addition to the formulary as the preferred integrase inhibitor and in place of raltegravir (Isentress).

<u>Background:</u> Raltegravir is an oral HIV integrase inhibitor used in combination with other antiretroviral agents for the treatment of HIV-1 infection.

<u>Assessment:</u> Dolutegravir has demonstrated non inferiority to raltegravir and is increasingly being used as the preferred integrase inhibitor in the outpatient setting.

#### Recommendation(s):

 Given the recommendation to add dolutegravir (Tivicay) as the preferred integrase inhibitor, the P&T Committee approved the Pharmacy Service recommendation to remove raltegravir (Isentress) from the hospital formulary

#### Salmeterol (Serevent) Recommendation for formulary restriction

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Salmeterol is a long acting beta agonist indicated for the chronic management of COPD and asthma

<u>Background:</u> Salmeterol is offered as a "diskus" device which administers a powder that is inhaled twice daily. The medication may not be shared between patients nor can it be sent home with the patient upon discharge.

#### **Assessment:**

- Each salmeterol device costs \$206
- A therapeutically equivalent medication, formoterol nebulized solution costs \$4 each
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of salmeterol to an equipotent dose of formoterol nebulized solution
- A conversion from salmeterol to formoterol nebulized solution would save TCMC approximately \$1000 annually

- The P&T Committee approved the Pharmacy Service recommendation that all orders for salmeterol inhalers be restricted to Pulmonologists only.
  - Per this agreement, Pharmacy will not routinely stock this inhaler with the understanding that therapy would be delayed until the next day when the inhaler could be ordered and delivered. Nebulized formoterol solution would be administered in the interim
- All other orders for salmeterol inhalers will be converted to an equivalent dose of formoterol nebulized solution as per the Automatic Therapeutic Interchange policy pending P&T approval
- Both recommendations above were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)

#### Tivicay (dolutegravir): Recommendation for formulary addition

Requestor: Manuel Escobar, PharmD, Infectious Diseases Pharmacist

Declared conflicts of interest: None

Situation: Tivicay is an HIV integrase inhibitor

<u>Background:</u> Tivicay is approved to be used in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients weighing at least 30 kg

Dose: Treatment-naive or treatment-experienced but integrase strand inhibitor-naïve: 50 mg orally once daily

Integrase strand inhibitor (INSTI)-experienced with known or suspected INSTI-associated resistance: 50 mg orally twice daily

#### **Assessment:**

- In clinical trials, Tivicay has demonstrated efficacy in combination with an effective background regimen in treatment naive and antiretroviral-experienced HIV infection
- FDA Black Box warnings: None
- Cost impact: \$1,444 for #30 count bottle

- The Pharmacy Service in cooperation with the ID Service recommended addition of Tivicay to the formulary with the following criteria for use:
  - Restricted to patients already taking Tivicay for continuity of outpatient care during admission
  - Restricted to ID physicians for new starts
- The P&T Committee approved the above recommendations and criteria for use. Per discussion by Committee members, including Dr. Smith (Infectious Diseases), Tivicay would not be routinely stocked but ordered when needed for qualifying patients.



## Verapamil Sustained Release (Calan SR): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

**Declared conflicts of interest: None** 

<u>Situation:</u> Verapamil is a non-dihydropyridine type calcium channel blocker with vasodilating and negative chronotropic effects. It is used for the management of hypertension, PSVT, and atrial fibrillation/flutter.

<u>Background:</u> Verapamil is offered as an immediate release, sustained-release, and extended release product. Currently all three formulations are on the TCMC formulary.

#### Assessment:

- The availability of multiple long-acting preparations of verapamil is not cost efficient and has resulted in medication errors
- The various long-acting verapamil preparations are considered clinically identical in efficacy
- The Pharmacy Service is recommending a revision to the Automatic Therapeutic Interchange policy in which orders for verapamil sustained-release (Calan SR/Isoptin SR) would be converted to an equivalent dose of verapamil extended release (Verelan ER)

- The P&T Committee approved the Pharmacy Service recommendation that all strengths of verapamil sustained-release (Calan SR/Isoptin SR) be removed from the TCMC formulary at this time given conversion to therapeutically equivalent product is possible
- All future orders for verapamil sustained-release (Calan SR/Isoptin SR) will be converted to an equivalent dose of verapamil extended release (Verelan ER) as per the Automatic Therapeutic Interchange Policy

# Governance & Legislative Committee (No meeting held in April, 2018)

## Tri-City ical Center Audit, Compliance & Ethics Committee April 18, 2018 Assembly Room 1 8:30 a.m-10:30 a.m.

Members Present: Director Larry W. Schallock(Chair); Director James Dagostino; Director Julie Nygaard; Kathryn Fitzwilliam, Community

Member; Leslie Schwartz, Community Member

Non-Voting Members: Steve Dietlin (CEO); Scott Livingstone, COO; Ray Rivas, CFO; Garlos Cruz, CCO

Others Present:, Teri Donnellan, Executive Assistant; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Contract

Analyst - Paralegal; Patricia Guerra, Education Specialist

Absent: Cary Mells, M.D.; Physician Member; Susan Bond, General Counsel; Faith Devine, Community Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock.		
2. Approval of Agenda	It was moved by Director Dagostino and seconded by Director Nygaard to approve the agenda as presented. The motion passed unanimously.	Agenda approved.	
<ol> <li>Comments by members of the public and committee membe on any item of interest to the public before Committee's consideration of the item</li> </ol>	Antonio Contractor Con		
4. Ratification of minutes – January 18, 2018	It was moved by Mr. Leslie Schwartz and seconded Director Dagostino to approve the minutes of January 18, 2018, as presented. The motion passed unanimously.	Minutes ratified.	
<ol> <li>Old Business</li> <li>a) Discussion regarding FY20 Financial Statement Audit Proposal</li> </ol>	Mr. Ray Rivas, CFO reported at the committee's last meeting he was directed to obtain a proposal from Moss Adams to conduct the FY2018 Financial Statement Audit and if they came back with little to no increase the	Recommendation to be sent to the Board of Directors to approve the Fiscal Year 2018 Financial	Mr. Rivas

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	committee would consider engaging them to perform the Audit. Mr. Rivas reviewed the fees which reflected an overall decrease from FY2017 of \$3,500. Discussion was held regarding the Single Audit Report which is a requirement of the HUD loan. Mr. Dietlin stated there is some work involved in preparing the Single Audit and Moss Adams must also attest to its validity. It was noted that there was a switch in audit partners last year and it is a good practice to rotate auditors every few years.  It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam to recommend approval of the FY2018 Financial Statement Audit Proposal as presented. The motion passed unanimously.	Statement Audit Proposal as presented.	
New Business     a) Administrative Policies &		<b>&gt;</b>	
Procedures:			
Fraud Recognition Response #395	With regard to the Fraud Recognition Response policy it was recommended that the acronym HIM (Health		
<ol> <li>Hospital Issued Notice of Non- coverage of Medicare- Covered Services (HINN) #398</li> </ol>	Information Management) be spelled out for clarity. It was also suggested the 8610 policy prefix be struck throughout		
Important Message from     Medicare & Notification of	for consistency		
Hospital Discharge Appeal Rights - #392	Discussion was held regarding the fact that Mr. Cruz is both the Compliance Officer and Privacy Officer and whether		
4) Medical Directorships #572	language in the policy should be amended to reflect that.		
<ol> <li>Monitoring Compliance – Auditing &amp; Reporting – Annual Compliance Work Plan →#552</li> </ol>	Mr. Dietlinisuggestedithe language in the policy remain as written assisticreates flexibility for administrative changes in title and release.		
Monitoring Compliance     Auditing & Reporting –	title and role as necessary.  2) There were no modifications to the Hospital Issued		
Compliance Reviews and Audits - #553	Notice of Non-Coverage of Medicare Covered Services		
Physician & Allied Health     Professional Service Contracts	policy.		
- #580 8) Sales of Items or Services to	There were no modifications to the Important Message from Medicare & Notification of Hospital Discharge Appeal		

	Discussion	Action Recommendations/ Conclusions	Person Respons	
Physicians and Other Potential Referral Sources - #575	Rights policy.  4) and 7) The Medical Directorships policy and Physician & Allied Health Professional Service Contracts policy were discussed simultaneously. Mr. Schwartz questioned the need for two separate policies. Mr. Cruz explained that the agreements for a Medical Directorship and Physician Contract are two different types of agreements. Mr. Livingstone noted it is possible that one physician could have both a Medical Directorship agreement and a Physician contract. Director Nygaard questioned if there is a mechanism in place to evaluate the results of the Directorships. Mr. Livingstone stated there is an evaluation tool that is being rolled out Director Dagostino questioned if the physician needs to be on staff the physician must be on staff which is identified in the Medical Staff Bylaws.  5) and 6) The Monitoring Compliance — Auditing & Reporting — Annual Compliance Work Plan and Monitoring Compliance Auditing & Reporting — Compliance Reviews and Audits policy were folled into one policy and describes the role of the Chief Compliance Officer.  8) Ms. Fitzwilliam requested clarification on what types of items are considered in the Sales of Items or Services to Physicians and Other Potential Referral Sources policy. Mr. Livingstone stated older type equipment that the hospital owns and is replacing would be an example. It was recommended that E. Procedure 8. be amended to read "The Audit, Compliance and Ethics Committee will oversee compliance with this policy." A typo was noted on page 48 (strike the duplicate phrase "any other").			
	It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to recommend approval of the Administrative Policies & Procedures with amendments as described. The motion passed unanimously.	Recommendation to be sent to the Board of Directors to approve Administrative Policies with amendments as described; items to be added	Ms. Donr	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible	
	Ms. Guerra left the meeting at 9:00 a.m.	to Board Agenda and included in agenda packet.		
Chief Compliance Officer Report Dashboard Update Work Plan Update Government Audit Trends	Mr. Carlos Cruz, CCO presented a Compliance Program report reviewing the following:  > Compliance Program Marketing  • "Meet and Greets" with Departments  • Staff Rounding  • Values Line Business & Gards that include the five principles RIGHT.  • Newsletter on the five W's of the Compliance Program which provides a summary of what the compliance program is all about.  Mr. Cruz reported he recently attended and spoke at the Healthcare Compliance Association Institute in which nearly 3,000 people participated including staff from the Office of Inspector General, Centers for Medicare and Medicaid Services and Department of Justice.  Mr. Cruz discussed the National Compliance Trends as follows:  > CMS reviewed over 1 billion claim for proper reimbursement  • Fay2016: \$3.3 billion in payment recoveries  • Fy2017: \$2.6 billion in payment recoveries  • Fy2017: \$2.6 billion in payment recoveries  > Opioid Fraud and Abuse  > Stark Law/Antil Kickback Statute  > EHR related Fraud and Abuse (Meaningful Use Attestations)  > Telehealth & Telemedicine.  Ms. Fitzwilliam questioned how contracted staff is educated on compliance. Mr. Cruz stated vendors are required to follow our policies and procedures and are held to the same standard as an employee.	Information Only.	Ms. Donnella	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
. Motion to go into Closed Sessio	There was extensive discussion on Opioid use and steps the hospital is taking to monitor Opioid fraud and abuse. Mr. Cruz stated monthly audits are performed and we are working diligently with the Pyxis system, ensuring the system is locked down following use.  Mr. Cruz discussed the TCHD Compliance Program Dashboard which mirrors the plan and follows the "Seven Elements of an Effective Compliance Program" as follows:  1. Policies & Procedures 2. Standards of Conduct 3. Training and Education 4. Open Lines of Communication 5. Enforcement 6. Internal Auditing and Monitoring 7. Prompt Response  Lastly, Mr. Cruz provided a summary of the FY2018/19 Work Plan's Key Focus Areas as follows:  1. Compliance Office Structure 2. Compliance Program Marketing 3. Compliance Program Oversight 4. Compliance Program Oversight 4. Compliance Program Oversight 6. Auditing and Monitoring 7. Open Lines of Communication 8. HIPAA Privacy and Security 9. Operational Support  Chairman Schallock complemented Mr. Cruz on his thorough and professional presentation.	/	
	Director Dagostino to go into closed session at 9:30 a.m. The motion passed unanimously.		
11. Open Session	The committee returned to open session at 9:45 a.m. with		

		Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
		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 recommended the May meeting be cancelled and the primary focus of the July 19 <sup>th</sup> meeting would be the Audit Entrance Report by Moss Adams.	The Committee's next meeting is scheduled for July 19, 2018.	
16.	Adjournment	Chairman Schallock adjourned the meeting at 9:50 a.m.	>	

#### AUDIT COMPLIANCE AND ETHICS COMMITTEE April 19<sup>th</sup>, 2018

Administrative Policies & Procedures	Policy #	Reason	Recommendations
Fraud Recognition Response	395	3 year review, practice change	Forward To BOD For Approval with Revisions
Hospital Issued Notice of     Noncoverage of Medicare- Covered Services (HINN)	398	NEW	Forward To BOD For Approval with Revisions
Important Message From     Medicare and Notification of     Hospital Discharge Appeal Rights	392	3 year review, practice change	Forward To BOD For Approval
4. Medical Directorships	572	practice change	Forward To BOD For Approval
Monitoring Compliance - Auditing     & Reporting - Annual Compliance     Workplan	552	3 year review, practice change	Forward To BOD For Approval
Monitoring Compliance Auditing     and Reporting - Compliance     Reviews and Audits	553	DELETE	Forward To BOD For Approval
Physician and Allied Health     Professional Service Contracts	580	3 year review, practice change	Forward To BOD For Approval
Sales of Items or Services to     Physicians and Other Potential     Referral Sources	575	3 year review, practice change	Forward To BOD For Approval with Revisions

### Administrative Policy Patient Care

ISSUE DATE:

03/11

SUBJECT: Fraud Recognition and Response

**REVISION DATE:** 

POLICY NUMBER: 8610-395

Department Approval:

01/18

Administrative Policies & Procedures Committee Approval:

<del>01/11</del>01/18

Organization Compliance Committee:

02/18

Medical Executive Committee Approval:

<del>02/11</del>03/18

Audit, Compliance and Ethics Committee:

04/18

**Board of Directors Approval:** 

03/11

#### A. PURPOSE:

To describe the measures to be followed when health care is obtained under a fictitious name or in another person's name. This includes situations when a person intentionally misrepresents himself/herself and when a person gives his/her real name, but the hospital or other facility accesses the wrong medical record so that the medical records of two patients are commingled.

#### B. **DEFINITION(S)**:

- 1. Identity theft: means the act of knowingly obtaining, possessing, buying, or using, the personal identifying information of another:
  - 4)-with the intent to commit any unlawful act including, but not limited to, obtaining or attempting to obtain credit, goods, services or medical information in the name of such other person; and
  - b. (2) (a) without the consent of such other person; or (b) without the lawful authority to obtain, possess, buy or use such identifying information.
- 2. Theft of Services:
  - a. means (1)-intentionally obtaining services by deception, fraud, coercion, false pretense or any other means to avoid payment for the services; and
  - 4.b. (2)-having control over the disposition of services to others, knowingly diverts those services to the person's own benefit or to the benefit of another not entitled thereto.

#### C. POLICY:

Tri-City Healthcare District (TCHD) strives to prevent the intentional or inadvertent misuse of patient names, identities, and medical records; to report criminal activity relating to identity theft and theft of services to appropriate authorities; and to take steps to correct and/or prevent further harm to any person whose name or other identifying information is used unlawfully or inappropriately.

#### D. PROCEDURE:

1. Request-Identification at Registration/iIntake pPoints - Hospital emergency department and all other registration/intake areas-staff should request, review and include in each patient's file a copy of the patients photo identification (ID) issued by a local, state, or federal government agency (i.e., driver's license, passport, military ID, etc.). In the event the patient does not have a photo ID, ask for two forms of non-photo ID, one of which has been issued by a state or federal agency (i.e., Social Security card and utility bill or company or school ID). When the patient is under 18 or if the patient is unable due to their condition to produce ID, the responsible party's ID shall be requested.

- Identification at Subsequent Patient Visits Each time a patient visits, TCHD staff should
  check whether the ID provided is valid, and matches any photo in the patient's medical record to
  the ID provided for visit. During the registration process, if an identity alert flag appears in the
  TCHD Master Patient Index (MPI), the staff member should call the Registration Supervisor.
  - a. Special Considerations:
    - i. Emergency Care no delay. Providing ID is not a condition for obtaining emergency care. The process of confirming a patient's identity must never delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.
    - ii. Responding to Questions If asked the reason for the identifying procedures, **TCHD staff should** explain that the procedures are "for patient protection to prevent identity theft and theft of services."
- Refusal to Provide or Lack of ID No one should be refused care because they do not have
  acceptable ID with them. Patients should be asked to bring appropriate documents to their next
  visit. and registration staff may offer to take a photograph of the patient in accordance with any
  approved registration staff photograph policy. Refer to Photo-Identification of Patients Policy.
- Signs of Possible Identify Theft Employees should be alert for cases of possible identity theft. Potential signs of identity theft include, but are not limited to, the following: (refer to Administrative Policy: Identity Theft [Red Flag Rules] 596):
  - a. Any patient appearing and giving an identity that has been flagged in TCHD's MPI or Identity Theft Database.
  - b. A patient providing photo ID that does not match patient.
  - c. A patient giving a Social Security number different than one used on a previous visit.
  - d. A patient giving information that conflicts with information in the patient's file or received from third parties, such as insurance companies.
  - e. Family members/friends calling the patient by a name different than that provided by the patient at registration.
- e.4. TCHDAdministrative Policy: Identity Theft (Red Flag Rules) 8640-596 sets forth the TCHD Identity Theft Prevention Program (ITPP).
- Identity Theft Investigation/Follow-Up:
  - a. If an employee TCHD staff member reasonably believes identity theft has occurred or may be occurring, he/she must immediately notify the Registration Supervisor. The Registration Supervisor will notify the Chief Compliance and Privacy Officer. TCMC will be informed of the suspected identity on an as needed basis.
  - 4-b. When Identity Theft is alleged by a Patient Advise the patient to report the identity theft incident to law enforcement and to the Federal Trade Commission (FTC) and complete the Identity theft report. A unique number will be generated to track this report. Use of these two reports should substantiate that identity theft did in fact occur. Once the identity theft allegation is supported by an FTC Identity report, the facility must flag the account of the patient alleging identity theft so that medical personnel are alert to the issue that the medical record may contain inaccurate information about the patient.
  - a.c. When Identity Theft Occurs A person obtains or uses the personal identifying information of another to obtain (or to attempt to obtain) medical services or information in the name of such other person, TCMCHD will take the following steps:
    - Notifications When identity theft is reasonably suspected or is known to have occurred as soon as possible, report the theft to the Compliance Officer. The Compliance Officer will make decisions on the findings, external reporting law enforcement agency and make necessary notifications.
      - Reporting Medicaid Fraud –f Medicaid fraud (i.e., a patient uses another person's Medicaid information to obtain medical care), the fraud must be reported immediately to the Medicaid OIG at 800-447-8477.
      - 2. Mail theft For incidents involving mail theft, the United States Postal Inspection Service will be contacted.

- 3. Security Breach If the identity theft involves unauthorized access of unencrypted computerized data would permit access to an individual's financial account, the Compliance Officer will direct reporting in accordance with California laws to any resident of California whose unencrypted personal information was or is reasonably believed to have been acquired by an unauthorized person. Such reporting will be made in the most expedient time possible and without unreasonable delay, consistent with the legitimate needs of law enforcement.
- b.d. Accounts on Hold The Director of Patient Financial Services will put all patient accounts affected by the **suspected** identity theft on hold pending the outcome of the investigation.
- e.e. Reporting of **Identity thest** -Victims of identity theft should be encouraged to cooperate with law enforcement in identifying and prosecuting the suspected identity thief. They also should report the theft to the FTC using the link provided <a href="https://www.identitytheft.gov">https://www.identitytheft.gov</a>. The FTC process for helping victims of identity theft.
- f. Correcting medical and payment records of identity theft victims —If a case of identity theft is confirmed after appropriate investigation and review, TCMCHD will ensure and it has been determined that identify thi
  - i. (1)-Inaccurate health information is not inadvertently relied upon in treating a patient.
  - ii. (2) a-Patient or a third-party payer is not billed for services the patient did not receive, and (3).
  - d-iii. PHI is protected from inappropriate disclosure, patient medical and payment records must be corrected when a case of identity theft occurs.
    - i-1. Medical records ‡The Health Information Management (HIM) department will make appropriate corrections to the patient's medical record. Corrections shall be made in accordance with TCMC Medical Record Policy: Making Corrections to Supplemental Dictionary Policy and TCMC HIPAAAdministrative Policy: Amendment of Protected Health Information 520. A detailed explanation of the corrections shall be generated by the entity and verified by the patient. Pursuant to Administrative Policy: Amendment of Protected Health Information 520TCHD HIPAA Policy, the HIM department may need to send amended information to persons who have received incorrect or incomplete information. The HIM department shall remove all related documents from Cerner and make replacements with appropriately revised documents. The patient's verification of the corrected medical record shall be documented and included as part of the case file forwarded to the Compliance Officer.
    - ii.2. Payment records The billing department will make appropriate corrections to the patient's billing information, inform and provide documentation to any third-party payer affected by the adjustments, and make any necessary repayments to ensure that the patient and the payer pay only for services actually provided to the patient. Corrections shall be made in accordance with TCMCHD billing record corrections policy. A detailed explanation of the corrections shall be generated by the entity and verified by the patient. The patient's verification of the corrected billing records shall be documented and included as part of the case file forwarded to the Compliance Officer.
    - iii.3. Flagging The Registration Supervisor will add an MPI Alert Flag of "Identity issue/call Security" to each MPI record affected by the identity theft event.

- iv.4. Release of Hold The Registration Supervisor will verify that all demographic and insurance information is correct after the visit is transferred to the appropriate MPI record. Once all medical and billing records have been corrected, Patient Financial Services Director will release the bill hold and bill appropriately.
- e-g. Assisting Identity Theft Victims:
  - i. Copies of Records on Written Request Identity theft victims are entitled to obtain a copy of the billing and medical record relating to the identity theft free of charge. The facility must provide these records within thirty (30) days of receipt of the victim's written request. The facility also must provide these records to any law enforcement agency which the victim authorizes. Document receipt of and copy all such information. The facility may refuse to provide business transaction records if the facility determines in good faith that:
    - (1) the true identity of the person asking for the information cannot be verified:
    - 2. (2) the request for the information is based on a misrepresentation; or
    - information. (3) state or federal law prohibits the facility from disclosing such information.
  - ii. Mitigation The hospital should mitigate, to the extent practicable, any harmful effect that is known as a result of unlawful use or disclosure of **protected health information** (PHI) in connection with a case of identity theft.
- Eh. Recoveries from Suspect If known, the hospital may bill the identity theft suspect for unlawfully obtained services. Consult with tThe Chief Compliance Officer should be consulted for further guidance.
- g-i. Accounting for Disclosures The entity's Privacy Officer should determine whether, as result of identity theft, PHI was inappropriately disclosed. If PHI was inappropriately disclosed, the entity's HIM department must account for such disclosures in accordance with the TCHD-HIPAAAdministrative Policy:, Accounting ferof Disclosures of Protected Health Information (PHI) 528.
- 5.6. When Patient Misidentification Occurs If it is determined that patient misidentification, has occurred (for example, when a patient gives his or her real name, but the incorrect medical record is pulled up and the medical information of two patients is subsequently intermingled), the hospital shall take the following steps:
  - a. Notifications When patient misidentification has occurred, notify the appropriate Director' needed to remedy the situation. For example: Privacy Officer, HIM Director, Patient Financial Services Director, and the Compliance Officer. The Compliance Officer will review and make decisions on the findings and make all external reporting and notification decisions.
  - Accounts on Hold The Patient Financial Services Director will put all patient accounts
    affected by the patient misidentification on hold pending the outcome of the
    investigation.
  - c. Notifying Affected Patients Directed by the **Chief** Compliance Officer, notify– Patients affected by the misidentification.
  - d. Correcting Medical and Payment Records- Patient medical and payment records must be corrected when a case of patient misidentification occurs.
    - i. Medical Records the HIM department will make appropriate corrections to the patient's medical record. Corrections shall be made in accordance with TCMC Patient Care Services Policy: Medical Record, Making Corrections to Documentation policyProcedure and TCMC-HIPAA Administrative Policy: Amendment of Protected Health Information 520, A detailed explanation of the corrections shall be generated by the entity and verified by the patient. Pursuant to TCHD HIPAA-policy, the HIM department may need to send amended information to persons who have received in correct or incomplete information. The HIM department shall remove all related documents from Cerner and make

- replacements with appropriately revised documents. The patient's verification of the corrected medical record shall be documented and included as part of the case file forwarded to the **Chief** Compliance Officer
- ii. Payment Records the billing department will make appropriate corrections to the patient's billing information, inform and provide documentation to any third-party payer affected by the adjustments, and make any necessary repayments to ensure that the patient and the payer pay only for services actually provided to the patient. Corrections shall be made in accordance with TCMCHD billing record corrections policy. A detailed explanation of the corrections shall be generated by the entity and verified by the patient. The patient's verification of the corrected billing records shall be documented and included as part of the case file forwarded to the Compliance Officer.
- -Release of Hold The Registration Supervisor will verify that all demographic and insurance information is correct after the visit is transferred to the appropriate record. Once all medical and billing records have been corrected, Patient Financial Services Director will release the bill hold and bill appropriately.
- e. Accounting for Disclosures The entity's Privacy Officer should determine whether PHI was inappropriately disclosed. If PHI was inappropriately disclosed, the HIM department must account for such disclosures in accordance with AdministrativeTCHD HIPAA Policy:, Accounting for Disclosures of Protected Health Information (PHI) 528.

#### 6. Definitions

- a. Identity theft means the act of: knowingly-obtaining, possessing, buying, or-using, the personal identifying information of another: (1) with the intent to commit any unlawful act including, but not limited to, obtaining or attempting to obtain-credit, goods, services or medical information in the name of such other-person; and (2) (a) without the consent of such other person; or (b) without the lawful authority to obtain, possess, buy or use such identifying information.
- b.f. Theft of services includes: (1) intentionally obtaining-services by deception, fraud, coercion, false protonse or any other-means to avoid payment for the services; and (2) having control over-the disposition of services to others, knowingly diverts those services to the person's own benefit or to the benefit of another-not entitled thereto.

#### E. EXTERNAL LINK(S):

e.1. Federal Trade Commission: <a href="https://www.identitytheft.gov">https://www.identitytheft.gov</a>

#### F. RELATED DOCUMENT(S):

- 1. Administrative Policy: Accounting of Disclosures of Protected Health Information (PHI) 528
- 2. Administrative Policy: Amendment of Protected Health Information 520
- d.3. Administrative Policy: Identity Theft (Red Flag Rule) 596
- 4. Medical Record Policy: Making Corrections to Supplemental Dictionary Policy
- 5. Patient Care Services Policy: Medical Record, Making Corrections to Documentation Procedure

#### E.G. REFERENCE(S):

- HHS.GOV Uses and Disclosures for Treatment, Payment, and Health Care Operations 45 CFR
- 4.2. https://www.consumer.ftc.
- 2.3. Identity Theft Rule, 16 C.F.R. 681.I



#### Administrative Policy **Patient Care**

**ISSUE DATE:** 

**NEW** 

SUBJECT: Hospital Issued Notice of

Noncoverage of Medicare-Covered

Services (HINN)

**REVISION DATE: NEW** 

POLICY NUMBER: 8610-498

**Department Review:** 

10/17

Administrative Policies & procedures Committee Approval:

10/17

**Organizational Compliance Committee Approval:** 

02/18

Audit, Compliance and Ethics Committee Approval:

04/18

**Board of Directors Approval:** 

#### A. **PURPOSE:**

To explain the CMS ruling regarding the Notice of Medicare Provider Non-Coverage for the Medicare beneficiaries.

#### B. **POLICY:**

It is the policy of the hospital to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with Hospital Issued Notice of Noncoverage of Medicare-covered services (HINN).

#### C. **PROCEDURE:**

- Hospitals give HINNs to beneficiaries when issues of noncoverage arise for hospital-level inpatient care. The HINN may be given prior to admission, at admission, or at any point during the inpatient stay. It may be issued by hospital staff or utilization review committees based on Medicare instructions, including: coverage guidelines, notices, bulletins, or other written guides or directives from intermediaries or Quality Improvement Organizations (QIOs). After the hospital issues a notice of noncoverage, the beneficiary or his/her representative is considered to have knowledge that services are not covered and is liable for customary charges. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary or his/her representative. Potential liability may arise when the hospital determines that certain inpatient services are never covered by Medicare. It may also arise when an inpatient stay, either in whole or in part, or a specific, severable service during an otherwise covered stay: Is not considered reasonable and necessary, Can be provided safely in another setting is custodial in nature.
- 2. Types of HINNS:
  - HINN 1 Preadmission/Admission HINN: the hospital may issue a preadmission/admission HINN when the hospital has determined at the time of preadmission or admission that a beneficiary's stay will be a non-covered stay.
    - Preadmission HINN -- The beneficiary or his/her representative is liable for customary charges for all services furnished if he/she enters the hospital after receipt of a preadmission HINN.
    - Admission HINN -- Determine liability as follows: ii.
      - 1) HINN Issued on the Day of Admission - The beneficiary or his/her representative is liable for customary charges for all services furnished after the admission HINN is received. However, to hold a beneficiary or

- his/her representative liable for charges on the day of admission, the hospital must issue the admission HINN no later than 3:00 p.m. on the day of admission. If the hospital does not meet these requirements, the beneficiary or his/her representative is protected from liability until the day following receipt of the admission HINN (e.g., a HINN issued for an admission after 3:00 p.m. or a late evening admission).
- 2) HINN Issued After the Day of Admission The beneficiary or his/her representative is liable for customary charges for all services furnished beginning the day following the date of receipt of the admission HINN.
  - Timing for Preadmission/Admission HINN Request & Review-When a beneficiary or his/her representative requests review of a preadmission or an admission HINN, the QIO will review any records pertaining to health care services furnished. This includes records pertaining to any inpatient hospital services provided or proposed to be provided to the Medicare beneficiary whether or not, in the hospital's view, the services are covered.
    - i) Immediate Review If the beneficiary or his/her representative disagrees with the hospital preadmission notice, he/she may request your review, by telephone or in writing, within 3 calendar days of receipt of the HINN. If admitted, the beneficiary or his/her representative may request your review at any point during the stay. In either situation, the QIO will review the case within 2 working days following the beneficiary's or his/her representative's request, and issue either a denial notice or a notice explaining that the care would be, or is, covered.
    - Review after Discharge or When Beneficiary Was Not Admitted to Hospital The beneficiary or his/her representative may request review within 30 calendar days after receipt of the notice. The QIO completes this review within the timeframe specified for any retrospective review 30 calendar days. Once the QIO review is completed, either a denial notice or a notice explaining that the care would be, or is, covered is issued. In all cases of appropriately requested reviews, QIOs will formally determine if the hospital notification was valid, if the hospital's findings were valid, and if beneficiaries will be liable should they remain in the hospital. If the right to reconsideration is exercised, final notification does not occur until the reconsideration is complete.
- b. HINN 10 Hospital Requested Review (HRR): When a hospital determines that a beneficiary no longer requires an acute level of inpatient care, but the attending physician does not agree, the hospital may request a QIO review of the medical record—known as a hospital requested review (HRR). Hospitals must notify the beneficiary that the review has been requested. The QIO review of the hospital's determination considers whether or not continued inpatient care is needed (42 CFR 405.1208(b)(1), effective July 1, 2005).
- c. HINN 11 is used for non-covered items or services provided during an otherwise covered inpatient stay. The notice may be used to hold beneficiaries liable for certain non-covered services. The item or service at issue must be a diagnostic or therapeutic service excluded from Medicare coverage as medically unnecessary and the beneficiary must require continued inpatient hospital care.
- d. HINN 12 is a liability notice to be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay

after the appeal is completed or the time frame for requesting an expedited review is past. The compliance with this notice does not fall under the review authority of the QIO. (Refer to IMFM Policy)

- i. HINN 12 is designed to inform patients who remain in the hospital without seeking timely review of their liability for services provided after the date of the proposed discharge. Timely review (by midnight of the date of the proposed discharge) would limit the patient's liability to applicable deductibles and coinsurance until noon of the day after the discharge date on which the QIO notifies the patient of its agreement with the hospital. Failure to seek timely review appears to subject patients who remain in the hospital to liability for all Part A inpatient services provided after the date of the proposed discharge, unless the QIO determines otherwise.
- e. Beneficiary Payment Responsibility
  - i. HINNs do not address every aspect of beneficiary responsibility for payment. Beneficiaries remain liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services never covered by Medicare, even in periods where covered care is also delivered. Hospitals are not required to issue HINNs when the beneficiary will not be billed/liable.

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

 Administrative Policy: Important Message From Medicare and Notification of Hospital Discharge Appeal Rights 392

#### E. REFERENCE(S):

- Center for Medicare & Medicaid Services (2017, April 13). Beneficiary Notices Initiative (BNI). Retrieved from <a href="https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/">https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/</a>
- 2. Center for Medicare & Medicaid Services. Details for Title 100-04: Medicare Claims Processing Manual. Retrieved from <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending">https://www.cms.gov/Regulations-and-Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending</a>
- 3. Center for Medicare & Medicaid Services. Details for Title 100-10: Quality Improvement Organization Manual. Retrieved from <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019035.html?DLPage=2&DLSort=0&DLSortDir=ascending">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019035.html?DLPage=2&DLSort=0&DLSortDir=ascending</a>
- CMS Manual System (2005, October 14). Correction to Change Request 3949, Section 50.3.3 in IOM to Add 23x Type of Bill. Retrieved from <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R712CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Transmittals/downloads/R712CP.pdf</a>
- 5. Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary, Title 42 CFR 411.404 (1989).
- 6. Preadmission/Admission HINN. Medicare Claims Processing Manual, Transmittal 982



#### Administrative Policy-Manual **Patient Care**

**ISSUE DATE:** 

03/10

SUBJECT: Important Message from Medicare

and Notification of Hospital **Discharge Appeal Rights** 

**REVISION DATE: 03/10** 

POLICY NUMBER: 8610-392

**Department Review:** 

Administrative Policies & Procedures Committee Approval:

**Organizational Compliance Committee Approval:** 

Audit, Compliance and Ethics Committee Approval:

**Board of Directors Approval:** 

09/17

03/10

01/1009/17

02/1002/18

03/1004/18

#### A. **PURPOSE:**

- To comply with new-the Centers for Medicare and Medicaid Services (CMS) regulations regulatory requirements that hospitals notifyregarding discharge appeal netices to all patients enrelled in Medicare or Medicare Advantage insurance plans beneficiaries who are hospital inpatients about their hospital discharge rights. Applies to acute care inpatients only.
- All Medicare and Medicare-Advantage plan members will-be-presented with the CMS-R-193 upon admission to the hospital-or within two calendar days of admission. This will be performed by the registration staff as part of the admission paperwork.

#### B. **DEFINITION(S):**

- CMS-R-193 Form Rev 5-07:
- a.1. Important Netice-Message from Medicare (IMFM) CMS-R-193: A hospital inpatient admission notice given to all beneficiaries with Medicare, Medicare and Medicaid (dualeligible), Medicare and another insurance program, Medicare as a secondary payer. The newest version replaces all-previously issued revisions of the same form number, as well as the former Notice of Discharge and Medicare Appeal-Rights-(NODMAR) form.
  - Notice provides patient with information and directions on how to appeal their hospital discharge if they feel it is inappropriate.
- CMS-10066 form:
  - Detailed Notice of-Discharge. New form that-explains in writing the reasons for a patient's-discharge. To be completed by Case Manager or House Supervisor.
- 3.2. Quality Improvement Organization (QIO):
  - Organization that reviews all patient appeals. QIO enacted by Federal statute "to improve the efficiency, effectiveness, economy and quality or services delivered to Medicare Beneficiaries".
  - Health Services Advisory Group (HSAG) is the local QIO for TCMC.
- 3. Representative:
  - A representative is defined broadly to include individuals authorized to act on behalf of the beneficiary; someone acting responsibly on behalf of an incapacitated or incompetent beneficiary; or someone requested by the beneficiary to act as his or her agent.
- 4. Detailed Notice of Discharge (CMS-10066):
  - Hospitals must deliver the Important Message from Medicare to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal

rights. Beneficiaries who choose to appeal a discharge decision will receive a more detailed notice.

#### C. POLICY:

1. Tri-City Healthcare District (TCHD) must issue the IMFM within two (2) days of admission and must obtain the signature of the beneficiary or his/her representative. TCHD must deliver a copy of the signed notice to each beneficiary not more than two (2) days before the day of discharge. Follow-up notice is not required if delivery of the initial IMFM falls within two (2) calendar days of discharge, if the beneficiary is being transferred from one inpatient hospital setting to another inpatient hospital setting, or when a beneficiary exhausts Part A hospital days. TCHD must retain a copy of the signed notice.

#### D. PROCEDURE:

- 1. Initial Notice:
  - a. TCHD personnel must provide the IMFM at or near admission but no later than two (2) calendar days from the day of admission or at preadmission, but not more than seven (7) calendar days before admission, and obtain the signature and signature date of the patient or representative to indicate receipt of notice.
  - C.b. The original is given to the patient with a copy retained by the hospital.
- 1. The patient or representative will sign and date the form to acknowledge understanding of the contents.
  - a. The original will stay with the patient chart, the second copy will be kept with the financial paperwork, and the third will be given to the patient.
  - b. If the patient refuses to sign the form, it-will-be-noted on the form by the registrar.
  - c. The floor unit secretaries will monitor appropriate charts for compliance at set intervals.

    These charts that do not have a form attached at the time of admission will have the form-placed on the chart. Case management will obtain signatures as needed.

    i. The business office copy will be placed in a designated area for daily pickup.
- 2. Follow-Up Notice:
  - a. The follow-up IMFM must also be provided to the patient as soon as possible prior to discharge, but no more than two (2) days before.
    - i. When a discharge seems likely in one (1) to two (2) days, the follow-up notice should be given to the patient, so the patient has ample time to review and act on it.
    - ii. If the follow up notice is delivered on the day of discharge, the patient must be given at least four (4) hours prior to discharge to consider their rights.
  - b. TCHD must document delivery of the notice in order to demonstrate compliance with this requirement.
  - c. If TCHD delivers the follow-up notice, and the beneficiary status subsequently changes, so that the discharge is beyond the two (2) day timeframe, TCHD must deliver another copy of the signed notice again within two (2) calendar days of the new planned discharge date.
  - d. Follow up notification will be performed-within-48-hours of discharge from acute care. The patient will be presented with a second form CMS-R-193. The patient will sign the form to capture the date of notification. This will be coordinated through the patient's nurse or case management.
    - i. Patient should be presented the form as soon as possible, if discharge is less than 48 hours away.
- ii. If the patient stay is less than 48 hours, follow up-notification is not required.
- 2. If the patient does not want to appeal their discharge, no further action is required.
- 3. Beneficiary Refusal to Sign:
  - a. If the beneficiary refuses to sign the notice, the hospital should note the refusal and date of refusal on the form and this will be considered the date of notice.
- If the patient wants to appeal their discharge:

- Patient will-be required to call Health Services Advisory Group (HSAG) at-(800)-841-1602-to-file-their-appeal.
- b. Patient must call-HSAG-no-later-than-the-day-of-discharge.
  - i. Hospital-staff-should assist patient with the filing process if needed.
- Case Management (weekdays 0800-1630) or the House Supervisor (Weekends and after hours) will be notified of the appeal.
- Upon notification of the appeal, the Case-Manager-or-House-Supervisor will provide the patient with a completed CMS-10066.
  - i. Form provides detailed reason(s) for discharge.
  - ii. Form copy will be provided to HSAG by the hospital.
- Appeal should take no more than one day after HSAG receives the necessary information.
- f. During the appeal process, patient will continue stay in present accommodations.
- g. If patient appeal is successful, Medicare will continue to cover the patient's acute care.
- h. If the QIO finds the patient is ready for discharge, the Medicare will continue to cover patient's stay until noon of the day following the QIO-notification.
- 4.——If the patient misses the appeal deadline, they may still ask for a review by contacting either the QIO (for traditional Medicare) or their health plan (if Medicare Advantage).
  - a. Patient may be charged for services provided after planned discharge date.
- 4. Medical Record Documentation:
  - a. TCHD should place a copy of the initial notice in the patient's medical record.
  - b. TCHD must document timely delivery of the follow-up copy of the IMFM in the patient records, when applicable.
  - c. TCHD should also document any attempted contact with beneficiary representatives, including telephone calls, messages and subsequent certified mail.
- 5. Copies:
  - a. IMFM form (Initial Notice):
    - i. 2 Copies:
      - 1. Original notice for patient is in the medical record
      - 2. Patient's copy
  - b. IMFM form (Follow up Notice):
    - i. 2 copies:
      - 1. Original notice for patient is in the medical record
      - 2. Patient's copy
  - c. Detailed Notice:
    - i. 2 copies:
      - 1. Original notice for hospital
      - 2. Patient's copy
    - ii. Additional copies may be needed if the patient requests a review, as the QIO will require a copy.
  - d. Prior to the patient signing and dating an IMFM and/or Detailed Notice of Discharge, TCHD must ensure the patient comprehends the contents of the notice.
  - e. Notices should not be delivered in an emergency medical situation.
- 6. Expedited Reviews:
  - a. A patient has a right to request a review of the discharge decision, by asking for an expedited review by the QIO when the hospital, with physician/Allied Health Professional (AHP) concurrence, determines that inpatient care is no longer necessary. The process is as follows:
    - i. The patient submits a request for review to the QIO no later than midnight of the day of discharge that has been ordered by the physician/AHP.
    - ii. The request may be in writing or by telephone and must be before the patient leaves the hospital.

- 1. If the request is not in this timeframe, and the patient remains in the hospital, he or she may request a review at any time, but will be held responsible for the charges incurred after the date of discharge ordered.
- iii. When the patient requests a review prior to midnight the day of discharge, the patient is not financially responsible for inpatient hospital services (except coinsurance and deductibles) furnished before noon the day after the patient receives notification of the determination from the QIO.
- iv. If the QIO does not agree with the patient, the liability for continued services begins at noon of the day after the QIO notifies the patient.
- v. If the QIO does agree with the patient, the patient is not financially responsible for continued care, until the hospital once again determines that the patient no longer requires inpatient care, secures the concurrence of the physician responsible for the patient or the QIO and notifies the patient with a follow-up copy of the IMFM.

#### D.E. FORMRELATED DOCUMENT(S)-REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:

- 1. Important Message from Medicare (IMFM)
- 2.1. CMS-R-193 An Important Message From Medicare About Your Rights
- 3.2. CMS-10066 Detailed Notice of Discharge

#### F. REFERENCE(S):

4.1. CMS Transmittal 1257, May 2007, CR 5622

Important Message from-Medicare (IMFM)

### **IMPORTANT MESSAGE FROM MEDICARE**

### Important-Message-From Medicare (IMFM)

- Is a CMS requirement that is about patient's discharge rights.
- The purpose of this letter is to inform the patient that he/she will be discharged in 1 2 days and have the right to:
  - Evaluate the appropriateness of the discharge plans
  - Communicate with their physicians, care manager, and family, and decide if he/she agrees with the discharge
- If the patient-does not agree with the discharge plan, then the patient has a right to appeal the discharge-plans.
- At the time of providing the IMFM to the patient-and/or family member, it is important to highlight the telephone number (877) 588-1123.

### Process Review:

### REGISTRATION

- Obtains patient-signature on the initial IMFM-at-admission and gives patient a signed copy.
   Registration-scans-the original copy in the-patient's medical chart.
- If a patient appeals their discharge and the QIO upholds their decision for discharge, then the financial counselor will explain financial liability to the patient/representative.

### CASE MANAGEMENT DEPARTMENT

- Obtains the patient signature on the follow-up-notice IMFM and gives the patient a signed copy. This is done on Mondays Wednesdays Fridays. Place the IMFM into the chart so Medical Records can scan it in once the patient discharges.
- If the QIO-notifies TCMC that the patient has appealed their-discharge, the Case-Manager will issue a Detailed-Notice of Discharge. Once the form is completed and delivered to the patient, the original-form will be placed in the chart and the RN-CM will email the IMFM to Registration to-scan-into the chart in preparation for the appeal. Email-to: Jessica Ruh, David-Benitez, Nina Luna, and Elizabeth Atiga.

### **NURSING**

- At the time of discharge, if the patient indicates they do not feel they are ready for discharge, or disagree with the discharge plan, contact/consult the Case Management Department.
- If patient appeals his/her discharge, contact the Case Management Department to notify the physician of the Appeal.

The IMFM form has been revised 8/17and is available in both English-and Spanish. Order-form CMS-R-193.

# CMS-R-193 An Important Message From Medicare About Your Rights

Department of Health & Human Services Centers for Medicare & Medicaid Services OMB Approval No. 0938-0692

Patient Name: Patient ID Number: Physician:

An Importa	int Message	From	Medicare	About	Your	Rights
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### As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you
  may need after you are discharged, if ordered by your doctor. You have a right to know about these
  services, who will pay for them, and where you can get them.
- · Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

### Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

### If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement
  Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide
  whether you are ready to leave the hospital.
  - If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to
  pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

Please sign and date here to show you received this not	ce and understand your rights.
Signature of Patient or Representative	Date/Time

### Steps To Appeal Your Discharge

Step 1: You must contact the QIO no later than your planned discharge date and before you leave the
hospital. If you do this, you will not have to pay for the services you receive during the appeal (except
for charges like copays and deductibles).

Here is the contact information for the QIO:			
Name of QIO (in bold)			
Telephone Number of QIO			

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting the QIO.
- The name of this hospital is:

Hospital Name	Provider ID Number
	 l

- Step 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other
  Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to
  be discharged.
- Step 3: The QIO will ask for your opinion. You or your representative need to be available to speak
  with the QIO, if requested. You or your representative may give the QIO a written statement, but you
  are not required to do so.
- · Step 4: The QIO will review your medical records and other important information about your case.
- Step 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day <u>after</u> the QIO notifies you of its decision.

### If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- · You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048. CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: <a href="mailto:AltFormatRequest@cms.hhs.gov">AltFormatRequest@cms.hhs.gov</a>.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 9938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop CI-26-05, Baltimore, Maryland 21241-1850.

# CMS-10066 Detailed Notice of Discharge

Patient Name: Patient ID Number: Physician:	OMB Approval No. 0938-1019 Date Issued:
{Insert	Hospital or Plan Logo here}
Detailed	l Notice Of Discharge
by Medicare to review your case. This notice your managed care plan (if you belong to one	mprovement Organization (QIO), an independent reviewer hired gives you a detailed explanation about why your hospital and ), in agreement with your doctor, believe that your inpatient . This is based on Medicare cal condition.
This is not an official Medicare decision. Temprovement Organization (Q1O).	The decision on your appeal will come from your Quality
Medicare Coverage Policies:	
	npatient hospital services that are not medically necessary d in another setting. (Refer to 42 Code of Federal Regulations,
Medicare Managed Care po	olicies, if applicable: {insert specific managed care policies}
Other	{insert other applicable policies}
Specific information about your current	nt medical condition:
	ents sent to the QIO, or copies of the specific policies or criteria{insert hospital and/or
CMS does not discriminate in its programs and please call: 1-800-MEDICARE or email: AltF	d activities. To request this publication in an alternative format, formatRequest@ems.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security

Boulevard, Alln: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21 244-1850.

CMS 10066 (Exp. 10/31/2019)



### Administrative Policy-Manual Compliance

**ISSUE DATE:** 

01/13

**SUBJECT: Medical Directorships** 

**REVISION DATE(S): 07/17** 

POLICY NUMBER: 8750-572

**Department Approval:** 

03/1607/17

Administrative Policies and Procedures Approval:

07/17

**Medical Executive Committee Approval:** 

08/17

**Organizational Compliance Committee Approval:** 

02/18

Audit, Compliance and Ethics Committee Approval:

<del>02/13</del>04/18

**Board of Directors Approval:** 

02/13

### A. PURPOSE:

The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls, that:

- All medical directorship arrangements are undertaken only when Tri-City Healthcare District (TCHD) has a legitimate need for a physician to provide the type and quantity of medical directorship services contemplated to promote quality, cost-effective care, or to fulfill other legitimate needs of the DistrictTCHD;
- b. The remuneration paid pursuant to all medical directorship arrangements is commercially reasonable and consistent with fair market value for the medical directorship services furnished;
- All medical directorship services furnished pursuant to a medical directorship C. arrangement are adequately and timely documented by the medical director;
- d. All medical directorship arrangements comply with applicable laws and regulations. including the federal Anti-Kickback law and the Stark law; and
- e. Under no circumstance will a directorship arrangement involve TCHD paying remuneration to a physician, directly or indirectly, with the intent to induce the referral of patients or generation of business.

#### B. **GENERAL POLICIES:**

TCHD may not enter into a medical directorship arrangement without an objectively determined, legitimate need for the medical directorship services contemplated by the medical directorship arrangement.

### C. **DEFINITION(S):**

- Medical Directorship Arrangement: means an arrangement pursuant to which a provider provides remuneration to a physician for the performance of medico-administrative services furnished by the physician on behalf of the provider.
- 2. Physician: means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.
- 3. Medical Directorship Services or Services: mean medico-administrative services furnished by a physician on behalf of a provider, consistent with this policy
- 4. Remuneration: means anything of value, including, but not limited to, cash, items, or services.
- Fair Market Value: means the value in arm's-length transactions, consistent with the 5. compensation that would be included in a service agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position

- to generate business for the other party at the time of the service agreement.
- 6. Medical Director: means a physician performing medical director services as an independent contractor of a provider pursuant to a medical director agreement.
- 7. Federal health care program: means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, Tri-Care/VA/ CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corps Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs), and Section 1011 Requests.

### D. SCOPE OF POLICY:

- 1. This policy applies to
  - a. Tri-City Healthcare-DistrictTCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"):
  - b. Any other entity or organization in which Tri-City Healthcare DistrictTCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tri-City Healthcare-DistrictTCHD or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tri-City Healthcare District Facility") (collectively, "Tri-City Healthcare District").

### E. PROCEDURES

- Hospital Implementation: TCHD shall ensure that this policy is adhered to by following all of the steps set forth in this policy.
  - a. Step 1 Identify the Need for the Services
    - i. TCHD's clinical and/or administrative staff shall identify any mandates or recommendations from legal authorities (e.g., Medicare requirement for a director of a rehabilitation unit, 42 C.F.R. § 412.29(f), inpatient psychiatric services, 42 C.F.R. § 412.27(d), nuclear medicine services, 42 C.F.R. § 482.53(a), respiratory care services, 42 C.F.R. § 482.57(a), skilled nursing facility, etc.), government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or the provider's medical staff or governing board, and any other evidence, indicating that one or more physicians should be retained to furnish the medical directorship services contemplated by the medical directorship arrangement in order to promote quality, cost-effective care or fulfill other legitimate needs.
  - b. Step 2 Project the Number of Hours Required
    - i. TCHD's clinical and/or administrative shall make an objective determination that the number of hours of medical directorship services contemplated by the medical directorship arrangement is reasonable and necessary to accomplish TCHD's legitimate needs for the medical directorship services. TCHD must prepare a written projection of the number of hours reasonably necessary to discharge the medical directorship services based on:
      - any benchmarks referenced by legal authorities, government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or TCHD's medical staff or governing board;
      - 2) data from time logs; and/or
      - other factors, such as the number of physicians with medical staff privileges in the applicable specialty, the size of the applicable department, unit or service line, the average daily census of the applicable department, unit or service line, and the medical acuity and needs of the patients in the applicable department, unit or service line.
  - Step 3 Demonstrate the Professional Qualifications of the Proposed Medical Director

- i. TCHD shall objectively determine that the medical director is qualified and capable of performing the medical directorship services. To demonstrate each medical director's qualifications, TCHD must:
  - Verify that each medical director is qualified and capable of furnishing the medical directorship services (i.e., the medical director must confirm that he/she does not have other preexisting obligations which would limit or restrict the medical director from fully performing the medical directorship services);
  - 2) Obtain a copy of each proposed medical director's curriculum vitae;
  - Verify, through a search of the U.S. General Services Administration's (GSA) Lists of Parties Excluded from Federal Procurement and Non-procurement Programs, the Office of Inspector General's (OIG) of the Department of Health and Human Services List of Excluded Individuals/Entities, and any applicable state healthcare exclusion list, that each medical director (and, in the context of a medical directorship agreement with a group practice, the group) has no exclusions, suspensions or debarments from participation in any Federal health care program.
- d. Step 4 Calculate Fair Market Value Compensation
  - i. TCHD must objectively determine and document that the remuneration being offered to the physician for the medical directorship services is consistent with fair market value. In order to ensure that the remuneration is consistent with fair market value, TCHD shall derive an hourly rate to be utilized in calculating the remuneration by obtaining a fair market value opinion from a reputable and qualified fair market value consultanttaking the average-salary, not to exceed fair market value, for the physician's specialty of the most recent publications of two national salary-surveys and dividing the resulting figure by 2,000 hours (the "Hourly Rate").
  - ii. Notwithstanding the foregoing, in exceptional cases, if TCHD's administrative or clinical staff believes that a compensation amount that differs from and exceeds the average hourly compensation derived above is fair market value, and all other requirements of this policy are met, they may seek approval of the proposed hourly compensation from TCHD's Chief Compliance Officer or legal counsel.
- e. Step 5 Review the Requirements of the Medical Directorship Agreement
  - TCHD shall confirm that the proposed medical directorship arrangement will meet all of the following terms:
    - The medical directorship arrangement shall be evidenced by a written medical directorship agreement contained in the Contract Database signed and dated by all parties. There shall be no oral or implied understandings that are not incorporated in the written agreement. In the event TCHD desires for a physician to serve as a medical director of more than one department, TCHD shall prepare separate agreements, require separate logs and make separate payments to the physician to ensure that expenses are appropriately allocated for cost reporting purposes.
    - The medical directorship agreement shall require that the medical director contemporaneously record his or her medical directorship services on the medical director activity log/timesheet.
    - 3) Prior to TCHD's entrance into an agreement with a physician group for medical director services, the group practice must furnish a written representation and warranty that (1) the compensation of each physician affiliated with the group including, without limitation, shareholders, members, partners, employees and independent contractors (a) will be

commercially reasonable and consistent with fair market value; and (b) will not vary with, or reflect or relate to – either directly or indirectly – the volume or value of patient referrals (actual or anticipated) to, or other business generated for, the hospital; and (2) that the group practice agrees to comply with all relevant claims submission and billing laws and regulations.

- The medical directorship agreement shall set forth with specificity all of the medical directorship services to be furnished by each medical director.
- 5) The designated duties shall not include:
  - a) (1) advertising-Advertising or marketing on behalf of TCHD, (2)
  - b) elinical Clinical duties for which a proposed medical director or an affiliated group practice is permitted to bill and retain payment from patients or third party payers, (3)
  - c) duties-Duties which a proposed medical director is obligated to perform free of charge as a result of his or her licensure or medical staff membership, including, without limitation, attendance at meetings that the proposed medical director is otherwise required to attend, such as regularly scheduled or mandatory medical staff or governing board meetings, (4) e
  - Continuing medical education (unless approved by TCHD's Compliance Officer or legal counsel), (5) r
  - e) Review of medical journals and periodicals, (6) a
  - f) Any entertainment activities, (7) e
  - g) Completing time logs, including, without limitation, activity logs, or (8) d
  - 4)h) Duties that involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. The designated duties shall be specific to the medical directorship arrangement in question.
- 5)6) The term of the medical directorship agreement shall be at least one year, but shall not exceed five years. The medical directorship agreement may contain an automatic month-to-month renewal provision for up to six (6) months provided the arrangement is on the same terms and conditions as the immediately preceding agreement but shall otherwise require affirmative renewal by mutual written agreement of the parties.
- 6)7) The medical directorship agreement shall provide that, in the event the agreement is terminated during the first year of the term, then neither the provider and any medical director, nor the provider and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first twelve months of the intended term of the agreement. Notwithstanding, if the agreement does not contain similar language and the agreement is terminated during the first twelve months of the term, then neither the provider and any medical director, nor the provider and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first year of the intended term of the agreement.
- 7)8) The medical directorship arrangement shall not be conditioned on any proposed medical director or, in the event of a group agreement, the group practice or any physician affiliated with the group practice, (a) making referrals to TCHD, (b) being in a position to make or influence referrals to TCHD, or (c) otherwise generating business for TCHD; provided, however, that the medical directorship agreement shall require that the proposed medical director obtain and maintain active staff

- privileges at TCHD.
- 8)9) The remuneration paid to any medical director and/or affiliated group practice under the medical directorship agreement shall not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any actual or expected referrals to, or business otherwise generated for, TCHD by any medical director or, in the event of a group agreement, by the group practice or any individual or entity affiliated with the group practice.
- 9)10) No medical director, or, in the event of a group agreement, physician affiliated with the group practice, shall be precluded or restricted in any way from (a) establishing staff privileges at any other hospital or facility, (b) referring patients to or utilizing the services of any other hospital or facility, or (c) otherwise generating business for any other hospital or facility.
- 40)11) The medical directorship agreement shall provide that remuneration shall not be paid to a medical director and/or affiliated group practice (as appropriate) for a given payment period unless the medical director furnishes adequate, contemporaneous documentation indicating he or she fully discharged all designated duties during the payment period.
- 41)12) Except for terminations permitted by the medical directorship agreement, or unless otherwise approved by legal counsel, the remuneration set forth in the medical directorship arrangement shall not be renegotiated, renewed, extended or amended after the medical directorship agreement is executed by the parties.
- 42)13) Each medical director and any affiliated group practice shall agree to treat in a nondiscriminatory manner patients receiving medical benefits or assistance under any federal health care program.
- 43)14) Other than as specifically provided for in this policy, the remuneration shall not directly or indirectly benefit any individual or entity in a position to make or influence patient referrals to, or otherwise generate business for, the provider.
- 44)15) The directorship agreement will require the physician and the group practice, if applicable, to abide by TCHD's Code of Conduct and Compliance Program. The physician and group, if applicable, shall complete any training required under Compliance Program.
- f. Step 6 Complete TCHD's Contract Review Process
  - No medical directorship agreement shall be executed until completion of TCHD's Contract Review Process as defined in the Contracting Manual.
- g. Step 7 Documenting the Medical Director's Completion of Duties Prior to Payment
  - i. Each medical director shall be required to contemporaneously document his or her time spent performing his or her designated duties under a medical director agreement. Such documentation shall be submitted to Accounts Payable on a monthly basis, in the form of the activity log/time sheet attached to the medical directorship agreement. Each medical director shall personally complete, sign and date his or her activity log. Only time that a medical director spends on his or her designated duties under a medical directorship agreement shall be reimbursable, and all other time, including, but not limited to, time relating to the medical director's private practice, shall not be reimbursable.
  - ii. TCHD shall not furnish remuneration to a medical director for a given month unless and until:
    - The medical director legibly completes in all material respects the activity log/time sheet applicable to such month;
    - 2) The medical director signs, dates and submits the activity log/time sheet applicable to a given month by the date set forth in the directorship

agreement;

- 3) The Department/Unit Director/Supervisor shall review and sign the logs for applicability of reported activities;
- iii. A medical director's failure to sign, date and submit his or her activity log applicable to a given month by the due date set forth in the agreement shall result in a forfeiture of compensation due for that particular month.
- iv. If in any given month while a medical directorship agreement is in effect, a medical director provides fewer hours of medical director services than the projected number of hours, then the medical director or group practice (as appropriate) shall be compensated at the hourly rate for each hour of medical directorship services actually provided as set forth in the medical directorship agreement.
- v. The Chief Financial Officer (CFO) is responsible for ensuring that medical directorship payments are recorded in accordance with accounting policies and are charged only to accounts designated for such arrangements.
- 2. Renewal/Amendment
  - Renewal or amendment of the agreement is permitted only through a full review of the entire arrangement through the process as provided above.
- Documentation Retention
  - a. The Contracts Manager-shall-retain-all documents, packages, agreements, and other documentation relating to each medical director agreement in accordance with TCHD's document-management policies. All Medical Director Contracts and associated documents will be entered into the appropriate TCHD Contract Retention System (such as MediTract).
- 4. Enforcement
  - a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject the employee to appropriate disciplinary action pursuant to all applicable policies and procedures, up to and including termination. Such disciplinary action may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

### B. REFERENCE(S):

- 1. Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
- 2. Definition of Immediate Family Member, 42 C.F.R. § 411.351
- 3. Fair Market Value exception, 42 C.F.R. § 411.357(I)
- 4. Inpatient psychiatric services, 42 C.F.R § 412.29(f)
- Nuclear medicine services, 42 C.F.R § 412.27(d)
- 6. Personal services and management contracts 42 C.F.R. § 1001.952(d)
- 7. Personal Services Arrangements exception, 42 U.S.C. § 1395nn(e)(3); 42 C.F.R. § 411.357(d)
- 8. Respiratory care services, 42 C.F.R § 482.53(a)
- Safe Harbor for Personal Services and Management Contracts
- 10. Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens
- 11. Skilled nursing facility, 42 C.F.R § 482.57(a)
- 12. Stark Law, 42 U.S.C. § 1395nn, and implementing regulations
- 13. TCMCHD Handbook for Contracting-Handbook



### Administrative Policy Compliance

**ISSUE DATE:** 

May 31, 2003/12

SUBJECT: Monitoring Compliance/ Auditing

and Reporting; Annual Compliance

Work Plan

**REVISION DATE(S):** 

POLICY NUMBER: 8750-552

**Department Approval:** 

11/17

Administrative Policies and Procedures Approval:

11/17

**Organizational Compliance Committee Approval** 

02/18

Audit, Compliance and Ethics Committee Approval:

04/18

**Board of Directors Approval:** 

03/12

### A. **PURPOSE:**

Pelicy 8750-552To provides (1) a statement of Tri-City Healthcare District's (DistrictTCHD) policy with respect to the development of an annual compliance work plan ("Work Plan"), and (2) to ensure that the District's practices are consistent with its stated policy, a statement of the DistrictTCHD's policy of conducting periodic and ad hoc compliance reviews and audits of the compliance program and the DistrictTCHD's performance under the compliance program.

### **INTRODUCTION:**

Ongoing monitoring and evaluation is essential to the development and maintenance of an effective compliance program. By developing annual work plans and conducting audits and reviews in response to reported concerns, the compliance program ensures that the DistrictTCHD meets its commitment to conduct business consistent with fundamental ethical standards and to comply with all applicable laws and regulations. Tri-City Healthcare-District's-Chief Compliance Officer (with the assistance of the Compliance Committee, outside consultants and counsel, as necessary) will recommend and facilitate, as appropriate, the identification of compliance related risk areas of relevance to hospitals, health systems, and the health care industry in general. These risk areas will be documented in an annual Work Plan.

### C. GENERAL-POLICYANNUAL COMPLIANCE WORK PLAN:

- The District TCHD's Chief Compliance Officer (CCO) (with the assistance of the Director of Compliance Audit & and Monitoring, Compliance Committee, outside consultants and counsel, as necessary) will recommend and facilitate, as appropriate, the identification of compliance-related risk areas of relevance to hospitals, health systems, and the health care industry in general. These risk areas will be documented in an annual work plan.
- <del>1.</del>2. Risk areas may be identified through any number of channels including, by way of example:
  - the Office of Inspector General's (OIG) annual work plan;
  - recent OIG and/or Department of Justice ("DOJ") enforcement actions and settlements; b.
  - C. audit reports published by the OIG;
  - d. health care news reports on recent or ongoing government investigations in the health care space;
  - e. payor denial reports;
  - f. internal District reviews:
  - exit surveys/interviews with employees and contractors; and g.

- h. Confidential Reporting Line (Values Line) reports.
- 2.3. The work plan shall be developed by the Director of Compliance Audit and Monitoring under the supervision of the Chief-Gempliance-OfficerCCO, who shall:
  - implement processes with the assistance of various District TCHD departments (such as the Finance Department, by way of example) for assessing the District TCHD's compliance with respect to the risk areas identified in the work plan;
  - b. supervise the reviews and assessments related to each risk area;
  - c. based on the reviews and assessments, determine whether to develop or enhance training and/or policies related to the risk areas; and
  - d. where appropriate, identify and implement corrective actions.

### 3.4. Approval

- a. The annual work plan will be presented to and be approved by senior management and the District TCHD Board of Directors (Board).
- b. The Beard will ensure that tThe Ghief Compliance OfficerCCO is will be afforded a budget that will enable him or her to implement the work plan.

### a.D. COMPLIANCE PROGRAM EFFECTIVENESS REVIEWS:

- 1. The Chief Compliance Officer CCO and Director of Compliance Auditing and Monitoring (with the assistance, as appropriate, of outside independent review consultants and/or counsel, as described in Section 3.C-below) shall develop a protocol for performing periodic reviews of the District TCHD's policies and practices to determine the effectiveness of the compliance program. The protocol shall assist in the assessment of the following elements of the compliance program:
  - a. Compliance program policies (including any requirements relating to documentation)
  - b. Effectiveness of compliance training and education provided to all District-TCHD employees
  - c. Appropriateness of the monitoring and auditing conducted by the compliance program
  - d. Awareness of the compliance program reporting mechanisms, including use of the DistrictTCHD's values line
  - e. Promptness of investigations of reported compliance concerns
  - e.f. Process for the development of corrective actions in response to reported concerns

# E. FOCUSED REVIEWS AND AUDITS:

- 1. When suspected noncompliance with laws and/or policies is reported, the Chief Compliance OfficerCCO and/or the Director of Compliance Auditing &and Monitoring shall initiate a formal review and/or audit of the conduct in question.
  - a. Technique:
    - i. The protocol developed by the Chief Compliance OfficerCCO may provide for sampling, full claim review, contract review, pre-billing reviews, email and other correspondence review or other appropriate measures.
  - b. Review Assistance:
    - i. The compliance program reviews and audits shall be conducted under the supervision of the Chief Compliance OfficerCCO, Director of Compliance Audit and Monitoring and/or legal counsel, as appropriate. In addition to, or in lieu of, internal reviewers, outside independent review consultants and/or counsel may be used to assist, as appropriate.
  - c. Reviewer Qualifications and Independence:
    - i. The entity or individual(s) conducting the compliance program reviews and audits (whether internal or external to the DistrictTCHD) shall be independent insofar as they must be able to review the DistrictTCHD's practices and make objective, independent determinations as to the accuracy or effectiveness of those practices.

- ii. The reviewers/auditors shall have the qualifications and experience necessary to adequately identify potential issues related to the subject they are reviewing.
- iii. The reviewers/auditors shall have access to the resources and information necessary to conduct the compliance program reviews and audits, including full access to documents and employees.

### b.F. DOCUMENTATION:

- In-conformity with generally-accepted compliance review-procedures, The final version of work papers, notes and other documentation generated in connection with every review shall be maintained in the compliance program files.
- d.2. After completing each annual work plan, the Chief Compliance OfficerCCO shall furnish senior management and the Board of Directors-with a written report of principal findings, conclusions and recommendations.
- e-3. The review findings, conclusions and recommendations (including the written report) shall be documented in the compliance program files.

### b.G. DOCUMENTATIONRELATED DOCUMENT(S):

- 1. Administrative Policy: Compliance Program Overview 8750-532
- 2. Administrative Policy: Monitoring Compliance Auditing & Reporting Exit Interviews 8750-554
- 3. Tri-City Healthcare District Code of Conduct

### H. <u>REFERENCE(S):</u>

- 1. Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.
- 4-2. Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.



# Administrative Policy Compliance

DELETE: Incorporated into Administrative Policy: 552 Monitoring Compliance/ Auditing and Reporting; Annual Compliance Work Plan

ISSUE DATE:

May 31, 2012

SUBJECT: Monitoring

Compliance/Auditing and Reporting; Compliance Reviews and Audits

**REVISION DATE:** 

POLICY NUMBER: 8750-553

Department Approval: 11/17
Administrative Policies and Procedures Approval: 11/17
Organizational Compliance Committee Approval 02/18
Audit, Compliance and Ethics Committee Approval: 04/18
Board of Directors Approval: 03/12

### A. PURPOSE:

1. — Policy-8750-553 provides (1) a statement of Tri-City Healthcare District's policy with-respect to conducting-periodic and ad hoc compliance reviews and audits of the Compliance Program-and the District's performance under the Compliance Program.

# B. <u>COMPLIANCE PROGRAM REVIEWS</u>:

- 1. <u>Subject Matter Areas</u>. The Chief Compliance Officer-(with-the-assistance, as appropriate, of outside independent review consultants and/or counsel, as described in Section 3.C below) shall develop a protocol for performing periodic and ad-hoc reviews and audits of the District's policies and practices. This protocol shall provide for reviews/audits-of-at-least the following areas:
  - a.——Compliance with the following Compliance Program Policies (including any requirements relating to documentation):
    - i. Chief Compliance Officer: CCO Policies
    - ii.- --- Hiring-and-Employment: HE-Policies
    - iii. Education and Training: ET Policies
    - iv. Monitoring-Compliance: MCA Policies
      - ——Communicating and Reporting Misconduct/Irregularities: CRCC Policies
    - vi. Responding to Compliance Issues/Corrective Action: RCI Policies
- Compliance with the Policies developed for specific risk areas identified by the Chief-Compliance Officer.
- 3. Compliance with particular laws and regulations with respect to compliance matters or concerns that may arise from time to time.
  - a.— <u>Technique</u>. The protocol developed by the Chief Compliance Officer-may-provide-for-sampling, full-claim review, contract review, pre-billing-reviews, email and other-correspondence review or other appropriate-measures.
  - b. Review Assistance. The Compliance Program reviews and audits shall be conducted under the supervision of the Chief Compliance Officer and/or legal counsel, as appropriate. In addition to, or in lieu of, internal reviewers, outside independent review consultants and/or counsel may be used to assist, as appropriate.
  - Reviewer Qualifications and Independence.
    - The entity or individual(s) conducting the Compliance Program reviews and audits (whether internal or external to the District) shall be independent

- insofar as they must be able to review the District's practices and make ebjective, independent determinations as to the accuracy or offectiveness of those practices.
- ii. The reviewers/auditors-shall have the qualifications and experiencenecessary to adequately identify potential issues related to the subject theyare reviewing.
- iii. The reviewers/auditors shall have access to the resources and information necessary to conduct the Compliance Program reviews and audits, including full access to documents and employees.

### C. <u>DOCUMENTATION</u>:

- The reviewers/auditors shall document their findings and share them with the Chief-Compliance Officer. The Chief Compliance Officer shall then consider appropriate next-steps, including additional reviews and/or any corrective action-needed to achieve-compliance with the Compliance Program-Policies or Code of Conduct. The Chief-Compliance Officer shall report his/her-conclusions to the Compliance Committee, the Board of Directors and the CEO.
- 2.1. In conformity with generally accepted-compliance-review and audit procedures, final copies-of-work-papers, notes and other documentation-generated in connection with every Compliance-Review and the findings and conclusions shall be maintained in the Compliance-Program files, consistent with the District's document-retention policies.



# Administrative Policy Compliance

ISSUE DATE: 04/13 SUBJECT: Physician and Allied Health

**Professional Service Contracts** 

REVISION DATE(S): 04/13 POLICY NUMBER: 8750-580

Department Approval: 07/17
Administrative Policies and Procedures Approval: 07/17
Medical Executive Committee Approval: 08/17
Organizational Compliance Committee Approval: 02/18
Audit, Compliance and Ethics Committee Approval: 04/18
Board of Directors Approval: 04/13

### A. PURPOSE:

- 1. The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls:
  - all personal-professional services arrangementscontracts are undertaken only when
     Tri-City Healthcare District (TCHD) has a legitimate need for a physician or allied
     health professional to provide the type and quantity of services contemplated to promote
     quality, cost-effective care or to fulfill other legitimate needs of the District;
  - b. the remuneration paid per all personal professional services arrangements contracts is commercially reasonable and consistent with fair market value for the services furnished;
  - c. all services furnished per a personal professional services arrangement are adequately and contemporaneously documented by the physician or allied health professional;
  - d. all personal professional services arrangements contracts comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law; and
  - e. under no circumstance will a personal professional services arrangement involve paying remuneration to a physician, directly or indirectly, with the intent to induce the physician to refer patients to, or otherwise generate business for, TCHD.

### B. GENERAL POLICIES:

1. TCHD may not enter into a professional services arrangement without an objectively determined, legitimate need for the services contemplated by the professional services arrangement. Prior to entry into, or renewal of, a professional services arrangement, the TCHD Department requesting such arrangement follow TCHD's Contracting Manual, and provide an explanation regarding the need for the services, the need for payment from TCHD rather than having the physician bill third party payers, and the number of hours contemplated under the agreement. These contracts are subject to Board approval.

### C. **DEFINITION(S)**:

- "Professional Services Arrangement": -means an arrangement pursuant to which TCHD
  provides remuneration to a physician for the performance of professional medical, medicoadministrative, or consulting services furnished by the physician on behalf of TCHD, but does
  not include services otherwise covered by other policies, such as Medical Directorships.
- "Physician":-means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor. For purposes of this policy, "physician" also includes allied health professionals.
- 3. "Remuneration":-means anything of value, including, but not limited to, cash, items, or services.

- 4. "Fair Market Value":-means the value in arm's-length transactions, consistent with the compensation that would be included in a services agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party at the time of the service agreement
- 5. "Federal health care program": means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to, Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, TRICARE/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.
- 6. "Group Practice": means two or more Physicians who practice medicine through a single legal entity, using a common trade name and a common tax identification number, including a faculty practice plan or other physician group practice organization affiliated with an academic medical center.

### D. SCOPE OF POLICY:

- 1. This policy applies to
  - a. (1)-TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
  - **b.** (2) any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and
  - E.c. (3)-any hospital or healthcare facility in which Tri-City Healthcare District or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").

## E. PROCEDURES:

- Step 1 Identify the Need for the Services
  - a. The TCHD Department shall identify why the services are best contracted for and compensated by TCHD rather than having the physician bill a payor independently for the service.
  - b. In the case of on-call services, the Department
    - i. shall identify any mandates or recommendations from legal or regulatory authorities (e.g., EMTALA, Joint Commission, other state regulations), and any other evidence, that on-call coverage in the particular specialty or subspecialty should be secured,
    - ii. shall also document whether such on-call services are required without compensation under the medical staff bylaws or rules and regulations; and
    - iii. shall also document prior efforts to obtain such services on a voluntary basis.
- 2. Step 2 Project the Number of Hours/Specific Services Required
  - a. Medico-administrative and consulting services should generally be contracted for based on a fixed number of hours per week or month. TCHD shall not enter such contracts until after having determined that the number of hours of medico-administrative or consulting services contemplated by the personal services arrangement is reasonable and necessary to accomplish TCHD's legitimate needs for the services. The requesting Department must prepare a projection of the number of hours reasonably necessary to discharge the medico-administrative or consulting services based on:
    - i. any benchmarks referenced by legal authorities, government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or the Tri-City Health Care District entity's medical staff or governing board;

- ii. data from time logs; and/or
- iii. other factors, such as a detailed description of the scope of the consulting project.
- b. Professional medical services should be contracted for either on an hourly basis or on a per unit of service basis. Hourly services must meet the requirements above. Services rendered on a per unit of service basis should be identified by Physician using a CPT code number and descriptor.
- c. On-call services should be contracted for on the basis of 24-hour coverage.
- 3. Step 3 Demonstrate the Qualifications of the Physician
  - a. TCHD must determine that the physician is qualified and capable of performing the services by:
    - verifying that the physician is capable of furnishing the services (i.e., the physician must confirm that he/she does not have other preexisting obligations which would limit or restrict the physician from fully performing the services);
    - ii. obtaining a copy of the physician's curriculum vitae;
    - iii. verifying, if not evident from existing information, that Physician is currently licensed in California; verifying that the physician is qualified to provide the services (e.g., that the physician possesses relevant training and/or experience in the area); and
    - iv. verifying, through a search of the U.S. General Services Administration's (GSA) Lists of Parties Excluded from Federal Procurement and Non-procurement Programs, the Office of Inspector General (OIG) of the Department of Health and Human Services List of Excluded Individuals/Entities, and any applicable state healthcare exclusion list, that the physician (and, in the context of a personal services agreement with a group practice, the group) has no exclusions, suspensions or debarments from participation in any federal health care program.
- 4. Step 4 Calculate Fair Market Value Compensation
  - a. TCHD may not enter into a personal services arrangement without first objectively determining and documenting that the remuneration being offered to the physician for the services is consistent with fair market value.
    - i. TCHD shall identify the basis for selection of the benchmark(s) utilized as most appropriate for the service in question.
    - ii. Both monetary and any other compensation will be taken into consideration in determining fair market value.
- 5. Step 5 Review the Requirements of the Personal Services Agreement
  - a. TCHD shall confirm that the proposed personal services arrangement will meet all of the following terms to be included in the personal services agreement:
    - i. The personal services arrangement shall be evidenced by a written agreement signed and dated by all parties. There shall be no oral or implied understandings that are not incorporated in the written agreement. If the physician is not affiliated with a group practice, the agreement shall be between TCHD and the physician who will provide the services (the individual agreement). If the physician is an employee, independent contractor, partner, member or is otherwise affiliated with a group practice (or practices through a sole shareholder PC), the agreement shall be among TCHD and the group practice (the group agreement) or the sole shareholder PC (the sole shareholder PC agreement) and the agreement shall identify the physician who will provide the personal services.
    - ii. The personal services agreement shall require that the physician contemporaneously record any medico-administrative or consulting services, or professional medical services furnished on an hourly basis, on a physician activity log or timesheet. The personal services agreement

shall require that any professional medical services paid on a perprocedure basis be documented by the physician contemporaneously on a per-procedure basis. On-call agreements paid on a per-diem basis may be documented by reference to monthly panel schedules which are verified by TCHD. Physician Governing Board members shall not be required to submit logs for Governing Board duties, but attendance may be verified by referencing the Governing Board minutes.

- iii. The personal services agreement shall set forth with specificity all of the services to be furnished by the physician. The designated duties shall not include
  - 1) advertising or marketing on behalf of TCHD,
  - duties which the physician is obligated to perform free of charge as a result of his or her licensure or medical staff membership, including, without limitation, attendance at meetings that the physician is otherwise required to attend, such as regularly scheduled or mandatory medical staff or governing board meetings (unless the physician is also a Governing Board member and has signed a separate appointment letter),
  - 3) continuing medical education,
  - 4) review of medical journals and periodicals,
  - 5) any entertainment activities,
  - 6) completing time logs, including, without limitation, activity logs, or
  - 7) duties that involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. The designated duties shall be specific to the personal services arrangement in question.
- iv. If the personal services agreement is terminated during the first year of the term, then neither TCHD and the physician, nor TCHD and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first year of the intended term of the agreement.
- v. The personal services arrangement shall not be conditioned on the physician, or, in the event of a group agreement, the group practice or any physician affiliated with the group practice,
  - 1) making referrals to TCHD,
  - 2) being in a position to make or influence referrals to TCHD, or
  - otherwise generating business for TCHD; provided, however, that the agreement may require that the physician obtain and maintain active staff privileges at TCHD if appropriate for the services in question.
- vi. The remuneration paid to the physician and/or affiliated group practice under the personal services agreement (which may include per unit of service-based compensation) shall not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any actual or expected referrals to, or business otherwise generated for, TCHD by the physician or, in the event of a group agreement, by the group practice or any individual or entity affiliated with the group practice.
- vii. No physician, or, in the event of a group agreement, any physician affiliated with the group practice, shall be precluded or restricted in any way from
  - 1) establishing staff privileges at any other hospital,
  - 2) referring patients to or utilizing the services of any other hospital, or
  - otherwise generating business for any other hospital.

- viii. The physician and any affiliated group practice shall agree to treat in a nondiscriminatory manner patients receiving medical benefits or assistance under any federal health care program.
- ix. The personal services agreement will require the physician and the group practice, if applicable, to abide by TCHD's Compliance Program, including its Code of Conduct.
- 6. Step 6 Prepare the Contractual Arrangements
  - a. For each proposed professional services contracts, the TCHD department director shall prepare all of the following documentation for submission with the Contract Request Form (CRF) package and associated documents will be entered into the appropriate TCHD Contract Retention System (such as MediTract):
    - i. A fully completed CRF, signed by a Chief Officer, setting forth the total dollar value (or, as applicable, the estimated maximum total dollar value) of the remuneration that may be furnished by TCHD under the professional services contract, and any other agreement, during the term;
    - ii. Copies of all internal and external correspondence (including e-mails, memos or other like materials) that have been generated in connection with the proposed professional services contracts;
    - iii. A copy of the physician's current curriculum vitae;
    - iv. The results of an OIG/GSA and applicable state healthcare exclusion list search noting no exclusions, suspensions or debarments of the physician (in the case of an individual agreement), or of the physician and the group practice (in the case of a group agreement), from participation in any Federal health care program; <a href="http://exclusions.oig.hhs.gov">http://exclusions.oig.hhs.gov</a>
    - v. Physician's Certificate of Insurance (COI)
    - vi. If furnishing professional medical services, a copy of the physician's current medical license; http://www2.mbc.ca.gov/LicenseLookupSystem/PhysicianSurgeon/Search.aspx
    - vii. Any original source or other documentation required to support the statements included in the cover memorandum; and
    - viii. Any other information required by TCHD's Legal and Compliance Department.
- 7. Step 7 Obtain Legal Review and Approval
  - a. No professional services contract shall be executed or renewed without properly completing the steps detailed in TCHD's Contracts Manual.
- 8. Step 8 Documenting the Physician's Completion of Duties Prior to Payment
  - a. The physician shall be required to contemporaneously document his or her time spent performing his or her designated duties under the personal services agreement. Such documentation shall be submitted to TCHD on a monthly basis, in the form of the activity log attached to the personal services agreement. The physician shall personally complete, sign and date his or her activity log. Professional medical services paid on a per-service basis may be documented by (a) a monthly invoice that identifies each service by patient name or number, date of service and CPT code(s), or (b) individual Form 1500s. On-call services paid on a per diem basis may be documented by the monthly call schedule as verified at month-end by TCHD.
  - b. Only time that a physician spends on his or her designated duties under a personal services agreement shall be reimbursable, and all other time, including, but not limited to, time relating to the physician's private practice, shall not be reimbursable.
  - c. Except for on-call services paid on a per-diem basis, and personal medical services paid on a unit of service basis and invoiced to TCHD, TCHD shall not furnish remuneration to a physician for a given month unless and until:

- i. the physician legibly completes in all material respects the activity log applicable to such month;
- ii. the physician signs, dates and submits the activity log applicable to a given month by the date set forth in the personal services agreement;
- iii. the Department Director shall review and sign the logs for applicability of reported activities.
  - A physician's failure to sign, date and submit his or her activity log applicable to a given month by the due date set forth in the agreement shall result in a forfeiture of compensation due for that particular month.
  - Por professional services contracts where the compensation is fixed in the aggregate and based on an hourly rate times a projected number of hours, if, in any given month while a professional services contract is in effect, a physician provides fewer hours of professional services than the projected number of hours, then the physician or group practice (as appropriate) shall be compensated at the hourly rate for each hour of services actually provided as set forth in the professional services contract.

### 9. Document Retention

a. TCHD shall retain all documentation relating to the contract, including the Contract Request Form and documentation of fair market value will be entered into the appropriate TCHD Contract Retention System (such as MediTract) in accordance with the CHA document retention recommendations in existence at the time of document execution.

### 10. Responsible Person

The Compliance Officer and CFO are responsible for assuring adherence to the contracting and payment portions of this policy, respectively.

### 11. Auditing and Monitoring

a. TCHD's Audit, Compliance & Ethics Committee will audit compliance with this policy as part of its routine audits.

### 12. Enforcement

a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

### F. REFERENCE(S):

- 1. Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b):
- 2. Definition of Immediate Family Member, 42 C.F.R. § 411.351. CAM Standard Form Non-Invasive Cardiology Panel Agreement [Direct Pay]
- Fair Market Value exception, 42 C.F.R. § 411.357(I).
- 4. Personal Services Arrangements exception, 42 U.S.C. § 1395nn(e)(3); 42 C.F.R. § 411.357(d).
- 5. Safe Harbor for Personal Services and Management Contracts, 42 C.F.R. § 1001.952(d).
- 6. Stark Law, 42 U.S.C. § 1395nn, and implementing regulations
- 7. Tri-City Health Care District Code of Conduct
- 8. Tri-City Health Care District Contractual Arrangements Manual

### ATTACHMENT 1

### . PROCEDURES:

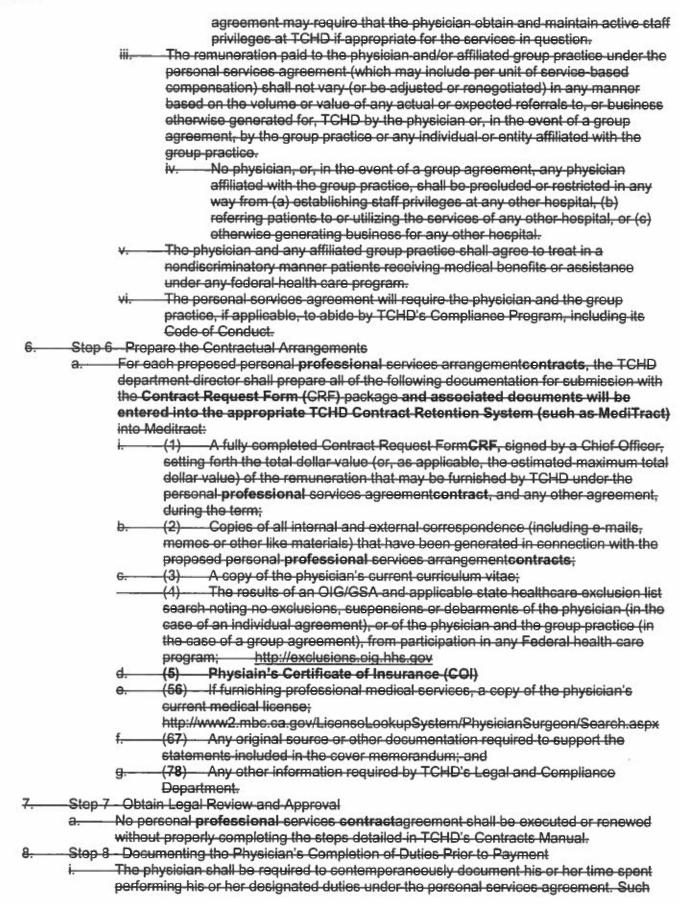
### Step 1 - Identify the Need for the Services

- a. The TCHD Department shall identify why the services are best contracted for and compensated by TCHD rather than having the physician bill a payor independently for the service.
  - b. In the case of on call services, the Department (a) shall identify any mandates or recommendations from legal or regulatory authorities (e.g., EMTALA, Joint Commission, other state regulations), and any other evidence, that on call coverage in the particular specialty or subspecialty should be secured, (b) shall also document whether such on call services are required without compensation under the medical staff bylaws or rules and regulations; and (c) shall also document prior efforts to obtain such services on a voluntary basis.
- Step 2 Project the Number of Hours/Specific Services Required
  - a. Medico-administrative and consulting services should generally be contracted for based on a fixed number of hours per week or month. TGHD shall not enter such contracts until after having determined that the number of hours of medico-administrative-or-consulting services contemplated by the personal services arrangement is reasonable and necessary to accomplish TCHD's legitimate needs for the services. The requesting Department must prepare a projection of the number of hours reasonably necessary to discharge the medico-administrative or consulting services based on:
    - any benchmarks referenced by legal authorities, government organizations, provider accreditation bodies, medical education program accreditation bodies, independent third party consultants, third party payers, or the Tri-City Health Care District entity's medical staff or governing board;
    - ii. data from time logs; and/or
    - other factors, such as a detailed description of the scope of the consulting project.
  - b. Professional medical services should be contracted for either on an hourly basis or on a per unit of service basis. Hourly services must meet the requirements of Paragraph (1) above. Services rendered on a per unit of service basis should be identified by Physician using a CPT code number and descriptor.
  - On-call services should be contracted for on the basis of 24-hour coverage.
- Step 3 Demonstrate the Qualifications of the Physician
  - TCHD must determine that the physician is qualified and capable of performing the services by: (1) verifying that the physician is capable of furnishing the services (i.e., the physician must confirm that he/she does not have other preexisting obligations which would limit or restrict the physician from fully performing the services); (2) obtaining a copy of the physician's curriculum vitae; (3) verifying, if not evident from existing information, that Physician is currently liconsed in California; verifying that the physician is qualified to provide the services (e.g., that the physician possesses relevant training and/or experience in the area); and (4)verifying, through a search of the U.S. General Services Administration's (GSA) Lists of Parties Excluded from Federal Procurement and Non-procurement Programs, the Office of Inspector General (OIG) of the Department of Health and Human Services List of Excluded Individuals/Entities, and any applicable state healthcare exclusion list, that the physician (and, in the context of a personal services agreement with a group practice, the group) has ne exclusions, suspensions or debarments from participation in any federal health-care program.
- Step 4 Calculate Fair Market Value Compensation

- a. TCHD may not enter into a personal services arrangement without first objectively determining and documenting that the remuneration being effered to the physician for the services is consistent with fair market value. (1) TCHE shall identify the basis for selection of the benchmark(s) utilized as most appropriate for the service in question. (2) Both monetary and any other compensation will be taken into consideration in determining fair market value.
- Step 5 Review the Requirements of the Personal Services Agreement
   a. TCHD shall confirm that the proposed personal services arrangement will meet all of the following terms to be included in the personal services agreement:
  - b. (1) The personal services arrangement shall be evidenced by a written agreement signed and dated by all parties. There shall be no oral or implied understandings that are not incorporated in the written agreement. If the physician is not affiliated with a group practice, the agreement shall be between TCHD and the physician who will provide the services (the individual agreement). If the physician is an employee, independent contractor, partner, member or is otherwise affiliated with a group practice (or practices through a sole shareholder PC), the agreement shall be among TCHD and the group practice (the group agreement) or the sole shareholder PC (the sole shareholder PC agreement) and the agreement shall identify the physician who will provide the personal services.
  - c. (2) The personal services agreement shall require that the physician contemporaneously record any medice administrative or consulting services, or professional medical services furnished on an heurly basis, on a physician activity log or timesheet. The personal services agreement shall require that any professional medical services paid on a per-procedure basis be documented by the physician contemporaneously on a per-procedure basis. On-call agreements paid on a per-diem basis may be documented by reference to menthly panel schedules which are verified by TCHD. Physician Governing Beard members shall not be required to submit-logs for Governing Beard duties, but attendance may be verified by referencing the Governing Beard minutes.
    - d. (3) The personal services agreement shall set forth with specificity all of the services to be furnished by the physician. The designated duties shall not include (1) advertising or marketing on behalf of TCHD, (2) duties which the physician is obligated to perform free of charge as a result of his or her licensure or medical staff membership, including, without limitation, attendance at meetings that the physician is otherwise required to attend, such as regularly scheduled or mandatory medical staff or governing board meetings (unless the physician is also a Governing Board member and has signed a separate appointment letter), (3) continuing medical education, (4) review of medical journals and periodicals, (5) any entertainment activities, (6) completing time logs, including, without limitation, activity logs, or (7) duties that involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. The designated duties shall be specific to the personal services arrangement in question.

If the personal services agreement is terminated during the first year of the term, then neither TCHD and the physician, nor TCHD and any affiliated group practice, shall enter into an arrangement for the same items and services for the remainder of the first year of the intended term of the agreement.

ii. The personal services arrangement shall not be conditioned on the physician, or, in the event of a group agreement, the group practice or any physician affiliated with the group practice, (a) making referrals to TCHD, (b) being in a position to make or influence referrals to TCHD, or (c) otherwise generating business for TCHD; provided, however, that the



- documentation shall be submitted to TCHD on a monthly basis, in the form of the activity log attached to the personal services agreement. The physician shall personally semplete, sign and date his or her activity log. Professional medical services paid on a per-service basis may be documented by (a) a monthly invoice that identifies each service by patient name or number, date of service and CPT code(s), or (b) individual Form-1500s. On-call services paid on a per diem basis may be documented by the monthly call schedule as verified at month-end by TCHD.
- ii. Only time that a physician spends on his or her designated duties under a personal services agreement shall be reimbursable, and all other time, including, but not limited to, time relating to the physician's private practice, shall not be reimbursable.
- iii. Except for on-call services paid on a per-diem basis, and personal medical services paid on a unit of service basis and invoiced to TCHD, TCHD shall not furnish remuneration to a physician for a given month unless and until:
  - the physician legibly completes in all material respects the activity log applicable to such month;
  - (2) the physician signs, dates and submits the activity log applicable to a given month by the date set forth in the personal services agreement;
  - d. (3) the Department-Director shall-review and sign-the-logs for applicability of reported activities.
    - A physician's failure to sign, date and submit his or her activity log applicable to a given month by the due date set forth in the agreement shall result in a ferfeiture of compensation due for that particular month. For personal professional services agreements contracts where the compensation is fixed in the aggregate and based on an hourly rate times a projected number of hours, if, in any given month while a personal professional services contractagreement is in effect, a physician prevides fewer hours of personal professional services than the projected number of hours, then the physician or group practice (as appropriate) shall be compensated at the hourly rate for each hour of services actually provided as set forth in the personal professional services agreement contract.

### Document Retention

a. TCHD shall retain all documentation relating to the centract, including the Centract Request Form and documentation of fair market value will be entered into the appropriate TCHD Contract Retention System (such as MediTract) in accordance with the CHA document retention recommendations in existence at the time of document execution.

### 10. Responsible Person

 The Compliance Officer and CFO are responsible for assuring adherence to the contracting and payment portions of this policy, respectively.

### Auditing and Monitoring

 TCHD's Audit, Compliance & Ethics Committee will audit compliance with this policy as part of its routine audits.

### 12. Enforcement

a. All-omployees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.



### Administrative Policy-Manual Compliance

**ISSUE DATE:** 

04/13

SUBJECT: Sales of Items or Services to

**Physicians and Other Potential** 

Referral Sources

POLICY NUMBER: 8750-575

REVISION DATE(S): 04/13

**Department Approval:** 

06/1607/17

**Administrative Policies and Procedures Approval:** 

07/17

**Medical Executive Committee Approval:** 

08/17

**Organizational Compliance Committee Approval:** Audit, Compliance and Ethics Committee Approval: 02/18 04/1304/18

**Board of Directors Approval:** 

04/13

### **PURPOSE** A.

The purpose of this policy is tTo ensure, through the implementation of prudent and reasonable controls that purchase arrangements and payments comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law.

### B. **GENERAL POLICIES:**

Tri-City Healthcare District (TCHD) shall only enter into purchase arrangements with physicians, allied health professionals, or other potential referral sources that comply with applicable laws and regulations, including the federal Anti-Kickback law and the Stark law. TCHD does not sell or provide medical malpractice insurance to physicians. TCHD Departments shall follow the steps set forth in this policy and the attached procedures when entering into purchase arrangements with physicians, allied health professionals, or other potential referral sources. Examples include management services, staffing services, sales of laboratory-related services, drugs or pharmaceuticals, instrument sterilization services, private practice transcription services, and joint marketing arrangements.

### C. **DEFINITION(S):**

- Purchase Arrangement means an arrangement pursuant to which TCHD sells an item or service to a physician, allied health professional, or other potential referral source.
- 2. Remuneration - means-anything of value, including, but not limited to, cash, items or services.
- 3. Physician means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.
- 4. Other Potential Referral Source - means-any individual (other than a physician) or entity in a position to make or influence referrals to, or otherwise generate business for, TCHD.
- 5. Group Practice - means-two or more physicians who practice through a single legal entity, using a common trade name and a common tax identification number, including a faculty practice plan or other physician group practice organization affiliated with an academic medical center.
- 6. Fair Market Value - means-the value that would be ascribed to the item or service in an armslength transaction, as the result of bona-fide bargaining between well-informed parties who are not otherwise in a position to generate business for the other party.
- 7. Director - as used in this policy means Department Director, or an employee with the level of authority and responsibility associated with that of a Department Director.

### D. SCOPE OF POLICY:

- 1. This policy applies to:
  - a. TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
  - b. Any other <del>any other entity</del> or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and
  - c. Any hospital or healthcare facility in which—Tri-City-Healthcare-DistrictTCHD or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").

### E. PROCEDURE:

- 1. Step 1 Determine that Purchase is Reasonable and Necessary
  - a. When a department proposes to sell items or services to a Physician, group practice or other potential referral source, the items and services, as applicable, shall not exceed that which is reasonable and necessary for the legitimate business purposes of the arrangement. The department director shall make reasonable inquiry into whether the items and services will be used for the legitimate business purposes of the purchaser.
- 2. Step 2 Determine Fair Market Value of Items or Services
  - a. No purchase arrangement with a referral source may be entered unless (a) the purchase price (which may include a fixed aggregate price or a fixed per-item or unit of service based price) is set in advance and (b) TCHD has determined that the purchase price is consistent with fair market value for the item(s) or service(s) purchased and has obtained approval from the Chief Compliance Officer.
  - b. For services to be compensated on a per-unit of service basis, documentation of fair market value must be demonstrated by reference to benchmarks relevant to the service being contracted for. Such benchmarks may include applicable Medicare and Medicaid rates, prevailing managed care rates in the relevant market, amounts received by the hospital from third party payors for the specific contracted services in question, weighted averages of the above benchmarks based on historical or anticipated case mix and payor mix, or independent valuations. TCHD shall identify and document the basis for selection of the benchmark(s) utilized as most appropriate for the service in question.
- 3. Step 3 Review the Terms of the Purchase Agreement
  - a. The director requesting the arrangement shall ensure the purchase agreement is commercially reasonable without regard to any referrals made between the parties.
  - b. No Physician, allied health professional, or other potential referral source shall be precluded or restricted in any way by a purchase agreement from (a) establishing staff privileges at any non-TCHD hospital or facility, (b) referring patients or utilizing the services of any non-TCHD hospital or facility, or (c) otherwise generating business for any non-TCHD hospital or facility.
  - c. The above steps shall be confirmed by the Chief Compliance Officer.
- Step 4 Obtain Legal Review and Approval
  - a. The director requesting the arrangement shall comply with TCHD's Contracting Manual, obtaining appropriate review and approval of business terms from thea Chief Compliance Officer followed by approval of the Legal Department as needed on a case by case basis.
- 5. Step 5 Collect Amounts Due to Tri-City Healtheare-DistrictTCHD Entities
  - a. The director requesting the arrangement is responsible for ensuring that diligent efforts are made to collect any and all money due from the Physician, group practice, or referral source in accordance with the terms of the underlying purchase arrangement.
  - b. The director is responsible to promptly report any noncompliance with the arrangement to the Compliance Officer. TCHD shall maintain all documentation of its efforts to collect delinquent receivables.
  - c. The hospital shall not write off a referral source's receivable without the prior approval of Legal & Compliance.
- 6. Document Retention:

- a. TCHD shall retain all Contract Request Form Packages, agreements and other documentation relating to each lease / purchase arrangement according to the requirements of Records Management and associated documents will be entered into the appropriate Contract Retention System (such as MediTract).
- 7. Responsible Person:
  - a. The requesting director is responsible for compliance with this policy and procedures. The Chief Compliance Officer and CFO are responsible to ensure reasonable measures are in place to detect noncompliance.
- 8. Auditing and Monitoring:
  - a. The Audit, Compliance &and Ethics Committee will monitor oversee compliance with this policy as part of its routine audits.
- 9. Enforcement:
  - a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law

# F. REFERENCE(S) LIST:

- 1. Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
- 2. Payments by a Physician for Items and Services, 42 U.S.C. § 1395nn(e)(8); 42 C.F.R. § 411.357(i). Definition of Immediate Family Member, 42 C.F.R. § 411.351
- Safe Harbor for Personal Services and Management Contracts, 42 C.F.R. § 1001.952(d)
- Stark Law, 42 U.S.C. § 1395nn and implementing regulations
- 5. TCHD Contract Manual

# TRI-CITY HEALTHCARE DISTRICT MINUTES FOR A REGULAR MEETING OF THE BOARD OF DIRECTORS

March 29, 2018 – 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 March 29, 2018.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

### Also present were:

Greg Moser, Board Counsel
Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Dr. Victor Souza, 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

Chairman Dagostino requested the addition of three agenda items:

- Closed Session Appointment of Public Employee Board Counsel
- Closed Session Conference with Legal Counsel regarding one matter of Potential Litigation
- Open Session New Business Consideration to cast the vote in favor of Director Nygaard for the Consolidated Redevelopment Oversight Board Election

It was moved by Director Mitchell to approve the agenda as amended. Director Kellett seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the March 29, 2018 Regular Board of Directors Meeting Agenda.

There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's Counsel. Board Counsel, Mr. Greg Moser made an oral announcement of the items listed on the March 29, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Approval of Closed Session minutes, Conference with Legal Counsel regarding two matters of Potential Litigation and Appointment of Public Employee: Board Counsel.

5. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Mitchell 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 Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, Board Counsel
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in closed session. He reported that we have amended the agenda to include two open session items: 1)

Appointment of Public Employee: Board Counsel and 2) Consideration to cast the

vote in favor of Director Nygaard for the Consolidated Redevelopment Oversight Board Election which will be discussed under New Business.

- Director Nygaard 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 24.
- 12. Educational Session

Revenue Cycle - Ray Rivas, CFO

Mr. Ray Rivas, CFO presented a detailed presentation on the Revenue Cycle which includes the following areas:

- > Patient Access
- > Case Management
- > Health Information Management
- > Patient Accounting

Mr. Rivas discussed the Charge Master which is reported annually to OSHPD and is approximately 9,600 lines. He provided examples of several DRGs and their respective charges and reimbursements based on payor. A pie chart was presented that reflected TCMC Payor Mix for the month of February. Mr. Rivas pointed out that Self Pay went up to 4.5% and YTD has been running around 3%.

Lastly Mr. Rivas discussed denials by type including the following:

- > TAR: Treatment Authorization Request Medi-Cal
- > MAC: Medicare Administrative Contractor Medicare (Noridian)
- > RAC: Recovery Audit Contractor Medicare
- > SAC: Stephenson, Acquisto & Coleman Law Firm, Technical Contract Issues
- > MRI: Managed Resources, Inc. Managed Care

Mr. Rivas stated we were successful on almost 800,880 denials which represented about 75% of the total appeals that were closed and we are working to get that number even higher.

Directors asked questions throughout the presentation and expressed their appreciation for this informative presentation.

No action taken.

13. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer reported the Foundation, along with Drs. Greg Sahagian and Abigail Lawler gave a presentation today at Oceana Hills Retirement community on Alzheimer's. As a result of that presentation and the Foundation's money component to the presentation six of their 40 guests indicated a desire to learn more about their estate planning and scheduled appointments with the Foundation.

Mr. Newhart reported the Socks & Shoes Drive was held approximately one month ago and we collected far more socks and shoes than we did in our first year. Socks and shoes continue to come in and just yesterday we received several hundred pairs of socks for a Sorority in Escondido. Mr. Newhart stated there was extensive promotion across social media on the Socks & Shoes Drive which included a segment on KUSI. Mr. Newhart commented on several companies that got involved this year which included DJO Global who donated boxes of medical shoes for diabetic patients; VANs, the lifestyle apparel brand and our friends at Cobian. Mr. Newhart stated this was an excellent community awareness event that brought in new donors and the cash donations far exceeded last year. Mr. Newhart stated individuals who were too busy to drop by or shop on their own made gifts on line by asking the Foundation to acquire the socks and shoes and do the shopping for them.

Mr. Newhart reported yesterday was our Doctor's Day event. He reported that approximately 130 Tri-City physicians were recognized with gifts made in their honor by community members compared to 71 last year. Mr. Newhart stated the Doctor's Day appeal exceeded our expectations as far as the number of physicians being honored by the community. Mr. Newhart read a sampling of the 70 plus messages, some of which were sent anonymously.

Mr. Newhart reported the month of April is for a Nurse appeal to recognize the nursing care received at Tri-City. Just as the physicians were awarded pins, the nurses specifically mentioned will receive a special recognition and see those messages as well.

Mr. Newhart also commented on the Foundation's core events – August 20<sup>th</sup> is the Golf event at the Fairbanks Ranch Country Club and the Diamond Ball on October 27<sup>th</sup> with special guest Bill Engvall of the Blue Collar Comedy Tour.

Mr. Newhart stated the Teddy Bears that have been placed at the Dais are given to every baby born at Tri-City and are distributed when the baby has their newborn hearing screen. It is a way to let people know that we appreciate them choosing Tri-City for their care.

No action taken.

### Report from Chief Executive Officer CEO

Mr. Steve Dietlin expressed his appreciation to the Foundation who is doing a lot of great things.

Mr. Dietlin elaborated on Mr. Rivas's Revenue Cycle presentation and the great questions raised by Board members. He stated we have to continue to remain proactive and flexible in order to preserve the future here at Tri-City. It is important to continually evolve and manage healthcare delivery while maintaining the highest quality.

Mr. Dietlin stated we celebrated the great physicians that are here with Doctor's Day yesterday. He recognized the outstanding quality that is brought here to this hospital every day by the physicians. Mr. Dietlin expressed his appreciation to Dr. Souza and the rest of the Tri-City Medical staff for all their collaboration. Dr. Souza is a great example and was also recognized as one of the finalists for the San Diego Business Journal's Healthcare Hero's awards.

Mr. Dietlin commented on our partnership with the American Heart Association and the fact that next Wednesday is National Walking Day. He stated we are going to have an event out on the grassy area and talk about the value of remaining active and healthy and take a lap around the Tri-City half mile course. He invited everyone out to participate in the event.

Lastly, Mr. Dietlin read excerpts from a few letters from patients who received their care at Tri-City.

No action taken.

Dr. Souza expressed his appreciation to Mr. Dietlin for reading the excerpts of the patient letters. It reminds us of why we are here and what we are doing.

Dr. Souza thanked everyone who was able to attend the Physician's appreciation luncheon. He stated we have a phenomenal Medical Staff who have a long history here and want to make this hospital shine!

Lastly, Dr. Souza expressed his appreciation for the gift baskets for the physicians. It showed Administration's support and was a nice touch for the physicians.

15. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- ➤ Net Operating Revenue \$239,606
- ➤ Operating Expense \$249,125
- > EROE (\$5,957)
- ➤ EBITDA \$4,451

Mr. Rivas stated we do have a positive EBITDA which is an indication that our cash exceeds our expenses and thus far this year we have a positive cash flow.

- 5-

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census 177
- Adjusted Patient Days 75,881
- ➤ Surgery Cases 4,289
- ➤ Deliveries 1,560,
- ➤ ED visits 41,279

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue \$29,214
- ➤ Operating Expense \$30,165
- ➤ EBITDA \$75
- ➤ EROE (\$542)

Mr. Rivas reported on current month Key Indicators as follows:

➤ Average Daily Census – 186

- Adjusted Patient Days 9,201
- ➤ Surgery Cases 528
- ➤ Deliveries 169, 39 of which were C-sections
- ➤ ED Visits 4,619

Mr. Rivas reported on the following indicators for FY18 Average:

- > Net Patient Accounts Receivable \$45.6
- > Days in Net Accounts Receivable 48.9

Chairman Dagostino commented that following the upcoming strategy sessions in May we will have to take another hard look at how we are going to improve that bottom line.

Mr. Rivas commented that the average length of stay remains high but is trending in the right direction.

Mr. Rivas also commented on supply cost which has been problematic this year due to hurricanes that shut down some plants in Puerto Rico forcing us to get supplies wherever we can. Year to date we are almost \$4 million over budget in just that category.

No action taken.

### New Business

- a. LAFCO Update (discussed in conjunction with item b.)
- b. Consideration to approve a Memorandum of Understanding between Fallbrook Hospital and Tri-City Healthcare District related to Phasing of Tax Increment

Mr. Moser reported the Board of Supervisors has approved the tax exchange resolution and LAFCO has approved the changes in the boundaries that were requested.

Mr. Moser explained the Memorandum of Understanding between the District and the Fallbrook Healthcare District describes a three year program of easing back the cuts that Fallbrook will be taking because of the \$181,000 tax exchange due to the LAFCO changes. Mr. Moser stated there is a typographical error in the LAFCO resolution that Counsel for Fallbrook has already brought to their attention which states that the tax exchange agreement is between the District and Palomar which is incorrect. Mr. Moser stated his understanding is that Fallbrook will be acting on this Resolution at their April 11<sup>th</sup> meeting and then the Board will be able to approve new boundaries and new maps for district elections at their regular meeting in April. We are on schedule to get the Registrar what they need by May 4<sup>th</sup>.

Director Nygaard questioned if we feel confident that Fallbrook is in support of this Memorandum of Understanding. Mr. Moser stated that Fallbrook's counsel Blaze Jackson is in the audience and invited him to the podium.

Mr. Jackson expressed his appreciation for the opportunity to comment. He stated Fallbrook very much appreciates this Board's willingness to consider and ideally approve the Memorandum of Understanding arrangement which will help "ease the pain" over a period of time for Fallbrook. Mr. Jackson stated the \$181,000 represents roughly 10% of its annual revenues in the absence of this change. Mr. Jackson stated the Memorandum of Understanding has been vetted through one of their Board committees and will go forward to the Board with a positive recommendation.

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors approve a Memorandum of Understanding between Fallbrook Hospital and Tri-City Healthcare District related to Phasing of Tax Increment. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Grass, Kellett, Mitchell, Nygaard,

Reno and Schallock

NOES: Directors: None ABSTAIN: Directors: None ABSENT: Directors: None

Consideration to cast the vote in favor of Director Nygaard for the
 Consolidated Redevelopment Oversight Board Election (addition to agenda)

Chairman Dagostino stated the Board had been asked to consider nominating a Board member to serve on LAFCO Distribution of Redevelopment Funds Oversight Board. In January, 2018, the Board unanimously voted to nominate Director Nygaard on behalf of the Board. Chairman Dagostino stated Director Nygaard has made it through the ballot process and now the Board is being asked to cast the ballot in favor of Director Nygaard.

Director Nygaard questioned if she needed to abstain from the vote. Board Counsel, Mr. Moser stated Director Nygaard is not required to abstain.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors cast the vote in favor of Director Nygaard for the Consolidated Redevelopment Oversight Board Election. 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

d. Appointment of Public Employee: Board Counsel (addition to agenda)

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors accept the contract with Archer Norris to serve as TriCity Healthcare District's Board Counsel. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Grass, Kellett, Mitchell, Nygaard,

Reno and Schallock

NOES: Directors: None ABSTAIN: Directors: None ABSENT: Directors: None

e. Consideration to amend TCHD Bylaws

Board Counsel Mr. Moser stated the recommended change in Article V is to allow the Board Chair to make interim appointments when it appears that a committee will have only one Board member attending a committee meeting. The amendment would ensure there are at least two Board members present at committee meetings. Mr. Moser stated it would be an interim appointment only and applies to a single meeting.

Director Reno requested clarification on the names of the standing committees. Mr. Moser referred Director Reno to pages 51 and 52 of the agenda packet.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the amended Bylaws as presented. 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

f. Approval of Resolution No. 790, A Resolution of the Board of Directors of Tri-City Healthcare District Amending the Conflict of Interest Code.

Mr. Moser stated the amendment to the Conflict of Interest Code is essentially a housekeeping measure that will accomplish two things: 1) It changes the list of individuals who need to file Form 700s due to the fact that some positions have been eliminated and 2) It requires only the Board members and the CEO's Form 700 be filed with the county and all other filers will file with the District's Board secretary. Mr. Moser stated this is a change that the county has requested to lessen their burden. Mr. Moser explained that the proposed Conflict of Interest Code will not be in effect for the April filing period due to the fact that a 45-day public comment period is required. The Code will then come back at a future Board meeting after the 45 day review period.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve Resolution No., 790, a Resolution of the

Board of Directors of Tri-City Healthcare District Amending the Conflict of Interest Code. 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

g. Consideration to amend Board Policy 18-042 related to section "Promote quality medical care".

Ms. Sharon Schultz, CNE reported in preparation for our upcoming Joint Commission survey and review of the standards and elements of performance it was noted that Board Policy 15-042 identified the CEO and the Medical Staff but failed to identify the Chief Nurse Executive as one of those responsible for the provision of care. Ms. Schultz requested the Board consider approving the amended Board Policy which states in part that "the Board identifies the Nurse Executive function at the senior leadership level to provide effective leadership and to coordinate leaders to deliver the nursing care treatment and services".

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors amend Board Policy 15-042 as presented. Director Schallock seconded the motion.

Chairman Dagostino explained that the reason for the amendment is to clarify and document for the Joint Commission who is responsible for providing quality medical care at the hospital.

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

- 17. Old Business None
- 18. Chief of Staff
  - Consideration of March Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 26, 2018.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the March Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 26, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Grass, Kellett, Mitchell,

Reno Nygaard, Reno and Schallock

NOES: Directors: None ABSTAIN: Directors: None ABSENT: Directors: None

- Approval of Medical Staff Rules & Regulations:
  - 1) Division of Neurology
  - 2) Division of Internal Medicine
  - 3) Department of Radiology
  - 4) Department of Pediatrics

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the Medical Staff Rules & Regulations for the Division of Neurology, Division of Internal Medicine, Department of Radiology and Department of Pediatrics as recommended by the Medical Executive Committee at their meeting on March 26, 2018. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Grass, Kellett, Mitchell,

Reno Nygaard, Reno and Schallock

NOES: Directors: None ABSTAIN: Directors: None ABSENT: Directors: None

c. Recommendation from Medical Quality Peer Review and the Credentials Committee regarding Cardiothoracic Surgery.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the recommendation from Medical Quality Peer Review and the Credentials Committee regarding Cardiothoracic Surgery as recommended by the Medical Executive Committee at their meeting on March 26, 2018. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Dagostino, Grass, Kellett, Mitchell,

Reno Nygaard, Reno and Schallock

NOES: Directors: None ABSTAIN: Directors: None ABSENT: Directors: None

Consideration of Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Grass seconded the motion.

Director Schallock called for the vote.

Director Nygaard stated she would be abstaining from the minutes of February 22, 2018. Director Reno stated she would be voting no on the minutes of February 22, 2018

#### The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett and

Mitchell and Schallock

NOES: ABSTAIN: Directors:

Reno Nygaard

ABSENT: Directors:

None

## 20. Discussion of items pulled from Consent Agenda

There were no items pulled from the Consent Calendar.

# 21. Reports

Chairman Dagostino reported some legislative handouts have been distributed at the dais and at the back table that CHA has supported or opposed.

Director Nygaard suggested a "News" section be added to the Board's portal where Board members can share articles and legislative websites of interest.

#### 22. Legislative Update

#### **CSDA**

Chairman Dagostino stated the Board recently voted to join the California Special District's Association (CSDA) and he met with Chris Palmer, CSDA Public Affairs Field Coordinator to discuss our membership and how CSDA can benefit Tri-City. Chairman Dagostino questioned if Board members would be interested in hearing an educational presentation by Mr. Palmer at an upcoming meeting. Director Nygaard stated the CSDA holds many educational events that the Board may find beneficial. Board members stated they would be interested in meeting Mr. Palmer and directed Ms. Donnellan to schedule a time for him at one of our upcoming Board meetings.

On a separate legislative matter Mr. Moser stated he has drafted some amendments to Government Code Section 1090 that provides some protections for local government officials. Mr. Moser stated the bill has made it to print and is known as SB949 and is being carried by Senator Ben Allen who is the Chair of the Education Committee. Mr. Moser explained the bill relates mainly to Charter Schools which have never been subject to Government Code Section 1090 but may also appeal to cities, counties and special districts. Mr. Moser suggested that we encourage organizations that we are part of support that Bill.

Chairman Dagostino referred to his report contained in today's agenda packet from the Governance Forum and specifically discussed SB1975 which is a bill to allow the EMS personnel to transport patients with Behavioral Health or sobriety to an outpatient Behavioral Health facility or sobriety center rather than to the Emergency Room.

Chairman Dagostino stated CHA is sponsoring that Bill and our physicians are not in favor of the bill as it allows EMS personnel to get into diagnostics and raises potential liability issues particularly when they are in radio communication with EMS personnel. Chairman Dagostino stated Tri-City, along with Scripps and Palomar made their points known to CHA and he has personally asked if CHA would work with the Emergency Department physicians on an amendment that would address their liability issue. Chairman Dagostino stated CHA has commented that since San Diego does not have Behavioral Health and Sobriety Centers it would not affect San Diego. Director Mitchell commented that EMS personnel may be qualified to make such decisions, however it is well beyond their scope of practice and it would be imperative to revise the Paramedic Practice Act. Director Reno commented that after a recent automobile accident she had to sign a waiver in order for paramedics to transport her to Tri-City rather than Scripps and would like that addressed in this Bill. Chairman Dagostino explained the author of the bill would have to agree to include it in their Bill.

Director Grass questioned if the Bill calls for additional education and the changing of the paramedic curriculum in the schools? Chairman Dagostino responded that the Bill states that the paramedics are going to be specially trained however does not address the changing of the paramedic curriculum.

Chairman Dagostino also commented on a Bill that creates criteria for the discharge of homeless people. Chairman Dagostino stated it is an attempt to be kind to this classification of patients but it is not practical and CHA is opposing that Bill.

Lastly, Chairman Dagostino commented on the 340B program. He stated Marie Waldron, who is a Republican member of the California State Assembly felt that suspending the 340B program was going to hurt her District Hospital, Palomar as well as Tri-City. Chairman Dagostino stated that Ms. Waldron, with CHA's support will write a letter supporting the continuation of 340B and circulate through the caucus.

### 23. Comments by Members of the Public

Chairman Dagostino recognized Mr. Kyle Thayer.

Mr. Kyle Thayer, Carlsbad resident and San Diego county paramedic commented on SB1795 which is a bill to allow the EMS personnel to transport certain classifications of patients to other areas. He encouraged further consideration of the bill which he believes would be a way for the hospital to potentially save money and get patients triaged to the appropriate location.

### Additional Comments by Chief Executive Officer

There were no additional comments from the Chief Executive Officer.

#### 25. Board Communications

Reports from Board Members

Director Mitchell wished everyone a happy and safe Easter.

Director Grass reported on behalf of the Auxiliary that the *Tails on the Trails* walk is scheduled for May 19<sup>th</sup> at 9:00 a.m. at. Mance Buchanon Park in Oceanside.

Director Nygaard did not have any comments.

Director Reno expressed her appreciation to all the physicians for their care and support. She stated the support for our physicians was evident by the turnout for the Doctor's Day luncheon yesterday and the thank-you notes that the Foundation received on behalf of our physicians.

Director Reno wished physicians and staff a happy Easter.

Director Kellett wished everyone a happy Easter.

Director Schallock commented that former employee Mike Henchman passed away recently. He stated Mike was involved in the Telecommunications here at Tri-City for a very long time and was integral in how we have moved forward in this new digital age.

Director Schallock expressed his appreciation to Mr. Moser for his time and efforts in assisting the Board over the past nine years. He wished Mr. Moser much luck going forward!

26. Report from Chairperson

Chairman Dagostino expressed his appreciation to Mr. Moser for his counsel and assistance during his tenure as Board Chair.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:30 p.m.

ATTEST:	James J. Dagostino, DPT, PT Chairman
Leigh Anne Grass, Secretary	

# TRI-CITY HEALTHCARE DISTRICT MINUTES FOR AN ADJOURNED SPECIAL MEETING OF THE BOARD OF DIRECTORS

March 22, 2018 – 3:00 o'clock p.m. Adjourned to March 27, 2018 – 1:00 p.m. Assembly Room 3 – Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

An Adjourned Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 3:00 p.m. on March 27, 2018.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

#### Also present were:

Steve Dietlin, Chief Executive Officer Teri Donnellan, Executive Assistant Susan Bond, General Counsel Rick Crooks, Executive Protection Agent

- The Board Chairman, Director Dagostino, called the adjourned special meeting to order at 1:00 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.
- 5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Grass to go into closed session. The motion passed unanimously (7-0).

- 8. Open Session
- 9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in Closed Session.

10. There being no further business, Chairman Dagostino adjourned the meeting at 3:30 p.m.

James J. Dagostino	
Chairman	

ATTEST:

Leigh Anne Grass

Secretary

## TRI-CITY HEALTHCARE DISTRICT MINUTES FOR A SPECIAL MEETING OF THE BOARD OF DIRECTORS

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The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, DPT, PT Director Leigh Anne Grass Director Cyril F. Kellett, MD Director Laura Mitchell Director Julie Nygaard Director RoseMarie V. Reno Director Larry W. Schallock

#### Also present were:

Steve Dietlin, Chief Executive Officer Teri Donnellan, Executive Assistant Susan Bond, General Counsel Rick Crooks, Executive Protection Agent

- 1. The Board Chairman, Director Dagostino, called the meeting to order at 3:00 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.
- 2. Public Comments Announcement

Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

It was moved by Director Kellett to approve the agenda as presented. Director Mitchell seconded the motion. The motion passed unanimously (7-0).

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino made an oral announcement of the items listed on the March 22, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Appointment of Public Employee: Board Counsel and Conference with Legal Counsel regarding one matter of Existing Litigation.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Nygaard to go into Closed Session. The motion passed unanimously (7-0).

8. Open Session

Secretary

9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported today's meeting will be continued to Tuesday, March 27<sup>th</sup> at 1:00 p.m. in Assembly Room 3.

6. There being no further business, Chairman Dagostino adjourned the meeting at 5:30 p.m. to March 27<sup>th</sup> at 1:00 p.m.

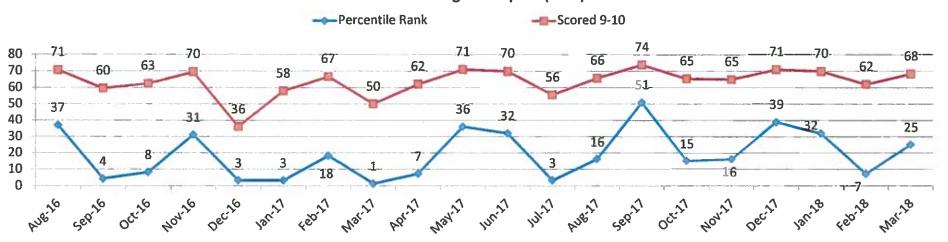
TTEST:	James J. Dagostino Chairman
Leigh Anne Grass	



# ADVANCED HEALTH CARE

# **Stakeholder Experiences**

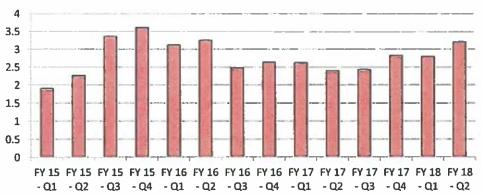
## **Overall Rating of Hospital (0-10)**



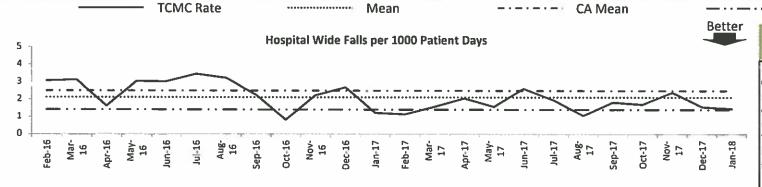
# **Voluntary Employee Turnover Rate**



# **Involuntary Employee Turnover Rate**



# **Current Trending Measures**

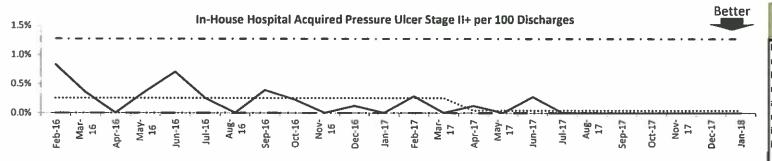


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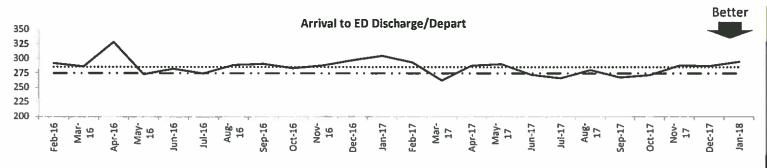
**TCMC Target** 

1.Majority falls are still related to BR2. Continue to hardwire hourly rounding3, train staff as needed on use of transfer equipment4.Audit all patients at a high fall risk4. Continue to perform fall audit on Tuesdays and Thursdays, 5. Roll out the updated Falls Safety Plan for patient and family.



## **Action Plan**

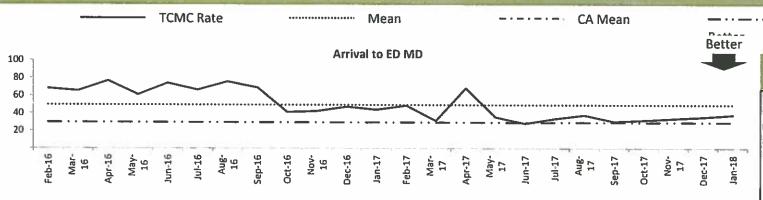
Request expansion of HAPI charter, 1. Perform regular assessments of high risk patients with Braden score of 18 or less. 2. Continue chart review for consistency of documentation of appropriate treatment/preventative measures. 4. Continue to enforce the implementation of the electronic report that identifies high risk patients.



# **Action Plan**

There as an influx of patients due to influenza and high acuity of illness. Continue to monitor

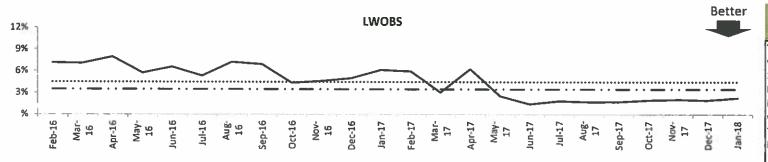
# **Current Trending Measures**



# TCMC Target

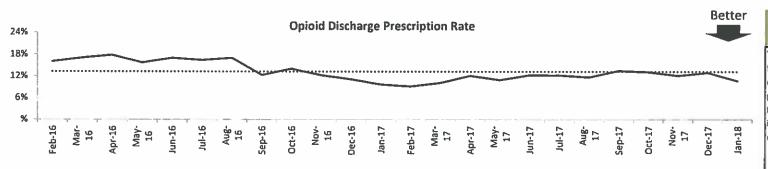


This process remains below CA Mean for a facility classified as a high volume facility/ED. Flu season has seen an increase in census, acuity, continue to monitor



### **Action Plan**

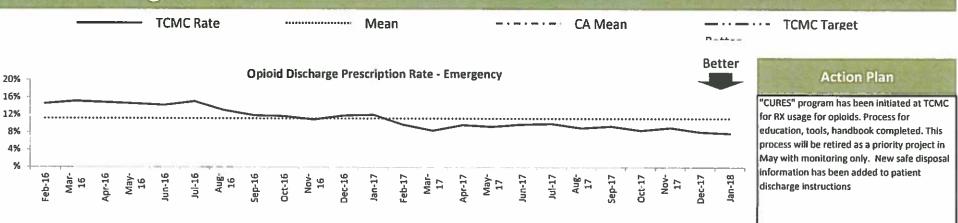
To-date TCMC is at 1.69%. The Goal for 2016 was 6.9%, Goal for 2017 was 3.5%. Achieved 2017 goal. Continue to improve with extended hours for provider coverage in "team triage", improve patient communication regarding wait times and all patients are regristered at Triage. No wall time implemented with noted improvements

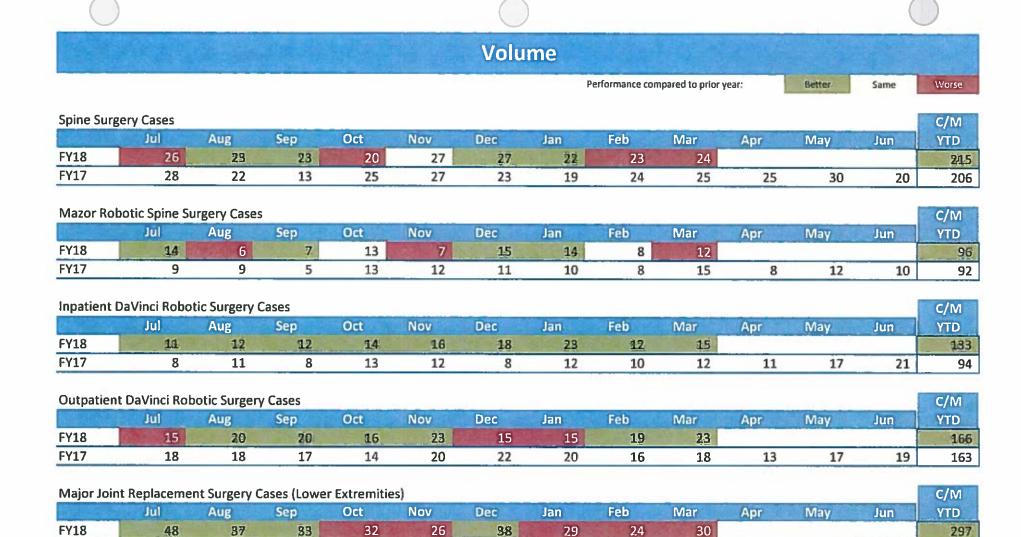


#### **Action Plan**

"CURES" program has been initiated at TCMC for RX usage for opioids. Process for education, tools, handbook completed. This process will be retired as a priority project in May with monitoring only. New safe disposal information has been added to patient discharge instructions

# **Current Trending Measures**





FY17

							Р	erformance cor	πpared to prior γ	/ear:	Better	Same	Worse
Inpatient E	Behavioral He	ealth - Avera	age Daily Ce	nsus (ADC)									C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7				14.4
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 Reh	ab Unit - Ave	rage Daily C	ensus (ADC	:)									C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	9.0	6.7	6.2	9.5	8.3	7.8	7.2	8.7	7.5				7.8
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	0.8	9.4	6.7
Neonatal I	ntensive Car	o Unit (NICU	I) - Average	Daily Conc	us (ADC)								chi
reconutari	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M
FY18	11.3	16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	Apr	iviay	Jun	YTD 12.9
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
10.00	0.00			10400			377		V 12	3			
Hospital -	Average Dail	ly Census (A	DC)				1112		0.00				C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	169.7	181.9	163.4	173.4	160.9	172.5	210.7	185.8	186.4		3000		178.3
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
Deliveries													C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	210	222	194	206	184	166	209	169	186				1,746
FY17	223	239	274	230	197	200	217	197	202	172	188	175	1,979
Innationt (	Cardiac Interv	vantions											CINA
mpatient	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	lun	C/M YTD
FY18	12	11	11	11	11	18	14	reu	IVIdI	Ahi	iviay	Jun	
FY17	12	11	12	16	11	14	15	11	6	15	12	18	88 91
1 (1/	14	11	14	10	11	14	13	11	O	13	12	10	21

								Performance co	ompared to prio	г уеаг:	Better	Same	Worse
Outpatien	nt Cardiac In	terventions		× .				73 - 18e 793					C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	4	7	7	3	4	3	4						32
FY17	4	4	6	6	5	7	2	2	7	9	6	1	34
Open Hea	irt Surgery C	ases											C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	8	7	7	11	3	14	11	10	4				75
FY17	10	9	8	7	6	9	8	6	16	9	6	6	79
TCMC Adj	usted Facto	r (Total Rev	enue/IP Rev	enue)									C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	1.75	1.80	1.81	1.80	1.83	1.72	1.64	1.77	1.78	2.5		8 69	1.76
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

# Financial Strength

TCMC C	Days in Accou		HE (M/N)								115-15-15		C/M	Goal
STATE OF THE PARTY.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
Y18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8			Sec.	48.9	48-52
Y17	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	
CMC	ays in Accou	ints Payable	(A/P)										C/M	Goal
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
Y18	82.1	79.1	78.8	83.4	87.7	81.3	82.9	85.2	78.8				82.1	75-100
Y17	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	
CHD E	ROE \$ in Tho	usands (Exce	ss Revenue o	ver Expenses	)								C/M	C/M
200	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budge
/18	(\$394)	(\$429)	(\$224)	(\$171)	(\$2,571)	(\$383)	(\$1,242)	(\$542)	(\$337)	NA PARIS			(\$6,294)	(\$76)
Y17	\$288	\$211	\$746	\$1,118	\$414	\$317	(\$226)	\$181	(\$2,912)	(\$63)	\$296	\$1,510	\$1,246	
CHD E	ROE % of Tat	al Operating	Revenue						ALANA A				C/M	C/M
Name and Address of the Owner, where	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budge
											and the state of t			_
/18		-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%				-7 33%	1 -0.03%
	-1.33% 1.04%	-1.39% 0.75%	-0.76% 2.69%	-0.55% 3.99%	-9.47% 1.51%	-1.26% 1.15%	-3.94% -0.79%	-1.86% 0.67%	-1.09% -9.92%	-0.22%	0.99%	5.04%	-2.33% 1.49%	-0.03%
Y17	-1.33% 1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%			-0.22%	0.99%	5.04%	1.49%	
Y17	-1.33% 1.04%	0.75%	2.69% rnings before	3.99%	1.51% es, Depreciati	1.15%	-0.79% ortization)	0.67%	-9.92%				1.49% C/M	C/M
Y17 CHD E	-1.33% 1.04% BITDA \$ in Th	0.75% housands (Ea	2.69% rnings before Sep	3.99% e Interest, Tax Oct	1.51% es, Depreciati Nov	1.15% on and Amo	-0.79% ortization) Jan	0.67% Feb	-9.92% Mar	-0.22% Apr	0.99% May	5.04% Jun	1.49% C/M YTD	C/M YTD Budg
Y17 CHD E Y18	-1.33% 1.04% BITDA \$ in Th	0.75% housands (Ea Aug	2.69% rnings before	3.99% Interest, Tax	1.51% es, Depreciati	1.15% on and Amo	-0.79% ortization)	0.67%	-9.92%				1.49% C/M YTD \$5,414	C/M YTD Budge
Y17 CHD E Y18 Y17	-1.33% 1.04% BITDA \$ in Th Jul \$898 \$1,583	0.75% housands (Ea Aug \$864	2.69% rnings before Sep \$1,091 \$2,015	3.99% Interest, Tax Oct \$1,146	1.51% les, Depreciati Nov (\$1,288)	1.15% on and Amo Dec \$908	-0.79% ortization) Jan \$81	0.67% Feb \$751	-9.92% Mar \$963	Арг	Мау	Jun	1.49% C/M YTD \$5,414 \$5,094	C/M YTD Budg \$11,999
Y17 CHD E Y18 Y17	-1.33% 1.04% BITDA \$ in Th Jul \$898 \$1,583	0.75% nousands (Ea Aug \$864 \$1,496	2.69% rnings before Sep \$1,091 \$2,015	3.99% Interest, Tax Oct \$1,146	1.51% les, Depreciati Nov (\$1,288)	1.15% on and Amo Dec \$908	-0.79% ortization) Jan \$81	0.67% Feb \$751	-9.92% Mar \$963	Apr. \$1,213	May \$1,558	Jun	1.49% C/M YTD \$5,414 \$5,094 C/M	C/M YTD Budg \$11,999
Y17 CHD E Y18 Y17 CHD E	-1.33% 1.04%  BITDA \$ in Th Jul \$898 \$1,583  BITDA % of T	0.75% housands (Ea Aug \$864 \$1,496 Total Operatio	2.69% rnings before Sep \$1,091 \$2,015	3.99% e Interest, Tax Oct \$1,146 \$2,365	1.51% res, Depreciati Nov (\$1,288) \$1,711	1.15% fon and Amo Dec \$908 \$1,556	-0.79%  ortization)  Jan  \$81  \$1,010	0.67% Feb \$751 \$1,428	-9.92% Mar \$963 (\$1,630)	Арг	Мау	Jun \$2,741	1.49% C/M YTD \$5,414 \$5,094	C/M YTD Budg \$11,999
Y17 CHD E Y18 Y17 CHD E	-1.33% 1.04%  BITDA \$ in Th Jul \$898 \$1,583  BITDA % of T	0.75% housands (Ea Aug \$864 \$1,496 fotal Operation	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep	3.99% e Interest, Tax Oct \$1,146 \$2,365	1.51%  res, Depreciati  Nov  (\$1,288)  \$1,711	1.15% fon and Amo Dec \$908 \$1,556	-0.79%  ortization)  Jan \$81 \$1,010	0.67%  Feb \$751 \$1,428	-9.92% Mar \$963 (\$1,630)	Apr. \$1,213	May \$1,558	Jun \$2,741	1.49%  C/M  YTD  \$5,414  \$5,094  C/M  YTD	C/M YTD Budg \$11,999 C/M YTD Budg
Y17 CHD E Y18 Y17 CHD E Y17	-1.33% 1.04%  BITDA \$ in Th Jul \$898 \$1,583  BITDA % of T Jul 3.03% 5.70%	0.75% housands (Ea Aug \$864 \$1,496  Total Operation Aug 2.80% 5.32%	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27%	3.99% e Interest, Tax Oct \$1,146 \$2,365  Oct 3.66% 8.43%	1.51%  res, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27%	1.15% fon and Amo Dec \$908 \$1,556 Dec 2.99%	-0.79%  prtization)  Jan \$81 \$1,010  Jan 0.26%	0.67%  Feb \$751 \$1,428  Feb 2.57%	-9.92%  Mar \$963 (\$1,630)  Mar 3.13%	Apr \$1,213 Apr	May \$1,558 May	Jun \$2,741 Jun	1.49%  C/M  YTD  \$5,414  \$5,094  C/M  YTD  2.00%  6.09%	C/M YTD Budg \$11,999 C/M YTD Budg 4.39%
Y17 CHD E Y18 Y17 CHD E Y18 Y17	-1.33% 1.04%  BITDA \$ in Th Jul \$898 \$1,583  BITDA % of T Jul 3.03% 5.70%	0.75% housands (Ea Aug \$864 \$1,496  Total Operation Aug 2.80% 5.32%	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27% lent) per Adje	3.99% e Interest, Tax Oct \$1,146 \$2,365 Oct 3.66%	1.51%  res, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27%	1.15% fon and Amo Dec \$908 \$1,556 Dec 2.99%	-0.79%  prtization)  Jan \$81 \$1,010  Jan 0.26% 3.52%	0.67%  Feb \$751 \$1,428  Feb 2.57% 5.28%	-9.92%  Mar \$963 (\$1,630)  Mar 3.13% -5.55%	Apr \$1,213 Apr 4.23%	\$1,558 May 5.21%	Jun \$2,741 Jun 9.16%	1.49%  C/M  YTD  \$5,414  \$5,094  C/M  YTD  2.00%  6.09%	C/M YTD Budg \$11,999 C/M YTD Budg 4.39%
Y17 CHD E Y18 Y17 CHD E Y18 Y17 CHD E	-1.33% 1.04% BITDA \$ in Th Jul \$898 \$1,583 BITDA % of T Jul 3.03% 5.70%	0.75% housands (Ea Aug \$864 \$1,496  Total Operation Aug 2.80% 5.32%  -Time Equiva	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27% lent) per Adju	3.99% e Interest, Tax Oct \$1,146 \$2,365  Oct 3.66% 8.43% usted Occupie	1.51%  res, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27%  ed Bed Nov	1.15% fon and Amo Dec \$908 \$1,556  Dec 2.99% 5.64%	-0.79%  prtization)  Jan  \$81  \$1,010  Jan  0.26%  3.52%	0.67%  Feb \$751 \$1,428  Feb 2.57% 5.28%	-9.92%  Mar \$963 (\$1,630)  Mar 3.13% -5.55%	Apr \$1,213 Apr	May \$1,558 May	Jun \$2,741 Jun	1.49%  C/M YTD  \$5,414  \$5,094  C/M YTD  2.00%  6.09%  C/M YTD	C/M YTD Budg \$11,999 C/M YTD Budg 4.39%
Y17 CHD E Y18 Y17 CHD E Y18 Y17 CMC P	-1.33% 1.04% BITDA \$ in The Jule \$898 \$1,583 BITDA % of Telegraph Jule 3.03% 5.70%	0.75% housands (Ea Aug \$864 \$1,496  Total Operation Aug 2.80% 5.32%  -Time Equiva Aug	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27% lent) per Adje	3.99% e Interest, Tax Oct \$1,146 \$2,365  Oct 3.66% 8.43%  usted Occupie	1.51%  res, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27% ed Bed	1.15% fon and Amo Dec \$908 \$1,556 Dec 2.99% 5.64%	-0.79%  prtization)  Jan \$81 \$1,010  Jan 0.26% 3.52%	0.67%  Feb \$751 \$1,428  Feb 2.57% 5.28%	-9.92%  Mar \$963 (\$1,630)  Mar 3.13% -5.55%	Apr \$1,213 Apr 4.23%	\$1,558 May 5.21%	Jun \$2,741 Jun 9.16%	1.49%  C/M  YTD  \$5,414  \$5,094  C/M  YTD  2.00%  6.09%	C/M YTD Budg \$11,999 C/M YTD Budg 4.39%
Y17 CHD E Y18 Y17 CHD E Y18 Y17 CMC P	-1.33% 1.04% BITDA \$ in The Jule \$898 \$1,583 BITDA % of Telegraph Jule \$5.70% Caid FTE (Fulle Jule 6.51 6.04	0.75% housands (Ea Aug \$864 \$1,496 Total Operation Aug 2.80% 5.32% -Time Equiva Aug 5.92 5.84	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27% lent) per Adju Sep 6.90 5.74	3.99% e Interest, Tax Oct \$1,146 \$2,365  Oct 3.66% 8.43% usted Occupie Oct 6.26 5.85	1.51%  les, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27%  ed Bed  Nov 6.50 6.43	1.15% fon and Amo Dec \$908 \$1,556  Dec 2.99% 5.64%  Dec 6.43	-0.79%  prtization)  Jan  \$81  \$1,010  Jan  0.26%  3.52%  Jan  5.95	0.67%  Feb \$751 \$1,428  Feb 2.57% 5.28%	-9.92%  Mar \$963 (\$1,630)  Mar 3.13% -5.55%  Mar 5.86	Apr \$1,213 Apr 4.23% Apr	May \$1,558 May 5.21%	Jun \$2,741 Jun 9.16% Jun	1.49%  C/M YTD \$5,414 \$5,094  C/M YTD 2.00% 6.09%  C/M YTD 6.24	C/M YTD Budg \$11,999 C/M YTD Budg 4.39%
Y17 CHD E Y18 Y17 CHD E Y18 Y17 CHD E Y18 Y17 CMC P	-1.33% 1.04% BITDA \$ in The Jule \$898 \$1,583 BITDA % of Telegraph Jule \$5.70% Caid FTE (Fulle Jule 6.51 6.04	0.75% housands (Ea Aug \$864 \$1,496 Total Operation Aug 2.80% 5.32% -Time Equiva Aug 5.92 5.84	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27% lent) per Adju Sep 6.90 5.74	3.99% e Interest, Tax Oct \$1,146 \$2,365  Oct 3.66% 8.43% usted Occupie Oct 6.26	1.51%  les, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27%  ed Bed  Nov 6.50 6.43	1.15% fon and Amo Dec \$908 \$1,556  Dec 2.99% 5.64%  Dec 6.43	-0.79%  prtization)  Jan  \$81  \$1,010  Jan  0.26%  3.52%  Jan  5.95	0.67%  Feb \$751 \$1,428  Feb 2.57% 5.28%	-9.92%  Mar \$963 (\$1,630)  Mar 3.13% -5.55%  Mar 5.86	Apr \$1,213 Apr 4.23% Apr	May \$1,558 May 5.21%	Jun \$2,741 Jun 9.16% Jun	1.49%  C/M YTD \$5,414 \$5,094  C/M YTD 2.00% 6.09%  C/M YTD 6.24	C/M YTD Budg \$11,999  C/M YTD Budg 4.39%  C/M YTD Budg
FY18 FY17 FCHD E FY18 FY17 FCMC P	-1.33% 1.04% BITDA \$ in The Jule \$898 \$1,583 BITDA % of Telegraph Jule 5.70% Paid FTE (Full-Jule 6.51 6.04 iquidity \$ in telegraph Jule 5.04	0.75% housands (Ea Aug \$864 \$1,496 fotal Operatin Aug 2.80% 5.32% -Time Equiva Aug 5.92 5.84 Millions (Cas	2.69% rnings before Sep \$1,091 \$2,015 ng Revenue Sep 3.69% 7.27% lent) per Adju Sep 6.90 5.74 n + Available	3.99% e Interest, Tax Oct \$1,146 \$2,365  Oct 3.66% 8.43% usted Occupie Oct 6.26 5.85  Revolving Lin	1.51%  les, Depreciati  Nov (\$1,288) \$1,711  Nov -4.74% 6.27% ed Bed Nov 6.50 6.43 e of Credit)	1.15% fon and Amo Dec \$908 \$1,556  Dec 2.99% 5.64%  Dec 6.43 6.16	-0.79%  prtization)  Jan  \$81  \$1,010  Jan  0.26%  3.52%  Jan  5.95  6.26	0.67%  Feb \$751 \$1,428  Feb 2.57% 5.28%  Feb 5.99 6.14	-9.92%  Mar \$963 (\$1,630)  Mar 3.13% -5.55%  Mar 5.86 6.25	Apr \$1,213 Apr 4.23% Apr 6.30	May \$1,558 May 5.21% May 6.18	Jun \$2,741 Jun 9.16% Jun 6.56	1.49%  C/M YTD \$5,414 \$5,094  C/M YTD 2.00% 6.09%  C/M YTD 6.24	C/M YTD Budge \$11,999  C/M YTD Budge 4.39%  C/M YTD Budge



# ADVANCED HEALTH CARE

# Construction Report As of March 2018

Project	FOP/Board Approval Date	% of Design	Construction Start or Estimated Construction Start Date	Estimated Construction Completion Date*	% of Construction Complete		Total Budget	Actual Expenditures		Remaining Budget	Status / Comments
R #3 Surgical Lights Replacement	July-17	100%	December-17	March-18	100%	\$	445,380.00	\$ 390,100.77	\$	55,279.23	Construction completed.
R #4 Surgical Lights Replacement	September-17	100%	April-18	July-18	0%	\$	510,761.00	\$ 39,855.87	\$		Scheduling construction.
etail Pharmacy	September-17	100%	January-18	April-18	80%	\$	373,293.00	<b>\$</b> 199,597.28	\$		Construction in progress.
HU Seclusion Room	September-17	100%	January-18	April-18	80%	5	295,482.00	\$ 22,755.66	\$		Construction in progress.
onocine Room Addition	December-17	100%	January-18	April-18	90%	S	257,082.00	\$ 34,338.46	\$		Construction in progress.
rrface Parking Lot	December-17	100%	February-18	June-18	40%	\$	2.473,975.00	\$ 344.553.00	s		Construction in progress.
Total Construction Projects							4,355,973.00				

\*Estimated completion is based on actual physical project progress and not on amounts invoiced to the District



# Tri-City Medical Center

**Building Operating Leases** 

		Base		Total Rent			
Lessor	Sq. Ft.	Rate per Sq. Ft.		per current month	Lease1 Beginning	ferm Ending	Services & Location
6121 Paseo Del Norte, LLC	34.71.	94, F t.	-	monu	Degillilling	Enang	Selvices & Locatori
6128 Paseo Del Norte, Suite 180							OSNC - Carlsbad
Carlsbad, CA 92011	Approx				ĺ		6121 Paseo Del Norte, Suite 200
V#83024	9,552	\$3.48	(a)	44,164.55	07/01/17	06/30/27	Carlsbad, CA 92011
American Health & Retirement		1	<del>\-/-</del>		01701111		Canada, Ortozott
DBA: Vista Medical Plaza	1	ļ.					
140 Lomas Santa Fe Dr., Ste 103	1		1				PCP Clinic - Venus
Solona Beach, CA 92075	Approx						2067 W. Vista Way, Ste 160
V#82904	1,558	\$2.39	/~>	4,917.74	01/27/17	05/21/20	Vista, CA 92083
	1,336	\$2.35	(8)	4,917.74	01/2//1/	03/31/20	VISIA, CA 92003
Camelot Investments, LLC				l			
5800 Armada Dr., #200							PCP Clinic - Radiance
Carlsbad, CA 92008	Approx		l				3998 Vista Way, Ste. C
V#15608	3,563	\$1.86	(a)	10,517.14	04/01/16	01/31/20	Oceanside, CA 92056
Cardiff Investments LLC							
2729 Ocean St							OSNC - Oceanside
Carlsbad, CA 92008							3905 Waring Road
V#83204	10,218	\$2.50	(a)	27,970.32	07/01/17	06/30/22	Oceanside, CA 92056
Creek View Medical Assoc							
1926 Via Centre Dr. Suite A							PCP Clinic - Vista
Vista, CA 92081	Approx						1926 Via Centre Drive, Ste A
V#81981	6,200	\$2.70	(a)	20,540.00	02/01/15	01/31/20	Vista, CA
CreekView Orthopaedic Bldg, LLC							
1958 Via Centre Drive							OSNC - Vista
Vista, Ca 92081	Approx						1958 Via Centre Drive
V#83025	4.995	\$2.50	(a)	15,184.80	07/01/17	06/30/22	Vista, Ca 92081
Efiln Investments, LLC	1,722		\-/	10,101,00	0		710(0) 00 02001
Clancy Medical Group					ļ		
20136 Elfin Creek Trail	1				[		PCP Clinic - Clancy
Escondido, CA 92029							2375 Metrose Dr. Vista
V#82575	3,140	\$2.56	(a)	9.642.26	12/01/15	12/31/20	Vista, CA 92081
GCO	10,110	Q2.00	\ <del>-</del> /	0,042,20	12/01/10	12101720	V1512, 071 52551
3621 Vista Way							Performance Improvement
Oceanside, CA 92056							3927 Waring Road, Ste.D
#V81473	1,583	\$1.92	/a)	3,398.15	01/01/13	03/31/18	Oceanside, Ca 92056
nvestors Property Mgmt. Group	1,003	91.02	14/	0,000.10	0./01/13	93/3/1/10	Occandide, Od 32000
c/o Levitt Family Trust							OP Physical Therapy
2181 El Camino Real, Ste. 206					1		OP OT & OP Speech Therapy
Oceanside, Ca 92054	1				i		2124 E. El Camino Real, Ste. 100
V#81028	5.214	\$1.86	(e)	10,640.98	09/01/17	09/24/40	Oceanside, Ca 92054
Welrose Plaza Complex, LP	3,214		(4)	10,040,80	09/01/17	00/31/19	OCEGII340E, QA 32034
c/o Five K Management, Inc.					i		
P O Box 2522							Outpotient Rehauteunt Health
F O Box 2522 La Jolla, CA 92038				Į.			Outpatient Behavioral Health
La Jolla, CA 92036 V#43849	7 247	\$1.35	,,	10 101 01	07/04/45		510 West Vista Way
OPS Enterprises, LLC	7,247	\$1.33	(4)	10,101.01	07/01/16	00/30/21	Vista, Ca 92083
							Chemotherapy/infusion Oncology
3617 Vista Way, Bldg. 5							Center
Oceanside, Ca 92056	4 700	64.40	<u>,                                    </u>	00.047.00	40/04/40	40/04/00	3617 Vista Way, Bidg.5
#V81250	4,760	\$4.12	(a)	26,047.00	10/01/12	10/01/22	Oceanside, Ca 92056
Ridgeway/Bradford CA LP							
DBA: Vista Town Center							
PO Box 19068							Vacant Building
rvine, CA 92663			, , <u> </u>			485-111-	510 Hacienda Drive Suite 108-A
/#81503	3,307	\$1.10	(a)	5,135.39	10/28/13	10/31/18	Vista, CA 92081
Tota	MI I		. I	\$ 188,259.34			

<sup>(</sup>a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.





Education & Travel Expense Month Ending March 2018

#### Cost

Centers	Description	Invoice #	Amount	Vendor#	Attendees
6010	2018 LEADERSHIP ACADEMY TRAINING	30918	310.00	83176	JONATHAN DEVERA
6150	LEAD ACADEMY MANAGEMENT TRAINING	22118	420.09	77699	EMMA HILBOURN
6185	ONS CANCER CERTIFICATION	21318	220.00	83227	GEMMA-ELIZABETH MARIE JOHNSON
6185	ONCOLOGY CERTIFICATION	22118	240.00	80084	COURTNEY NELSON
7427	CPAN RECERTIFICATION	32018	315.00	80547	ALYCE BUDDE
7770	ONSITE DOCUMENTATION BOOTCAMP EDU	31318	3,870.00	83228	PHYSICAL THERAPY STAFF
7772	ONSITE DOCUMENTATION BOOTCAMP EDU	31318	1,000.00	83228	OP PHYSICAL THERAPY STAFF
7777	ONSITE DOCUMENTATION BOOTCAMP EDU	31318	1,870.00	83228	PT & OP CARLSBAD STAFF
7781	ONSITE DOCUMENTATION BOOTCAMP EDU	31318	500.00	83228	SPEECH THERAPY STAFF
7781	NEONATAL FEES ENDESCOPY	22818	750.00	63110	ELISA BENNETT SOTO
7790	ONSITE DOCUMENTATION BOOTCAMP EDU	31318	500.00	83228	OCCUPATIONAL THERAPY STAFF
8340	DISHMACHINE CLEANING & TRAINING	33446702	232.86	33407	FOOD & NUTRITION STAFF
8390	CHA MED SAFETY COMMITTEE	11618	195.27	81328	THERESA VIDALS
8450	CSHE ANNUAL MTG	30118	425,00	15332	CHRIS MIECHOWSKI
8450	CSHE ANNUAL MTG	30118	425.00	15332	STEVE BERNER
8618	2018 MANAGED CARE SYS ENHANCEMENT CONFERENCE	30518	200.00	82657	ANDREW SPRINGETT
8620	CHA GOVERNANCE QTR MEETING - TRAVEL	21418	303.88	81515	JAMES DAGOSTINO
8700	HEALTH RECORD CONFIDENTIALITY	31218JEN#	275.00	15106	NORRINE JENKINS
8710	CHIEF OF STAFF BOOT CAMP	31418	1,228,56	82538	SHERRY MILLER
8740	ONS/ONCC CHEMOTHERAPY RENEWAL CERTIFICATION	30218	103.00	81066	KIM MARKS
8740	PCCH RECERTIFICATION	30218	120.00	80741	SHIRLEY BENTLEY
8740	PCCN RECERTIFICATION	30218	120.00	79041	TINA WOODEN
8740	NEONATAL RESUCITATION PROVIDER	30218	140.00	81968	KARMEN FRANCES SALGADO
8740	PALS FULL COURSE	31618	148.00	83223	CAMPBELL, KEISHA
8740	ACLS RECERTIFICATION	30218	150.00	82656	ADAYA, ALEX
8740	ADVANCED CARDIOVASCULAR LIFE SUPPORT	30918	150.00	79011	MARIA CYNTHIA TESTMAN
8740	ACLS RECERTIFICATION	32318	150.00	81974	MARIA ESCUETA-JACKSON
8740	ACLS RECERTIFICATION	30218	160.00	80644	MARIE T. WATKINS, RN
	ACLS RECERTIFICATION	32318	200.00	82653	DANIEL BARNES
8740	AWHONN FETAL MONITORING INSTRUCTOR CLASS	31618	200.00	47320	DEE ANN G. NISHIOKA
8758	HOSPITAL ACCREDIDATION ESSENTIALS - JOINT COMMISSION	32118	1,193.10	83225	KELLY WELLS

<sup>\*\*</sup>This report shows reimbursements to employees and Board members in the Education

<sup>&</sup>amp; Travel expense category in excess of \$100.00.

<sup>\*\*</sup>Detailed backup is available from the Finance department upon request.