TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A REGULAR MEETING November 8, 2018 – 2:00 o'clock p.m. Classroom 7 - Eugene L. Geil Pavilion Open Session – Assembly Rooms 1, 2 & 3 4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	1.5 hours	
	a. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (Matters)		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new services or programs Date of Disclosure: Various		
	d. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard

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
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Special Recognitions –		
	a) Recognition of former Board Committee Community Members on Board Committees that have been dissolved: 1) Employee Fiduciary Committee-	10 min.	Chair
	a) Gwen Sanders		
	2) Human Resources Committee – a) Gwen Sanders b) Joe Quince		
	3) Governance & Legislative Committee – a) Dr. Paul Slowik b) Robin Iveson		
	b) Dr. Gene Ma and Emergency Department Recognition	10 min.	CNE
13	Educational Presentation –		
	a) "Speak Up" Culture – Carlos Cruz, CCO	10 min.	cco
14	Report from TCHD Auxiliary – Mary Gleisberg, President	10 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	Report from Chief Governmental External Affairs Officer	10 min.	Standard
19	New Business 1) Consideration to approve a Physician Recruitment Agreement with Dr. Hussna Wakily, General Surgeon	10 min.	Sr. Dir./Busi. Development
20	Old Business – None		
21	Chief of Staff – No Credentialing Actions	5 min.	Standard
22	Consideration of Consent Calendar	5 min.	Standard
	Administrative & Board Committees		
	(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.		
	(2) All items listed were recommended by the Committee.		

 Agenda Item	Time Allotted	Requestor
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(3) Requested items to be pulled <u>require a second</u> .		
(1) Administrative Committee		
 a) Patient Care Policies & Procedures 1) Fire Prevention & Management In Invasive Procedure Areas 2) Off Unit Transfer Policy (DELETE) 3) Outpatient Post Anesthesia Procedure Discharge Transportation Guidelines Policy 4) Pain Management Policy 5) Patient Food Refrigerators/Freezers Procedure 6) Patient Transport Log Procedure (DELETE) 7) Pneumatic Tourniquet Machine Procedure 8) Preventing Admissions and Procedures Beyond Medical Staff Privileges Policy 9) Transfer of Patients, Intra-Facility 10) Vaginal Packaging for Gyn and or Urological Surgery Patients, Removal of Procedure 		
b) Acute Care 1) Scope of Services		
c) Pre-printed Orders1) Discharge Referral Services Orders 8711-4539 (DELETE)		
 d) Rehabilitation 1) Mission Statement – 100 2) Staff Meetings 3) Statement of Accountability – 102 		
e) Surgical Services 1) Post Anesthesia Patient Discharge Transportation Guidelines Policy (DELETE)		
(2) Board Committees		
A. Community Healthcare Alliance Committee Director Nygaard, Committee Chair (No meeting held in October, 2018)		CHAC Comm.
B. 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.
 Approval of an agreement with The Regents of the University of California, Team Physicians of Southern California Medical Group and Tri-City Healthcare District for an Emergency Residency Program to provide education and training to trainees, for a term of 60 months, beginning July 1, 2018 through June 30, 2023, for an annual cost of \$104,689.56 and a total cost for the term of \$523,447.80. Approval of an agreement with Dr. Dandy Lee as the Medical 		*

Agenda Item	Time Allotted	Requestor
1, 2018 through September 30, 2020, not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of \$150 for an annual cost not to exceed \$28,800 and a total cost for the term, not to exceed \$57,600.		
3) Approval of an agreement with Choctaw Construction Company, Inc. for \$582,785 and the total project budget of \$1,099,949 for Pharmacy USP 800 upgrades.		
4) Approval of an agreement with Becton Dickinson-Pyxis for lease of medical supply automated cabinets for a term of 60 months, beginning February 1, 2019, and ending January 31, 2024 for an annual cost of \$406,320 and a total cost for the term of \$2,031,600.		
5) Approval of an agreement with Dr. Anton Kushnaryov as an ED-Call coverage physician for ENT for a term of 12 months, beginning July 1, 2018 through June 30, 2019, at a daily6 rate of \$550, for a term cost of \$200,750.		
6) Approval to add Dr. Raheleh Esfandiari to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 21 months, beginning October4 1, 2018 through June 30, 2020.		1
C. Professional Affairs Committee Director Grass, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes)		PAC
a) Policies & Procedures:		
Patient Care Services Policies & Procedures: a) Transferring and Receiving Patients from Outside Tri-City Medical Center		
Administrative a) Employee Compensation		
Patient Care Management a) Utilization Management Plan		Audit Come
D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 0		Audit, Comp. & Ethics Comm.
(Committee minutes included in Board Agenda packets for informational purposes)		
Approval to appoint Kathryn Fitzwilliam to the role of "Subject Matter Expert".		

	Time	
Agenda Item	Allotted	Requestor

	(3) Minutes – Approval of:		Standard
	 a) Special Board of Directors Meeting – September 25, 2018 b) Regular Board of Directors Meeting – September 27, 2018 		
	(4) Meetings and Conferences – None		
	(5) Dues and Memberships - None		
23	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
24	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (September, 2018) (d) Reimbursement Disclosure Report – September, 2018) (e) Seminar/Conference Reports – None	0-5 min.	Standard
25	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board on any item not on the agenda.	5-10 minutes	Standard
26	Additional Comments by Chief Executive Officer	5 min.	Standard
27	Special Recognition		1.00
	a) Cyril F. Kellett – for dedication, commitment and service on the Tri-City Healthcare District Board of Directors over the past 29 years	10 min.	Chair
28	Board Communications (three minutes per Board member)	18 min.	Standard
29	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2.5 hours	
30	Oral Announcement of Items to be Discussed During Closed Session		
31	Motion to Return to Closed Session (if needed)		
32	Open Session		
33	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
34	Adjournment		







Physician Recruitment Proposal – General Surgery

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

Physician Name: Hussna Wakily, M.D.
Areas of Service: General Surgery

Key Terms of Agreement:

Effective Date: January 1, 2019 or the date Dr. Wakily becomes a credentialed member in good

standing of the Tri-City Healthcare District Medical Staff

Community Need: TCHD Physician Needs Assessment shows significant community need for General

Surgery

Service Area: Area defined by the lowest number of contiguous zip codes from which the hospital

draws at least 75% of its inpatients

Income Guarantee: \$650,000 NTE (\$325,000 per year) for a 2-year income guarantee followed by 3-year

forgiveness

Sign-on Bonus: \$20,000

Relocation: \$10,000 (Not part of the loan)

Loan Amount, Not to Exceed: \$670,000 Total Spend: \$680,000

Unique Features: Dr. Wakily will join the group practice of Coastal Surgeons with Drs. Jamshidi, Deemer & Toosie

Requirements:

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

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development / Scott Livingstone, Chief Operating Officer

Motion:

public health of the communities served by the District to approve the loan amount, not to exceed \$670,000 and a total expenditure of \$680,000, in order to recruit Hussna Wakily, M.D. as a General Surgery physician practicing medicine in the communities served by the District. This will be accomplished through a Group Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) with Coastal Surgeons.





ADMINISTRATION REVIEW CONSENT AGENDA October 18th, 2018

CONTACT: Sharon Schultz, CNE

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Policies and Procedures	Reason	Recommendations				
Patient Care Services Policies & Procedures						
Fire Prevention & Management In Invasive Procedure Areas	3 Year Review, Practice Change	Forward to BOD for Approval				
2. Off Unit Transfer Process Policy	DELETE	Forward to BOD for Approval				
Outpatient Post Anesthesia Procedure Discharge Transportation Guidelines Policy	3 Year Review, Practice Change	Forward to BOD for Approval				
4. Pain Management Policy	3 Year Review, Practice Change	Forward to BOD for Approval				
Patient Food Refrigerators/ Freezers Procedure	Practice Change	Forward to BOD for Approval				
Patient Transport Patient Transport Log Procedure	DELETE	Forward to BOD for Approval				
7. Pneumatic Tourniquet Machine Procedure	3 Year Review, Practice Change	Forward to BOD for Approval				
 Preventing Admissions and Procedures Beyond Medical Staff Privileges Policy 	3 Year Review, Practice Change	Forward to BOD for Approval				
9. Transfer of Patients, Intra-Facility	3 Year Review, Practice Change	Forward to BOD for Approval				
10. Vaginal Packaging for Gyn and-or Urological Surgery Patients, Removal of Procedure	3 Year Review, Practice Change	Forward to BOD for Approval				
Acute Care						
Scope of Services	Practice Change	Forward to BOD for Approval				
Pre-Printed Orders						
 Discharge Referral Services Orders 8711- 4539 	DELETE	Forward to BOD for Approval				
Rehabilitation						
1. Mission Statement - 100	3 Year Review	Forward to BOD for Approval				
2. Staff Meetings	3 Year Review	Forward to BOD for Approval				
3. Statement of Accountability - 102	3 Year Review	Forward to BOD for Approval				
Surgical Services						
Post Anesthesia Patient Discharge Transportation Guidelines Policy	DELETE	Forward to BOD for Approval				

Tri-City Me	dical Center	Distribution: Patient Care Services		
PROCEDURE:	FIRE PREVENTION AND MANAG	SEMENT IN INVASIVE PROCEDURE AREAS		
Purpose:	of fire in invasive procedures, and event of a fire in the invasive proce To heighten awareness of increases.	for a fire to occur, describe factors to reduce the risk outline responsibilities of each team member in the edure area. ased fire risk during airway, head, neck, and upper tocol to mitigate fire risk during these procedures.		
Supportive Data:	Communication between health a safe environment in surgery.	care team members is essential in order to provide All staff involved with head and neck surgery shall e surgical procedure to prevent or manage a fire. IFPA)		
Equipment:	· · · · · · · · · · · · · · · · · · ·			

A. <u>DEFINITIONS</u>:

1. <u>Head and neck surgery</u>: Any procedure performed on the body above the level of the xiphoid process (i.e., procedures performed on the airway, head, neck and upper chest).

A.B. BACKGROUND:

- Fire requires the presence of three components, known as the "fire triad" or "fire triangle":
 - Fuel— All materials can burn in an oxygen-enriched environment. The list of flammable materials-Fuel sources in surgery include, but are not limited to, includes, but is not limited to, drapes, dressings, gowns, mattresses, sheets, towels, gauze, syringes, hair, gastrointestinal gases, petroleum-based ointments, alcohol-containing solutions (e.g., certain prep solutions), most plastics (e.g., oxygen masks, nasal cannulae, tracheal tubes, suction catheters), flexible endoscopes, fiberoptic cable coverings, packaging materials, and body tissue (eschar can ignite). Preventing contact between fuels and ignition sources breaks the fire triangle, thereby preventing fire.
 - b. Oxidizer—An oxidizer-enriched atmosphere occurs when there is any increase in oxygen concentration above room air level, and/or in the presence of any concentration of nitrous oxide. Examples of oxidizers in surgery are Ooxygen, and nitrous oxide, medical-air, and ambient air-support a fire. An oxidizer-enriched atmosphere increases the likelihood and intensity of combustion. Any concentration of oxygen in excess of 21 percent is considered enriched. An oxidizer-enriched atmosphere commonly exists within closed or semi-closed breathing systems, including the patient's airway. Gases can accumulate around the operative site as well as under drapes and in body cavities, such as the oropharynx.
 - c. Ignition Sources—Include electrosurgical units (used for hemostasis, cutting of tissues, and ablation of surface tissues), fiber-optic light sourcescables (tips can become quite hot, contact must be avoided with the drapes, the patient, and personnel due to potential for burns), high speed-drills and burrs (produce incandescent sparks that can fly off the target tissue and ignite some fuels, especially in an oxygen enriched atmosphere), defibrillator paddles or pads (generate a significant spark), and lasers.
- 2. Fire is a risk to both patients and personnel in the operating room because all three elements of the fire triangle (i.e., the necessary elements for a fire to occur) typically are present.
- 3. The surgical team shall manage ignition sources, fuel and oxidizers.
- 4. Approximately 65% of surgical fires occur in the airway, head, neck, or upper chest.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/09, 5/12, 06/18	05/12, 06/18	05/12, 0718	07/18	n/a	06/12, 09/18	10/18	07/12, n/a	07/12



B.C. FIRE PREVENTION IN THE INVASIVE PROCEDURE AREA:

- Manage ignition sources appropriately:
 - Follow all safety guidelines when using cautery, lasers, high-speed drills, burrs, fiber optic light sources, and defibrillators.
 - b. Control electrosurgical units carefully:
 - i. Holster electrocautery pencils while not in use. Do not allow heat sources (such as cautery tips or activated light cords) to contact the drapes.
 - ii. Verbally confirm heat source settings with the surgeon and use the lowest settings possible.
 - ii.iii. The electrocautery device should be hand-controlled, with an on/off switch.
 - iii.iv. Allow the electrocautery device to be activated only by the person wielding it.
 - iv.v. Deactivate the electrocautery device before removing it from the surgical site.
 - ↓-vi. If open O₂ sources are employed, use bipolar electrocautery whenever possible and clinically appropriate (i.e., for cauterization during head and neck surgery, including tracheal and oral surgery). Bipolar electrocautery creates little or no sparking or arcing.
 - vi.vii. Never use insulating sleeves cut from catheters over electrocautery active electrode tips.
 - vii.viii. Electrocautery is not recommended to enter the trachea during tracheostomy. If deemed necessary to use electrocautery to enter the trachea, the surgeon/procedural physician and Anesthesiologist must confer prior to the procedure. The anesthesiologist shall be provided adequate warning before the trachea will be opened.
 - c. Fiber-optic light cable management:
 - i. Fiber- optic light cables may provide an ignition source if they are disconnected from the working element (e.g., scope). Avoid contact of fiber-optic light cord tip to drapes, sponges, or other fuel sources.
 - ii. The end of the scope may become hot if an attached light cord has been on.

 Never place the scope down on the patient or drapes. During periods of nonuse, place the light source in standby mode and place the scope on a mayo
 stand or basin.
 - iii. Members of the surgical team shall communicate changes in light source status, (i.e., standby versus on).
 - e.d. Laser management (contracted service):
 - i. A laser-trained nurse-or-technician will be provided to operate the laser, and will not leave the procedure area while the laser is in use. If an RN-is-operating the laser, a second RN-will assume the circulating role.
 - Place the laser in stand-by mode when not in active use.
 - iii. Activate the laser only when the tip is under the surgeon's direct vision.
 - iv. Allow only the person-using-the laser to activate-it contract laser technician to operate/activate the laser.
 - v. Deactivate the laser and place it in standby mode before removing it from the surgical site.
 - vi. When performing laser surgery through an endoscope, pass the laser fiber through the endoscope before introducing the scope into the patient. This will minimize the risk of damaging the fiber. Verify the fiber's functionality before inserting the scope in the patient.
 - vii. During lower-airway surgery, keep the laser fiber tip in view and make sure it is clear of the end of the bronchoscope or tracheal tube before laser emission.
 - viii. Use appropriate laser-resistant tracheal tubes during upper-airway surgery. Follow the directions in the product literature and on the labels, which typically include information regarding the tube's laser resistance and use of dyes in the cuff.

- ix. To indicate a puncture, use saline fill to prevent cuff ignition, and immediately replace the tube if the cuff becomes punctured.
- 2. Coordinate with the anesthesiologist to manage oxygen sources appropriately:
 - a. At all times, the minimum concentration of oxygen shall be used to provide for adequate oxygenation of the patient.
 - b. The anesthesiologist shall administer oxygen at FiO₂ of 0.30. Total fresh-gas flow of 12L/minute-or greater shall-be utilized for this to prevent-rebreathing of expired gases and dilution-by room air.
 - i. The anesthesia provider shall alert the surgical team of the need to increase the inspired oxygen concentration if acceptable oxygen saturation is not obtained using this concentration.
 - ii. Oxygen shall be titrated up incrementally to achieve adequate oxygen saturation.
 - iii. FiO₂ of 0.35 or greater, the surgical team shall re-assess the fire safety precautions planned for the procedure and make any adjustment necessary to ensure ignition potential and fuel sources have been minimized.
 - a. Turn off nasal oxygen (as tolerated by the patient) while using cautery and laser around the face.
 - b.c. The anesthesiologist shall be provided adequate warning before an ignition source is activated in the presence of open gas delivery. If possible, stop supplemental O₂ delivery (if-concentration is more than 30%) at least one minute before and during use of an electrocautery device or laser, or decrease the oxygen concentration to the minimum required to avoid hypoxia. beginning the use of electrocautery or laser surgery on the head-or-neck. If possible, stop the use of nitrous oxide one to three minutes before and during use of an electrocautery device or laser.
 - If open oxygen delivery is planned during a head and neck-surgery, the anesthesiologist shall consider the use a laryngeal mask airway (LMA) for monitored anesthesia care with moderate to deep sedation or if the patient exhibits oxygen dependence.
 - d. BIPAP machines are not allowed in the Operating Room. Continuous Positive Airway Pressure (CPAP) modality is available on the North American Dragaer Apollo® Aanesthesia Mmachines.
 - e.e. Minimize the buildup of O₂ and N₂O (i.e., from an uncuffed tracheal tube or a laryngeal mask-airwayopen oxygen delivery) beneath the drapes.
 - i. Use a properly applied incise drape, if possible, to help isolate head and neck incisions from O₂-enriched atmospheres and from flammable vapors beneath the drapes. Proper application of an incise drape ensures that there are no gas communication channels from the under-drape space to the surgical site.
 - ii. Use active gas scavenging of the space beneath drapes during open O₂ delivery, or of the oropharynx of an intubated patient. When scavenging beneath drapes, exercise caution so the space beneath the drapes does not collapse.
 - iii. During surgery in the oropharynx, consider using suction to scavenge the field prior to use of an ignition source. Metal suction tips are preferred over plastic suction tips in this situation.
 - iii-iv. Use suction as near as possible to any potential breathing gas leak to scavenge the gases from the oropharynx of an intubated patient.
 - v. Consider delivery of 5-10L/minute of air under the drapes to wash out excess oxygen.
 - iv-vi. Never use the drapes as a tent to enrich the oxygen atmosphere as a spark can ignite them. It is possible for the drapes to become engulfed in flames.
- Use of Fflammable agents:
 - a. When using flammable agents for surgical skin preps, such as alcohol-based products:
 - i. , aAllow adequate time for prep to dry and vapors to dissipate before applying drapes and using surgical equipment. Follow prep manufacturer's instructions for use (IFU) guidelines for recommended dry time.

- ii. Avoid pooling or wicking of flammable liquid preps. If pooling has occurred, it must be corrected and site must be allowed adequate dry time, before surgical drapes are applied.
- a.iii. Solution-soaked materials must be removed from the surgical field prior to draping and use of surgical devices.
- b. Be aware of the flammability of tinctures, solutions, and dressings used during procedures, and take steps to avoid igniting their vapors.
- c. Avoid the use of petroleum-based eye ointments, as they are potentially flammable.
- 4. Coat facial-hair (including eyebrows, beard, and mustache) near the surgical site with water-soluble surgical lubricating jelly to make the hair nonflammable.
- 5. Moisten sponges and gauze when used in proximity to ignition sources.
- 6. Have solutions on the surgical field (saline and/or water) at the start of each case to quickly douse fire if needed.
 - In addition to ordered irrigation fluids, water is required to be on the surgical field at the start of the case (with the exception of open heart cases, in which other fluids are used).
 - a-b. In all head and neck surgeries, a 30-60mL syringe of saline shall be available on the surgical field.
- 7. Know the type and locations of fire extinguishers in the procedure area.
- 8. Always have a bed or transport gurney available immediately outside of the procedure room for easy accessibility in the event of evacuation.
- 9. Continuously monitor throughout the procedure for early warning signs of fire, including an unexpected flash, flame, smoke or heat, unusual sounds (e.g., a "pop", "snap" or "foomp") or odors, unexpected movement of drapes, discoloration of drapes or breathing circuit, or unexpected patient movement or complaint.
- 10. For all procedures above the xiphoid process (i.e., surgeries/procedures in the airway, head, neck and upper chest) perform a Fire Safety Time Out before the start of the procedure. The Fire Safety Time Out shall include the following:
 - a. If open delivery of oxygen is necessary, the anesthesiologist and surgeon shall confirm the oxygen concentration.
 - i. Consider the use of medical air rather than oxygen, if patient condition permits.
 - ii. Assess the need for 100% oxygen during open delivery; limit oxygen concentration to 30%, if possible.
 - iii. Consider the use of suction to scavenge under the drapes when open delivery of oxygen is used.
 - iv. Changes in oxygen concentration delivered shall be communicated to the team throughout the procedure.
 - b. Arrange drapes to minimize oxygen build-up (i.e., no tenting of drapes).
 - c. Apply an incise drape to the surgical area to isolate the head and neck area from oxygen and flammable vapors, if possible.
 - d. Confirm water is available on the sterile field, in a labeled basin/pitcher. Saline may be used in the event that water is contraindicated on the field for a particular procedure (e.g., open hearts).
 - e. Coat hair within the prep area with water-soluble lubricating jelly.
 - f. Set heat sources on the lowest settings possible.
 - g. During tracheal/oral surgery:
 - i. Use bipolar electrocautery, if possible.
 - ii. Scavenge the field with a metal suction tip prior to using an ignition source.
 - iii. Consider Ppacking wet sponges around an uncuffed endotracheal (ET) tube to minimize leakage of gases.
 - h. During laser surgery:
 - i. Use a laser resistant ET tube.
 - ii. Use a cuffed ET tube, if possible, inflated with saline and dye in the cuff to act as a marker for cuff puncture.
 - 8-iii. Consider Ppacking the back of the throat with wet sponges.

G.D. FIRE MANAGEMENT IN THE INVASIVE PROCEDURE AREA:

- 1. If a fire occurs on the sterile field, immediately announce to the procedural team that there is a fire, halt the procedure, and institute "RACE"
 - a. Rescue
 - i. Immediately douse the fire with water or saline, if possible.
 - ii. If feasible, immediately stop the delivery of oxygen or nitrous oxide until the fire is extinguished.
 - iii. If fire persists, pull the burning drapes to the floor (away from the patient, personnel, and equipment, if possible).
 - iv. Protect the patient to limit injury.
 - v. If the fire continues, control bleeding, cover the wound in a sterile manner (if possible), and prepare to move the patient and personnel to a safe area.
 - b. Activate
 - Dial "66" and state "Code Red in (state location)".
 - ii. Call for help to the location of the fire.
 - c. Contain
 - Keep doors of procedural area closed to prevent spread of smoke and/or fire to other areas.
 - d. Extinguish/Evacuate
 - i. If fire continues, attempt to extinguish with fire extinguisher.
 - 1) Know the type and location of fire extinguishers in the procedural area, what type of fire you have and how it is to be extinguished.
 - 4)2) Each OR is equipped with a CO₂ fire extinguisher.
 - ii. If fire persists, the patient and personnel must be horizontally evacuated to a safe area on the same floor.
 - iii. Maintain an accurate count of patients and staff members during the evacuation.
 - iv. After evacuation of the procedural room, the last person to leave the room should close the doors and place a wet towel **or blanket** at the base of the door.
 - v. Turn off medical gas supply to the room as directed by the anesthesiologist.
- 2. Roles of Procedural Team Members during a fire (as applicable to the procedural area):
 - a. Circulating Nurse
 - i. Alert necessary personnel by activating the fire alarm system- Call "66" and state "Code Red in (state location)."
 - ii. Ensure patient's safety by remaining with him / her and offering support.
 - iii. Extinguish small fires or douse with liquid if appropriate.
 - iv. Remove any burning material from the patient or sterile field, and extinguish it on the floor.
 - v. Prevent fire from spreading to shoes or clothing by not stepping on **itburning** materials.
 - vi. Provide the scrub person and anesthesia care provider with needed supplies.
 - vii. Collaborate with the anesthesia care provider on the need to turn off the medical gas shutoff valves (when applicable).
 - viii. Carefully unplug all equipment if the fire is electrical.
 - ix. Be aware of the safest route for evacuation.
 - x. Obtain a transport gurney if necessary.
 - xi. Remove IV solutions from poles and place them with the patient for transporting out of the invasive procedure area.
 - xii. Help the anesthesia care provider disconnect any leads, lines, or other equipment that may be needed for transporting the patient without delay in leaving the procedural area.
 - b. Scrub Nurse/Technician
 - Remove materials from the patient that may be on fire and douse the fire on the field with water or saline.
 - ii. Assist with the conclusion of the procedure, if possible.

- iii. Obtain sterile towels or covers for the surgical site and instruments.
- iv. Gather a minimal number of instruments onto the Mayo Tray or Basin and place them with the patient for transport.
- v. Assist with patient transfer from the procedure table to the Gurney / Bed for transport out of the procedural area.

c. Surgeon/Procedural Physician

- Remove materials from the patient that may be on fire and douse fire on the field with water or saline.
- ii. Control bleeding and prepare the patient for evacuation.
- iii. Place sterile towels or covers over the surgical site.
- iv. Conclude the procedure as soon as possible if the patient is not in immediate danger.
- v. If necessary, help move the patient for evacuation out of the procedure area.

d. Anesthesiologist

- i. Shut off the flow of oxygen/nitrous oxide to the patient or field and maintain breathing for the patient with a valve mask respirator (i.e., Ambu bag).
- ii. Collaborate with the circulating nurse on the need to turn off the medical gas shutoff valves.
- iii. Disconnect all electrically powered equipment on the anesthesia machine.
- iv. Disconnect any leads, lines, or other equipment that may be anchoring the patient to the area.
- v. Maintain the patient's anesthetic state and collect the necessary medications to continue anesthesia during transport.
- vi. Place additional IV fluids on the bed for transport with the patient, if time permits.

e. Shift Supervisor/Manager

- i. Document time the fire started.
- ii. Establish how many people are in the department.
- iii. Set up a communication point and identify a person to staff it.
- iv. Determine the state of ongoing surgeriessurgery / procedures in each area.
- v. Consult with the Anesthesia Care Provider (when applicable) in charge on how to handle each patient.
- vi. Assign personnel to assist where needed.
- vii. Ask visitors to leave if necessary.
- viii. Evacuate patients who may need to be moved immediately.

f. Ancillary Personnel

- i. Help clear corridors for evacuation.
- ii. Secure equipment for transporting the patient as directed by the circulating nurse.
- iii. Follow instructions for evacuating the patient if needed.
- iv. Assist as directed.
- 3. For a fire in the airway or breathing circuit, as fast as possible:
 - a. Remove the tracheal tube.
 - b. Stop the flow of all airway gases.
 - c. Remove all flammable and burning materials from the airway.
 - d. Pour saline or water into the patient's airway.
 - e. If the airway or breathing circuit fire is extinguished, the Anesthesiologist will reestablish ventilation by mask, avoiding supplemental oxygen and nitrous oxide if possible.
 - f. Extinguish and examine the tracheal tube to assess whether fragments were left in the airway.
 - Consider bronchoscopy to look for tracheal tube fragments, assess injury, and remove residual debris.
 - g. Assess the patient's status and devise a plan for ongoing care.
- 4. Ongoing care involves management of the burn. Call for specialty consults as directed by the surgeon/procedural physician.
- 5. Keep accurate records of all events surrounding the incident.

- 6. Continue to provide follow-up medical and/or surgical care until patient is discharged to postprocedural area.
- 7. After the fire, quarantine all of the involved equipment and materials, and have it checked and catalogued by Biomed.
 - a. The Safety Officer, Biomed, and the Fire Marshall may conduct a thorough investigation of the cause of the fire.
- 8. Debrief the staff involved in the incident, and evaluate systems and procedures to prevent fires in the procedural area and to effectively manage fires that occur.
- 9. Report instances of procedural fires as a means of raising awareness and ultimately preventing the occurrences of fires in the future. Reports can be made to The Joint Commission, ECRI (Medical Device Safety Reports), and the Food and Drug Administration.

E. RELATED DOCUMENT(S):

Code Red Fire Drill Evaluation Form

D.F. REFERENCE(S):

- AORN Perioperative Standards and Recommended Practices, 2011
- 1. Practice Advisory for the Prevention and Management of Operating Room Fires, An Updated Report by the American Society of Anesthesiologists Task Force on Operating Room Fires: Anesthesiology, 20082013; 118:00-00., 108: 786-801.
- 2. Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.
- 2.3. Rothrock, J. C. (2015). Alexander's Care of the Patient in Surgery (15th ed). St. Louis, MO: Elsevier.

	Invasive-Areas Code Red Fire Drill Evaluation Form									
Fi	Fire drill date: Designated observer:									
Cr	iteria:	Yes	No	Comments						
	Evacuation plan is posted.									
	Randomly chosen staff member(s)									
	Describes evacuation routes									
	Knows how to report a fire			-						
	 Knows location of extinguisher 									
•	Fire extinguishers									
	 In place, seal intact, charged, properly mounted 									
	 Labeled as to type and class of fire 									
	Serviced within past 12 months									
	Checked monthly									
	 Staff member describes how to operate fire extinguisher by using PASS method 									
•	Fire exits									
	Free and unobstructed									
	Marked with working illuminated signs									
•	Corridors of egress are free of equipment / obstructions									
•	Fire / smoke barrier doors closed during activation of pull station									
•	Staff members activated RACE, the standard fire emergency response procedure.									
•	Staff members use proper body mechanics to transport patients.									
•	Staff members close all doors									
	Charge nurse / designee shuts off all medical gases									
•	All patients are accounted for with medical records intact									
Re	sponse evaluated:									
•	Did staff members act in a calm and organized manner?									
•	Did staff members perform as a cohesive team?									
Op	portunities for improvement:									
Sta	ff member (observer) signature:									





Tri-City Medical Center Oceanside, California

PATIENT CARE SERVICES

DELETE – incorporated into Patient Care Services Policy: Transfer of Patients within the Facility.

ISSUE DATE:

10/17

SUBJECT: Off Unit Transfer Process

REVISION DATE(S):

Patient Care Services Content Expert Approval:

Clinical Policies and Procedures Approval:

Nurse Executive Committee Approval:

Pharmacy & Therapeutics Committee Approval: Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

09/1712/17

09/1704/18

09/1704/18

n/a

n/a

10/18 10/17n/a

10/17

DEFINITION(S):

Safety Hand-Off: Providing safety-information including, but not-limited to:

Patient name: diagnosis

Orientation (for example alert, confused, forgetful)

Code status

Isolation status

Communication barriers (hard of hearing, legally blind, non-English speaking)

Patient safety concerns, for example fall risk, equipment, conditions affecting ability to transfer safely

₽.

When-a-patient is transferred from their current-location to another department:

- The sending department will document-the date/time patient-leaves department and location patient-being transferred to in the electronic health record (EHR).
- The receiving department will document the date/time patient arrives in department in the EHR.
- The hard copy of the patient's chart will be sent with the patient, if applicable.

If the patient is assigned a primary nurse:

- The primary nurse will provide a safety-hand-off-to transporter if the patient is transferred unaccompanied by a licensed nurse.
- Assess the patient-on return to unit and document any changes in the patient's status in the-EHR.
- Telemetry and Acute Care Services (ACS) Menitored units nursing staff shall notify the Monitor Technician by telephone-or the monitory-system-off-unit function.

RELATED DOCUMENT(S):

- Patient Care Services: Hand-Off, Communication
- Patient Care-Services: Monitor-Technicians (MTs): Communication Process 2.1.



PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 0710/13

SUBJECT: Outpatient Post Anesthesia/

Procedure Discharge/ Transportation Guidelines

REVISION DATE(S): -

POLICY NUMBER:

Patient Care Services Content Expert Approval:

01/1705/18

Clinical Policies & Procedures Committee Approval:

07/1302/1706/18

Nurse Executive Committee Approval:

08/1307/18

Department of Anesthesiology Approval: Pharmacy & Therapeutics Committee Approval: 09/18

Medical Executive Committee:

n/a 09/1309/18

Administration Approval:

10/18

Professional Affairs Committee Approval:

10/13n/a

Board of Directors Approval:

10/13

A. **PURPOSE:**

To establish guidelines for discharge of outpatients undergoing procedures at Tri-City Medical CenterHealthcare District (TCHD).

POLICY:

- Procedures with no sedation/anesthesia:
 - Patients who have procedures without anesthesia or sedation are discharged upon the order of the treating physician.
 - b. Patients may use transportation of their choice (privately owned vehicle [POV], taxi, public transportation).
 - A responsible adultperson to accompany the patient is recommended, but not required.
- 2. Procedures with sedation/anesthesia:
 - Patients undergoing procedures with sedation or anesthesia are discharged upon the order of the treating physician and have met discharge criteria.
 - Patients who have received sedation or anesthesia are required to be discharged in the b. company of a responsible adultPatients undergoing procedures with sedation or anesthesia are required to be discharged in the company of a responsible adultperson and have a pre-arranged ride home.
 - If the patient is unable to arrange for a responsible adult to accompany them home, the patient must be admitted for evernight observation
 - Patients who have received sedation or anosthosia must have a pre-arranged ride home, either by POV or taxi.
- 3. Pre Procedure:
 - Patients scheduled for procedures with planned sedation/anesthesia will be notified prior to the day of their procedure that they must arrange a ride and a responsible adultperson to take them to their destination post procedure or their procedure willmay be cancelled.
 - a.i. Patients will be offered a list of transportation resources for their information.
 - b. The patient will sign a form stating they were notified of this policy, if seen in a Preoperative Education appointment. Patients not seen in the Preoperative

Patient Care Services Policy Manual
Policy Title Safe Medical Device Act: Tracking & Reporting-Outpatient Post Anesthesia/ Procedure Discharge/ Transportation Guidelines
Page 2 of 3

Education center prior to their procedure will be advised of the above requirement, and the person making the call will document the discussion.

- c. The day of the procedure, the responsible adultperson must accompany the patient to the procedural admission area and confirm availability and contact information.
- 4. Post Procedure:
 - a. If the responsible adultperson cannot be contacted at the time of discharge, the departmentunit manager is contacted to assist with resolution.
 - e.i. Manager resolution includes documented consultation and agreement with the surgeon/procedural physician and anesthesiologist.
- 4.5. Urgent case/unanticipated use of sedation/anesthesia:
 - a. If the procedure is of an urgent nature, and the patient is unable to arrange for a responsible adultperson to accompany them home, the patient must be admitted for evernight observation contact the department manager to assist with resolution.
 - b. The treating physician is advised and orders to admit-for evernight observation are requested.

C. RELATED DOCUMENT(S):

1. Transportation Resources

Transportation Resources

<u>Medical Transportation:</u> (Insurance companies dictate their ambulance providers-contact TCMC Case Management dept for assistance)

American Medical Response (AMR) 760-726-4842

Americare Ambulance 760-739-9723

*Balboa Ambulance 760-724-8181 (TCMC Contracted Ambulance Provider)

Care Ambulance 858-653-4500

CARE-A-VAN 760-729-5199

LIFT (SanDag must be enrolled) 760-726-1111

Logisticare 877-440-7433

MaxCare 619-303-6705

Mercy Medical Transport 760-739-8026

SD Medical Services (aka Rural Metro) 858-499-1500

Schaefer Ambulance 619-583-7714

TLC Medical Transport 619-284-7433 (Open PO with company-TCMC Case Management Dept would need to know you used this for a patient because they will receive the bill)

Non Medical Assisted Transport: (TCMC Case Management Dept would need to know you used this for a patient because they will receive the bill)

- *Amada Senior Care 866-701-4557
- *Home Instead 760-639-6472
- *Meridian Home Care 858-529-1886

Non Medical Transport:

*LYFT (Unit Secretaries trained to order)

Taxi Voucher or Bus Pass (Charge RN or MSW arrange)

*Preferred



PATIENT CARE SERVICES

ISSUE DATE: 12/93 SUBJECT: Pain Management

REVISION DATE(S): 05/94, 08/97, 09/00, 07/03, 05/05,—POLICY NUMBER: IV.W

04/06, 11/07, 04/08, 11/08, 12/08,

01/12, 11/14

Patient Care Services Content Expert Approval: 11/17

Clinical Policies & Procedures Committee Approval: 04/1502/18 **Nurse Executive Committee Approval:**

Department of Anesthesiology:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval: Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

04/1503/18

05/18

04/1503/18 06/1506/18

10/18

07/15n/a

07/15

A. **PURPOSE:**

To use effective pain management techniques to provide appropriate pain relief designed for each patient on an individual basis.

POLICY:

- Pain management begins with the assessment of the patient's level of pain at the time of admission, continues throughout their stay, and is considered in discharge planning.
 - Perform a pain assessment with each patient report of new or different pain.
- 2. Pain management is an interdisciplinary process.
- 3. All patients have a right to pain relief and shall receive pain management.
- The patient (including neonatal, pediatric, adolescent, and adult) and family/caregiver are educated about the following as appropriate to his/her condition and assessed needs for understanding:
 - a. Pain
 - b. Risk for pain
 - Importance of effective pain management C.
 - d. Pain assessment process
 - Methods for pain management
- 5. Patient shall be assured of adequate pain management.
 - Information shall be obtained from the patient and/or family/caregiver as appropriate with regard to cultural, ethnic, and/or religious preference in determining methods of pain management (e.g. pharmacologic versus non-pharmacologic).
- 6. Pain level assessment is considered the "fifth" vital sign. Assessment and reassessment of pain level and pain relief shall be performed with routine vital signs and as needed. Findings shall be documented in the electronic medical-health record (EHR).
- 7. All patients will be assessed for sedation prior to administration of opiates. The Registered Nurse (RN) should also consider concurrent medications that the patient is receiving that can cause an increased sedative effect (i.e., muscle relaxers, tramadol, benzodiazepines and antihistamines).
- Health care providers shall maintain patient safety while managing the patient's pain. 8.
- 9. An appropriate pain rating scale shall be used to assess pain that is consistent with the patient's age, condition, and ability to understand. (see-Attachment A):

C. PROCEDURE:

- Provide a calm, supportive atmosphere.
- 2. Assess patient's characteristics of pain consistent with the patient's age, condition, and ability to understand (may include but is not limited to):
 - Acceptable pain level
 - i. If patient is unable to verbalize acceptable level, document reason in the medical record EHR.
 - ii. If condition changes and patient is able to verbalize acceptable pain level, the level must be documented.
 - b. Physical, behavior, and emotional signs and symptoms of pain
 - i. Presence of pain
 - ii. Physical exam and observation of pain site as clinically indicated which may include intensity, location, quality, duration, alleviating factors and/or aggravating factors.
- Document pain assessment in the medical recordEHR.
- 4. For opiates, document pre and post-intervention sedation level using the appropriate sedation scale (see Sedation Evaluation Resource Guide).
- 5. Call the physician/Allied Health Provider (AHP) for clarification when multiple pain medications are ordered for the same patient without a designated pain level (see Patient Care Services Policy: Medication Administration).
 - Pain levels are defined as:
 - i. Mild pain (pain level 1 3)
 - . Moderate pain (pain level 4 7)
 - iii. Severe pain (pain level 8 10)
- 6. Perform appropriate interventions based on the patient's stated pain level as needed to achieve patient's acceptable pain level.
 - a. Pharmacologic interventions require a physician/Allied-Health ProviderAHP order.
 - b. Non-pharmacologic interventions that do not require a physician/Allied Health ProviderAHP order may include the following:
 - i. Children, adolescents, adults:
 - 1) Distraction
 - 2) Positioning
 - 3) Relaxation
 - 4) Music therapy
 - 5) Guided imagery
 - 6) Massage
 - 7) Range of motion
 - 8) Heat or cold therapy
 - ii. Infants:
 - 1) Swaddling
 - 2) Holding
 - 3) Repositioning
 - 4) Pacifier
 - Oral Sucrose
 - c. Non-pharmacologic interventions that require a physician /Allied Health-ProviderAHP order may include the following:
 - i. Mechanical devices providing heat or cold therapy
 - ii. Transcutaneous Electrical Stimulation (TENS)
 - d. Reassessment of pain level and level of consciousness shall should be done thirty sixty (30-60) minutes after intravenous, intramuscular, or subcutaneous intervention. be completed after each pain management intervention (pharmacological and non-pharmacological) once a sufficient time has elapsed for the treatment to reach peak effect (within two [2] hours of intervention goalgeneral guidelines: 30

minutes for intravenous [IV], 60 minutes for PO/IM, and 15-60 minutes for non-pharmacological). Document in-PRN response in medical record EHR.

- i. The Post-Anesthesia Care Unit is excluded from the requirement to document a prn response for pain-medication given more frequent than 30 minute intervals to establish pain control. In the Post-Anesthesia Care Unit, when pain medication is ordered morewith a frequentlycy sooner less than 30 minute intervals (i.e. every five (5) minutes), the nurse will only document the effectiveness of the PRN response for thewhen after the last dose given.
- d. Reassessment of pain level and level of consciousness should be done one (1) hour after PO intervention. Document in PRN response in medical record.
- e. Opiate related side effects (i.e., sedation) should be re-assessed prior to IV or PO pain intervention to determine if patient is eligible to receive the medication.
- f. Notify the physician/Allied Health-ProviderAHP if pain is not relieved within one (1) hour and no other interventions are available to the patient.
 - i. If the patient refuses pain intervention measures/procedures, the care provider shall discuss the patient's pain management goals with the patient and reassess potential interventions. Refusal of pain management intervention, reassessment findings, and discussion with patient regarding pain management shall be documented in the medical record.
- g. Notify the physician/Allied-Health-ProviderAHP if patient continues to report unacceptable pain level, but is not eligible to receive additional interventions due to excessive sedation.
- Educate patient regarding pain management and document education in the medical recordEHR.
 - a. The "Patient's Rights Regarding Pain Control" document is located in the Patient Handbook.
- Consider patient/family preferences, as well as cultural, ethnic, and religious beliefs, when determining the pharmacological and non-pharmacological methods to be used for pain management.

D. SPECIAL CIRCUMSTANCES:

- 1. Assess for existence of special circumstances (elderly, aphasia, dementia, mental disabilities, age, coma, and end of life), which require modification of traditional approaches to assessment; in the patient with known pathology or behavior that indicates the presence of pain.
 - a. Pain in the elderly
 - i. Allow patient to use appropriate aids he/she requires for seeing/hearing
 - ii. Be aware that pain perception does not decrease with age
 - iii. Be aware that metabolism of drugs will decrease with age and lower starting doses may be warranted
 - b. Pain in pediatric and newborn patients
 - i. Consider using pain faces (Wong-Baker scale)
 - ii. Consider using NPASS (Neonatal Pain, Agitation, and Sedation Scale)
 - iii. Use NIPS scale neonatal-infant Pain Scale
 - c. Pain in the non-English speaking or sensory impaired patient
 - i. Refer to Patient Care Services Policies: II.H Communication with the Sensory Impaired and-or Persons with Language Barriers (Blind//Deaf) and II.J Interpretation and Translation Services.
 - d. Denial of pain in the patient with known pathology or behavior indicating the existence of pain
 - i. Explore possible causes, attempt to find solutions or provide information to help patient choose better level of pain control
 - ii. Consider a trial dose of analgesic

- e. Pain in patients with impaired communication (coma, severe emotional disturbance, dementia, or with end stage diseases)
 - i. Include family or close caregivers in making determination regarding patient's pain level, consider using Proxy Pain Rating.
 - ii. Consider a trial dose of analgesics, or other form of intervention if pain is suspected.
 - iii. Observe systematically for possible pain behaviors related to vocalizations, facial expressions, behavior changes, and autonomic responses
 - iv. Utilize presumptive treatment of pain for patients who cannot speak and who undergo painful treatments or procedures.
 - v. Utilize a non-verbal pain scale (for example NVPS or CNPI or CPOT)
- f. Opiate-related side effects (i.e. sedation) must be assessed and re-assessed in all of the above patient populations.
- 2. Determine patient's ability to manage pain and/or appropriateness of treatment modality (e.g. Patient Controlled Analgesia ([PCA]).

E. SAFETY:

- 1. Patients receiving PCA:
 - **1.a.** Discontinue PCA in patients with deteriorating level of consciousness and notify the physician/Allied-Health ProviderAHP.
 - 2.b. Instruct family/caregivers to report patient's pain or inability to use PCA to the nurse. Family/caregivers should not push PCA button for patient.
- 3-2. Inspect all of patient's medications and identify those with potential to cause sedation (e.g. opiates, benzodiazepines, anticonvulsants, etc.). Use all sedating medications with caution as their effect may be additive.
- 4.3. Clarify any supplemental pain medication ordered by physician/Allied Health ProviderAHP other than anesthesiologist with the anesthesiologist before administration in patients receiving intrathecal or epidural opioids.
- 5.4. Monitor the use of ice or heat therapy and the use of transcutaneous electrical nerve stimulation (TENS) patches at least every four (4) hours for the development of burns and/or skin breakdown
- 6.5. Inspect site of fentanyl patches every shift for evidence of inflammation.
- Observe patients who are receiving a narcotic/opioid for excessive sedation following administration.
 - 7.a. Naloxone should be readily available to antagonize enough narcotic so that the patient is able to maintain adequate ventilation but leaves enough opioid available in the system to relieve pain.
- 8-7. Avoid abrupt discontinuation of an opioid in a known or suspected physically dependent patient.
- 9.8. Regulate all continuous IV pain medications on an infusion pump.
- 10.9. Notify physician/Allied Health-ProviderAHP for any unrelieved pain.
- 41.10. Report to the physician/Allied-Health ProviderAHP any signs/symptoms of over sedation or any other unexpected physiological and behavioral outcomes:
 - a. Apnea
 - b. Respiratory rate less than ten (10) breaths per minute or less than twenty (20) breaths per minute for children under two (2) years of age
 - c. Sp0₂ less than 92% or as ordered
 - d. Hypotension
 - e. Allergic reactions
 - f. Change in level of consciousness (e.g. unresponsive, somnolent, difficult to arouse)
 - g. Nausea/vomiting
 - h. Itching
 - i. Urinary retention
 - j. Absent bowel sounds

--FORMS/RELATED DOCUMENTS:

- 1. Adult Pain Evaluation Resource-Guide
 - a. Numeric Scale
 - b. Wong-Baker-Face Scale
 - c. Adult Non-Verbal-Pain Scale (NVPS)
 - d. Ventilated Patient Non-Verbal-Pain Scale (NVPS)
 - e. Prexy Pain Rating
- Pediatric Pain Evaluation Resource Guide
 - a. Numeric-Scale
 - b. Wong-Baker Face Scale
 - Behavioral Scales
 - i. FLACC
 - ii. Neonatal Pain, Agitation, and Sedation Scale (NPASS)

Sedation Evaluation Resource Guide

F. RELATED DOCUMENT(S):

- 1. Adult Pain Evaluation Resource Guide
 - a. Numeric Scale
 - b. Wong-Baker Face Scale
 - c. Adult Non-Verbal Pain Scale (NVPS)
 - d. Ventilated Patient Non-Verbal Pain Scale (NVPS)
 - e. Proxy Pain Rating
- 2. Pediatric Pain Evaluation Resource Guide
 - a. Numeric Scale
 - b. Wong-Baker Face Scale
 - c. Behavioral Scales
 - i. FLACC
 - ii. Neonatal Pain, Agitation, and Sedation Scale (NPASS)
 - iii. Neonatal Infant Pain Scale (NIPS)
- 3. Sedation Evaluation Resource Guide
- 4. Patient's Rights Regarding Pain Control
- G.5. Patient Care Services Policy: Communication with the Sensory Impaired and-or Persons with Language Barriers
- 4.6. Patient Care Services Policy: Interpretation and Translation Services
- 2.7. Patient Care Services Policy: Medication Administration

H.G. REFERENCE(S):

- 1. Altimier, L., Brown, B., & Tedeschi, L. (2011). *Neonatal nursing policies, procedures, competencies, and clinical pathways*, 4 ed. Glenview, IL: National Association of Neonatal Nurses.
- 2. Amis, D. and Green, J. (2004). Assessment of effective coping during labor. Lamaze International Retrieved April 24, 2008. www.lamaze.org.
- 2.3. Booker, S.Q. & Herr, K. A., (2016). Assessment and Measurement of Pain in Adults in Later Life. Clin Geriatr Med 32, 677-692
- 3.4. California Healthcare Association Consent Manual Health and Safety Code Section 124960. (2015).
- 4.5. Gomella, T.L. (2013). Neonatology: management, procedures, on-call problems, diseases, and drugs,7ed. New York, NY:McGraw Hill Education.
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- 6-7. Lehr, V., Cortez, J., Grever, W., & Cepeda, E. Randomized Placedbo-Controlled Trial of Sucrose Analgesia on Neonatal Skin Blood Flow and Pain Response During Heel Lance. *Journal of Pain*.
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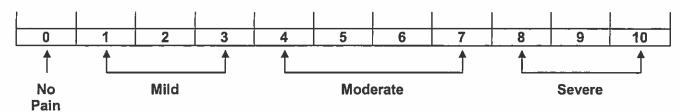
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8-9. Pasero C, McCaffery M. (2011): Pain Assessment and Pharmacologic Management. St. Louis: Mosby/Elsevier.

Adult Pain Evaluation Resource Guide

ADULT PAIN EVALUATION RESOURCE GUIDE

1. NUMERIC SCALE (0 - 10): For patients who can self-report



2. WONG - BAKER FACES

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



3. ADULT NON-VERBAL PAIN SCALE (NVPS): For patients who are unable to respond/determine the pain rating (0-10)

Subscales	0	1	2
FACE	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead.	Frequent grimace, tearing, frowning, wrinkled forehead.
ACTIVITY	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes.
GUARDING	Lying quietly, no positioning of hands over areas of body	Splinting areas of body, tense	Rigid, stiff
PHYSIOLOGIC I (Vital Signs)	Stable vital signs (no change in past 4 hours).	Change from baseline over past 4 hours in any of the following: SPB greater than 20mm HG HR greater than 20 beats/minute RR greater than 10 breaths/minute	Change from baseline over past 4 hours in any of the following: SPB greater than 30mm HG HR greater than 25 beats/minute RR greater than 20 breaths/minute
PHYSIOLOGIC II	Warm, dry skin	Dilated pupils, perspiring, flushing	Diaphoretic, pallor

4. <u>VENTILATED PATIENT NON-VERBAL PAIN SCALE (NVPS)</u>: For patients who are unable to respond/determine the pain rating (Best used in critical care areas) (0 – 10)

Subscales	0	1	2		
FACE	No particular expression or smile.	Occasional grimace, tearing, frowning, wrinkled forehead.	Frequent grimace, tearing, frowning, wrinkled forehead.		
ACTIVITY	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes.		
GUARDING	Lying quietly, no positioning of hands over areas of body	Splinting areas of body, tense	Rigid, stiff		
PHYSIOLOGY (Vital Signs)	Stable vital signs	Change from baseline in any of the following: SPB greater than 20mm HG HR greater than 20 beats /minute	Change from baseline in any of the following: SPB greater than 30mm HG HR greater than 25 beats/minute		
RESPIRATORY Baseline RR/SpO2 Compliant with ventilate		RR greater than 10 above baseline, or 5% √SpO2 Mild asynchrony with ventilator	RR greater than20 above baseline, or 10% ↓SpO2 Severe asynchrony with ventilator		

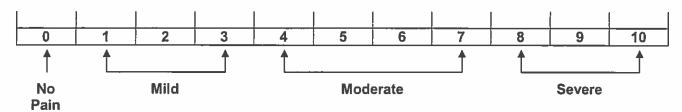
5. PROXY PAIN RATING: The family or caregiver thinks the patent is in pain.

Proxy Pain Rating:												
No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain possible

Pediatric Pain Evaluation Resource Guide

PEDIATRIC/NEONATAL PAIN EVALUATION RESOURCE GUIDE

1. NUMERIC SCALE (0 - 10): For patients who can self-report



2. WONG- BAKER FACES

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



3. **BEHAVIORAL SCALES:** For patients who cannot respond verbally

	FLACC SCALE								
	0	1	2						
Face	No particular expression or smile	Occasional grimace or frown	Frequent to constant frown						
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up						
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back & forth, tense	Arches, rigid, or jerking						
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steady, screams or sobs, frequent complaints						
Consolability	Content, relaxed	Reassured by hugging touching, or "Talking to", distractible	Difficult to console or comfort						

4. NEONATAL PAIN, AGITATION, & SEDATION SCALE (NPASS)

		ation	Normal	Pain/A	gitation	
Criteria	Criteria -2 -1		0	_ 1	2	
Crying Irritability	No cry to painful stimuli	Briefly moans/cries to painful stimuli	Little crying Not irritable	Irritable/crying at intervals, consolable	Continuous high-pitched/ silent-cry. Inconsolable	
Behavior State	No arousal to any stimuli, No spontaneous movement	Arouses minimally to stimuli. Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking. Constantly awake or arouses minimally to movement (not sedated)	
Facial Expression	everaccion to		Relaxed	Intermittent painful expression	Continual painful expression	
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex. ↓ Muscle tone	Relaxed hands & feet Normal tone	Intermittent clenched toes, fists or finger splay, Body not tense	Continual clenched toes, fists or finger splay. Body is tense	
Vital Signs HR, RR, BP SaO₂	ventilation/app variability from ventilation/app baseline with		Baseline/normal for gestational age	↑ 10-20% from base-line Sao2 76-85% to stimulation – quick ↑	↑greater than 20% from baseline SaO₂ less than 75% to stimulation — slow ↑ Out of sync with vent	

5. Neonatal Infant Pain Scale (NIPS)

Parameter	Finding	Points
Facial Expression	Relaxed	0
racial Expression	Grimace	1
	Relaxed Grimace No Cry Whimper Vigorous Crying Relaxed Change In Breathing Restrained Relaxed Flexed Extended Restrained Restrained Restrained Restrained Sestrained Relaxed Flexed Extended Relaxed Flexed Flexed Flexed Extended Sleeping	0
Cry	Whimper	1
	Vigorous Crying	2
Breathing Patterns	Relaxed	0
- Dreating Fatterns	Change In Breathing	1
	Restrained	0
Arms	Relaxed	0
Aims	Flexed	1
	Extended	1
	Restrained	0
Legs	Relaxed	0
regs	Flexed	1
	Extended	_ 1
	Sleeping	0
State Of Arousal	Awake	0
	Fussy	1

Sedation Evaluation Resource Guide

Sedation Evaluation Resource Guide

Pasero Opioid-induced Se	dation Scale	(POSS) w	ith Interventions
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- S= Sleep, easy to arouse Acceptable; no action necessary; may increase opioid dose if needed 1 = Awake and alert Acceptable; no action necessary; may increase opioid dose if needed 2 = Slightly drowsy, easily aroused Acceptable; no action necessary; may increase opioid dose if needed 3 = Frequently drowsy, arousable, drifts off to sleep during conversation Unacceptable; Required Assessment: RN full respiratory assessment including: rate, rhythm, depth, auscultation including, patient taking deep breaths. Review past 12-18 hours pain flowsheet. Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory Initiate ETCO2 (required order TBD) 1. Notify provider requesting a decreased dose of opioid 2. Administer a non-sedating, non-opioid such as acetaminophen or a NSAID, if ordered Critical 3. Increase stimulation such as: Thinking Ask patient to take deep breaths every 5 - 10 min Ambulate patient, sit patient up in chair, walk to bathroom
- 4 = Somnolent, minimal or no response to verbal and physical stimulation Unacceptable;

	Stop	opioid;
--	------	---------

□ Consider administering naloxone

Stay with patient, stimulate, and support respiration as indicated by patient status;

Call Rapid Response Team (Code Blue) if indicated; notify primary² or anesthesia provider;

Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

Ramsey Scale

Level of sedation for adults using the Ramsey Scale:

- 1 = Patient anxious and agitated or restless or both
- 2 = Patient cooperative, oriented and tranquil
- 3 = Patient responds to commands only
- 4 = A brisk response to loud auditory stimulus
- 5 = A sluggish response to loud auditory stimulus
- 6 = No response to loud auditory stimulus

Richmond Agitation Sedation Scale (RASS)

Points	Classification	Description				
4	Combative	Overly combative or violent/ danger to staff				
3	Very agitated	Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff				
2	Agitated	Frequent nonpurposeful movement or patient- ventilator dyssynchrony				
1	Restless	Anxious or apprehensive but movements not aggressive or violent				
0	Alert and calm					
-1	Drowsy	Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact to voice.				
-2	Light sedation	Brief (less than 10 seconds) awakens with eye contact to voice				
-3	Moderate sedation	Any movement to voice (no eye contact)				
-4 Deep sedation		No response to voice, but movement to physical stimulants				
-5	Unarousable	No response to voice or physical stimulation.				

PROCEDURE:

PATIENT FOOD REFRIGERATORS/FREEZERS

Purpose:

To ensure patient care refrigerators for food are monitored, defrosted, and cleaned.

A. PROCEDURE:

- All patient food refrigerators shall be cleaned/defrosted as needed.
 - The patient food refrigerators/freezers will be checked when inventoried/stocked by Food and Nutrition personnel.
 - Nursing will be responsible for refrigerators not routinely stocked.
 - Food and Nutrition is responsible for cleaning the refrigerators/freezers routinely b. stocked by food and nutrition personnel.
 - Engineering is responsible for defrosting.
- 2. Temperature ranges for patient food storageed:
 - a. in rRefrigerators should range from 30 to 40 degrees Fahrenheit (F).
 - 2.b. Freezers minus (-)10 to 0 degrees Fahrenheit (F).
- All refrigerators/freezers must have a thermometer. 3.
- 3.4. The patient food refrigerators shall have an electronic surveillance system Awarepoint probe monitoring the temperature 24 hours a day, seven (7) days a week. Access the Awarepoint website-from-the Tri-City-Intranet
- 4-5. The electronic surveillance system Awarepoint will send an initial email to the Food and Nutrition supervisors from 0500 to 2100 and to Engineering from 2100 to 0500 if the temperature is out of range
- If the temperature falls outside the correct range, the nNursing/fFood and nNutrition 5.6. personnel/supervisor/Engineering shall:
 - Check the freezer compartment for over icing. If the freezer requires defrosting arrange for defrosting. Place work order for Engineering to follow up immediately.
 - If the freezer is not the problem, the nNursing/fFood and nNutrition b. personnel/supervisor/Engineering will contact nursing-personnel to adjust the thermostat. Nursing/Food and Nutrition personnel The supervisor/Engineering will monitor results in one hour.
- 6-7. If the temperature is not corrected one (1) hour after adjusting the thermostat, a work order will be placed to Engineering.
 - Food and Nutrition supervisors will evaluate the need to relocate food items until a. temperature is corrected.
 - a₊i. Nursing must call the Food and Nutrition department for refrigerators/freezers not routinely stocked.
 - Corrective actions shall be documented in the electronic surveillance Awarepoint b. system.
- 8. If the electronic surveillance system fails the temperature will be monitored manually.
 - Food and nutrition personnel are responsible for documenting the temperatures a. one time per day for the refrigerators/freezers they routinely stock.
 - Nursing is responsible for documenting the temperatures for refrigerators/freezers not routinely stocked by Food and Nutrition.
 - Corrective actions shall be documented on the temperature log. b.

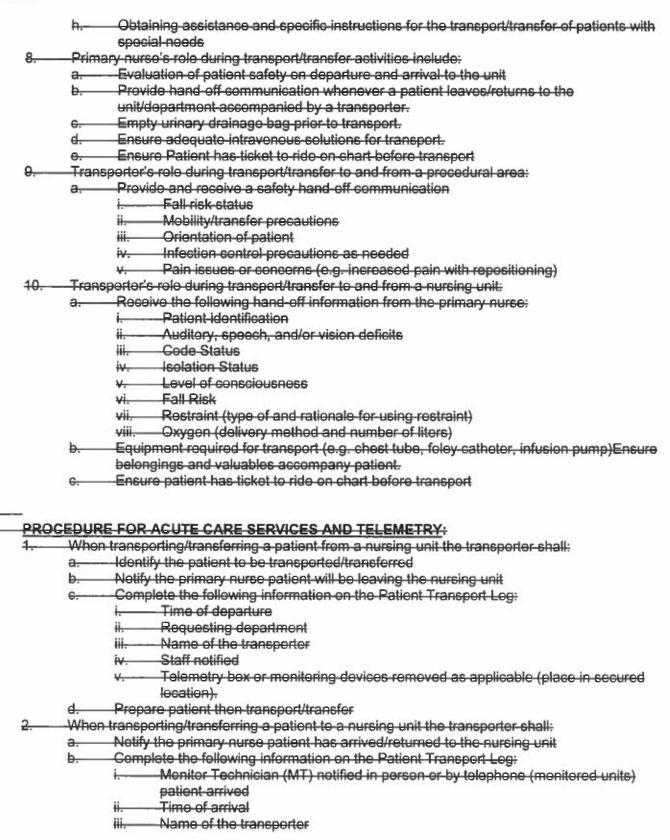
Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/00, 06/03, 07/07, 11/10, 10/17, 06/18	11/10, 11/17, 08/18	11/10, 12/17, 09/18	n/a	n/a	n/a	10/18	01/11, 01/18, n/a	01/11, 01/18

Tri-City Me	dical Center	Patient Care Services			
PROCEDURE:	PATIENT TRANSPORT/PATIENT	TRANSPORT	LOG		
Purpose:	To identify the safe practices and of transporting/transferring patients to				
Supportive Data: Equipment:	Patient Care Services Hand-Off Co Patient Transport Log Wheelchair, gurney, or cardiac cha Cardiac Monitor (if required for trans	mmunication ir			
	Alaris Pump (if required for transport) Oxygen deliver method and oxygen tank (if required for transport)				

POLICY:

- 1. All-patients shall have their identity verified by two identifiers per Patient Care Services (PCS) Identification, Patient, Policy.
- 2. Potential hazards associated with patient transport and transfer activities shall be identified and safe practices established.
- The patient shall always be attended during transport or transfer.
- During use of a transport-vehicle, design features to be considered and implemented when present-include:
 - a. Locking-devices on wheels
 - Side-rails on beds and for cribs, rails high-enough to prevent a-standing child from falling out
 - Intravenous-(IV) poles
 - d. Holding devices for oxygen tanks
 - e. Positioning capabilities
 - f. Controls that are easy to operate and within the operator's reach
 - g. Maneuverability
 - h. Sufficient-size
 - i. Removable-headboards and-footboards
 - Mattress-stabilizing devices
 - k. Surfaces that-are easily cleaned
- 5. Transporters shall demonstrate competency in the operation of equipment to be used.
- 6. Patient movement-assistive devices and/or the number of staff members should be adequate to provide for the patient and staff safety-during transport/transfer-activities.
 - Staff shall wait for adequate numbers(s) of staff/devices to safely transfer or move a
 patient to prevent injury to self or others. Refer to PCS Lift Team Policy for additional
 information
 - Proper body mechanics shall be used when transferring or moving a patient
- 7. -- Safety measures to be-implemented during-patient transport/transfer include but are not limited to:
 - Locking wheels-and stabilizing-transport vehicles or patient beds during-transfer activities
 - b. Elevating-side-rails
 - Hanging and securing IV-containers away from patient's head
 - d. Protecting-patients' head, arms and legs
 - e. Ensuring-that transport-staff-remains at the head-of-the transport-vehicle
 - f. Pushing patients feet-first-and avoiding rapid-movements, especially-during turns, except when being placed on an elevator the patients shall be placed in the elevator headfirst
 - Maintaining the integrity and function of IVs, catheters, tubes, drainage systems and monitoring equipment

Patient Care Services Content Expert	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/07, 06/10, 07/13, 11/17	06/10, 11/13, 04/18	07/10, 11/13, 04/18	n/a	09/18	10/18	07/10, 02/14, n/a	07/10, 02/14



Patient Care Services Procedure Manual Patient Transport/Patient Transport Log Page 3 of 4

iv. Staff notified 3. Patient Transport Log a. The current day's Patient Transport Log shall be located near the nurse's station or secretaries' dosk on each nursing unit on a clipboard. b. The night Assistant Nurse Manager (ANM) or designee shall ensure a new Patient Transport Log with the current date is available every morning prior to 0600. c. Completed Patient Transport Logs shall be maintained on each nursing unit per unit specific standards. D. FORM(S): 1. Patient Transport Log E. RELATED DOCUMENT(S): 1. PCS Hand Off Communication Policy 2. PCS Identification, Patient Policy 3. PCS Lift Team Policy

Tri-City Medical Center		Patient Care Services						
PROCEDURE:	EDURE: PNEUMATIC TOURNIQUET MACHINEUSE AND SAFETY							
Purpose:	To outline the-nursing responsibilities for the safe use of pneumatic tourniquets. which are primarily used to occlude blood flow, obtain a near bloodless field for extremity surgery, and to confine a bolus of anesthotic in an extremity for IV regional anesthosis. Pneumatic tourniquets are frequently used for procedures involving the extremities. A tourniquet is a fabric-covered cylindrical bladder inflated by compressed gas or ambient air. It applies circumferential pressure on arterial a venous circulation, resulting in a relatively bloodless surgical field to promote visualization of structures during the procedure. Limb exsanguination is achieved by elevating and/or wrapping the limb, distally to proximally, with an ACE or esmarch rubber bandage before tourniquet inflation. Pain from the tourniquet i one of the most common complications related to pneumatic tourniquet use. Other possible complications include cardiovascular, respiratory, cerebral circulatory, and hematological effects related to the metabolic changes that res from ischemia caused by pneumatic tourniquet use, as well as temperature changes, postoperative swelling of the affected limb, and arterial injury. A microprocessor centrolled-automatic pneumatic tourniquet is designed to centrol arter blood flow in an extremity by regulating desired cuff prossure (compressed air) and specific time setting to produce a bloodless operating field							
Supportive Data:								
Equipment:		nachine (plugged into electrical outlet) et cuff (appropriately sized for patient)						

A. POLICY:

- Pneumatic tourniquets and accessories should be inspected, tested and maintained by Biomed at the recommended time intervals according to manufacturer's recommendations.
- Tourniquet-should-be-tested for integrity and function-prior-to-each-use.
- 3. If a pneumatic tourniquet is not working-properly-or-is-damaged, it-should-be-removed-from service-immediately along with all accessories and reported to-Biomed-for-maintenance.
- 4.2. The Pphysician/Allied Health Professional (AHP) performing the procedure/caring for the patient determines if a the use-of-tourniquete' will be used for the procedure, after considering the risks and benefits to the patient, position and placement on the extremity.—and pressure setting to be used during the procedure.
- 3. The Registered Nurse (RN) shall assess the patient preoperatively for risks and potential contraindications related to the use of a pneumatic tourniquet, including, but not limited to: nerve injury, skin injury (e.g., blistering, bruising, or necrosis), impaired circulation or peripheral vascular compromise, previous revascularization of the extremity, extremities with a dialysis graft, compartment syndrome, deep vein thrombosis (DVT), extremity infection, tumor distal to the tourniquet and pain.
- 4. Prior to tourniquet cuff placement, the RN shall assess the patient's Sskin integrity at the intended tourniquet site, as well as size and shape of the extremity and peripheral pulses distal to the cuff-shall-be-assessed-before cuff placement.
 - a. The width of the tourniquet and size should be individualized to the size and shape of the patient's limb.
- 6.- Prophylactic-antibiotics should be completely-infused-before-tourniquet-cuff-inflation.
- 7. The width-of the tourniquet and size should be individualized-to-size-and-shape of the patient's limb.

1	Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
	8/94, 6/09,5/12; 5/18	05/12,06/18	5/12 , 0718	07/18	n/a	06/12, 09/18	10/18	07/12 , n/a	07/12

- 5. Procedures involving pneumatic tourniquet control on two extremities should have the tourniquet tubing labeled to clearly identify which tubing belongs to which cuff and which is associated with each component of the tourniquet system.
- **8.6.** Tourniquet cuff should be applied to the verified operative extremity in a location with adequate muscle mass to preserve nerves and vessels.
- 7. Tourniquet inflation pressure is determined by the physician/AHP and shall be established based on the systolic blood pressure, age of the patient and circumference of the extremity.
 - a. Inflation should be kept to the minimum effective pressure.
 - Recommended-maximum cuff pressure is 300-350mmHg-for-the thigh and 250-300mmHg for the arm-and lower leg.
- 9.8. Tourniquet time will be kept to a minimum and deflation managed to minimize risks to the patient.
- 9. Pneumatic tourniquets should be inflated and deflated under the direction of the surgeon/AHP and the anesthesiologist.
- 10. The surgeon willshall be kept informed of the duration of tourniquet time. When prolonged tourniquet time is needed, it is recommended that the tourniquet should-be released for reperfusion of the limb every-hourafter two (2) hours of tourniquet inflation time, allowing for blood to circulate for 15 minutes. Then tourniquet may then be reinflated for another hour.
- 11. Pneumatic tourniquet activation indicators and pressure displays should be visible and audible alarms should be sufficiently loud to be heard above other sounds in the OR/procedure room.
- 41.12. After deflation, the tourniquet and padding should be removed from the extremity to allow full circulation to return to **the** extremity.
- 42.13. The patient should be monitored for pain and temperature while the tourniquet is inflated.

 When dual-bladder-tourniquet cuffs are used with intravenous regional anesthesia, the tourniquet should be deflated as determined by the anesthesia professional.
- 14. The patient should be monitored for 15 minutes after deflation of tourniquet forpostoperatively for the following:
 - a. Vital signs, including oxygen saturation and temperature
 - b. Skin condition under the tourniquet (i.e., temperature, color, integrity)
 - c. Pulses distal to the tourniquet cuff
 - d. Surgical wound site (i.e., dressings, drains)
 - 13.e. Blood loss
 - a. Lowered blood pressure
 - b. Lowered O2 sat
 - c. Increased end tidal CO2
 - d. Lowered core temperature
 - e. Increased intracranial pressure
 - f. Increased possibility of embolism
- 14. Use of tourniquet and patient outcome should be reported during patient handoff to the Post-Anesthesia-Gare Unit (PACU) nurse during-handoff report.

B. **PROCEDURE**:

- Plug into proper electrical outlet. Check cuff for proper operational condition and leaks.
- Observe all electrical safety precautions as with any electrical device.
- 1. Prior to tourniquet use, the RN shall ensure the entire tourniquet system is complete, clean, and functioning according to the manufacturer's instructions for use (IFU).
 - a. If a pneumatic tourniquet is not working properly or is damaged, it should be removed from service immediately and reported to Biomed for maintenance.
- 3.2. Turn on the pneumatic tourniquet machine and allow the machine on and allow the machine to go though its checks and calibration before inflating to perform automatic system checks.

- according to the manufacturer's IFU. Please refer to operator's manual for additional information.
- 3. Select the proper size tourniquet cuff-size. Tourniquet cuffs should overlap a minimum of three (3) inches and a maximum of six (6) inches.
 - a. A tourniquet cuff that is too short can loosen after inflation.
 - 4.b. A tourniquet cuff with excess overlap can pinch skin folds Overlap of 3 6" is ideal.
- 4. Verify the correct surgical site prior to tourniquet cuff application.
- 5. Apply padding (i.e., low-lint soft padding, such as a limb protection sleeve, or two layers of stockinette) (if surgeon requests) around the limb at the intended tourniquet cuff site, according to manufacturer's IFU.
 - a. Padding should be smooth and wrinkle-free.
- 6. Apply and the tourniquet cuff-(proper location) in a snug, smooth, wrinkle free manner which helps reduce the chances of mechanical injury to the skin including blistering. Manufacturer does not recommend padding over the padding, according to manufacturer's IFU, ensuring the cuff tubing is positioned on or near the lateral aspect of the extremity.
 - 5.a. Lateral placement of the cuff tubing may help avoid pressure on nerves of the extremity and prevent kinking of the tubing.
- 6-7. Keep the patient's skin dry under the tourniquet cuff. Avoid pooling of prep solutions or irrigation under the cuff.allowing prep and scrub-gel solutions from-seeping under padding/tourniquet-cuff-during prep where they may cause-chemical burns. Retating cuff produces shearing forces which may damage-underlying tissues.
- 8. Avoid rotating the cuff after application. If the cuff must be repositioned, it shall be removed and reapplied in the desired location.
- 7-9. Connect the tubing from the pneumatic tourniquet machine to the to-cuff, according to manufacturer's IFU. from main cuff connection.
- 3-10. SelectProgram pressure settings as ordered settings by the physician/AHP. :Program and operate the tourniquet according to manufacturer's IFU.
 - a. To set-pressure push pressure-button in, turn the shuttle knob to the right-to-increase or to the left to decrease pressure settings.
 - b. To set time-or-increase time limit (machine will automatically set for 60 min), push time button in and turn shuttle knob to the right to increase or to the left to decrease time amount. Be sure to turn-machine off and on-between cases so the machine can-reset for 60 minutes.
- 9. The main suff "inflate" switch is depressed as ordered by physician, which activates suff.
- 10. Depress the main cuff "deflate" switch at the end-of-the procedure as ordered by physician, which deactivates cuff.
- Completely remove the deflated cuff and any underlying padding immediately following final cuff deflation.
- Examine extremity after the tourniquet is removed for color, warmth, and the presence of a palpable pulse.
- 13. For Bier-Block-Procedure-use-a-double cuff.
 - a. The proximal end-of-the cuff is connected to the main cuff-connection;
 - b. The distal end of the cuff is connected to the second cuff connector.
- 14. After-use, all re-usable used-tourniquets will be sent to SPD to be cleaned, rinsed and dried using an EPA detergent disinfectant.

C. **DOCUMENTATION:**

- 1. On Operating Room Record under TourniquetDocument tourniquet information in the Electronic Health Record (EHR), including the following information:
 - a. Tourniquet equipment ID number (i.e., serial number)
 - b. Cuff pressure
 - Time inflated and deflated
 - d. Location of tourniquet cuff

- e. Skin integrity condition under the cuff before tourniquet cuff application and after tourniquet cuff removaluse of the Tourniquet
- f. Identity-Name of person placing-applying the ‡tourniquet cuff
- f.g. Name of person removing and removing the Ttourniquet cuff
- Condition-of-distal extremity after-procedure
- 2. Surgery RN's document tourniquet use in the Operating Room (OR) Record.

D. REFERENCE(S):

- 1. Rousable Tourniquet System-Controller Operations Manual. Dover, Ohio. Zimmer ATS 1500.
- 2. Tourniquet-System Operator & Service Manual. Dover, Ohio. Zimmer-ATS,2000
- 3. Automatic Tourniquet System Operator & Service Manual. Dover, Ohio. Zimmer ATS 3000.
- 1. "Perioperative Standards and Recommended Practices." Aern, Inc. Rothrock, J. C. (2015). Alexander's Care of the Patient in Surgery (15th edition). St. Louis, MO: Elsevier.
- 4.2. Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.



PATIENT CARE SERVICES

ISSUE DATE: 10/02 SUBJECT: Preventing Admissions and

Procedures Beyond Medical Staff

Privileges

Patient Care Services Content Expert Approval: 07/18
Clinical Policies & Procedures Committee Approval: 41/1408/18
Nurse Executive Committee Approval: 41/1409/18

Medical Staff Department/Division Approval: n/a
Pharmacy & Therapeutics Committee Approval: n/a

Medical Executive Committee Approval: 01/1509/18
Administration Approval: 10/18

Professional Affairs Committee Approval: 02/15n/a
Board of Directors Approval: 02/15

A. PURPOSE:

1. Consistent with the Hospital's and Medical Staff's obligation, this policy provides the mechanism for personnel to ensure that practitioners seeking to admit, treat, or perform procedures on patients at Tri-City Healthcare DistrictMedical-Center (TCHDMC) have current Medical Staff membership and/or appropriate privileges. In addition, to ensure the current clinical privileges and proctoring requirements for all Medical Staff members are available to the nursing units and hospital departments.

B. POLICY:

- Personnel responsible for scheduling admissions are responsible for verifying the admitting physician has been appointed to the Medical Staff with admitting privileges or has been granted temporary admitting privileges.
- If a request for admission is made by a physician without Medical Staff privileges, admission of the patient must be denied. If the physician still wishes to hospitalize the patient, personnel should recommend patient care be transferred to a physician who has Medical Staff admitting privileges.
- 3. Personnel responsible for scheduling surgery shall verify the surgeon, anesthesiologist and/or surgical assistant(s) has privileges to perform the designated procedure(s), and whether proctoring is required. If the practitioner does not have privileges to perform the procedure(s), personnel shall not schedule the procedure and shall follow his/her department process for follow up. If proctoring is required, personnel shall obtain the name of the proctor from the practitioner.
- 4. Personnel in charge of the labor & delivery, operating rooms, nursery, various treatment rooms or any area where special procedures or treatment shall be carried out, are responsible for verifying the practitioner has the specific privilege(s) to perform the requested procedure(s), and whether proctoring is required. If the practitioner does not have privileges to perform the procedure(s), personnel shall not allow the procedure to be performed and shall follow his/her department process for follow up. If proctoring is required, personnel shall obtain the name of the proctor from the practitioner.
- 5. The DirectorManager of Medical Staff Office and Manager of Risk and Regulation-shall be notified immediately of any incident involving a practitioner performing a procedure for which

- he/she has no privileges including a description of the circumstances surrounding the incident.
- 6. Privileges to admit or perform the procedure(s) shall be verified on the Tri-City Medical Center Intranet as follows.
 - a. Log onto <u>Tri-City</u> Intranet
 - b. Click on Essentials
 - c. Click on Applications & Resources
 - d. Click on E-PRIV
 - e. Enter User Name (mdpriv) and Password (priv2)
 - f. Click on Login
 - g.e. Select search criteria (either "Search by Name" or "Search by Specialty")
 - h.f. Click on appropriate practitioner to view privileges
- 7. In the event the TCMC Intranet is not accessible, the unit/department requiring information regarding a practitioner's privileges shall contact the Medical Staff Office.
- 8. The Medical Staff Office maintains a current hardcopy of each practitioner's privileges, including proctoring status.



PATIENT CARE SERVICES

ISSUE DATE:

NEW06/14

SUBJECT: Transport /Transfer of Patients

Within, Intra- the Facility

REVISION DATE(S):

POLICY NUMBER: NEW

Patient Care Services Content Expert Approval:

07/17

Clinical Policies & Procedures Committee Approval:

12/1308/1704/1805/18

Nurse Executive Committee Approval:

12/1304/1807/18

Department of Anesthesiology Approval:

09/18

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

01/1409/18

Administration Approval:

10/18

Professional Affairs Committee Approval:

06/14n/a

Board of Directors Approval:

06/14

A. PURPOSE:

To ensure safe and appropriate intra-facility-patient transport/transfers within the facility.

B. DEFINITION(S):

Intra-Facility Transfer: patients transferred from one-department-level of care to another within Tri-City-Medical Center (TCMC), excluding transfers to the Progressive Care-Unit (PCU).

C.B. POLICY:

- 1. Patient safety, infection control, and requests shall be considered in all transfer decisions.
 - 1.a. Patients shall-not be transferred/transported while on bilateral inspiratory positive airway-pressure (BIPAP) per Pulmonary Procedure: BIPAP/Non-Invasive Positive Pressure Ventilation
- 2. Nursing staff, in collaboration with the AdministrativeAssistant Nurse Manager (ANM)

 /Administrative Supervisor (AS), may transfer patients based on infection control indications;
 bed placement needs, and per family/patient request as beds permit.
- 3. The patient shall always be attended during transport or transfer.
- 3.4. Patients on 5150 or on voluntary hold must be accompanied by staff member.
- 5. Patient movement assistive devices and/or the number of staff members assisting, should be adequate to provide for the patient and staff safety during transport or transfer activities.
 - Staff shall wait for adequate numbers(s) of staff and/or devices, to safely transfer or move a patient to prevent injury to self or others. Refer to Patient Care Services (PCS) Policy: Lift Team for additional information.
 - b. Proper body mechanics shall be used when transferring (moving) or transporting a patient.
- 6. Safety measures to be implemented during patient transport or transfer include, but are not limited to:
 - a. Locking wheels and stabilizing transport vehicles or patient beds during transfer activities.
 - b. Elevating side rails.
 - c. Hanging and securing intravenous (IV) containers away from patient's head.
 - d. Protecting patient's head, arms and legs.
 - e. Ensuring that transport staffs remains at the head of the transport vehicle.

- f. Pushing patient's feet first and avoiding rapid movements, especially during turns; except when being placed on an elevator, the patients shall be placed in the elevator headfirst.
 - i. Excludes justice involved patients, see PCS Policy: Justice Involved Patients
- g. Maintaining the integrity and function of IVs, catheters, tubes, drainage systems and monitoring equipment.
- h. Obtaining assistance and specific instructions for the transport/transfer of patients with special needs.
- 7. Hand-off communication shall be performed before and after transport/transfer per Patient Care Services Policy: Hand-Off Communication.
- 8. When a patient is transferred from their primary location to another department:
 - The primary department will document the date/time patient leaves the department and location patient being transferred to in the electronic health record (EHR).
 - The receiving department will document the date/time patient arrives in department in the EHR.
 - b. The hard copy of the patient's chart will be sent with the patient, if applicable.
- 9. When the patient returns to the primary department, the date and time will be documented.
- 10. If the patient is assigned a primary nurse:
 - a. The primary nurse will provide a safety hand-off to transporter if the patient is transferred unaccompanied by a licensed nurse.
 - b. Assess the patient on return to unit and document any changes in the patient's status in the EHR.
- 4-11. Telemetry and Acute Care Services (ACS) Monitored units nursing staff shall notify the Monitor Technician (MT) by telephone or the monitor system off unit function per the PCS Policy: Monitor Technicians (MTs): Communication Process.

D.C. CHANGE IN LEVEL OF CARE PROCESSPROCEDURE:

- Transferring unit obtains physician order for transfer.
 - a. The Registered Nurse (RN) requests for the physician/Allied Health Professional (AHP) to complete transfer orders and reconcile the medications.
 - b. Patients may be transferred internally based on assessment findings, physician orders, acuity changes, infection control needs, or safety.
 - c. Patients going to Acute Rehab or Behavioral Health Unit (BHU) must be discharged from the inpatient encounter and admitted to Acute Rehab or BHU as a new encounter facilitated by Registration.
 - d. Behavioral Health Unit (BHU) patients may be transferred to Emergency Department (ED) for medical evaluation to meet inpatient admission criteria.
 - If patients are admitted to an inpatient unit, they must be discharged from BHU and readmitted.
 - e. Inpatients that require emergent evaluation and intervention may be transferred to the ED for medical care.
- Transferring unit notifies Administrative Nurse (ANM)-/Administrative Supervisor (AS) of transfer order and place inputs requests to the bed board tracking system.
- ANM-/AS notifies transferring unit of new patient room assignment via the bed tracking system.
- 4. Transferring unit ensures all physician orders are current and appropriate, and all medications reconciled for non-urgent transfers.
 - a. When patients are transferred from the Intensive Care Unit (ICU), all orders for diagnostic tests shall be assessed for continued appropriateness by the physician/AHP either with the transfer order or within 24 hours of transfer.
- 5. Accepting unit ensures all physician orders are reconciled for urgent transfers.

- 5.6. The transferring unit completes the transfer transaction on the computer, ensuring correct and accurate accommodation, and service codes.
 - a. Patients going to Acute Rehab or BHU must be discharged from the inpatient encounter and admitted to Acute Rehab or BHU as a new encounter facilitated by Registration.

D. REGISTERED NURSE RESPONSIBILITIES:

- 6.-- Transferring nurse shall provide hand-off communication to accepting nurse-allowing opportunity for questions and clarification of verbal report.
 - a. Document-Hand-Off Communication between healthcare-providers in the medical record.
- 7. The transferring nurse shall provide a brief safety hand-off, including information regarding the equipment in use, to the transporter.
- 1. Provide hand-off communication to receiving unit and/or transporter per Patient Care Services Policy: Hand-Off Communication
- 2. Evaluate of-patient condition prior to departure and arrival to the unit.
- 3. Empty urinary drainage bag prior to transport.
- 4. Ensure adequate IV solutions for transport.
- 5. Ensure Ppatients on a cardiac monitor aremust be transported/transferred on a cardiac monitor with;
 - 8.a. aAn RN competent in EKG recognitioncertified in Advanced Cardiac Life Support (ACLS) (adult) or Pediatric Advanced Life Support (PALS)/ENPC (pediatric).
 - Patients currently on a cardiac monitorTelemetry may be transportedtransferred for diagnostic-testing without monitor based on the order of the physician.
- b. A resuscitation bag/mask, oxygen (sufficient amount to transfer) and oral airway
 If patient is pre-medicated for diagnostic test, such as Magnetic Resonance Imaging (MRI), withreceived a benzodiazepine and/or a narcotic within one hour of leaving the floor, a nurse must accompany the patient during transport. The patient must be monitored with a continuous pulse oximetry device, at the minimum, during transport and while off the unit. A nurse should be available at all times to observe the patient for change in condition.
 - a. Vitals signs will be obtained based on the clinical condition of the patient or upon change in condition during-the-following-times, at the-minimum:
 - b. Prior to leaving the unit
 - c. Upon arrival-to the testing-area
 - d. After completion of the test
 - a.e. Upon return to the patient's primary location
- 7. If transferring to another inpatient unit the transferring nurse shall:
 - 9.a. The transferring nurse shall eExplain the rationale of the transfer to patient and assist with notification of patient's spouse/family/significant other.
 - 10.b. Send all patient related items and/or equipment with patient and labels all personal items including intravenous piggybacks (IVPBs), intravenous (IVs), and patient-specific medications.

E. TRANSPORTER RESPONSIBILITIES:

- 1. Receive hand-off per Patient Care Services Policy: Hand-Off Communication.
- 2. Transporting or transferring a patient from a nursing unit, the transporter shall:
 - a. Identify the patient to be transported/transferred.
 - b. Notify the primary nurse that the patient will be leaving the nursing unit.
 - c. Cardiac or Medically monitored patients notify MT per the PCS Policy: Monitor Technicians (MTs): Communication Process
 - i. Gall-the Monitor Technician (MT)-from the patient's room-and provide the name of transport area or nursing unit.

- ii. Remove the monitoring box and place on the patient's bedside table. Do not place on meal trays, patient's bed or chair.
- d. Prepare patient for transport or transfer.
- e. If transferring to another inpatient unit, ensure belongings and valuables accompany the patient.
- 3. Transporting/transferring a patient to a nursing unit the transporter shall:
 - a. Notify the primary nurse/relief registered nurse (RN) or advanced care technician (ACT) patient has arrived/returned to the nursing unit.
 - b. Ensure the following:
 - i. Patient is repositioned safely in bed.
 - ii. Bed wheels are locked.
 - iii. Bed in placed in the low position.
 - iv. Call button and television remote are within patient's reach.
 - v. Bedside table is within patient's reach.
 - c. Cardiac or Medically monitored patients notify MT per the PCS Policy: Monitor Technicians (MTs): Communication Process
 - i. Place the monitor on patient.
 - ii. Gall monitor technician (MT) from the patient's room to ensure a visible heart rate is present.
 - a-1) If informed by the MT a visible heart rate is not present, notify a nurse or ACT.
- b.4. Once the patient is transported to a new unit, The transporter shall nNotify the receiving unit's nurses, assist patient to room, and provide a safety hand-off to the receiving nurse.
- 11. When a patient is transported to new unit, an off-unit transfer form must be completed.

E.F. RELATED DOCUMENT(S):

- NICU Policy: Transfer of Neonates and Infants Policy
- 2. Patient Care Services Policy: Chemotherapy Patient Intake to the Nursing Units (Direct Admit, Outpatient or Forensic) Procedure
- 3. Patient Care Services Policy: Hand-Off Communication
- 4. Patient Care Services Policy: Lift Team
- 5. Patient Care Services Policy: Monitor Technicians (MTs): Communication Process
- 2. Patient Care Services-Policy: Off Unit Transfer Process
- 6. Women's and Children's Services Policy: Infant Transport-Intrafacility-

Tri-City Medical Center		Patient Care Services		
PROCEDURE:	VAGINAL PACKING FOR REMO	OVAL FOR GYN AND/OR UROLOGICAL SURGERY		
Purpose:	To outline nursing responsibilities in the removal of vaginal packing, to completely remove vaginal packing while preventing unnecessary trauma and minimizing discomfort to the patient.			
Supportive Data:				
Equipment:	Non-sterile gloves Small red biohazard bag Perineal pad (i.e., "peri pad") 0.9% sodium chloride for irrigation 60mL irrigating syringe Non-sterile plastic backed incontinence pad (i.e., "Chux")			

A. PROCEDURE:

- 1. Requires a physician-orderConfirm physician/AHP order for vaginal packing removal.
- 1.2. Confirm the number of vaginal packs left inside the patient with the OR Nursing Record or physician/AHP documentation.
- 3. Inform-patient and eExplain the procedure for removal of the vaginal packing to the patient and obtain verbal consent.
- 4. Consider analgesia before vaginal packing removal, per physician/AHP order.
- 5. Obtain a second nurse to assist with vaginal packing removal.
- 6. Ensure patient privacy.
- 2.7. Adjust patient's bed to an ergonomic height for the staff member who will remove the vaginal packing.
- 3.8. Wash-handsPerform hand hygiene and don non-sterile gloves.
- 4.9. Prepare a red bio-hazardous plastic bag for disposal.
- 5.10. Drape-patient for privacyRemove the patient's underwear to expose the perineum. Position the patient in a supine position with knees bent, feet flat on the bed and legs slightly apart. Place a linen protector (Chux) under patient's buttocks.-and-place patient in a supine position to a dorsal-recumbent position with knees bent and feet apart.
- 11. Remove the old perineal pad and discard. Note perineal pad contents for documentation. Remove dirty gloves.
- 12. Perform hand hygiene and don clean non-sterile gloves.
- 13. Separate the labia majora and labia minora to visualize the vaginal packing. Moisten the vaginal packing with a syringe filled with 0.9% sodium chloride.
- 14. Encourage the patient to relax and take a deep breath.
- 15. Firmly grasp the end of the vaginal packing gauze (vaginal-packing), and use slowly and gentley motion to remove until entire packing is presentremoved. If needed, continue to moisten the packing as it is removed. Note the patient's response. If met with resistance or not able to remove the entire vaginal packing, and/or fresh-frank bleeding is noted, place a peripad over the area and notify the physician.
- 16. With the second nurse, confirm the integrity and entirety of the vaginal packing.
- 17. Discard the vaginal packing in the red biohazardous plastic bag. Remove dirty gloves.
- 18. Perform hand hygiene and don clean non-sterile gloves.
- 19. Perform perineal care and apply a new perineal pad.

ı[Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
	5/03; 5/09; 8/12 ; 04/18	08/12; 05/18	08/12; 05/18	07/18	n/a	09/12, 08/18	10/18	10/12, n/a	11/12

- 6.20. Remove and discard Chux and gloves.
- 21. Remove-gleves, and pPerform hand hygiene and don clean non-sterile gloves.
- 22. Assist the patient to a comfortable position and lower the bed.
- 23. Advise the patient to rest in bed for at least 30 minutes before mobilizing to decrease the risk of fainting or hemorrhage.
- 7.24. Dispose of trash appropriately.
- 8.25. Monitor and assess for vaginal drainage every 4 hours x 2. Note number of peri pads saturated per hour. Keep vaginal area clean and dry.
- 9-26. Advise patient to notify nurse if any bleeding is noted, and to not discard the peri pads without being until they are seen by the nurse.
- 40.27. Notify physician/AHP for any purulent drainage, burning pain, or heavy bleeding (greater than or equal to one saturated pad per hour).

B. <u>DOCUMENTATION:</u>

- Record the following in the patient's medical record:
 - a. Removal of vaginal packing, including number of packing pieces removed.
 - b. Patient's response to procedure.
 - c. Any drainage and/or bleeding.
 - d. Patient's tolerance of the procedure.

C. REFERENCE(S):

- 1. Rothrock, J. C. (2015). Alexander's Care of the Patient in Surgery (15th ed). St. Louis, MO: Elsevier.
- 1. Nieh, P.T., Marshall, F.F. (2007, 9th-Ed). "Surgery of bladder-cancer." Wein: Campbel-Walsh Urology, Chapter 78. Retrieved 05/04/2009:

http://www.mdconsult.com

 Schlicher, N.R. (JD). (2008). Balloon compression as treatment-for-refractory vaginal hemorrhage. Retrieved 05/04/2009:

http://www.mdconsult.com

3.—— Thayer County Health-Services: Isernhagen, M., Moore, S. (2008). Vaginal Packing, Removal of. Retrieved 05/11/2009:

http://74.6.146.127/search/cache

4. ThirdAge, Editorial Staff and contributors. (2008). Hysterectomy (surgical removal of the womb), vaginal hysterectomy, abdominal hysterectomy). Retrieved 05/11/2009:

http://www.thirdage.com



ACUTE CARE SERVICES

ISSUE DATE:

10/89

SUBJECT: Scope of Services

REVISION DATE(S): 09/04, 06/06, 08/06, 11/07, 02/09,

06/10, 08/11

Acute Care Services Department Approval:

09/1708/18

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

n/a

Administration Approval:

10/18

Professional Affairs Committee Approval:

10/17n/a

Board of Directors Approval:

10/17

A. **GOALS:**

- 1. To provide individualized quality patient care in a safe environment.
- 2. To reduce complications and unexpected outcomes
- 3. To continuously evaluate and improve the service provided.
- 4. To participate in interdisciplinary care by working closely with other disciplines.

BRIEF DESCRIPTION OF SERVICE: B.

Acute Care Services (1North/Acute Rehabilitation, 2 Pavilion, and 4 Pavilion) develop, implement and evaluate a plan of nursing care for adult (14 years and older), acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.

C. <u>METHODS USED TO ASSESS PATIENTS' NEEDS:</u>

Initial patient assessments are performed by the Registered Nurse upon arrival of the patient to the unit. Reassessments are performed post-operative, when a change in status occurs, when there is a change in the caregiver and at a minimum once every shift. Nurses utilize a variety of sources to gather pertinent information like physical assessment, data from the patient's chart, observations of team members, patient, families or significant others, and other disciplines.

D. SCOPE AND COMPLEXITY OF SERVICES:

- Patient care at Tri-City Medical Center encompasses health promotion, disease prevention, and treatment activities in the community, home acute care, inpatient and outpatient arena. Health care providers with specialized knowledge, judgement, and skill provide the care collaboratively. Patient care is planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize physical, psychological, and spiritual needs of patients.
- 2. Services provided include a variety of conditions/presentations of a medical/surgical nature. Non-surgical patients may include patients with respiratory, cardiovascular, neurologic, kidney/urinary diseases, cancer, immuno-suppressed conditions, abdominal pain, orthopedic infection, and short stay diagnostic procedures. Surgical patients may include general surgical, orthopedic, vascular and urologic procedures.
- The nursing services are coordinated with other disciplines and integrated in the interdisciplinary 3. care and treatment of the patients. Areas in the nursing assessment, if appropriate, trigger screenings for other departments including Dietary, Social Service, Case Management, Respiratory, Occupational Therapy, Physical Therapy, and Speech Therapy. Physician aligned case management and biweekly clinical collaboration meetings reflect one form of information exchange between disciplines and interdisciplinary care.

- 4. 1N: Orthopedic diagnoses are emphasized with an emphasis on orthopedic surgeries including total joint replacement, spinal surgeries, and hip replacements and bariatric surgeries.
- 5. Acute Rehabilitation: Orthopedic and neurological diagnoses as outlined in inpatient acute rehabilitation (ARU). The ARU provides restorative and maintenance programs for the adult (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services. The plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation unit.
- 6. 2 Pavilion: Oncological diagnoses are emphasized; along with women's surgeries and the DiVinci Robotic Surgery patients, in addition to general medical surgical diagnosis.
- 7. 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis.

E. STAFFING AND THE AVAILABILITY OF STAFF:

- 1. Staffing plans for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Each department has a formalized staffing grid which is reviewed at least annually based on the following: Hours per patient day/hours per unit of service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized in the Staffing Office and are kept in unit/departmental documents.
- 2. The units are staffed with a Clinical Manager, Clinical Nurse Leader, Clinical Educators, Assistant Nurse Managers, Diabetes Educator, Stroke Coordinator, Registered Nurses, Monitor techs, Acute Care Technicians and Chief Nurse Executive. The Manager has 24-hour responsibility for patient care and unit management Staff work 12-hour shifts.
- 3. The Assistant Nurse Manager or Relief Charge Nurse will make staff assignments according to patient acuity, staff availability, individual staff competencies, and the amount of supervision needed by staff members in accordance with Title 22 regulations. Patient acuity and specific patient needs are determined for each patient by the nurse for each shift, and then used for staffing. The staffing matrix provides information about staff/staff mix requirements based on acuity and minimum staffing requirements. Minimum staffing requirements provide a nurse/patient ratio of 1 RN for every 5 patients. The manager will confer if additional staff is needed. Staffing is also adjusted during each shift should the requirements change (See classification policy).
- 4. Basic Life Support (BLS) is required on all acute care units, Advanced Cardiac Life Support (ACLS) and National Institues of Health Stroke Scale (NIHSS) is required for 4P. Initial and biannual competency requirements for staff are defined and updated on a yearly basis.

F. ASSESSING DEPARTMENT SERVICES:

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

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

The level of care provided by the Acute Care Service units meets the needs of both inpatients
and outpatients through availability of staff who are competent to provide service for the current
patient population and the coordination of nursing services with services of other disciplines.

Acute Care Services Scope of Services Page 3 of 3

H. PERFORMANCE IMPROVEMENT

 In order to improve patient care, several indicators are monitored to measure care given and effect change (see PI plan). Data is reported quarterly to the Quality Council.

I. STANDARDS USED BY THE DEPARTMENT IN THE CARE OF PATIENTS:

J. MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT:

1. Medications, general and narcotics, are dispensed via the Pyxis system. Daily patient doses are stored and dispensed from the locked profile machine. Antibiotics and IV bags are kept in a separate area. Medications requiring refrigeration are stored at the appropriate temperatures. Nurses assess and document the administration/effectiveness/side effects of medication.

	MARK EACH SERVICE THAT THE PATIENT WILL	REQUIRE UPON DI	SCHARGE THIS ORDER WILL
>	INITIATE FOLLOW-UP WITH THE SPECIFIC CLINIC		
)		deletion by:
2	INPATIENT SERVICES:		Stephen Chavez-Matzel: 02/17
ï	Acute Rehabilitation Unit		Case Management: 02/17
	⊟ Evaluate for Treatment		
	El- Transfer to Acute Rehab Unit if patien	t-meets-criteria	PPO Committee: 02/17
1	,		UR Committee:01/18
ı	HOME HEALTH SERVICES:		MEC: 08/18
	⊟-Tri-City-Home Health	<u> </u>	Administration: 10/18
	2095 W. Vista Way, Suite 101, Vista, CA 920	83	PAC: n/a
	E Care South Home Health of San Diego		BOD:
	- 1870 Cordell Court, Sto. 106, El Cajon, CA 92	2020	
1	⊞-We Care		619-220-3800
1	4636 Mission Gorge Place, Suite 200A, San-D	iego: Ca 92120	
ı			
	HOSPICE SERVICES:		
	Tri-City Hospice		760-940-5801
1	2095 W. Vista Way, Suite 220, Vista, CA 9208	B3	
ı			
l	OUTPATIENT REHABILITATION SERVICES:		
١	Cardiac Rehabilitation		760-940-3096
1	⊟Evaluate		
ı	Evaluate and Treat		
ı	☐ Occupational Therapy		760-940-7278
١	⊟ Evaluate	•	100 040 1210
I	E Evaluate and Treat		
	☐ Physical Therapy — —		760-940-7278
í	======================================		00 0 10 1210
l	Evaluate and Treat		
ŀ	☐—Pulmonary-Rehabilitation	<u> </u>	760-940-3055
l	E-Evaluate		00 0 10 0000
l	Evaluate and Treat		
l	☐ Speech Therapy		760-940-7272
l	= Evaluate		00 010 1212
l	E Evaluate and Treat		
	— — manual dita il que		
	WOUND CARE SERVICES:		
l	☐ Tri-City Wound-Care-Center	-	760-940-5600
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l	Diaghttelist.		
l	Health Hitens:		
-	Read Back all T.O./V.O orders		
ĺ	Numerala Companya	The distance of the same	n . mil
	Nurse's – Signature Date Time	Physician's - Signature	Affix Patient Label
	Tri-City Medical Center	<i>P</i>	MIIA FALIERI LADEI
	4002 Vista Way • Oceanside • CA • 92056		
	DISCHARGE REFERRAL		
	SERVICES ORDERS		
1			
	Page 1 of 1		
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PHYSICIAN'S ORDERS

8711-4539 Revised (06/10)

Board Approved 08/10

REHABILITATION SERVICES POLICY MANUAL

ISSUE DATE:

09/15

SUBJECT: Mission Statement, Goals and

Objectives

REVISION DATE(S):

Rehabilitation Department Approval:

07/1505/18

Department of Medicine Approval:

n/a

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

n/a

Administration Approval:

10/18

Professional Affairs Committee Approval:

09/15n/a

Board of Directors Approval:

09/15

A. **POLICY:**

Tri-City Healthcare District Rehabilitation Services is dedicated to providing comprehensive, individualized and high quality healthcare to maximize the function and quality of life for all patients and members of our community.

2. Goals and Objectives:

> To render high quality rehabilitation services to assist each patient in reaching their maximum potential so they may assume their rightful place in society, while learning to live within the limits of their capabilities.

b. To alleviate pain, restore function, and improve quality of life by using accepted and current techniques & approaches in physical, occupational, speech, audiology and therapeutic recreation. These include tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate.



REHABILITATION SERVICES POLICY MANUAL

ISSUE DATE:

7/91

SUBJECT:

Staff Meetings

REVISION DATE(S): 1/94, 4/97, 10/99, 2/03, 1/06, 1/09,

3/12, 09/15

Rehabilitation Department Approval:

07/1505/18

Department of Medicine Approval:

n/a

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

n/a

Administration Approval:

11/d

Professional Affairs Committee Approval:

10/18 09/15n/a

Board of Directors Approval:

09/15

A. POLICY:

- 1. To ensure a regular forum for communication between management and staff which is discipline and area specific.
- Team meetings will occur at routine intervals, no less than once per month and subject to change per department needs. The meeting will be directed by Rehabilitation Services Leadership Team or a designee.

B. **PROCEDURE**:

- The Rehabilitation Services Leadership Team chooses an appropriate time and place for their meetings. These meetings are standing when possible. It is each Leadership Team Member's responsibility to communicate meeting specifics to their area staff.
- 2. The Rehabilitation Services Leadership Team presents any information that should reach staff prior to the department meeting.
- 3. Meetings are informal to encourage two-way communication.
- 4. Meeting minutes will be documented and shared with discipline and/or area specific staff.



REHABILITATION SERVICES POLICY MANUAL

ISSUE DATE:

6/88

SUBJECT: Statement of Accountability

REVISION DATE(S): 1/94, 4/97, 10/99, 10/00, 2/03, 1/09,

11/09, 3/12, 09/15

Rehabilitation Department Approval:

07/1505/18

Department of Medicine Approval:

n/a

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

n/a n/a

Administration Approval:

Professional Affairs Committee Approval:

10/18 09/45n/a

Board of Directors Approval:

09/15

A. **POLICY:**

- The Director of Rehabilitation Services is responsible to the Senior Director and the Rehabilitation Services Staff for the overall direction and supervision of the department and the administrative direction of Rehabilitation Services.
- In the event of the absence of the Director, an appropriate designee will be assigned, which 2. may include the Senior Director, a therapy supervisor, a vice president, a supervisor of another department, or other designee.



PERI-ANESTHESIA NURSING SERVICES POL

DELETE – incorporated into the Patient Care Services Policy: Outpatient Post Anesthesia/Procedure Discharge/Transportation Guideline

SUBJECT: POST-ANESTHESIA PATIENT DISCHARGE/TRANSPORTATION GUIDELINES

ISSUE DATE: 08/11 REVISION DATE(S):

Department Approval Date(s):

Department of Anesthesiology Approval Date(s):

Operating Room Committee Approval Date(s):

Pharmacy and Therapeutics Approval Date(s):

Medical Executive Committee Approval Date(s):

Administration Approval:

Professional Affairs Committee Approval Date(s):

n/a

Board of Directors Approval Date(s):

PURPOSE:

1. To establish guidelines for patient discharge related to availability of transportation for Post-Anesthesia Care Unit (PACU) and Special Procedures Recovery Area (SPRA). Patients are not to drive for 24 hours after surgery as they are considered under the influence. Patients are advised during their PreOp Education appointment that they are to have a ride home and someone to accompany them after surgery.

B. POLICY:

1. PACU

- a. All patients who have received general anesthesia must leave the hespital with a competent adult at least 18 years of age via personal car, taxi cab, or TCMC provided van transportation. They must be accompanied by the adult with no exceptions.
- All patients who have received-conscious sedation must also be escorted by a competent adult and be escorted home by either personal car, taxi, or TCMC provided van transportation. If this is not-possible these patients must be monitored in the PACU for a period of 4 hours before being released without a competent adult. After the period of four hours a ride may be provided by taxi or TCMC van transportation without an escort. Under no circumstances will-these-patients be allowed to drive themselves home.
- c. Physically indigent patients without demicile will be held in PACU for a minimum-of-4 hours (lenger if medically indicated) before-being discharged at the facilities front door.

SPRA

- a. Transfusion and infusion-patients do not receive sedation so they may drive themselves home or elect any other form-of-transportation.
- b. Cardiac Catheter Patients/ and Interventional Radiology Patients All patients who have received conscious sedation must also be escerted by a competent adult-and-be escerted home by either personal car, taxi, or TCMC provided van transportation. If this is not possible these patients must be monitored in SPRA for a period of 4 hours before being released without a competent adult. After the period of four hours a ride-may be provided by taxi-or TCMC van transportation without an escort. Under no circumstances will these patients be allowed to drive themselves home.
- c. Physically indigent patients without demicile will be hold in PACU for a minimum of 4 hours (longer if medically indicated) before being discharged at the facilities front door.
- PreOp Education

Post-Anesthesia Patient Discharge/Transportation Guidelines Page 2 of 2

- a. The patient will be notified during their pre-operative teaching appointment that they must have a responsible adult to take them to their destination post-operatively or their procedure will be cancelled.
- b. The patient will sign a form stating they were notified of this policy.
- 4. PreOperative Guidelines
 - a. The patient's pre-arranged ride home will escert them into pre-op-hold for verification that the patient will have a competent adult to take them home after their precedure and to arrange a way to notify the family member that the patient is ready for discharge.

Community Healthcare & Alliance Committee (No meeting held in October, 2018)

Tri-City M al Center Finance, Operations and Pinning Committee Minutes October 16, 2018

Members Present

Director Julie Nygaard, Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Jack Cumming Dr. Gene Ma (joined the meeting at 12:35 pm), Wayne Lingenfelter

(joined the meeting at 12:45 pm),

Non-Voting Members

Present:

Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Sharon Schultz, CNE, Carlos Cruz, CCO, Susan

Bond, General Counsel

Others:

Thomas Moore, Cristina Barrera, Eva England, Jeremy Raimo, Debra Feller, Sherry Miller, Maria Carapia, Kristy

Larkin, Candice Parras, Barbara Hainsworth

Members Absent:

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Call to order	Director Nygaard called the meeting to order at 12:31 pm.		
2. Approval of Agenda		MOTION It was moved by Director Kellett, Director Grass seconded, and it was unanimously approved to accept the agenda of October 16, 2018. Members: AYES: Nygaard, Kellett, Grass, Contardo, Yamanaka, Ferber, Cumming NOES: None ABSTAIN: None ABSENT: Ma, Lingenfelter	
 Comments by members of the public on any item of interest to the public before committee's consideration of the item. 	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of September 18, 2018	Minutes were ratified with one correction.	Minutes were ratified. MOTION	

Topic	Discussions, Conclusion. Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	Dr. Yamanaka advised a correction should be made to item 7, Consideration of the Consent Calendar, which reflects that Dr. Ma participated in the vote. Dr. Ma was not in attendance at the September meeting.	It was moved by Dr. Ferber, Director Grass seconded, and the minutes of September 18, 2018 are unanimously approved. Dr. Ma arrived after the vote, making his abstention unnecessary. Barbara Hainsworth to make the correction.	
5. Old Business			
 Affiliation Agreement The Regents of The University of California, Team Physicians of Southern California Medical Group & Tri-City Healthcare 	Susan Bond conveyed that this is a revision to the previously approved contract, changing the duration from one year to five years. Significant discussion ensued.	It was moved by Dr. Contardo, seconded by Director Kellett to authorize the agreement with The Regents of the University of California, Team Physicians of Southern California Medical Group, Inc. & Tri-City Healthcare District for an Emergency Residency Program to provide education and training to trainees, for a term of 60 months, beginning July 1, 2018 and ending June 30, 2023 for an annual cost of \$104,689.56 and a total cost for the term of \$523,447.80. Members: AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Cumming NOES: None ABSTAIN: None ABSTAIN: None	
6. New Business	None	to a control of the artist of the control of the co	148 77 (47)
a. Board of DirectorRecognitionDr. Cyril Kellett	On behalf of the committee, Director Nygaard acknowledged the invaluable contributions made by Dr. Cyril Kellett to Tri-City Medical. Also at this time, she presented him with a certificate of appreciation recognizing both his many years of service as a member of the		

lopic	Discussions, Conclusion. Recommendations	Action Recommendations/ Conclusions	F son(s) Responsible
	Board of Directors, and the Finance, Operations & Planning Committee.		
 b. Reminder: No FOP Meeting to be held in November 2018 December meeting scheduled on Tuesday, 12/4/18 	Director Nygaard reminded the Committee that there will be no Finance, Operations & Planning Committee meeting held in November, and that the December meeting will be held on Tuesday, December 4, 2018.		
7. Consideration of Consent Calendar:	Director Nygaard requested that the following item be pulled for discussion: • 7.b. Pharmacy USP 800 Upgrades – Choctaw Construction Company, Inc.	MOTION It was moved by Mr. Cumming to approve the Consent Calendar, Director Grass seconded. Members: AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Cumming NOES: None ABSTAIN: ABSENT: Lingenfelter	Chair
a. Medical DirectorAgreement – SurgeryDandy Lee, M.D.		Approved via Consent Calendar	Debra Feller
 b. Pharmacy USP 800	Scott Livingstone presented this agreement which requests the approval of the construction vendor to make the required USP 800 upgrades to the pharmacy. He further conveyed that the estimated time it will take to complete these modifications is expected to be between 6–9 months.	MOTION It was moved by Mr. Lingenfelter, seconded by Director Kellett to authorize the agreement with Choctaw Construction Company, Inc. for \$582,785 and the total project budget of \$1,099,949 for Pharmacy USP 800 upgrades.	
	Upon review of the write-up, Director Kellett requested a verbiage change in the Description of Services/Supplies area. The original statement read, "We,	AYES: Nygaard, Kellett, Grass, Contardo, Ma, Yamanaka, Ferber, Cumming NOES: None ABSTAIN:	

ropic	Discussions, Conclusion Recommendations	Action Recommendations/ Conclusions	F on(s) Responsible
	like many other facilities, had to apply for a waiver." Because the date of January 1, 2018 for compliance of these upgrades had passed, the statement will be modified to read, "Like many other facilities, Tri-City Medical Center applied for and was granted a waiver".	ABSENT: Lingenfelter Barbara Hainsworth to make the requested change.	
c. Pyxis Supply Cabinetry Lease Proposal Becton Dickinson – Pyxis Supply		Approved via Consent Calendar	
 d. Physician Agreement for ED On-Call Coverage – ENT Anton Kushnaryov, M.D. 		Approved via Consent Calendar	
e. Physician Recruitment Proposal • Hussna Wakily, M.D.		Approved via Consent Calendar	
f. Physician Agreement for ED On-Call Coverage – OB/GYN Raheleh Esfandiari, M.D.		Approved via Consent Calendar	
8. Financials:	Ray Rivas presented the financials ending September 30, 2018 (dollars in thousands) TCHD – Financial Summary Fiscal Year to Date Operating Revenue \$88,709 Operating Expense \$90,659 EBITDA \$3,381 EROE \$ (479) TCMC – Key Indicators Fiscal Year to Date		Ray Rivas

ropic	Discussions, Conclusion. Recommendations	Action Recommendations/ Conclusions	F on(s) Responsible
	Avg. Daily Census 154		
	Adjusted Patient Days 26,105		
	Surgery Cases 1,631		
	Deliveries 558		
	ED Visits 14,460		
	TCHD – Financial Summary		
	Current Month		
	Operating Revenue \$ 28,950		
	Operating Expense \$ 29,304		
	EBITDA \$ 1,417		
	EROE \$ 119		
	TCMC – Key Indicators		
	Current Month		
	Avg. Daily Census 146		
	Adjusted Patient Days 8,361		
	Surgery Cases 512		
	Deliveries 170		
	ED Visits 4,647		W
	TCMC - Net Patient A/R & Days in Net		
	A/R By Fiscal Year		
	Net Patient A/R Avg.		
	(in millions) \$ 42.7		
	Days in Net A/R Avg. 44.8		
	Graphs:		
	TCMC-Net Days in Patient		
	Accounts Receivable		
	TCMC-Average Daily Census,		
	Total Hospital-Excluding		
	Newborns		
	TCMC-Acute Average Length of		
	Stay		
9. Work Plan:		2 99	
a. Construction Report	Scott Livingstone gave a brief overview		Chris Miechowsk
	of the Construction Report.		
	He conveyed that they continue to wait		
	for the State of California to issue the		
	license for the Retail Pharmacy, which is		

Topic	Discussions, Conclusion Recommendations	Action Recommendations/ Conclusions	Responsible
	Director Nygaard solicited when the new parking area would be opened for use. Scott conveyed that the City of Oceanside has delayed approval of this project until the amended landscape plan submitted by the landscape architect, has received the necessary approval.		
b. Infusion Center	Sharon Schultz conveyed that the cost of the pharmaceuticals used by the Infusion Center has increased, and this has had an overall effect on the operating expenses and net revenue. Brief discussion ensued.		Sharon Schultz
c. ED Throughput	Candice Parras reported the following information: • The volume of left without being treated patients increased to over 4%, during the previous quarter • Door to discharge times, increased by an additional 27 minutes more, from the previous reduction of 55 minutes off the original discharge times • Psychiatric volumes have increased, and wait times have also increased to over 4 hours. • With the closure of CSU & the removal of the BHU locked unit designation, patient satisfaction has increased & wait times are much shorter • Left without treatment (LWOT) patient volumes are down to less than 1%, and will be reflected in		Candice Parras

Copic	Discussions, Conclusion. Recommendations	Action Recommendations/ Conclusions	F son(s) Responsible
	the next quarterly throughput report.		
d. Medical Director - Surgery	Debra Feller gave a comprehensive PowerPoint presentation which gave detailed / statistical information regarding the following: Process Improvements Overall Surgical Volumes Robotic Surgery Case Volumes Robotic Case Volume by Service Line OR Activity Analysis: Inpatients OR Activity Analysis: Outpatients Perioperative Surgical Home (PSH) Perioperative Surgical Home (PSH) Data Future Objectives Brief discussion ensued.		Debra Feller
e. Dashboard	No discussion		Ray Rivas
10. Comments by committee members	Director Nygaard referenced a recent newspaper article regarding TCMC. Steve Dietlin conveyed that TCMC has recently undergone a robust and collaborative, yet very successful JCAHO survey. He further detailed that certain EOC practices were reviewed by the surveyors and appropriately cited. Proof of correction to be provided and TCMC will be granted the full 3-year accreditation by The Joint Commission.		
Finance Operations and Planning	Director Kellett conveyed his gratitude for the certificate of appreciation recognizing		

Topic	Discussions, Conclusion Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	his long affiliation with Tri-City Medical Center. He further articulated that it is his belief that the collaboration of TCMC and UCSD Medical Center will present many opportunities for growth in the future for both entities.		
11. Date of next meeting	Tuesday, December 4, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 1:27 p.m.		



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: October 16, 2018 AFFILIATION AGREEMENT

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

Vendor's Name:

The Regents of The University of California, Team Physicians of Southern

California Medical Group, Inc. & Tri-City Healthcare District

Area of Service:

Education

Term of Agreement:

60 months, Beginning, July 1, 2018 - Ending, June 30, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$8,724.13	\$104,689.56	\$523,447.80

Description of Services/Supplies:

Emergency Residency Program – Providing Education and Training Programs to Trainees.

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

Person responsible for oversight of agreement: Susan Hadley, Director, Network Development / Steve Dietlin, Chief Executive Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with The Regents of the University of California, Team Physicians of Southern California Medical Group, Inc. & Tri-City Healthcare District for an Emergency Residency Program to provide education and training to trainees, for a term of 60 months, beginning July 1, 2018 and ending June 30, 2023 for an annual cost of \$104,689.56 and a total cost for the term of \$523,447.80.





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: October 16, 2018

Medical Director Agreement - Surgery

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

Physician's Name:

Dandy Lee, M.D.

Area of Service:

Surgery

Term of Agreement:

24 months, Beginning, October 1, 2018 – Ending September 30, 2020

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES (Verified by MD Ranger)

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
	Not to Exceed	Not to Exceed	Not to Exceed	Not to Exceed	Not to Exceed
\$150 16		192	\$2,400	\$28,800	\$57,600

Position Responsibilities:

- Functions as the Medical Director for the Surgery Department
- Provides clinical and administrative consultation for the operating room leadership
- Establishes and evaluates policies, procedures and protocols related to patient care, patient safety and medical developments (including new treatments modalities, drug information etc.)

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

Person responsible for oversight of agreement: Debra Feller, Clinical Director, Surgery / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Dandy Lee as the Medical Director for Surgery for a term of 24 months beginning October 1, 2018 and ending September 30, 2020. Not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of \$150 for an annual cost not to exceed \$28,800, and a total cost for the term not to exceed \$57,600.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: October 16, 2018 Pharmacy USP 800 Upgrades

Type of Agreement		Medical Directors	Panel	I X	Other: Pharmacy Upgrade
Status of Agreement	х	New Agreement	Renewal – New Rates		Renewal – Same Rates

Vendor's Name:

Choctaw Construction Company Inc.

Area of Service:

Pharmacy

Term of Agreement:

Completion of work

Maximum Totals:

Proposal:	Expected Costs:
Choctaw Construction Company, Inc. (Construction)	\$582,785
Design, Permits, Inspections, Contingency	\$517,164
Total Expected Project Cost:	\$1,099,949

Description of Services/Supplies:

- IV room remodel has to be done to meet California State Board of Pharmacy (SBOP) requirements. All
 facilities were expected to be in compliance by January 1, 2018 to align with new USP 800 regulations that
 were going to be enforced. USP 800 enforcement is delayed; however SBOP is still expecting compliant IV
 rooms. Like many other facilities, Tri-City Medical Center applied for and was granted a waiver.
- Choctaw Construction Company Inc. was able to come in substantially lower than the other bidders due to finding a local less expensive stainless steel manufacturer and by having a low company overhead (the Project Manager will be the owner of the company).
- Choctaw Construction Company Inc. was the lowest responsive and responsible bidder. Bid results below:

Company:	Bid Amount:
Choctaw Construction Company, Inc.	\$582,785
Jennette	\$795,000
Herman Construction Group	\$895,500
Weir	\$975,000

Document Submitted to Legal:	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: 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 Choctaw Construction Company, Inc. for \$582,785 and the total project budget of \$1,099,949 for Pharmacy USP 800 upgrades.





FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: October 16, 2018 Pyxis Supply Cabinetry Lease Proposal

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

Vendor's Name:

Becton Dickinson - Pyxis Supply

Area of Service:

All Departments with Pyxis Supply Cabinets

Term of Agreement:

60 months, Beginning, February 1, 2019 - Ending, January 31, 2024

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$33,860	\$406,320	\$2,031,600

One-time fee:

1) \$15,000 Implementation fee for Item Master

2) \$50,000 Cerner Integration fee

One time credit: One-time credit up front of \$106,041

Description of Services/Supplies:

- Renewal for version upgrade and lease of all Pyxis supply cabinets (75)
- Cabinetry is automated to charge patients as supplies are used and also reorder replacement stock
- Adding automation in Warehouse to manage product, Cerner integration and Item master interface
- All stations will now have Scanners to track product usage and expiration dates
- The newer version will also record products used on EMR as well as synchronize pricing across systems

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: Thomas Moore, Director, Supply Chain Management / Ray Rivas, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Becton Dickinson - Pyxis for lease of medical supply automated cabinetry for a term of 60 months, beginning February 1, 2019 and ending January 31, 2024 for an annual cost of \$406,320, and a total cost for the term of \$2,031,600.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: October 16, 2018 PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT

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

Physician's Name: Anton Kushnaryov, M.D.

Area of Service: Emergency Department On-Call: ENT

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

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

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: ENT

Existing panel, no increase in Expense

Rate/Day	Panel Days per Year	Panel Term Cost
\$550/Day	365	\$200,750

Position Responsibilities:

- Provide 24/7 patient coverage for all ENT 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:	Х	Yes	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 / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Anton Kushnaryov as an ED-call coverage physician for ENT for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 at a daily rate of \$550, for a term cost of \$200,750.



FINANCE, OPERATIONS & PLANNING COMMITTEE DATE OF MEETING: October 16, 2018 PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

Type of Agreement	Medical D	irectors X	Panel		Other:
Status of Agreement	New Agre	ement	Renewal – New Rates	Х	Renewal – Same Rates

Physician's Names:

Raheleh, Esfandiari M.D.

Area of Service:

Emergency Department On-Call: OB/GYN

Term of Agreement:

21 months, Beginning, October 1, 2018 - Ending, June 30, 2020

Within Hourly and/or Annualized Fair Market Value: YES

Maximum Totals:

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

Adding physician to existing panel, no increase in expense

Rate/Day	Annual Panel Days Annual Panel Co		Term Cost	
Man Eri / CROD	FY18: 253	\$202,400	\$406,400	
Mon-Fri / \$800	FY20: 255	\$204,000		
Sat-Sun / TCMC Recognized	FY18: 112	\$112,000	<u> </u>	
Holidays: \$1,000	FY20: 111	\$223,000		
	Total Term Cost		\$629,400	

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 for Review:	Х	Yes	No
Approved by Chief Compliance Officer:	Х	Yes	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 Raheleh, Esfandiari M.D. to the currently existing ED On-Call Coverage Panel for OB/GYN for a term of 21 onths, beginning October 1, 2018 and ending June 30, 2020.



Tri-City Medical Center Professional Affairs Committee Meeting Open Session Minutes October 25, 2018

Members Present: Chairperson Leigh Anne Grass, Director Laura Mitchell, Director RoseMarie Reno; Dr. Victor Souza.; Dr. Marcus Contardo; Dr. Gene Ma

Non-Voting Members Present: Scott Livingstone, COO, Sharon Schultz, CNE/ Sr. VP, Susan Bond, General Legal Counsel and Carlos Cruz, Chief Compliance Officer.

Others Present: Patricia Guerra and Teri Donnellan

Members Absent: Dr. Johnson

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible	
1. Call To Order	Chairperson Grass called the meeting to order at 12:03 PM in Assembly Room 1.		Director Grass	
2. Approval of Agenda	The committee reviewed the agenda; two policies were pulled from the agenda Conducting Searches Patient Room Belongings Policy and Medical Procedure and Interrogations Requested by Law Enforcement.	Motion to approve the amended agenda was made by Dr. Contardo and seconded by Director Mitchell.	Director Grass	
 Comments by members of the public on any item of interest to the public before committee's consideration of the item. 	Chairperson Grass read the paragraph regarding comments from members of the public.			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes from July 2018.	It was moved by Director Mitchell and seconded by Dr. Souza to approve the minutes of the July 12, 2018 meeting. Director Reno requested the minutes reflect that she abstained from the vote. Director Mitchell noted a minor typographical correction.	The amended minutes were approved unanimously.	Teri Donnellan
5. Consideration and Possible Approval of Policies & Procedures Patient Care Services 1. Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC)	Minor revisions were suggested to the Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC) policy. It was moved by Diector Reno and seconded by Dr. Contardo to recommend approval of the Patient Care Services Policy – Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC) with amendments as described. The motion pssed unanimously.	Recommendation to be sent to the Board of Directors to approve the Patient Care Services Policy – Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC); item to appear on Board agenda and included in agenda packet.	Teri Donnellan
Administrative Policies & Procedures 1. Conducting Searches Patient Room Belongings Policy 2. Employee Compensation 3. Medical Procedure and Interrogations Requested by Law Enforcement	1. Conducting Searched Patient Room Belongings Policy was deferred to the January meeting. 2. There were no revisions to the Employee Compensation Policy. Director Reno commented that employees have indicated they would be receiving two increases and questioned where the money was coming from. Chairperson Grass stated Director Reno's question did not apply to the policy at hand and the issue of employee compensation is not on the agenda for	Recommendation to be sent to the Board of Directors to approve Administrative Policy & Procedure Employee Compensation as presented; item to appear on Board agenda and included in agenda packet. Conducting Searches Patient Room Belongings Policy and Medical Procedure and Interrogations Requested by Law Enforcement Policy to be placed	Teri Donnellan

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	discussion. Ms. Sharon Schultz commented that union members receive increases as described in the Bargaining Agreement. 3. Medical Procedure and Interrogations Requested by Law Enforcement was deferred to the January meeting. It was moved by Director Reno and seconded by Director Contardo to recommend approval of Administrative Policicy & Procedure - Employee Compensation as presented. The motion passed unanimously.	on the January agenda.	
Patient Care Management			Teri Donnellan
1. Utilization Management Plan	Minor revisions were suggested to the Utilization Management Plan for clarification. It was moved by Director Mitchell and seconded by Dr. Souza to recommend approval of the Utilization Management Plan with amendments as described. presented. The motion passed unanimously.	Recommendation to be sent to the Board of Directors to approve the Utilization Management Plan as amended; item to appear on Board agenda and included in Board packet.	
7. Closed Session	It was moved by Director Reno and seconded by Dr. Contardo to go into Closed Session. The motion passed unanimously.	The Committee adjourned to Closed Session at 12:10 p.m.	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
8. Return to Open Session	The Committee returned to Open Session at 12:19 p.m.		
Reports of the Chairperson of Any Action Taken in Closed Session	Chairperson Grass stated there were no actions taken in Closed Session.		
10. Comments from Members of the Committee	There were no comments from members of the public		
11. Adjournment	Hearing no further business Chairperson Grass adjourned the meeting at 12:15 p.m.	The Committee's next meeting will be held on January 10, 2019.	



PROFESSIONAL AFFAIRS COMMITTEE October 25th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC)	3 Year Review, Practice Change	Forward To BOD For Approval with Revisions
Administrative Policies & Procedures		
Conducting Searches Patient Room Belongings Policy - 208	NEW	Pulled for Further Review
2. Employee Compensation - 475	3 Year Review, Practice Change	Forward To BOD For Approval
Medical Procedures and Interrogations Requested by Law Enforcement - 595	NEW	Pulled for Further Review
Patient Care Management		
Utilization Management Plan	Practice Change	Forward To BOD For Approval with Revisions



PATIENT CARE SERVICES-POLICY MANUAL

ISSUE DATE:

06/14

SUBJECT: Transferring and Receiving Patients

from Outside Tri-City Medical

Center (TCMC)

REVISION DATE(S):

POLICY NUMBER: NEW

Patient Care Services Content Expert Approval:

Clinical Policies & Procedures Committee Approval:

Nurse Executive Committee Approval: Medical Staff Department/Division Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

08/17

12/1308/1710/1704/18

12/1304/18

n/a n/a

09/18 10/18

06/1410/18

06/14

A.

To ensure safe and appropriate inter-facility patient transfers.

POLICY: B.

- Patient safety, infection control, and requests shall be considered in all transfer decisions.
- 2. Inter-facility transfers are indicated when continuing medical care provided by other medical facilities or alternate acute care facilities are required.
- 3. An inter-facility transfer requires a physician/Allied Health-Professional's (AHP) order and an accepting physician/AHP.
 - Skilled Nursing Facilities (SNF) may designate a staff physician/AHP.
 - The Case Manager or Administrative Supervisor shall coordinate Inter-facility transfers to acute care hospitals, SNF, or intermediate care facilities.
 - The Social Worker or Administrative SupervisorCase Manager shall coordinate ii. transfers to assisted living or board, and care facilities, and SNF.

C. PROCEDURE FOR TRANSFERRING PATIENTS OUTSIDE TCMC:

- The attending physician/AHP communicates with a physician/AHP at the receiving acute care facility and documents the acceptance of the patient by that physician/AHP.
- 2. The attending physician/AHP completes discharge orders and appropriate orders for medications and treatments for transfer to any facility.
- 3. The attending physician/AHP dictates a transfer summary with all appropriate information about the patient's course in the hospital, including but not limited to diagnosis, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan, and the summary shall be signed by the physician/AHP.
 - A copy of the summary shall be sent with the patient.
 - i. If the summary is not available at time of discharge, copies of physician/AHP's orders must accompany the patient.
- 4. The RN shall contact the receiving facility and provide hand-off communication.
- 5. The Inter-Facility Transfer Form shall be completed by the primary nurse.
- 6. Copies of orders, medical summary, progress notes, MAR, therapy notes, lab and radiology reports may accompany the patient as requested by the receiving facility.
- 7. The unit secretary/designee shall arrange transportation.

- 8. The patient agrees to transfer.
- 9. Patients' families may transfer a child from the ED to a children's hospital via personal vehicle under these conditions:
 - a. Parents/legal guardian agree
 - b. Risks and benefits are explained and documented
 - ED physician/AHP determines the patient is stable for transfer by privately owned vehicle (POV)
 - i. Patient eannet may be transported with Physician/AHP order by POV withif intravenous (IV) access in place and appropriate dressing, with instructions to go directly to children's hospital.
 - ii. Patient cannot be transported by POV if they have received IV pain medication with the last 30 20 minutes
 - d. Directions have been provided and the parents/responsible party reiterates understanding
 - e. Children's hospital is in agreement
 - f. Children's hospital is requested to contact the ED charge nurse to confirm arrival of the patient at their facility
 - i. If children's hospital does not contact the ED charge nurse within two (2) hours of patient leaving, the charge nurse should contact children's hospital to confirm arrival.
- 10. The healthcare provider shall attempt to notify the patient's spouse/family/significant other of transfer arrangements and scheduled departure time.
 - 40-a. Document notification/attempt in the electronic health record.
- 11. The primary nurse shall ensure all patients personal belongings are either transported with the patient or given to spouse/family/significant other see Patient Care Services Policy: Patient Valuables Liability and Control.
- 12. The transferring physician/AHP shall verify that the primary physician/AHP has been notified of the transfer.

D. PROCEDURE FOR RECEIVING PATIENTS FROM OUTSIDE FACILITIES:

- 1. All incoming transfer requests must be processed through the Administrative Supervisor (at phone number 760-644-6968)-or-the-Emergency Department-(ED) Case Manager.
 - Requests for ST-segment elevation myocardial infarction (STEM!) admissions will be received by the Mobile Intensive Care Nurse (MICN) via the dedicated phone line in the radio room.
 - b. For Women's and Children's Newborn Services (WNCS), admission requests are processed through the WCS charge nurse.
 - For NICU see NICU Transfer of Neonates and Infants Policy.
- 2. Upon receipt of transfer request, the Administrative Supervisor (AS)/ED-Case Manager shall:
 - a. Generate a Booking-Sheet. Enter request into the bed tracking system under Transfer Services.
 - i. Booking Sheets shall-be-retained for 1 year-on-site-to-serve as the transfer log.

 After 1 year, the log may be-stored off-site. Once physician/AHP accepts the transfer, a bed request is sent to bed board for placement.
 - iii. Once bed is assigned a communication notice to registration is to be sent by the AS or Unit Secretary of unit.
 - b. Assess bed and resource capabilities.
 - Transfers may not be accepted if TCMCHD does not have the capability or capacity to accept patients.
 - Document reason TCMCHD is unable to accept transfer en-Beeking Sheetin the bed board tracking system.

- Verify insurance information by sending face sheet from sending facility to Registration to verify insurance. All transfer must meet TCMCHD's insurance eligibility criteria.
- c. Inform transferring facility/physician/AHP they must:
 - i. Contact the accepting physician/AHP regarding patient's transfer to TCMCHD.
 - ii. Provide face sheet including insurance information, and history and physical if available.
- d. Contact appropriate accepting physician/AHP to confirm acceptance of incoming patient transfer including:
 - Name of facility/physician/AHP requesting transfer
 - ii. Direct phone number of requesting facility/physician/AHP
 - iii. Description of patient
 - iv. Reason for transfer
 - v. If unable to determine which physician/AHP to contact, contact the ED Case ManagerAS for guidance.
- e. The AS/ED Case-Manager shall obtain an admit level of care/service from the accepting physician/AHP.
 - If accepting physician/AHP denies transfer, request reason for transfer denial and document in the Booking Sheetbed board tracking system.
- 3. TCMCHD Emergency DepartmentED physicians/AHPs are available as a resource to help with the incoming transfer request process.

E. <u>SPECIAL CONSIDERATIONS FOR CCS ELIGIBLE PATIENTS:</u>

- 4.1. DefinitionsDEFINITION(S):
 - Pediatric Intensive Care Unit (PICU): A PICU is a unit within a California Children's Services (CCS) approved Tertiary or Pediatric Community Hospital that has the capability of providing definitive care for a wide range of complex, progressive, rapidly changing, medical, surgical and traumatic disorders, requiring a multidisciplinary approach to care for patients between 37 weeks gestation and/or two kilograms (kg) and those under 21 years of age who meet CCS medical eligibility criteria.
 - b. Tertiary Hospital: For the purpose of CCS, a tertiary hospital is a referral hospital providing comprehensive, multidisciplinary, regionalized pediatric care to children from birth up to 21 years of age which includes the provision of a full range of medical and surgical care for severely ill children, pediatric residency training with 24-hour CCS-paneled pediatrician coverage, an organized pediatric research program, and community outreach.
- 5.2. Criteria for transfer of persons up to the age of 21 or younger include, but are not limited to:
 - Depressed or deteriorating neurologic status
 - b. Severe respiratory distress responding inadequately to treatment and accompanied by cyanosis, retractions, apnea, stridor, grunting/ grasping respirations, status asthmaticus, and/or respiratory failure
 - c. Children requiring endotracheal intubation and/or ventilatory support
 - d. Serious cardiac rhythm disturbances
 - e. Heart Failure
 - f. Status post cardiopulmonary arrest
 - g. Shock
 - h. Severe hypothermia or hyperthermia
 - i. Hepatic failure
 - Near drowning
 - k. Severe dehydration
 - Severe metabolic disturbances
 - m. Severe electrolyte imbalances
 - n. Exposure or ingestion to a toxic substance

Patient Care Services Policy Manual
Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC)
Transfer of Patients, VI.D
Page 4 of 5

- o. Status epilepticus
- p. Services not provided at Tri-City Healthcare District (TCMCHD)
- q. Acute Trauma
- Any condition likely to require pediatric specialty intervention/assistance during hospitalization.
- 6.3. CCS-eligible clients who should be transferred to a CCS-approved tertiary hospital or CCS-approved PICU if the CCS-eligible client has:
 - a. Acute hepatic failure OR
 - b. Immediate dialysis requirements because of renal failure.
 - c. See Newborn-Intensive Care-UnitsNICU Policy: Transfer of Neonates And& Infants Policy.
- 7.4. For CCS eligible inpatients, the medical care of patients between 14 and 21 years of age, shall be under the direction of a CCS-paneled physician/AHP appropriate for the medical condition. Adolescents 14 up to 21 years of age with the following conditions will be transferred to facilities meeting CCS Standards for Special Care Centers for further diagnostic work-up, treatment services and/or follow-up care as indicated. The conditions include:
 - Complex congenital heart disease
 - b. Inherited metabolic disorders
 - c. Chronic renal disease
 - d. Chronic lung disease
 - e. Malignant neoplasm
 - f. Hemophilia
 - g. Hemoglobinopathies
 - h. Craniofacial anomalies
 - i. Myelomeningocele
 - j. Endocrine disorders
 - 8.k. Immunologic and infectious disorders including HIV infection
- 9.5. Upon receipt of a physician/AHP order to facilitate a patient transfer to tertiary care facility, the Case Manager or Administrative Supervisor (after hours) will contact that facility's "Transfer Center" to initiate the transfer request.
- E. <u>Electronic forms available on the Intranet:</u>
 - Booking Sheet Direct Admit/ED Admit/Transfer
- F. RELATED DOCUMENT(S):
 - 1. NICU PolicyNeonatal Intensive Care Unit: Transfer of Neonates and Infants
 - 4.2. Patient Care Services Policy: Patient Valuables Liability and Control

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

	Contact-Phone Numbers:
	AS
D 11 01 18 1000	(760)-644-6968
Booking Sheet Faxed 3022 Approved: Not-Approved:	Time AS Contacted:
Approved: Not-Approved:	Bed Assignment:
DIDECT ADMIT /	ED ADMIT / TRANSFER
	eking-Sheet
500	ARING ESTIGES
Today's Date: Contact Time:	Admit Date:
Patient's Name:	Patient's SS#:
Age: Sex:	DOB:
Requesting Physician:	Patient's SS#: DOB: Admitting Physician: Location of Patient:
Name of Person Requesting Bed:	Location of Patient:
Name of Person Requesting Bed: Centact #:	Contact#:
Direct-Admission-Request:	
·	
Inpatient: Observation:	<u> </u>
Admitting Diagnosis:	
Symptoms/ Complaints:	
Past Medical History:	
MRSA: (Either receive information	from the office or look up in past medical record on Cerner)
,	•
Desired-Unit:	
⊟-Medical/Surg	——
Insurance Status:	
Medicare-A-&-B:	Medi-Cal-(POS-Number):
HMO:	PPO:
Transfer Requests:	
Name of physician requesting transfer	Name-of-facility
Direct phone number of requesting physician	
Description of patient	
Reason for transfer	
⊟ Accept ⊟ Denial Reason for Denial	
AS:	



ADMINISTRATIVE POLICY HUMAN RESOURCES

ISSUE DATE:

04/04

SUBJECT: Employee Compensation

REVISION DATE(S): 03/12, 04/12

POLICY NUMBER: 8610-475

Administrative Human Resources Content Expert Approval:

Administrative Policies & Procedures Committee Approval:

Human Resources Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

08/18

n/a09/18

10/18

10/18

A. PURPOSE:

To establish and maintain a total compensation program for Tri-City Healthcare District (TCHD)
employees to include pay and benefits which is reviewed periodically to ensure internal equity,
external competitiveness, fair and effective administration, and financial feasibility.

B. POLICY:

- 1. Compensation policies and practices will be structured to attract, retain, reward, and motivate high quality and highly performing employees.
- 2. The compensation program will be administered fairly and without discrimination of any kind, in accordance with applicable State and Federal laws.
- 3. The compensation programs may include individual performance based on merit pay as well as incentive award programs based on organizational performance.
 - a. The Merit Award program is designed to reward individual employee job performance based upon an annual assessment through the Performance Appraisal program. The degree and form of the merit pay award structure may vary from year to year.
 - b. TCHD reserves the right to implement and design an incentive program to reward eligible employees for reaching individual and organizational strategic goals and objectives. The programs are administered according to the provisions of the program guidelines. The program guidelines are reviewed annually. The Board of Directors (BOD) has sole discretion for approval of changes to plan guidelines and payments. TCHD is committed to a pay program that is market competitive and internally equitable. TCHD is committed to a market based, competitive total compensation program. Its goal is to compensate employees at or above the average-median pay rates paid by comparable local and regional employers. Annual market assessments will be conducted in accordance with appropriate survey procedures. Final decisions regarding position placement within the pay line structure must consider, in addition to market data, organizational needs, and position relationships within job families, internal equity, and financial feasibility.
- 4. As part of its total compensation program, TCHD is committed to providing a market-competitive employee benefits program that is designed to meet the varying needs of employees with regard to health and welfare, retirement, and paid time off, as well as additional miscellaneous additional benefits designed to enhance employee total compensation.
 - a. Health and welfare benefits are provided through a Section 125 Flexible Benefits Plan (medical, dental, vision, chiropractic, and prescription insurance, basic life and accidental death and dismemberment insurance, supplemental life and dependent life insurance, and flexible spending accounts). Benefited employees are eligible to

Administrative Policy – Human Resources Employee Compensation – 8610-475 Page 2 of 2

- participate in the Flexible Benefits Plan. The plan is administered in accordance with the provisions of the plan document and applicable insurance contracts.
- b. Retirement benefits are provided through three (3) plans sponsored by TCHD: National Security and Retirement Program, Money Accumulation Pension Plan, and Deferred Compensation Plan. Eligibility varies by plan and is outlined in the applicable plan documents. Each plan is administered in accordance with the provisions of the applicable plan documents.
- c. Paid Time Off benefits are provided as outlined in **Administrative** Policy: #433, Paid Time-Off **Program**.
- d. TCHD reserves the right to change or terminate its benefits plans at any time.
- 5. Compensation policy and related practices and procedures are reviewed periodically and may change for a variety of reasons, including financial feasibility and market competiveness. Benefit plan documents shall be reviewed and amended annually.
- 6. The lead Human Resources Officer-official, with approval from the Chief Executive Officer (CEO), has authority and responsibility for administration of this policy.
- 7. Compensation for union represented positions will be determined by the negotiated collective bargaining agreement. Scheduled increases and amounts will be determined by the agreements.

C. RELATED DOCUMENT(S):

8-1. Administrative Policy: Paid Time-Off Program 433

D. REFERENCE(S):

9.1. Section 125 Flexible Benefits Plan



PATIENT CARE MANAGEMENT

ISSUE DATE: SUBJECT: Utilization Management Plan

REVISION DATE(S): 03/12

Patient Care Management Department Approval:

Utilization Review Committee Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

03/1507/18

11/1508/13

01/16

02/16

A. <u>INTRODUCTION:</u>

- 1. In accordance with the requirements of the Health and Human Services Conditions of Participation, State Operations Manual, Appendix A Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Centers for Medicare and Medicaid Service (CMS) guidelines and Standards of the Joint Commission, Tri-City Medical Center Governing Board delineate this UTILIZATION MANAGEMENT PLAN. This Plan reflects the actual process of reviewing patient care. The Utilization Management Plan has been developed to be approved by the Quality Assurance! Performance Improvement!Patient Safety Committee (QA/PI/PS), the Medical Executive Committee, and the Board of Directors.
- 2. The Utilization Management Program applies to all patients regardless of payment source. The program does not include utilization review conducted by members of the medical staff under control with, or via others means of delegation by a third party payerpayer. The Medical Center maintains the authority of decisions regarding review, including appropriate services, at the local level.

B. **AUTHORITY:**

- The Board of Directors has the ultimate responsibility for review of the quality, appropriateness, and medical necessity of admissions, continued stays, and supportive services. It delegates specific functions to the Medical Staff to develop and implement a comprehensive Utilization Management Plan. The authority and responsibility for providing personnel, resources, and equipment has been delegated to the Chief Executive Officer or Designee of Tri-City Medical Center.
- 2. The Utilization Management Plan is under the direction of the Utilization / DRG-Committee, and following approval of this Utilization Management Plan, the Utilization / DRG-Committee shall review and approve the Plan biennially for scope and objectives.

C. OBJECTIVES:

- All patients, regardless of type of insurance or source of payment, are monitored for overutilization, under-utilization, and inefficient scheduling of resources. The primary objectives of utilization review are the following:
 - a. Assure Care at a Level Appropriate to Patient Needs
 - b. Utilization review monitors the level of care on an ongoing basis to ensure that patients receive care in a facility appropriate for their needs.
 - c. A patient in an acute care facility requires the continuous availability of physicians, skilled nursing services, surgical services and/or ancillary services found only in the acute hospital setting.
- 2. Provide Professional Accountability

- a. Utilization review provides professional accountability for the utilization of health care resources to the patient and the person or organization paying for his/her care. It addresses issues of quality and cost controls to ensure the highest quality patient care at the lowest cost.
- 3. Educate the Medical Staff and Other Health Care Professionals
 - a. The ongoing utilization review activity and the identification of problem areas provide continuous education on quality of care and utilization issues to the Medical Staff and other health care professionals.

D. UTILIZATION MANAGEMENT COMMITTEE

- 1. Organization
 - a. The Committee shall be a medical staff committee of the hospital; will be composed of five (5) physicians, no less than two (2) physicians who must be either medical doctors or doctors of osteopathy and members of the Medical Staff, representing the admitting services of the medical staff, and assisted by other professional personnel.
 - b. The other members may be any of the other types of practitioners as specified in **State Operations Manual** §482.12(c)(1).
 - c. The Physician Advisor will be a member of the Committee.
 - d. All medical staff committee members shall be appointed the Chief of Staff. Appointment shall be for one year.
 - e. The Chief Nursing-Executive / Chief-Clinical-Operating Officer Director of Case

 Management will appoint non-medical staff representatives to the Committee annually.
 - f. Committee Representatives may include, but are not limited to:
 - i. Director of Case Management
 - ii. Nursing Administrator or representative
 - iii. Medical Records Director or representative as needed
 - iv. Case Management / Social Services' representative(s) as needed and may include:
 - CDI Specialist, Palliative-Supportive Care Director, Readmission Reduction Coordinator and Social Services representative(s) as needed
 - g. As per Medical Staff Bylaws, for a quorum, no less than two (2) physician committee members shall attend the Utilization / DRG-Committee Meetings.
- 2. Authority
 - Physician Advisor and Review Personnel
 - i. A designated Physician Advisor will be available for at least two hours daily per contractual agreement, Monday through Friday, to communicate with the Case Managers regarding questionable admissions, quality of care issues, day or cost outliers and continued stay cases. This communication will be in person, at least ence each working day and via telephone, or via email, at other times as necessary.
 - ii. The Physician Advisor has authority to initiate denial of an admission or extension of length of stay (pending QIO review and concurrence when required)
 - iii. The Case Managers will seek specific assistance and advice form-from the Physician Advisor in the following situations:
 - 1) When the Case Manager has reason to believe that an admission, continued stay, is not medically necessary based on criteria.
 - When the Case Manager is unable to make a decision as to whether there is a medical necessity for acute care, even when the guidelines are met.
 - 3) When there is a question of quality of care being rendered.
 - 4) When the implementation of discharge planning is delayed by either the patient, family and/or attending physician.

- 5) When under/over utilization and quality concerns are identified, as well as delays in services with the Attending Physician and intervention is necessary.
- iv. In most instances, the Physician Advisor shall render a decision within twentyfour (24) hours as to the approval or denial of an admission or continued stay.
 The Director of Case Management under the direction of the Administrator shall
 oversee review activities. Case Management review shall be conducted by
 personnel qualified to follow directive of the Utilization Management Committee
 and to apply clinical guidelines and regulations. Sufficient qualified reviewers will
 be assigned to meet the requirements of reviews.
- b. The Committee has the authority to give notice of non-coverage in accordance with federal and state law and other third party payor requirements.
- c. The Committee has the responsibility to:
 - Implement procedures for reviewing all stages of hospital admissions, including but not limited to:
 - 1) Medical necessity for admission, over- and under-utilization of ancillary services, delays in services, quality of care indicators,
 - Adequacy of medical record documentation, lengths of stay, and timeliness of discharges.
 - ii. Report review findings and recommendations to the appropriate Medical Center and/or Medical Staff persons or entities.
 - iii. Review third-party payor denials, make recommendations and/or take appropriate actions.
 - iv. Collect and analyze data necessary to carry out its responsibilities.
 - v. Analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution and/or refer to appropriate entities for resolution.
- 3. Upon invitation from the Chairperson, other representatives of the Hospital or medical staff may attend meetings. The Chairperson and other designated members of the committee shall serve as Physician Advisor if there is not an appointed advisor available.
- 4. Chairpersons of all standing committees shall have an open invitation to attend meetings of the Committee; other Medical Center personnel may attend upon invitation from the Committee.

E. UTILIZATION REVIEW ACTIVITIES:

- 1. Utilization Review Staff
 - a. The Utilization Review staff consists of qualified non-physician Medical Center personnel including, but not limited to, nurse case managers, social workers, and assistants who function under the direction of Department Director as staff to the Utilization Review Committee.
- Criteria:
 - a. The Case Managers shall use the prescribed and authorized criteria designated by medical staff while reviewing the severity of illness, intensity of service, and discharge screens. InterQual Criteria is utilized at Tri-City Medical Center.
- 3. Admission Review
 - All designated admissions shall have an initial InterQual® review performed not later than 24 business hours following admission to TCMC.
- 4. Concurrent Review
 - a. The concurrent review process will follow the admission review and will continue throughout the patient's hospital stay.
 - b. Concurrent reviews shall be provided to payors as requested.
 - c. Concurrent reviews for Medicare & Medicaid patients should be performed at least every two (2) days- as per department standards throughout the patient's hospital stay.

- i. For duration of stays, review only case that they (hospital) reasonably assume to be outlier cases based on extended length of stay, as described in as specified in State Operations Manual §412.80 (a)(1)(i); and
- ii. For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in as specified in State Operations Manual §412.80 (a)(1)(ii)
- d. In keeping with the "Ten (10) Bed Call List" protocol as determined by the San Diego County office for Medi-Cal, those Med-Cal or Medi-Cal Pending; CMS or CMS Pending patients who no longer meet an acute hospital level of care and are "awaiting placement" shall be identified as being on the "Ten (10) Bed Call List".
 - i. The Case Manager shall discuss case with the treating physician and work to obtain a physician order for the patient to be placed on "Ten (10) Bed Call status".
 - ii. The Ten (10) Bed Call List will be maintained by the Case Management department's appropriate support staff member
 - iii. Case Manager shall document "Ten (10) Bed Call" status in the patient's EMR.
- 5. Outlier Review
 - a. The Director of Case Management and Social Work Supervisor-Manager conduct weekly- frequent outlier review to ensure the ongoing medical necessity of any patient with an extended stay or high dollar amount of services. Physician Advisor may attend as needed.
 - b. Each Case Management-staff that has an Specific outlier cases in their panel of patients is responsible for presenting the case to the group are discussed in the biweekly Hospitalists Rounds, outlining clinical condition, discharge barriers, and action plan.
 - c. The target indicators for outlier review are:
 - i. Length of stay of 10 or more days or
 - ii. Total hospital charges of \$75,000 or greater
- Discharge Planning
 - Discharge planning is a collaborative effort of a multidisciplinary team of individuals performed as an integral component of the direct patient care process.
 - b. The concurrent utilization review process is one of several mechanisms designed to identify and refer patients needing discharge Care Coordination.
- 7. Relationship to Third Party Payors
 - a. The Hospital is responsible through the Case Management function for the process of reviewing patients' (beneficiaries') clinical information for the purpose of presenting claims to third parties, including the fiscal intermediary, the basis upon which payment is allowed by the intermediary, the condition under which the intermediary denies claims, and the claims appeal data about a case shall be open to review by fiscal intermediaries, state agencies, and the Quality Improvement Organizations (QIO). Information and data shall be protected to ensure confidentiality.

F. <u>COLLABORATION WITH CLINICAL PERFORMANCE IMPROVEMENT COUNCIL AND/OR THE</u> MEDICAL STAFF:

- 1. Case Management is one of the components of a hospital Quality Improvement Program, during the course of concurrent and retrospective review, the Case Managers will screen patient records for quality concerns, including those specific events designated by the Quality Management and Regulatory Compliance-Director Specialist. If concerns are identified through Case Management reviews, they will be documented on the care-management worksheet Allscripts. Case Management and Quality Improvement functions will be integrated as follows:
 - Quality And Utilization concerns are referred to the appropriate Medical Staff Review Committee:

- i. If a potential quality issue is identified during the review process and is considered to be of immediate need for correction, it will be immediately referred to the Physician Advisor. If the attending physician or Hospital Department Manager is unwilling to correct the problem to the satisfaction of the Physician Advisor, the Chairperson of the attending physician's department, Chief of Staff, or Administration will be immediately notified; the Risk Manager may also be notified.
- ii. If a potential quality issue is identified, however, and correction has already occurred, the case will be referred to the appropriate Medical Staff Committee or Department Manager.
- iii. Problem Diagnosis Related Groups (DRGs) will have Quality Improvement Teams assigned to evaluate the problem, determine the cause, and recommend corrective action.

G. HOSPITAL ADMINISTRATION

1. The Hospital Administration shall provide the necessary resources to ensure the proper functioning of the Case Management Program. This includes acting as a liaison with all departments, ensuring information is properly assembled, and by providing necessary forms, secretarial assistance, and meeting space. Administration shall be responsible for considering and acting upon decisions and recommendations stemming from the Case Management function with respect to Hospital policy, procedures, and staffing.

H. REFERENCE(S):

- State Operations Manual, Appendix A Survey Protocol, §482.30(b) Standard: Composition of Utilization Review Committee
- 2. State Operations Manual, Appendix A Survey Protocol, §482.30(c) Standard: Scope and Frequency of Review
- 3. State Operations Manual, Appendix A Survey Protocol, §482.12(c) Standard: Care of Patients
- 2.4. State Operations Manual, Subpart F Payment for Outlier Cases, §412.80(a)(1) Basic Rule: Discharges occurring on or after October 1, 1994 and before October 1, 1997

Tri-City M al Center Audit, Compliance & Ethics Committee October 18, 2018 Assembly Room 1 8:30 a.m-10:00 a. m.

Members Present: Director Larry W. Schallock(Chair); Director James Dagostino; Faith Devine, Community Member; Kathryn

Fitzwilliam,

Community Member; Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member

Non-Voting Members:

Steve Dietlin (CEO); Ray Rivas, CFO; Scott Livingstone, COO; Carlos Cruz, CCO; Susan Bond, General Counsel

Others Present:

Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Compliance Manager; Teri Donnellan, Executive

100

Assistant

Absent:

Director Julie Nygaard

Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock.		
It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously.	Agenda approved.	
There were no public comments.		
It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the minutes as presented. The motion passed with Ms. Fitzwilliam abstaining from the vote.	Minutes ratified.	
None		
Mr. Carlos Cruz; CCO briefly reviewed the Compliance Program Plan for FY2018-2019 which highlighted the	Information Only	Ms. Donnellan
	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously. There were no public comments. It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the minutes as presented. The motion passed with Ms. Fitzwilliam abstaining from the vote. None Mr. Carlos Cruz; CCO briefly reviewed the Compliance	Discussion Recommendations/ Conclusions The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously. There were no public comments. It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the minutes as presented. The motion passed with Ms. Fitzwilliam abstaining from the vote. None Mr. Carlos Cruz, CCO briefly reviewed the Compliance Program Plan for FY2018-2019 which highlighted the

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	 Department Structure Program Marketing Program Oversight Compliance Policies and Procedures Compliance Training and Education Auditing and Monitoring Open Lines of Communication HIPAA Privacy Program Operational Support Mr. Cruz stated the goal was to identify potential gaps and assess those gaps. Mr. Cruz stated a new Values Line upgrade was 		
	implemented which will allow us to benchmark ourselves against other organizations. He noted the Values Line phone number had to be updated and all staffawere informed of the new hotline number via via e-mail, posters, etc. Mr. Cruz also commented on Auditing & Monitoring EMR access reviews which identified an educational opportunity related to staff's access of their own medical records. Lastly, Mr. Cruz commented on a formal policy that is being developed for the 60-Day Repayment Requirement which is a condition of participation.		
b) Presentation: "Speak up" Culture	Mr. Carlos Cruz provided an educational presentation on Building a "Speak Up Culture. He explained the goal is to present this training to management and all levels of staff. The presentation described the False Claims Act and the definition of a "Whistle Blower". The five steps to reinforce the "Speak Up Culture" included the following: - Communicate – employees are the real eyes and ears of the organization - Reinforce – take time to promote avenues of reporting that might include internal sites, newsletters, informal meetings - Integrate – the "speak up" concept should be	Mr. Cruz to provide educational presentation on "Speak Up" culture at a future Board meeting.	Mr. Cruz

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	integrated in the organization's standards of behavior. Train Leaders and Staff – train management on whistleblowers and non-retaliation; train staff on the importance of reporting concerns Evaluate Program Regularly- track issues reported to compliance and Human Resources; conduct staff surveys. The presentation emphasized that the "tone" starts with Leadership who must cultivate an environment where employees feel safe/empowered to raise concerns. Discussion was held regarding how the Medical Staff is integrated in the compliance program. Mr. Cruz explained the training avenues available to the Medical Staff. Dr. Mells noted in addition Team Health requires all their physicians complete on line compliance training. It was suggested Mr. Cruz provide the full Board with an educational presentation on the "Speak Up" Culture.		
c) Consideration to appoint Kathryn Fitzwilliam to the role of "Subject Matter Expert"	Chairman Schallock reported per Board Policy, Ms. Fitzwilliam's term on the committee will expire next month as she will have served two two-year terms. He explained the committee's Charter which was recently amended allows the committee to appoint a "subject matter expert" who would be a non-voting member of the committee and whose term would not expire. Chairman Schallock stated Ms. Fitzwilliam has demonstrated her expertise in audit matters and requested that the committee appoint Ms. Fitzwilliam to the role of "subject matter expert". Chairman Schallock explained that Ms. Fitzwilliam has expressed an interest in serving the committee in this manner and if selected, will have the prerogative to attend meetings based on the agenda topics. It was moved by Chairman Schallock and seconded by Director Dagostino to recommend the Board appoint	Recommendation to be sent to the Board of	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Expert". The motion passed unanimously.	Kathryn Fitzwilliam to the role of "Subject Matter Expert"; item to be placed on Board Agenda.	
d) Administrative Policies & Procedures 1) Notice of Privacy Practices Policy #518	Mr. Carlos Cruz reported Policy #518 Notice of Privacy Practices has been revised to focus on all entities associated with the District rather than just the Medical Center. Mr. Cruz noted the intent is to also incorporate these changes in the Notice itself. Mr. Cruz clarified that the Notice would not apply to health club members however it would apply to those individuals who participate in the Medically integrated programs. It was suggested "patient" be defined in the policy as well as a "patient relationship". Additional revisions were suggested for clarity. Ms. Bond clarified that the Notice does not relate to the drawing of blood without consent.		
	It was recommended the Notice of Privacy Practices Policy #518 be revised as described and brought back to the Committee at the January meeting.	Notice of Privacy Practices Policy #518 to be revised and placed on the January's committee agenda for consideration.	Mr. Cruz/ Ms. Donnellan
Comments from Committee Members	There were no comments from Committee Members		
9. Committee Openings	There will be one Committee Opening in January, 2019.	Committee opening to be advertised in January.	Ms. Donnellan
10. Date of Next Meeting	Chairman Schallock stated the Committee's next meeting will be held on January 17, 2019.	The committee's next meeting is scheduled for January 17, 2019.	
11. Adjournment	Chairman Schallock adjourned the meeting at 9:50 a m.		-

TRI-CITY HEALTHCARE DISTRICT MINUTES FOR A SPECIAL MEETING OF THE BOARD OF DIRECTORS

September 25, 2018 – 6:00 o'clock p.m. Classroom 5 – Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on September 25, 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 RoseMarie V. Reno Director Larry W. Schallock

Absent was Director Nygaard

Also present were:

Steve Dietlin, Chief Executive Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Chief Operations Officer
Susan Bond, General Counsel
Ray Rivas, Chief Financial Officer
Anna Aguilar, Senior Director of Human Resources
Quinn Abler, Director of Total Rewards
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

- 1. The Board Chairman, Director Dagostino, called the meeting to order at 6:00 p.m. in Classroom 5 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.
- Public Comments Announcement

Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

Approval of agenda.

It was moved by Director Kellett to approve the agenda as presented. Director Mitchell seconded the motion. The motion passed (6-0-1) with Director Nygaard absent.

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino made an oral announcement of the item listed on the September 25, 2018 Special Board of Directors Meeting Agenda to be discussed during Closed

Session which included one matter of Potential Litigation and Evaluation of Legal Counsel Services.

6. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Grass to go into Closed Session at 6:05 p.m. The motion passed (6-0-1) with Director Nygaard absent.

- 8. Open Session
- 9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in closed session.

- New Business
 - a) Approval of Resolution No., 794, A Resolution of the Tri-City Healthcare District Board of Directors Appointing a New Employee Benefit Plans Committee (Committee) and Appointment of Committee as Plan Administrator ("Administrator") for the Tri-City Healthcare District Employee Benefit Plans.

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors approve Resolution No. 794, A Resolution of the Tri-City Healthcare District Board of Directors Appointing a New Employee Benefit Plans Committee (Committee) and Appointment of Committee as Plan Administrator ("Administrator") for the Tri-City Healthcare District Employee Benefit Plans with an amendment to include "reports be given semi-annually or as needed". Director Reno seconded the motion.

The vote on the motion was as follows:

AYES: DIRECTORS: Dagostino, Grass, Kellett, Mitchell,

and Schallock

NOES: DIRECTORS: None
ABSTAIN: DIRECTORS: Reno
ABSENT: DIRECTORS: Nygaard

- a) Report on Employee Pension Plan Information Only
 - 1) Presentations by Prudent and Lincoln

The Board heard reports from Michelle Wood, Senior Relationship Manager – Lincoln (Record Keeper) and Scott Simon, Principal and Dena Baker, Advisor from Prudent (Investment Advisors). The Board asked questions throughout the two presentations. The complete presentations are attached to the file copy of these minutes for reference.

Director Grass left the meeting at 6:43 p.m.

b) Staff report on Administration Benefit Plan Committee

Ms. Susan Bond reported we will be establishing an Employee Benefits Committee to serve as Plan Administrators. She explained that previously there was a Human Resources Committee and Employee Fiduciary Subcommittee that served as Plan

Administrators. These committees were dissolved by the Board of Directors at their meeting in May 2018. The Employee Benefits Committee will be trained by outside third party and employee benefits attorney, Jeff Chang, to ensure fiduciary compliance and best practice industry standards. The committee will be composed of five members from Tri-City Medical Center; Senior Director of HR, Director of Total Rewards & HRIS, Chief Financial Officer, Assistant Controller, and General Counsel. The new Plan Administrators will meet monthly and report to the board semi-annually or on an as needed basis. The new Plan Administrators will discuss:

- > Health and welfare benefits
- > Retirement Plans
- > Day-to-day operations of benefits
- > Investments
- > Issues of eligibility, plan interpretation, plan fees and expenses, plan recordkeeping, plan investments and benefits, claims and disputes.

Ms. Bond explained that from this point moving forward the Plan Administrators will review reports from Lincoln, and Prudent, discuss retirement benefit plans along with medical, dental, vision, life and accidental death and dismemberment (AD & D), cafeteria (flexible spending accounts), and long term disability plans (each a Plan and, collectively, "Plans") for the benefit of its eligible employees.

11. There being no further business, Chairman Dagostino adjourned the meeting at 7:00 p.m.

ATTEST:	James J. Dagostino Chairman
Leigh Anne Grass Secretary	

TRI-CITY HEALTHCARE DISTRICT MINUTES FOR A REGULAR MEETING OF THE BOARD OF DIRECTORS

September 27, 2018 – 2:30 o'clock p.m. Classroom 5 – 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 2:30 p.m. on September 27, 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 RoseMarie V. Reno Director Larry W. Schallock

Absent was Director Nygaard

Also present were:

Colin Coffey, Board Counsel (via teleconference)
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 2:30 p.m. in Classroom 5 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.
- 2. Approval of Agenda

Chairman Dagostino requested the following items be added to today's agenda due to the fact that the need(s) arose after the agenda was posted:

- Closed Session Report on Trade Secret with a disclosure date of 9/27/18;
- Open Session New Business: 1)Approval of an agreement with Vituity (CEP) for Psychiatric Medicine; 2) Approval of an addition of Dr. Hellen Chiao to the Gastroenterology General & ERCP ED Call Coverage Panel.

It was moved by Director Mitchell to approve the agenda as amended. Director Grass seconded the motion. The motion passed (6-0-0-1) with Director Nygaard absent.

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the September 27, 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 made an oral announcement of the items listed on the September 27, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee, approval of Closed Session Minutes and one Report Involving Trade Secret with a disclosure date of September 27, 2018

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Mitchell to go into Closed Session. The motion passed (6-0-0-1) with Director Nygaard absent.

- 6. The Board adjourned to Closed Session at 2:35 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, M.D. Director Laura E. Mitchell Director RoseMarie V. Reno Director Larry W. Schallock

Absent was Director Julie Nygaard

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
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.
- 10. Director Mitchell 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.

Chairman Dagostino requested that speakers adhere to the three minute time allotment.

Director Reno requested the podium be moved so that she could view her public. Board Counsel recommended that request be discussed outside of the Board meeting.

12. Special Recognition:

a) Dr. Rica Brown and the Emergency Department Team

Chairman Dagostino reported he personally received a letter and phone call from Dr. Davina Grossman, a former patient and President of Saint Augustine University regarding the outstanding care she received by Dr. Rica Brown and the Emergency Department Team. Dr. Grossman expressed a desire to come to the Board meeting and publicly acknowledge Dr. Brown and the staff who cared for her.

Dr. Grossman, Dr. Brown and members of the Emergency Department Team were invited to the podium. Dr. Grossman told a heartwarming story of her time in the Emergency Department. She stated she was extremely impressed with the level of competence shown by these individuals. She commented on how she felt so comfortable and cared for and what a difference Dr. Brown and her team made.

No action taken.

13. Educational Presentation

a) Medical Integration at the Tri-City Wellness Center - Susan Webster, Manager

Ms. Susan Webster, Medical Integration Program Manager at the Tri-City Wellness Center provided an educational presentation on Medical Integration programs at the Wellness Center. She explained the definition of Medical Integration is the link between healthcare and fitness. Ms. Webster stated their mission is to bridge the gap between medical treatment and independent exercise by giving members the tools they need for success. The four programs include the following:

MI Cardio – program for those who have had a cardiac event in their life and are coming out of cardiac rehab. The program improves the individuals overall physical dependence and includes progressive cardiovascular exercise in a small group setting, increases strength, decreases fatigue and builds balance.

MI Neuro – program for those with neurological disorders and Parkinson's. It is an evidence based exercise program that improves strength, gait and balance.

MI Ortho – program is used to maintain and improve upon gains from physical therapy. It includes joint integrity and bone health, a warm water pool for arthritis and strengthening.

MI Strength –created for those with cancer or diabetes. Data reflects that muscle mass can prevent recurrence of cancer. The program promotes physical independence, increased muscle mass, improved grip strength.

Ms. Webster stated prices have increased for Medical Integration to \$149 from \$35. Although there has been a 3% drop rate it shows that people are still willing to pay for these programs and these programs are necessary.

Lastly, Ms. Webster stated total revenue this September will be over \$14,000 and continues to grow.

Chairman Dagostino stated as a Physical Therapist, exercise is near and dear to his heart. He expressed his appreciation to Ms. Webster for stepping up and providing these programs.

14. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Newhart provided a brief report on the Foundation activities as follows:

- > For Good Newsletter will be arriving in homes today and another 5,000 copies will be circulated in the community. The Newsletter depicts the wonderful things that are happening at Tri-City and this month's Newsletter features an article on the Tri-City Wellness Medical Integration Parkinson's program.
- > The Foundation Golf Tournament was held in August and it was the largest ever with over 200 golfers. \$70,000 was raised for our Cardiac program.
- > The Foundation nominated Chris Miechowski, our Facilities Manager here at TCMC for Volunteer of the Year. Chris has been stellar in working with the Foundation for the past several years in boosting vendor support in our fund raising efforts.

 The Diamond Ball will be held on October 27th at the Park Aviara with world class
- comedian Bill Engvall.
- > The Foundation recently funded Cardiac MRI training for the team at North Western University.
- > The Foundation continues to support our homeless patients by purchasing items of clothing for the homeless patients when they are discharged.
- > The Foundation funded the reintroduction of the Hospice/Palliative Care Program here at TCMC.
- > Mr. Newhart expressed his appreciation to the Foundation Board and Rita Geldert, Foundation President for their countless hours.
- > Mr. Newhart also expressed his appreciation to the Foundation staff for their support.
- > Today is Mr. Newhart's last meeting as he moves on to pursue an opportunity in Colorado. He stated he leaves Tri-City happy with what we have accomplished and grateful for everyone's support.

Director Reno requested clarification on Mr. Newhart's title. Mr. Newhart stated his title was changed to Chief Development Officer upon completion of his MBA.

Board members expressed their appreciation to Mr. Newhart for his time and effort and wished him well in his future endeavors.

15. Report from TCHD Auxiliary

Chairman Dagostino stated the Auxiliary would like the Board to consider getting involved in helping to supplement the Junior Scholarship program. He stated the Administrative Team have personally awarded a scholarship in the past and

individual Board members have also awarded scholarships. Board members indicated they would be interested in exploring a Board Scholarship.

No action taken.

16. Report from Chief Executive Officer CEO

Mr. Steve Dietlin, CEO gave a brief report. He expressed his appreciation to today's presenters and guests, Dr. Davina Grossman, Ms. Susan Webster and the Foundation.

Mr. Dietlin encouraged everyone to attend the Diamond Ball, a great event with a great purpose and funds raised at the event will go right back into this community.

Mr. Dietlin reported the Joint Commission arrived on Monday morning for our triennial "deemed status survey" which is certification regarding compliance with the Conditions of Participation that are set out by federal regulations. The Joint Commission is the accrediting organization for Tri-City. Nine (9) surveyors spent the last four days throughout Tri-City tracing specific patient activity, charts, processes and procedures and in all over 15 elements of performance. He stated the surveyors were "top notch". They were collaborative, informative, educational and at times even inspirational.

Mr. Dietlin explained the survey is an analysis for evaluating risk. Their findings are categorized into low, moderate, high, and immediate threat to life. Preliminarily, Mr. Dietlin stated it is important to note that in the high risk and in the immediate threat to life categories of the matrix, the only findings were related to Mental Health as expected. Due to the actions appropriately taken and the planned suspension of the units and the mitigating actions that have been taken during the transition there will not be a validation survey in this area. Had those actions not been taken surveyors advised there would have been a validation survey. Mr. Dietlin stated all other findings were in the low and moderate categories and expect to be corrected appropriately. Upon receipt of the report from the Joint Commission we will submit evidence of compliance within 60 days of receiving that report. Mr. Dietlin expressed his appreciation to the entire leadership team of the hospital, employees, nurses, clinical and non-clinical staff, the Medical Staff and everyone who stepped up to make this a successful survey. He stated it was the most successful survey he has ever been involved with.

Mr. Dietlin reported later today Moss Adams will present on the FY2018 Financial Statement Audit. He stated it is another clean audit with an unmodified opinion and no proposed adjustments five years running. Mr. Dietlin expressed his appreciation to the Finance Team and Accounting staff for their diligence in putting out clean financials.

Mr. Dietlin turned the remainder of his time over to Ms. Sharon Schultz, CNE and Ms. Merebeth Richins who will provide an update on our HCAPS

On a side note, Ms. Schultz commented that the Joint Commission surveyors stated that all of our patients complemented us on the exceptional care that they receive at the hospital. There were no negative comments made by patients and were overwhelmingly positive. The surveyors also enjoyed seeing the Pulmonary Rehab patients playing their harmonicas and the volunteer who was playing the guitar in our

emergency department waiting area to keep that atmosphere more of a healing atmosphere. Ms. Schultz stated that is a credit to everyone here at the hospital and we are very proud of our physicians as well.

Ms. Schultz introduced Ms. Richins who has been our champion for our patient experience. Ms. Richins presented patient satisfaction results that reflected very good results. Ms. Richins stated our goal as an organization was to be at the 50th percentile and the majority of our results are actually above the 50th percentile. Ms. Richins stated this is really good news and is a testament of our leaders and their support. Ms. Richins stated a new rounding tool (Orchid Rounding) has been implemented and for the time period August 27 – September 26 rounding was done on 574 patients. Another initiative is increased employee satisfaction. Patients have an opportunity to do a thank-you card during the rounding which has boosted morale among staff. Ms. Richins stated in addition to the thank-you cards staff are able to participate in "appreciation grams" which are done quarterly.

Lastly, Ms. Richins presented the ED Dashboard which included 700+ respondents. Ms. Richins stated overall we are doing very well on our patient experience.

Director Reno questioned if rounds are made in the Emergency Department. Ms. Schultz responded that rounds are done through the ER every day through the late afternoon.

Director Reno questioned if we are planning to hire a new Foundation Director. Mr. Dietlin stated we are working with the Foundation Board in a collaborative effort to jointly decide how we are going to move forward.

Dr. Victor Souza acknowledged Ms. Richins, Ms. Schultz and the whole team that is working with HCAPS. He is excited to see the upward movement and wants to see it continue.

No action taken.

17. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- ➤ Net Operating Revenue \$59,759
- ➤ Operating Expense \$61,354
- ➤ EROE -(\$598)
- ➤ EBITDA \$1,963

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census 158
- Adjusted Patient Days 17,744
- ➤ Surgery Cases 1,119
- ➤ Deliveries 338
- ➤ ED visits 9,813

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue \$30,614
- ➤ Operating Expense \$31,229
- ➤ EBITDA \$1,168
- > EROE (\$121)

Mr. Rivas reported on current month Key Indicators as follows:

- ➤ Average Daily Census 156
- ➤ Adjusted Patient Days 8,868
- Surgery Cases 599
- ➤ Deliveries 202
- ➤ ED Visits 4,838

Mr. Rivas reported on the following indicators for FY18 Average:

- > Net Patient Accounts Receivable \$42.8
- Days in Net Accounts Receivable 44.0

No action was taken.

18. New Business

a) Consideration to accept the FY2018 Financial Statement Audit and Single Audit

Mr. Ray Rivas stated prior to introducing Moss Adams he would provide an overview of the financial statements for FY 2018. Year over year our operating net revenue went up from \$340 million last year to \$365 million, an increase of approximately \$13 million primarily due to the acquisition of OSNC. Expenses from OSNC went up correspondingly. Mr. Rivas stated OSNC was a good acquisition and he believes they will be a big part of our future. Mr. Rivas reported another key expense that went up year over year was our supplies. primarily related to pharmacy as the result of the hurricanes in Puerto Rico which diminished the supply. As a result of those increase in expense there is an EROE loss of \$4.2 million for the year, however Mr. Rivas pointed out that EBITDA is another bottom line measurement which measures our cash intake as opposed to expenses. EBIDTA is a positive number for the year at \$11.2 million. He explained most profit hospitals report EBIDTA as the bottom line so for a hospital our size we actually had a very good year EBITDA wise. Director Reno questioned how much our operations went up. Mr. Rivas stated total operating revenue went up by \$15 million mainly as a result of the OSNC acquisition. Director Reno questioned if our expenses exceeded the \$15 million. Mr. Rivas responded that expenses did exceed the \$15 million, largely related to the \$7.5 million for supplies and pharmacy expenses that was previously discussed. The result of the expenses compared to increases in revenue was a \$4.2 million loss. Again Mr. Rivas pointed out that is EROE but EBITDA is a measure of our cash intake as compared to our operating expense which is a more accurate. Director Schallock commented that pharmacy expense is a national issue and is ongoing.

With regard to the first two months of the current fiscal year, Mr. Rivas reported we are ahead of budget and on track to be profitable this year.

Director Grass commented on the low average length of stay and questioned if it might be attributed to healthcare trends moving toward outpatient care versus

inpatient care. Mr. Rivas stated that is large part of it. New technologies have made it possible to do more outpatient surgeries and procedures.

Mr. Rivas introduced Stacey Stelzriede, Partner with the accounting firm of Moss Adams. Also present today is Annie Norviel, Senior Manager.

Ms. Stelzriede provided a brief overview of the FY18 Financial Statement Audit. that was presented to the Audit, Compliance & Ethics Committee earlier last week. Ms. Stelzriede stated Moss Adams was engaged to audit the financial statements of the district for the year ended June 30, 2018 which also included an audit under the single audit requirements due to our HUD loan. She explained that the single audit is essentially a compliance audit to make sure we are complying with the HUD Regulatory Agreement and all of the elements within it.

In addition to the opinion on the financial statements, Moss Adams will issue two other opinions which are related to the single audit. One is a report on internal controls of our financial reporting. Ms. Stelzriede stated there were no financial findings to communicate and no compliance findings. The second opinion related to the single audit is compliance with the single audit itself related to the provisions and the regulatory agreement. There were also no control findings or compliance findings related to the single audit.

Ms. Stelzriede there were no significant difficulties in the audit. Management was very cooperative and forthcoming in providing what was needed to complete the audit.

Ms. Stelzriede commented on the following notes and provided a brief explanation of each:

- ➤ Note 6 Goodwill
- ➤ Note 8 Short term Debt
- ➤ Note 9 Long-term Debt
- ➤ Note 14 Commitments and Contingencies
- ➤ Note 15- Subsequent Events

Ms. Stelzriede Moss Adams will issue an unmodified opinion with no proposed adjustments. She congratulated management on their efforts and stated the Board should take comfort that the financial information coming out of finance on a monthly basis is reliable.

Lastly, Ms. Stelzriede reviewed the Financial Ratios and Metrics that included Cash on Hand (Days), Current Ratio, Days in Accounts Receivable, Debt to Capitalization and EBITDA% of Operating Income.

Director Reno stated she is not familiar with the covenants between TCMC and HUD. Ms. Stelzriede explained that the covenants with HUD do not require a certain threshold. Mr. Dietlin clarified there is no Cash on Hand requirements with HUD. Director Reno stated she would be interested in reviewing the HUD documents.

Director Reno stated legal fees appear to continually have an effect on the opening of the Medical Office Building and did the auditors see any problems with that. Ms. Stelzriede stated the Medical Office Building is under appeal and in a

holding pattern however there has not been a lot of legal activity in the current fiscal year. Mr. Rivas stated legal fees are the lowest they have been in seven years and have nothing to do with the opening of the Medical Office Building.

Chairman Dagostino questioned how we compare to other hospitals. Ms. Stelzriede stated our Current Ratio is strong compared to our piers. Our Debt to Capitalization is definitely lower which means we have some borrowing capacity. Days Cash on Hand is lower from a peer perspective. Days in AR are good and we do not have a lot of debt. Ms. Stelzriede stated overall the bottom line is positive and there are not a lot of hospitals out there that can say that.

Director Reno stated she is concerned with the Surgery Department income. Mr. Rivas responded that this month we have the highest number of surgeries in five years.

Director Reno complemented Ms. Stelzriede on the informative presentation.

It was moved by Director Reno that the Tri-City Healthcare Board of Directors accept the FY2018 Financial Statement Audit and Single Audit as recommended by the Audit, Compliance & Ethics Committee. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None None

ABSTAIN: ABSENT: Directors:

Nygaard

b) Consideration to amend Board Policy 18 -006 – Board of Director Meeting Minutes

Chairman Dagostino stated it came to his attention in discussion with counsel that Closed Session materials need to remain in the Closed Session. He explained Board Policy 18-006 has been "tightened" up and reflects the way documents should be handled for both Closed and Open Sessions.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors approve amended Board Policy 18-006 – Board of Director Meeting Minutes. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT:

Directors:

Nygaard

c) Consideration of Board Committee Community Member Recognition

Director Grass suggested Board Committee Community members who served on the Board Committees that have been dissolved be recognized for their service in some way. It was suggested that past practice be followed and the former Board Committee members be invited to the next Board meeting to receive a certificate of appreciation and enjoy cookies and tea.

The Board directed Ms. Donnellan to invite the former Board Committee members to the November 8th Regular Board meeting.

d) Consideration of former Board Committee Community Member's future service on Board Committees

Director Grass stated former Board committee members have questioned if they could be notified if an opening comes up on a committee that the Board thinks that individual may qualify for. She clarified it is not to give preference to any candidate, simply a notification to apply.

Director Schallock stated Ms. Donnellan has a process for publicly noticing in the paper and website when an opening occurs. In addition, any Board member has the prerogative to let an interested applicant who previously served on a committee and might be of value to the committee be made aware of the opening. He noted certain committees require an expertise in finance and audit matters.

e) Approval of an Agreement with Vituity (CEP) for Psychiatric Telemedicine

Ms. Sharon Schultz reported with the suspension of the Inpatient Behavioral Health Unit on October 2nd, we still have the need when patients present with mental health illnesses. The proposed agreement with Vituity will enable the hospitalists and Emergency Room physicians to call upon a consultant with medication and behavior management and possible need for transfer to an LPS facility.

Chairman Dagostino explained the Psychiatric Telemedicine program would be in lieu of having a psychiatric physician on site 24/7.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors authorize an agreement with Vituity (CEP) for \$538,375 for a term of 12 months beginning October 1, 2018 through September 30, 2019 for a term cost not to exceed \$538,375. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES: Directors:

Dagostino, Grass, Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT: Directors:

Nygaard

 f) Approval of an addition of Dr. Hellen Chiao to the Gastroenterology General & ERCP ED Call Coverage Panel Dr. Souza requested approval to add Dr. Chiao to the existing Emergency Department On Call Panel beginning October 1st. She will participate in the same fashion as the other physicians at no additional cost.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors authorize the addition of Dr. Hellen Chiao to the Gastroenterology General & ERCP ED-Call Coverage panel beginning October 1, 2018 through September 30, 2019, at a daily rate of \$700 for GI, for an annual cost of \$255,500 and for ERCP at a daily rate of \$500 for an annual cost of \$182,500 and a total cost of \$435,000. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None None

ABSTAIN: ABSENT:

Directors:

Nygaard

- 19. Old Business None
- 20. Chief of Staff
 - Consideration of September Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on September 24, 2018.

It was moved by Director Mitchell that the Tri-City Healthcare Board of Directors approve the September Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on September 24, 2018. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Reno and Schallock

NOES: ABSTAIN: Directors:

None

ABSENT:

Directors:

None Nygaard

21. Consideration of Consent Calendar

It was moved by Director Reno to approve the Consent Calendar. Director Grass seconded the motion.

Director Reno stated she would be voting "no" on all the minutes.

The vote on the main motion was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

and Schallock

NOES: Directors: Reno ABSTAIN: Directors: None ABSENT: Directors: Nygaard

The vote on the main motion, minus the item pulled was as follows:

AYES:

Directors:

Dagostino, Grass, Kellett, Mitchell,

Reno and Schallock

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT: Directors: Nygaard

- Discussion of items pulled from Consent Agenda
- 23. Reports

Chairman Dagostino gave a brief report on his attendance at the CHA Governance Forum. He stated the Governance Forum is modifying their structure to be more time and cost efficient and will meet twice a year rather than four times a year and one of the meetings will be held via video conference.

Director Mitchell commented that Chairman Dagostino's written report indicated CHA is now opposed to AB1795. Chairman Dagostino explained AB1795 would allow paramedics to make a judgment call as to where to transfer patients when it comes to sobriety and mental health without consulting anyone. Emergency Room physicians and Tri-City are pleased that CHA is now opposed to the Bill.

Director Schallock questioned if the trial program in which Carlsbad paramedics participated in was still operational. Ms. Schultz responded that only one patient was transported in the course of the year so it was not successful.

24. Comments by Members of the Public

No comments from the public.

25. Additional Comments by Chief Executive Officer

Mr. Dietlin had no additional comments

26. Board Communications

Reports from Board Members

Director Schallock expressed his appreciation to the Administrative staff and more importantly, the employees who help keep the organization survey ready.

Director Kellett echoed Director Schallock's comments related to the Joint Commission. He stated it is a real accolade for the Administration.

Director Kellett also expressed his appreciation for the clean, unmodified audit opinion which has been fairly typical of Tri-City in recent years.

Director Reno stated she appreciated the outstanding Audit report given by Moss Adams. She also commended the Administrative staff, Ms. Schultz and Mr. Dietlin for the Joint Commission evaluation and report.

Director Reno commented on the chain link barrier and questioned why we are putting distance between the community and the Board. She stated it creates coldness to the community. She also requested that the Board consider moving the podium just adjacent to the Board attorney's audiovisual so the Board can see the entire audience.

Director Grass congratulated the C-Suite as well as the managers, supervisors and employees for a job well done with Joint Commission.

Director Grass reported October is American Pharmacist Month. She recognized fellow Board member Larry Schallock who is a Pharmacist and expressed her appreciation to him for his service and education and feedback he has provided to physicians. Director Schallock stated he will be attending the 50th anniversary from Pharmacy School in Tucson at the end of October.

Director Grass reported October 14-20 is National Emergency Room Nurses week; October is also National Breast Cancer Awareness month and November is National Hospice Month.

Director Mitchell expressed her appreciation to staff for a very successful Joint Commission survey. She commented that having the Joint Commission survey on the heels of the Audit and maintaining survey readiness throughout the year is commended.

27. Report from Chairperson

Chairman Dagostino stated he participated in today's Leadership session with the Joint Commission. He commented that staff were very professional. Chairman Dagostino also expressed his appreciation to Dr. Souza and other members of the Medical Staff who took time out of their day to attend the Leadership session.

Chairman Dagostino commented on Dr. Grossman's letter and her personal acknowledgement of Dr. Brown and staff. Chairman Dagostino stated Dr. Grossman had stated to him that she has never seen the care and concern by physicians and staff that she witnessed here at Tri-City Medical Center. Chairman Dagostino stated this is just one of the many letters the Board and Administration receive on our outstanding care.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:43 p.m.

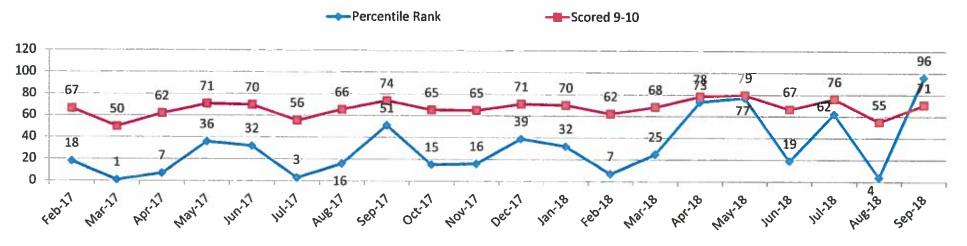
ATTEST:	James J. Dagostino, DPT, PT Chairman
Leigh Anne Grass, Secretary	



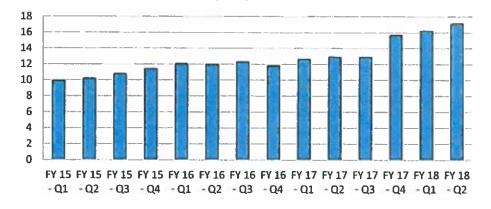
ADVANCED HEALTH CARE

Stakeholder Experiences

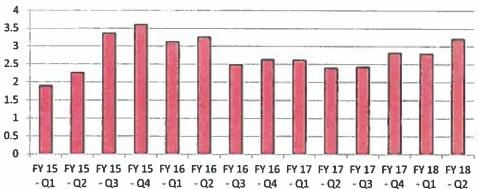
Overall Rating of Hospital (0-10)



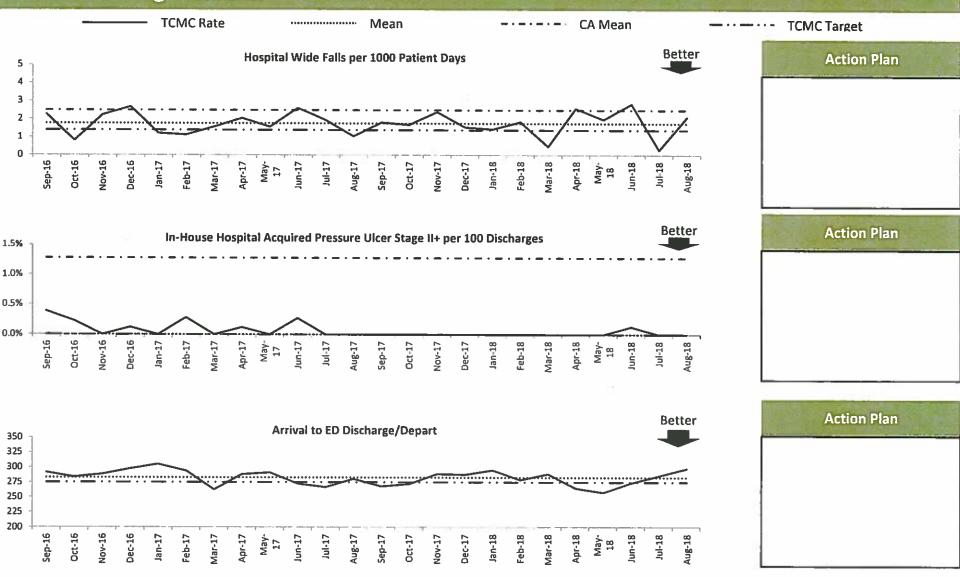
Voluntary Employee Turnover Rate



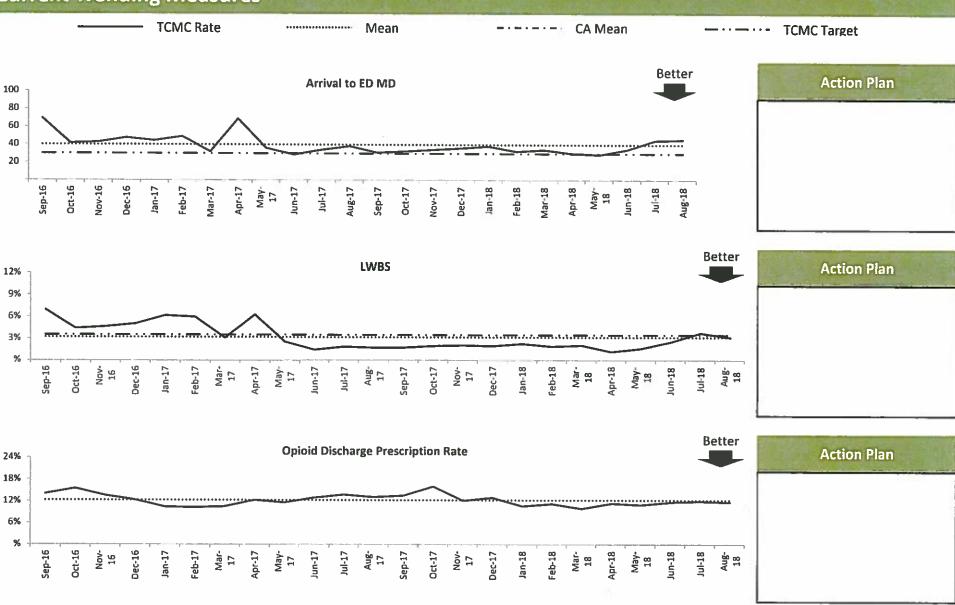
Involuntary Employee Turnover Rate



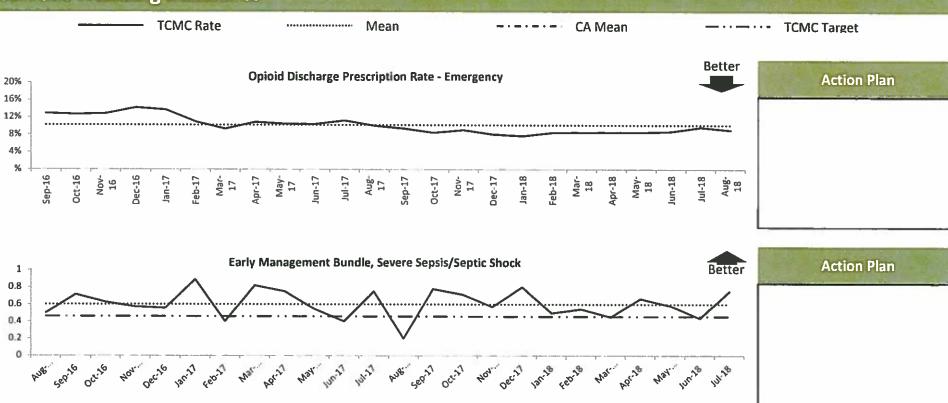
Current rending Measures

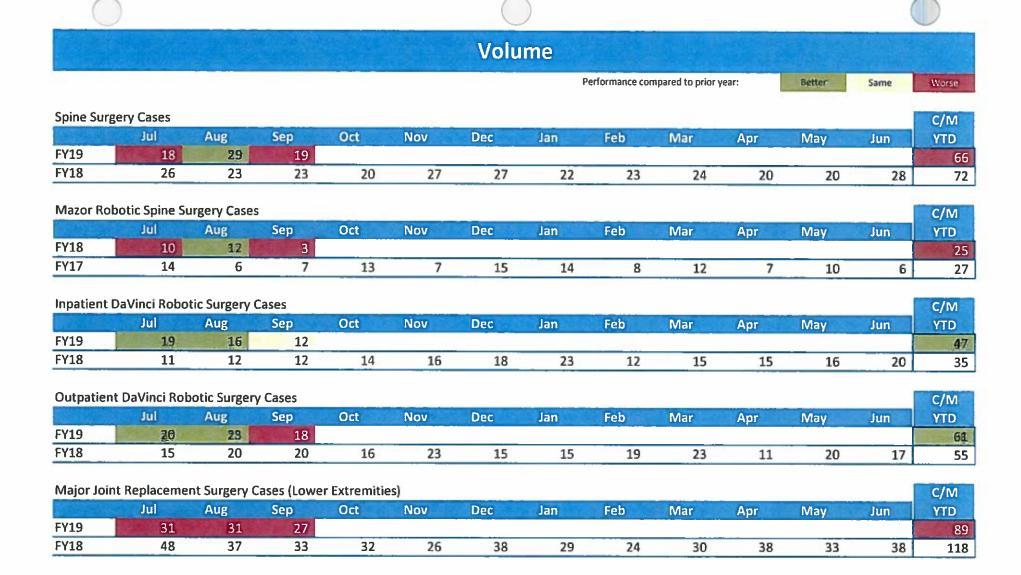


Current frending Measures



Current Trending Measures





Performance compared to prior year:	Better	Same	Worse	ľ

	Jul	Aug	5ep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY19	10.8	11.3	9.7										10.6
Y18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7	13.8	13.0	11.9	15.5
Acute Reh	nab Unit - Ave	rage Daily C	ensus (ADC)								1	C/M
20 S (18)	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY19	7.4	9.1	6.5	170						, ipi		7011	7.7
FY18	9.0	6.7	6.2	9.5	8.3	7.3	7.2	8.7	7.5	7.1	6.6	4.8	7.3
					1007-1	201				10 - 10 E 10 - 10 - 10 - 10 - 10 - 10 -	- 2-00		
Veonatal	Intensive Car	e Unit (NICL	J) - Average	Daily Cens	us (ADC)								C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY19	11.4	9.8	10.0										10.4
	22.7												
FY18	11.3	16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2	13.5	
		-		13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2	13.5	
FY18		16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2	13.5	
FY18	11.3	16.4	12.4	13.9 Oct	13.5 Nov	10.5 Dec	12.5 Jan	12.7 Feb	12.4 Mar	11.5 Apr	12.2 May	13.5 Jun	13.4
FY18 Hospital	11.3 - Average Dail	16.4 ly Census (A	12.4 DC)		2027								C/M YTD
FY18	11.3 - Average Dail Jul	16.4 ly Census (A Aug	12.4 DC) Sep		2027								13.4 C/M YTD 154.3
FY18 Hospital - FY19 FY18	11.3 - Average Dail Jul 160.3 169.7	16.4 ly Census (A Aug 155.9	12.4 DC) Sep 146.4	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD 154.3 171.8
FY18 Hospital - FY19 FY18	11.3 - Average Dail Jul 160.3 169.7	16.4 ly Census (A Aug 155.9 181.9	12.4 DC) Sep 146.4 163.4	Oct 173.4	Nov 160.9	Dec 172.5	Jan 210.7	Feb 185.8	Mar 186.4	Apr 163.2	May 161.9	Jun 165.9	C/M YTD 154.3 171.8
FY18 Hospital FY19 FY18 Deliveries	11.3 - Average Dail Jul 160.3 169.7	16.4 ly Census (A Aug 155.9 181.9	12.4 DC) Sep 146.4 163.4	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD 154.3 171.8 C/M YTD
FY18 Hospital FY19 FY18 Deliveries	Average Dail Jul 160.3 169.7 Jul 186	16.4 ly Census (A Aug 155.9 181.9 Aug 202	12.4 DC) Sep 146.4 163.4 Sep 170	Oct 173.4	Nov 160.9 Nov	Dec 172.5	Jan 210.7 Jan	Feb 185.8 Feb	Mar 186.4 Mar	Apr 163.2 Apr	May 161.9 May	Jun 165.9 Jun	13.4 C/M YTD 154.3 171.8 C/M YTD
FY18 Hospital FY19 FY18 Deliveries	11.3 - Average Dail Jul 160.3 169.7	16.4 ly Census (A Aug 155.9 181.9	12.4 DC) Sep 146.4 163.4	Oct 173.4	Nov 160.9	Dec 172.5	Jan 210.7	Feb 185.8	Mar 186.4	Apr 163.2	May 161.9	Jun 165.9	13.4 C/M YTD 154.3 171.8 C/M YTD
Hospital - FY19 FY18 Deliveries FY19 FY18	11.3 - Average Dail Jul 160.3 169.7 Jul 186 210	16.4 ly Census (A Aug 155.9 181.9 Aug 202 222	12.4 DC) Sep 146.4 163.4 Sep 170	Oct 173.4	Nov 160.9 Nov	Dec 172.5	Jan 210.7 Jan	Feb 185.8 Feb	Mar 186.4 Mar	Apr 163.2 Apr	May 161.9 May	Jun 165.9 Jun	C/M YTD 154.3 171.8 C/M YTD 558 626
Hospital FY19 FY18 Deliveries FY19 FY18	Average Dail Jul 160.3 169.7 Jul 186	16.4 ly Census (A Aug 155.9 181.9 Aug 202 222	12.4 DC) Sep 146.4 163.4 Sep 170 194	Oct 173.4	Nov 160.9 Nov 184	Dec 172.5 Dec 166	Jan 210.7 Jan	Feb 185.8 Feb 169	Mar 186.4 Mar 186	Apr 163.2 Apr 156	May 161.9 May 163	Jun 165.9 Jun 188	C/M YTD 154.3 171.8 C/M YTD 558 626
FY18 Hospital FY19 FY18 Deliveries FY19 FY19 FY18	Average Dail Jul 160.3 169.7 Jul 186 210 Cardiac Interv	16.4 ly Census (A Aug 155.9 181.9 Aug 202 222	12.4 DC) Sep 146.4 163.4 Sep 170	Oct 173.4 Oct 206	Nov 160.9	Dec 172.5	Jan 210.7 Jan 209	Feb 185.8 Feb	Mar 186.4 Mar	Apr 163.2 Apr	May 161.9 May	Jun 165.9 Jun	13.4 C/M YTD 154.3 171.8 C/M YTD 558 626



E	3etter	Same	Worse
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Outpatient Cardiac Interventions

Outputien	re caralae m	terventions					The same of the sa						C/ IVI
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY19	3	4						_					7
FY18	4	7	7	3	4	3	2	4	8	2	7	8	18

Openine	it Surgery C	.ases		S. Contract		12.1.0	The second second						C/IVI
465	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY19	8	8	6									. <u></u> .	22
FY18	8	7	7	11	3	14	11	10	4	10	8	5	22

Trial Charles and a second of the second control of the second con	TCMC Ad	iusted Factor	(Total Revenue	e/IP Revenue)
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TCMC Adjusted Factor (Total Revenue/IP Revenue)											C/M		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY19	1.79	1.83	1.9		-				1 10 11 11				1.84
FY18	1.75	1.80	1.81	1.80	1.83	1.72	1.64	1.77	1.78	1.85	1.86	1.79	1.79





ADVANCED HEALTH CARE

Financial Information

TCMC D	and the same of th	nts Receivabl											C/M	Goal
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
FY19	44.9	43.1	46.4					and the second		-			44.8	48-52
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8	47.0	46.6	45.8	48.1	
TCMC D	ays in Accou	nts Payable (/	A/P)										C/M	Goal
1000	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
FY19	84.9	86.5	90.2										87.2	75-100
FY18	82.1	79.1	78.8	83.4	87.7	81.3	82.9	85.2	78.8	83.2	89.2	83.0	80.0	
TCHD E	ROE \$ in Thou	ısands (Exces	s Revenue ov	er Expenses)									C/M	C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY19	(\$478)	(\$121)	\$119										(\$479)	\$ (1,045)
FY18	(\$394)	(\$429)	(\$224)	(\$171)	(\$2,571)	(\$383)	(\$1,242)	(\$542)	(\$337)	(\$679)	(\$408)	\$3,118	(\$1,048)	

TCHD ER	ROE % of Tota	al Operating	Revenue									-	C/M	C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY19	-1.64%	-0.39%	0.41%		12.00				Pilet -				-0.54%	-1.22%
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%	9.07%	-1.16%	- A





ADVANCED HEALTH CARE

Financial Information

CITO EU	III DA Ş IN I N	ousands (Ear	nings before	Interest, Taxe	s, Depreciatio	n and Amort	ization)						C/M	C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
Y19	\$796	\$1,168	\$1,417					The second second	10000				\$3,381	\$2,890
Y18	\$898	\$864	\$1,091	\$1,146	(\$1,288)	\$908	\$81	\$751	\$963	\$571	\$900	\$4,407	\$2,853	
TCHD EB	IITDA % of To	otal Operatin	g Revenue										C/M	C/M
TCHD EB	ITDA % of To	otal Operatin Aug	g Revenue Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		the same of the same of
CHD EB	THE RESIDENCE OF THE PARTY OF T	The second second	The second secon	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Мау	Jun	C/M YTD 3.81%	C/M YTD Budget

TCMC Pa	aid FTE (Full-	Time Equival	ent) per Adju	sted Occupied	Bed								C/M	C/M
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Budget
FY19	6.73	6.70	6.75	-	222								6.73	6.50
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95	5.99	5.86	6.29	6.43	6.43	6.42	

TCHO Liquidity \$	in Millione (Cash +	Available Revolving	Line of Credit

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY19	\$50.0	\$49.5	\$49.3	2007		-192			7891	- 120			
FY18	\$58.5	\$49.8	\$42.3	\$48.2	\$58.6	\$54.5	\$54.7	\$53.1	\$49.4	\$42.7	\$41.5	\$52.8	



Building Operating Leases

Month Ending September 30, 2018								
	Si Sulley.	Base		Total Rent				
	Co. Et	Rate per	100	per current	Lease	Children Street, Stree		
Lessor	Sq. Ft.	Sq. Ft.	1000	month	Beginning	Ending	Services & Location	
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	\$3.59	(a)	45,637.80	07/01/17	06/30/27	OSNC - Carlsbad 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	
American Health & Retirement						· · ·		
DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	Approx 1,558	\$2.47	(a)	5,029.28	01/27/17	05/31/20	PCP Clinic - Venus 2067 W. Vista Way, Ste 160 Vista, CA 92083	
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	\$1.91	(a)	10,231.22	04/01/16	01/31/20	PCP Clinic - Radiance 3998 Vista Way, Ste. C Oceanside, CA 92056	
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 V#83204	10,218	\$2.58	l(a)	26.711.35	07/01/17	06/30/22	OSNC - Oceanside 3905 Waring Road Oceanside, CA 92056	
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	\$2.70	(a)	20,540.00	02/01/15		PCP Clinic - Vista 1926 Via Centre Drive, Ste A Vista, CA	
CreekView Orthopaedic Bidg, LLC 1958 Via Centre Drive Vista, Ca 92081 V#83025	Approx 4,995	\$2.58	(a)	15,640.35	07/01/17	06/30/22	OSNC - Vista 1958 Via Centre Drive Vista, Ca 92081	
Efiln Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	\$2.62	(a)	9,867.81	12/01/15		PCP Clinic - Clancy 2375 Melrose Dr. Vista Vista, CA 92081	
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	\$1.86	(a)	10,571.65	09/01/17	08/31/19	OP Physical Therapy OP OT & OP Speech Therapy 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	\$1.35	(a)	10,101.01	07/01/16	06/30/21	Outpatient Behavloral Health 510 West Vista Way Vista, Ca 92083	
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4.760	\$4.12		26,047.00	10/01/12		Chemotherapy/Infusion Oncology Center 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663	1,100						Vacant Building 510 Hacienda Drive Suite 108-A	
V#81503	3,307	\$1.10	(a)	5,135.39	10/28/13	10/31/18	Vista, CA 92081	
Tota	21			\$ 185,512.86				

⁽a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.





Education & Travel Expense Month Ending September 2018

Cost

Center	Description	Invoice #	Amount	Vendor#	Attendees
6183	MSNCB - CMSRN EXAM FEE	82418	339.00	80084	COURTNEY NELSON
6185	CANCER BASICS ONLINE COURSE	91718	220.00	82274	ANNA SOUTH
7770	EDUCATION FOOD MODELS FOR ARU PATIENTS	92018	241.54	37799	PRIYA JOSHI
7792	CLINIC DRIVING REHAB ASSESSMENT	91318	158.35	37799	PRIYA JOSHI
8390	NATIONAL PHARMACY PURCHASING ASSOC CONFERNCE	82818	422.81	10894	LAURA BALL
8480	CERNER HEALTH CONFERENCE	91218	1,010.00	51699	MELODY PETERSON
8510	NOTARY MEMBERSHIP/RECORDING FEES	80918	221.00	82623	WINITA PHOGNSAMRAN
8631	2019 LEADERSHIP NORTH COUNTY	83118	1,349.00	79486	GLEN NEWHART
8740	PULMONARY CARE CONFERENCE	92118	100.00	65658	MARGARET STRIMPLE
8740	12 LEAD EKG INTERPRETATION	91318	100.00	78147	LINDA SPRAGUE
8740	OCN EXAM REVIEW	91318	100.00	83334	BERNADETTE WIEBOLDT
8740	CRCST EXAM	82318	125.00	83332	BENJAMIN R JACOB
8740	ACLS BLS RENEWAL	90718	140.00	82167	REBECCA PLUMLEE
8740	ACLS RENEWAL	90718	150.00	16257	JENNIFER HANLEY
8740	ACLS RENEWAL	91318	150.00	82315	COLIN HURLOW PAONESSA
8740	ACLS RENEWAL	90718	155.00	82127	LAUREN CASTONGUAY
8740	STOPPING THE PAIN WEBCAST	90718	199.99	82938	HILLARY FRIENDBERG
8740	NATIONAL NEONATAL NURSES CONFERENCE	91318	200.00	81651	KAREN SULLIVAN
8740	RN TO BSN	90718	2,500.00	78209	LISA MORGAN
8758	CONTINUITY OF CARE IN DISASTER	1135WE07201837653878	135.00	14365	KELLY WELLS



[&]amp; Travel expense category in excess of \$100.00.

^{**}Detailed backup is available from the Finance department upon request-