TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
January 31, 2019 – 2:30 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 Hour	
	a. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (1 Matter)		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Approval of prior Closed Session Minutes		
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 Recognition a) In recognition of Sharon Schultz, MSN, RN, MPH for her 13 years of service and dedication to Tri-City Medical Center both as the Director of Emergency Services and Chief Nurse Executive.	5 min.	Chair
13	Report from TCHD Auxiliary President – Mary Gleisberg	10 min.	Auxiliary President
14	December 2018 Financial Statement Results	10 min.	CFO
15	New Business a) Consideration to nominate Director Chavez to be considered on the CHA Governance Forum	5 min.	Director Reno
	b) Discussion and recommendations regarding Board's Self-Evaluation/ Retreat/Facilitators to be held in the fall of 2019	10 min.	Director Schallock
	c) Consideration to accept recommendations from CHAC Ad Hoc Committee related to its committee structure and function including amendments to the CHAC Charter	10 min.	Ad Hoc Committee
16	Old Business a) Consideration to award Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000.	10 min.	Director Schallock/ Connie Jones
17	Chief of Staff a) Consideration of January 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 28, 2019. b) Consideration of amended Medical Staff Bylaws c) Consideration of revision to Cardiology Privilege Card	10 min.	Chief of Staff
18	Consideration of Consent Calendar **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.***	5 min.	Standard

	Agenda Item	Time Allotted	Requestor

(3) Requested items to be pulled require a second.

(1) Administrative Committee

a) Patient Care Policies & Procedures
1) Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure
2) Cardiac Cath Lab Standardized Procedure
3) Care of the Newborn Standardized Procedure
4) Droperidol Administration, Monitoring and-or Discontinuing Drug Standardized Procedure (DELETE)
5) Identification of Newborns Procedure
6) Massive Transfusion Protocol Policy
7) Pneumococcal and Influenza Vaccine Screening and Administration Standardized Procedure
8) Sedation/Analgesia Used During Therapeutic or Diagnostic Procedure
9) Stroke Code, Emergency Department Procedure
10) Surgical Hand Asepsis Procedure

b) Administrative Policies & Procedures
1) Outsourcing Sterile Compounding Policy 206 (DELETE)

c) Food and Nutrition
1) Emergency Preparedness Food and Nutrition Disaster Plan Policy

d) Mammography Women
1) Communication of Results Women Center
2) Completion of Diagnostic Report
3) Distribution of Mammography Reports Policy
4) Film Retention, Check Out and Copying Policy
5) Mammography Medical Outcomes Audit Policy
6) Mammography QA Plan DIT Policy
7) Scheduling of Self Referring Mammography Patients Policy
8) Screening Mammography Policy
9) Self-Referring & Self-Requesting Patients Policy (DELETE)
10) Staff & Personnel Listing Women's Center Policy

e) Patient Care Management
1) Utilization Review Process

f) Pharmacy
1) Antidote Stocking
2) Restricted Antimicrobials

g) Progressive Care Unit
1) High Profile Patients in Progressive Care Unit (PCU) (NEW)

h) Radiology
1) Imaging Services General Safety Management #128 (DELETE)
2) MRI After Hours Coverage #122
3) MRI Emergency Procedures #111
4) MRI Safety Zones #113
5) Oral Contrast Administration #106
6) Patient Interaction #126

	Agenda Item	Time Allotted	Requestor
	7) Patient Procedure Refusal #127 8) Radiologists Coverage Non IR #125 9) Scope of Service #121 **i) Rehabilitation** 1) Physical Therapy Assistant Supervision 613 **j) Women & Newborn Services** 1) Adoption 2) Partners in Care for WNS 3) Release of Minor to Other than Birth Mother 4) Surrogacy **(2) Board Committees** **A. Community Healthcare Alliance Committee** Director Chavez, Committee Chair *(No meeting held in January, 2019)* **B. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 1 *(Committee minutes included in Board Agenda packets for informational purposes* 1) Approval of an agreement to add Dr. Anitha Rajamanickam to the currently existing Cardiology Physician EKG and Echocardiology Panel Agreement for a term of 36 months, beginning July 1, 2018 through June 30, 2021. 2) Approval of an agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning January 1, 2019 through December 31, 2019, at a cost of $3,200 per month, for a total cost for the term of $38,400. 3) Approval of a Lease Agreement for Suite 101 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Ohana Medical Services Organization, Inc. for a ten-year, five month term (125 months), at a rate of $7,971 per month, increasing base rent 3% yearly and with a total credit from the landlord not to exceed $239,609. 4) Approval of an agreement to add Dr. Cyrus Shabrang to the currently existing ED On Call Coverage Panel for Interventional Radiology for a term of 19 months, beginning December 1, 2018 through June 30, 2020. 5) Approval of an agreement with Cerner for Community Works for a term of 120 months (10 years), beginning February 2019 through January 2029, for an average annual cost of $6,149,113 and a total cost for the term of $61,401,130. 6) Approval of a Sublease Agreement for Suite 160 at 2067 West Vista Way, Vista, CA 92083 with Dr. Kenneth Carr for a month-to-month term to commence February 1, 2019 at the		CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	rate of $2,169.76 per month. 7) Approval of an agreement with Dr. Nicholas Jauregui, to provide medical oversight for the TCHD Supportive/Palliative Care Program for a term of 12 months beginning February 1, 2019 through January 31, 2020, not to exceed an average of 16 hours per month, and maximum of 200 hours annually, at an hourly rate of $200 for a term cost not to exceed $40,000. **C. Professional Affairs Committee** Director Reno, Committee Chair *(No meeting held in January, 2019* **D. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 1 *(No meeting held in January, 2019)* (3) Minutes – Approval of: a) Regular Board of Directors Meeting – December 13, 2018 (4) Meetings and Conferences – None (5) Dues and Memberships a) Modern Healthcare Board Subscription - $532.00		PAC Audit, Comp. & Ethics Comm. Standard
19	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
20	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (December, 2018) (d) Reimbursement Disclosure Report – December, 2018) (e) Seminar/Conference Reports – None	0-5 min.	Standard
21	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
22	Comments by Chief Executive Officer	5 min.	Standard
23	Board Communications (three minutes per Board member)	18 min.	Standard
24	Report from Chairperson	3 min.	Standard
25	Total Time Budgeted for Open Session	2 hours	
26	Oral Announcement of Items to be Discussed During Closed Session		
27	Motion to Return to Closed Session (if needed)		
28	Open Session		
29	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
30	Adjournment		

Tri-City Medical Center

MEMO

January 23, 2019

To: Tri-City Healthcare District Board of Directors
Fr: AD HOC CHAC Committee
Re: Community Healthcare Alliance Committee (CHAC)

Dear Members of the Board of Directors,

Please find attached documents for your review and consideration. These documents are being proposed to comply with new laws governing California healthcare district grants (AB 2019) and to ensure the grant funds are distributed to the best interest of the citizens served by the Tri-City Hospital District.

The attachments include:

- CHAC Committee Proposed Program Overview
- Community Healthcare Alliance Committee (CHAC) Committee Charter
- Assembly Bill No. 2019
- Assembly Bill No. 1728

The Board of Directors will need to create a new policy reflecting the new law, AB 1728, Section 32139, C 1-2, which will include a process for the district to ensure allocated grant funding is spent consistently with the grant application and the mission and purpose of the district.

PROPOSED GRANT CONSIDERATIONS

Fund Allotment

Current: Averaging $350,000 annually. This allotment has been adjusted in previous years based on availability of funds.

Proposed: Decreasing grant allotment to $100,000 annually, reissued annually upon availability of funding and approved by the TCHD Board of Directors.

Evaluation

Current: All grant applications are reviewed for eligibility and recommendation by the Grant Selection Committee comprised of members who sit on the CHAC Committee. The recommendations are then presented to the CHAC Committee for approval of recommendation prior to submission to the Board of Directors for final approval.

Proposed: CHAC committee members will determine the grant program's priority focus areas based on CHNA findings. All applications will be reviewed for eligibility, scope, and impact by assigned staff member(s). Assigned staff member(s) will score (rank) applicants in several categories that are aligned with application criteria. The CHAC Committee will also have input as committee members will be able to rank applicants with those rankings forming a portion of the applicant's overall score. Prescreened and recommended applicants will be submitted by the CHAC Committee to the Board of Directors for final approval.

Committee Membership

Current: Members are chosen by the Tri-City Healthcare District Board of Directors and must meet all requirements prescribed in Board Policy No. 15-031. Only those who live or work in the District are eligible to be members of the Committee. There are currently 32 voting and non-voting positions on the CHAC Committee represented by the following groups:

Voting Members representing the districts of Oceanside, Vista and Carlsbad

- Board Members
- District Residents
- Mayoral Nominees
- Chamber Of Commerce CEO'S
- School District Nominees
- Senior Commission Nominees
- Police And Fire Nominees
- Community Healthcare Organizations – VCC, NCHS & County of San Diego Health & Human Services Agency.
- Multicultural Nominees
- Chief of Staff

Non-Voting Advisory Members

- CEO
- COO
- CEAO

Other

- Administrative Support Staff

Proposed: It has been proposed that the committee membership be reviewed and possibly adjusted and/or decreased to promote commitment and relevance to current areas of focus.

Meeting Schedule

Current: CHAC currently meets monthly on the third Thursday of the month at 12:30pm.

Proposed: It is proposed that the CHAC Committee meet quarterly on the third Thursday of the month, at 12:30pm. Designated meeting months would be January, April, July and October.

Tri-City Medical Center

To: Tri-City Healthcare District Board of Directors
Re: Community Healthcare Alliance Committee (CHAC)
Purpose: 1. Actions to enhance the Tri-City Healthcare District's Grant Program with strategic initiatives to strengthen the public image of the district and meet underserved health needs in specified priority areas.
2. Meet 2019 requirements of AB 2019.
Attachments: Community Health Alliance Committee (CHAC) Charter
Assembly Bill No. 2019
Assembly Bill No. 1728

PROPOSED COMMITTEE OVERVIEW

Mission: To advance the health and wellness of those we serve.

Priority areas as identified in the Community Health Needs Assessment (CHNA) determined by the Triennial Hospital Association of San Diego and Imperial Counties (HASDIC). The current iteration covers 2019-2021.

PRIORITIES	SUGGESTED FOCUS AREAS
Behavioral Health	Alzheimer's Disease Mood Disorders Anxiety Alcohol & Drug Issues
Cardiovascular Health	Hypertension
Social Determinants of Health	Food Insecurity & Access to Healthy Foods Homeless | Housing Issues Education | Knowledge Poverty

Eligibility

- The requesting organization must be a not-for-profit organization
- The requesting project and use of funds must directly benefit the health and well-being of citizens living within the Tri-City Healthcare District boundaries only.
- Other hospitals, hospital districts, Federally Qualified Health Centers (FQHC) and government entities are excluded from consideration. School districts are not excluded from participating.
- Successful CHAC grant applications will address identified community health needs as determined by the Triennial Hospital Association of San Diego and Imperial Counties (HASDIC).
- Successful CHAC grant applicants will be funded for implementation of their program or project over the course of one year with the potential of two additional years of funding should significant progress be demonstrated. Projects are expected to be complete or self-sustainable after a maximum of three years of funding.

terim and Final Reports

- If awarded a grant, an annual update report will be due on the anniversary of the grant funded program or project. A Final Report on the results of the grant must be submitted in order to be considered for a future grant as described in the eligibility section.
- All deadlines for submission will be provided in advance.

Consecutive Funding

- All grant recipients are limited to a one (1) year cycle of funding for the same project and scope.
- Organizations receiving funding for the same project for any three consecutive years must submit an entirely different grant proposal to be considered for future funding.

Application Process

- All applications must be submitted electronically via the form provided by the Grant Committee Guidelines. No paper applications will be accepted. Applicants will receive confirmation of application submission.
- The electronic application includes the following pages and attachments. Each category will have instructions:
    - Cover Page
    - Proposal Narrative
    - Budget Narrative
    - Project Budget attached as a PDF
    - Organization's Annual Operating Budget attached as a PDF
    - Verification of Tax Exempt or Non-Profit Status attached as a PDF

Collaborative Projects

- There is no longer a collaborative grant category.

Deadline for Submission

- All completed applications are to be forwarded electronically to a designated Tri-City Healthcare District's staff member by a published deadline date.

Disqualifiers

- Incomplete application or missing information
- Exceeding the word count and electronic submission instructions
- Discrepancy in the budget figures
- The requesting agency does not qualify under IRS regulations
- The requesting agency has exceeded the three years of consecutive funding rule
- The application was submitted after the deadline day and/or time
- A Final Report was not submitted by the deadline date

AB-1728 Health care districts: board of directors. (2017-2018)

SHARE THIS:

Date Published: 09/25/2017 09:00 PM

Assembly Bill No. 1728

CHAPTER 265

An act to add Section 32139 to the Health and Safety Code, relating to health care districts.

[Approved by Governor September 23, 2017. Filed with Secretary of State September 23, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1728, Committee on Local Government. Health care districts: board of directors.

The Local Health Care District Law provides for local health care districts that govern certain health care facilities. Each health care district has a board of directors with specific duties and powers respecting the creation, administration, and maintenance of the district, including purchasing, receiving, having, taking, holding, leasing, using, and enjoying property.

This bill would require the board of directors to adopt an annual budget in a public meeting, on or before September 1 of each year, that conforms to generally accepted accounting and budgeting procedures for special districts, establish and maintain an Internet Web site that lists contact information for the district, and adopt annual policies for providing assistance or grant funding, if the district provides assistance or grants. By increasing the duties of the board of directors, relating to disclosure of public records and other duties, this bill would impose a state-mandated local program.

The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 32139 is added to the Health and Safety Code, in Article 2 of Chapter 2 of Division 3, to read:

32139. The board of directors shall do all of the following:

(a) Adopt an annual budget in a public meeting, on or before September 1 of each year, that conforms to generally accepted accounting and budgeting procedures for special districts.

(b) Establish and maintain an Internet Web site that lists contact information for the district. The Internet Web site may also list any of the following:

(1) The adopted budget.

(2) A list of current board members.

(3) Information regarding public meetings required pursuant to Section 32106 or the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code).

(4) A municipal service review or special study conducted by a local agency formation commission pursuant to the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 (Division 3 (commencing with Section 56000) of Title 5 of the Government Code), if any.

(5) Recipients of grant funding or assistance provided by the district, if any.

(6) Audits of the district's accounts and records pursuant to Section 26909 of the Government Code or Section 32133 of this code.

(7) Annual financial reports to the Controller, submitted pursuant to Section 53890 of the Government Code.

(8) Any other information the board deems relevant.

(c) Adopt annual policies for providing assistance or grant funding, if the district provides assistance or grants pursuant to Section 32126.5 or any other law. This policy shall include all of the following:

(1) A nexus between the allocation of assistance and grant funding with health care and the mission of the district.

(2) A process for the district to ensure allocated grant funding is spent consistently with the grant application and the mission and purpose of the district.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 32139 of the Health and Safety Code, furthers, within the meaning of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution, the purposes of that constitutional section as it relates to the right of public access to the meetings of local public bodies or the writings of local public officials and local agencies. Pursuant to paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution, the Legislature makes the following findings:

By requiring health care districts to post specified information on their Internet Web site, this act increases public access to public records, and thereby furthers the purposes of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district under this act would result from a legislative mandate that is within the scope of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

AB-2019 Health care districts. (2017-2018)

SHARE THIS:

Date Published: 09/05/2018 09:00 PM

Assembly Bill No. 2019

CHAPTER 257

An act to add Section 6270.7 to the Government Code, and to amend Section 32139 of, and to add Sections 32132.96 and 32140 to, the Health and Safety Code, relating to health care districts.

[Approved by Governor September 05, 2018. Filed with Secretary of State September 05, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2019, Aguiar-Curry. Health care districts.

The Local Health Care District Law provides for local health care districts that govern certain health care facilities. Each health care district has a board of directors with specific duties and powers respecting the creation, administration, and maintenance of the district. Existing law requires the board of directors to establish and maintain an Internet Web site that may include specified information, such as a list of current board members and recipients of grant funding or assistance provided by the district, if any, and to adopt annual policies for providing assistance or grant funding, as specified. Existing law authorizes certain health care districts to use the design-build process when contracting for the construction of a hospital or other buildings in those districts, as specified.

This bill would require the board of directors to include specified information, such as the district's policy for providing assistance or grant funding, on the district's Internet Web site. The bill would require that policy to contain, among other things, the district's plan for distributing grant funds for each fiscal year and a process for providing, accepting, and reviewing grant applications. The bill would also require the board to, upon filing a petition under federal bankruptcy law, provide written notice within 10 business days to the local agency formation commission of the principal county in which the district is located. The bill would require a district that is authorized and elects to use the design-build process, as specified, for the construction of housing to require that at least 20% of the residential units constructed be subject to a recorded affordability restriction for at least 55 years and be affordable to lower income households, very low income households, extremely low income households, and persons and families of low or moderate income, as defined, unless the city, county, or city and county in which the district is predominantly located has adopted a local ordinance that requires a greater percentage of the units be affordable to those groups or unless the construction is for purposes of building workforce housing, health facilities, or retirement facilities, as specified. By increasing the duties of the board of directors, including duties related to disclosure of public records, the bill would impose a state-mandated local program.

Existing law, the California Public Records Act, requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies.

This bill would require each health care district, in implementing the California Public Records Act, to maintain an Internet Web site in accordance with the provisions described above. Because the bill would require health care districts to perform additional duties, it would impose a state-mandated local program.

The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 6270.7 is added to the Government Code, to read:

6270.7. In implementing this chapter, each health care district shall maintain an Internet Web site in accordance with subdivision (b) of Section 32139 of the Health and Safety Code.

SEC. 2. Section 32132.96 is added to the Health and Safety Code, to read:

32132.96. (a) Except as provided in subdivision (b), (c), or (d), a district that is authorized and elects to use the design-build process described in Chapter 4 (commencing with Section 22160) of Part 3 of Division 2 of the Public Contract Code for the construction of housing shall require that at least 20 percent of the residential units constructed be subject to a recorded affordability restriction for at least 55 years and be affordable to all of the following:

(1) Lower income households, as defined in Section 50079.5.

(2) Very low income households, as defined in Section 50105.

(3) Extremely low income households, as defined in Section 50106.

(4) Persons and families of low or moderate income, as defined in Section 50093.

(b) Subdivision (a) shall not apply if the city, county, or city and county in which the district is predominantly located has adopted a local ordinance that requires a greater percentage of the units be affordable to lower income households, very low income households, extremely low income households, and persons and families of low or moderate income.

(c) Subdivision (a) shall not apply to any district that is authorized and elects to use the design-build process described in Chapter 4 (commencing with Section 22160) of Part 3 of Division 2 of the Public Contract Code for the construction of any health facilities or retirement facilities exclusively providing care or supportive services to the elderly, disabled adults, or individuals with dementia, including, but not limited to, residential care facilities for the elderly.

(d) Subdivision (a) shall not apply to any district that is authorized and elects to use the design-build process described in Chapter 4 (commencing with Section 22160) of Part 3 of Division 2 of the Public Contract Code for the construction of workforce housing that is otherwise required by local ordinance.

SEC. 3. Section 32139 of the Health and Safety Code is amended to read:

32139. The board of directors shall do all of the following:

(a) Adopt an annual budget in a public meeting, on or before September 1 of each year, that conforms to generally accepted accounting and budgeting procedures for special districts.

(b) Establish and maintain an Internet Web site that lists contact information for the district. The Internet Web site shall also list all of the following:

(1) The adopted budget.

(2) A list of current board members.

(3) Information regarding public meetings required pursuant to Section 32106 or the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code).

(4) A municipal service review or special study conducted by a local agency formation commission pursuant to the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 (Division 3 (commencing with Section 56000) of Title 5 of the Government Code), if any. The board may comply with this paragraph by posting a link on its Internet Web site to another government Internet Web site that contains the specified information.

(5) Recipients of grant funding or assistance provided by the district, if any.

(6) Audits of the district's accounts and records pursuant to Section 26909 of the Government Code or Section 32133 of this code. The board may comply with this paragraph by posting a link on its Internet Web site to another government Internet Web site that contains the specified information.

(7) Annual financial reports to the Controller, submitted pursuant to Section 53890 of the Government Code. The board may comply with this paragraph by posting a link on its Internet Web site to another government Internet Web site that contains the specified information.

(8) The district's policy for providing assistance or grant funding described in subdivision (c).

(9) Any other information the board deems relevant.

(c) Adopt annual policies for providing assistance or grant funding, if the district provides assistance or grants pursuant to Section 32126.5 or any other law. This policy shall include all of the following:

(1) A nexus between the allocation of assistance and grant funding with health care and the mission of the district.

(2) A process for the district to ensure allocated grant funding is spent consistently with the grant application and the mission and purpose of the district, including, but not limited to, requirements that a grant recipient must meet, such as grant contract terms and conditions, fiscal and programmatic monitoring by the district, and reporting to the district.

(3) The district's plan for distributing grant funds for each fiscal year.

(4) A process for providing, accepting, and reviewing grant applications.

(5) A prohibition against individual meetings regarding grant applications between a grant applicant and a district board member, officer, or staff outside of the district's established grant awards process. A district's established grant awards process may include the provision of technical assistance to grant applicants, upon request, by district grant program staff.

(6) Beginning January 1, 2020, guidelines for all of the following:

(A) Awarding grants to underserved individuals and communities, and to organizations that meet the needs of underserved individuals and communities.

(B) Considering the circumstances under which grants may be awarded to multiple or single recipients, and exceptions to these circumstances.

(C) Evaluating the financial need of grant applicants.

(D) Considering the types of programs eligible for grant funding, including direct patient care, preventive care, and wellness programs.

(E) Considering the circumstances under which grants may be provided to prior grant recipients, and exceptions to these circumstances.

(F) Considering sponsorships of charitable events.

(G) Funding other government agencies.

(H) Awarding grants to, and limiting funds for, foundations that are sponsored or controlled by, or associated with, a separate grant recipient.

SEC. 4. Section 32140 is added to the Health and Safety Code, to read:

32140. Upon filing a petition under federal bankruptcy law, the board of directors shall provide written notice within 10 business days to the local agency formation commission of the principal county in which it is located.

SEC. 5. The Legislature finds and declares that Section 1 of this act, which adds Section 6270.7 to the Government Code, and Section 2 of this act, which amends Section 32139 of the Health and Safety Code, further, within the meaning of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution, the purposes of that constitutional section as it relates to the right of public access to the meetings of local public bodies or the writings of local public officials and local agencies. Pursuant to paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution, the Legislature makes the following findings:

By requiring health care districts to post specified information on their Internet Web site, this act increases public access to public records, and thereby furthers the purposes of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district under this act would result from a legislative mandate that is within the scope of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
January 9, 2019

INITIAL APPOINTMENTS (Effective Dates: 2/01/2019 – 1/31/2021)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 2/01/2019 through 1/31/2021:

- **IBRAHIM, Aalamgeer MD/Psychiatry (Vituity)**
- **MAZZARULLI, Anthony MD/Psychiatry (Vituity)**
- **SANATHARA, Visant MD/Psychiatry (Vituity)**
- **SEIGLER, David MD/Psychiatry (Vituity)**
- **WALKER, Kolby DO/Psychiatry (Vituity)**
- **WERNEID, Kristian MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
January 9, 2019

BIENNIAL REAPPOINTMENTS: (Effective Dates 02/01/2019 –01/31/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 02/01/2019 through 01/31/2021, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **BERDJIS, Farhouch, MD/Pediatric Cardiology/Active Affiliate**
- **BORGSCHULTE, Gitte, MD/Internal Medicine/Active**
- **EPNER, Steven, MD/Radiology/Active**
- **HOSALKAR, Harish, MD/Orthopedic Surgery/Active**
- **KRAK, Michael, MD/Pediatrics/Active**
- **KUSHNARYOV, Anton, MD/Otolaryngology/Provisional**
- **MAZAREI, Rahele, DO/Obstetrics & Gynecology/Active**
- **MILLER, Nathan, MD/Pain Medicine/Active Affiliate**
- **MONGEON, Robert, MD/Internal Medicine/Active**
- **PIETILA, Michael, MD/Family Medicine/Provisional**
- **SCHER, Colin, MD/Pediatric Ophthalmology/Active Affiliate**
- **SCHWEIKERT, Suzanne, MD/Obstetrics & Gynecology/Refer and Follow**
- **SHIH, Robert, MD/Anesthesiology/Active Affiliate**
- **SHIMIZU, Kenneth, MD/Radiation Oncology/Active Affiliate**
- **THOMAS, David, MD/Dermatology/Refer and Follow**

RESIGNATIONS: (Effective date 01/31/2019 unless otherwise noted)

Automatic:

Voluntary:

- ESFANDIARI, Raheleh MD/OB/GYN
- FOX, Robert, MD/Anesthesiology
- HELMY, Marwah, MD/Teleradiology
- KAKIMOTO, William, MD/Radiology
- LOZANO, Jr., Jesus, MD/Anesthesiology
- MANOS, Paul, DO/Family Medicine
- PATEL, Visal, MD/Anesthesiology
- ROSENBURG, Jeffrey, MD/Cardiothoracic Surgery
- SCHEINBERG, Robert, MD/Dermatology
- THOMAS, Steven, MD/OB/GYN

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
January 9, 2019

PROCTORING RECOMMENDATIONS (Effective 2/1/2019, unless otherwise specified)

• BALL, Lindsay MD	Emergency Medicine
• BOONJINDASUP, Aaron MD	Urology
• DOAN, Michael MD	Anesthesiology
• LIAGHAT, Arash MD	Anesthesiology
• MOUSSAVIAN, Mehran DO	Cardiology
• RAJAMANICKAM, Anitha MD	Cardiology
• RASH, Dominique MD	Oncology
• SHABANIAN, Leila MD	Internal Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
January 9, 2019

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of January 31, 2019.

- BOONJINDASUP, Aaron MD — Urology
- COHEN, David MD — Cardiology
- GUTIERREZ, Miguel MD — Emergency Medicine
- HIGGINS, Steven MD — Cardiology
- KOCH, Richard MD — Emergency Medicine
- LEONDARD, Lisa MD — Emergency Medicine
- LI, Xiangli MD — Internal Medicine
- MARQUART, Elizabeth MD — Emergency Medicine
- PHILLIPS, Jason MD — Urology
- PREGERSON, David MD — Emergency Medicine
- RASH, Dominique MD — Oncology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
January 21, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 2/1/2019 – 1/31/2021)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 2/1/2019 through 1/31/2021:

- **BISHOP, Leslie NP/Allied Health Professional (The Neurology Center)**
- **FISHER-GAMEZ, Lori RNFA/Allied Health Professional**
- **LUU, Jackie PA-C/Allied Health Professional (TeamHealth)**
- **SIRAVO, Bianca CNM/Allied Health Professional (No. County Health Svcs.)**
- **STENZEL, Alison PA-C/Allied Health Professional (Verve Plastic Surgery)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 4
January 21, 2019

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 2/1/2019 – 1/31/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 2/1/2019 through 1/31/2021, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- AHUMADA, Alejandro, AuD/Allied Health Professional
- ALSTON, Vickie, CNM/Allied Health Professional
- FREHNER, Lindsey, PA/Allied Health Professional
- FROST, Robert, PA/Allied Health Professional
- HAMMONDS, Tommy, PA/Allied Health Professional
- HARTIG, Margaret, NP/Allied Health Professional
- IARAMILLO, Elizabeth, AuD/Allied Health Professional
- KARVER-CHRISTENSON, Elyse, CNM/Allied Health Professional
- KING, John, AuD/Allied Health Professional
- MATEO, Marie, CNM/Allied Health Professional
- MILLER, Cortney, FNP/Allied Health Professional
- MYERS, Shannon, AuD/Allied Health Professional
- PERLMAN, Tamara, CNM/Allied Health Professional
- SCHROEDER, Mary, CNM/Allied Health Professional
- STABLER, Holly, PA/Allied Health Professional
- Varner, Alicia, OT/Allied Health Professional
- VIERRA, Erin, NP/Allied Health Professional

Note: Provider remains on proctoring for all privileges. Proctored cases must be completed by July 31, 2019 otherwise privileges will automatically expire.

Attachment B

RESIGNATIONS: (Effective date 01/31/2019 unless otherwise noted)

- BALLANTINE, Katherine, CNM/Allied Health Professional
- CHOQUETTE, Alicia, PA/Allied Health Professional
- FOLKERTH, Jean, RNFA/Allied Health Professional
- INOCELDA, Andrew, PAC/Allied Health Professional
- JOHNSON, Mark, PAC/Allied Health Professional
- LONGACRE, Brett, NP/Allied Health Professional

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
January 21, 2019

Attachment C

PROCTORING RECOMMENDATIONS (Effective 2/1/2019, unless otherwise specified)

- BALLANTINE, Katherine CNM — Allied Health Professional
- COCO, Kathleen CNM — Allied Health Professional
- FROST, Robert PA-C — Allied Health Professional

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
January 21, 2019

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of January 31, 2019.

- **KAUR, Manpreet PA-C** **Allied Health Professional**

TRI-CITY HOSPITAL DISTRICT

MEDICAL STAFF BYLAWS

~~February 2017~~November 2018

PREAMBLE

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

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

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

DEFINITIONS

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

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

3. GOVERNING BODY means the Board of Directors of the Hospital.

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

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

6. HOSPITAL means Tri-City Hospital District (TCHD).

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

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

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

10. MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff.

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

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

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

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

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

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

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

ARTICLE I: NAME

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

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of TCHD~~MC~~ is a privilege which shall be extended only to professionally competent physicians, podiatrists and dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated policies of the Medical staff and those policies approved by the Medical Staff. No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital or via telemedicine unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Medical Staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

Allied Health Professionals (AHPs) are not eligible for membership on the Medical Staff but may be granted privileges or practice prerogatives commensurate with their license and credentials as reflected in the Allied Health Rules & Regulations.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists, or podiatrists who:

(a) Document their (1) current licensure and DEA (as clinically required, i.e. Pathology), (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) can provide the appropriate documentation if requested in support of their current ~~adequate~~ physical and mental health status to exercise their privileges requested with or without reasonable accommodations without posing a direct threat, and (6) not currently excluded from any governmental healthcare program, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonable expect to receive quality medical care.

~~(b) Due to the unique nature of the patient population in the community served by TCMC, which necessitates the immediate availability of practitioners for proper supervision of patients in the hospital, membership on the Medical Staff~~Membership is contingent upon the ability to respond to patient care needs within 30 minutes, or as delineated by respective Department/Division.

(c) Proof of adequate coverage for patient care in the absence of the practitioner is required.

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

~~(c)~~(e) Maintain current professional liability insurance coverage in accordance with Board Policy 14-038. Minimum coverage will be established by the Medical Executive Committee with the concurrence of the Governing Body. Coverage must extend to all clinical privileges sought to be exercised. For physicians with "claims made

malpractice insurance," prior acts coverage must be secured by the physician, i.e. tail and/or nose coverage must be documented. With respect to initial applicants, the prior acts coverage requirement may be waived or modified on a case-by-case basis by the Medical Executive Committee acting through the Chief of Staff or his ~~or /~~her designee.

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

2.2-2 PARTICULAR QUALIFICATIONS

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

(b) Limited License Practitioners

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

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

2.3 EFFECT OF OTHER AFFILIATIONS

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

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, religion (creed), color, national origin, sexual identity (including gender expression), political beliefs, marital status, military status, ~~–~~physical or mental impairment or sexual orientation that does not pose a threat to the quality of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to

paragraph 6.1-3, and those, which are the subject of a hearing pursuant to Article VII.

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

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

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

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

2.6 STANDARD OF CONDUCT

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

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

(a) Discrimination, which is defined as conduct by a Medical Staff member against any individual (e.g., against another Medical Staff member, house staff, hospital employee or patient) on the basis of race, religion (creed), color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, gender expression (identity) or sexual orientation.

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

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

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

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

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

3.2 ACTIVE STAFF

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

3.2-1 QUALIFICATIONS

The active staff shall consist of members who:

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

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

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

3.2-2 PRIVILEGES

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

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

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

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

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

3.2-3 TRANSFER OF ACTIVE STAFF MEMBERS

After one staff year in which a member of the active staff fails to regularly care for patients in accordance with Section 3.2-1(c), or be regularly involved in Medical Staff functions as determined by the Medical Executive Committee, that member shall be automatically transferred to the appropriate category if any, for which the member is qualified.

3.3 ACTIVE AFFILIATE STAFF

Are practitioners who are considered to be in good standing and who may admit or otherwise be involved in the care of patients at ~~TCMC~~TCHD, documenting a minimum of ~~twelve (12) patient care~~4-11 patient care activities within a two (2) year time period, or are telemedicine-only providers or providers currently taking ED Call panel.

3.3-1 QUALIFICATIONS

Shall consist of such practitioners who:

(a) Are not otherwise members of the Medical Staff and meet the general qualifications set forth in Section 2.2.

(b) Possess adequate clinical and professional expertise.

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

(d) Are members in good standing of the active Medical Staff of another health care facility.

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

3.3-2 PRIVILEGES

The Active Affiliate staff shall be entitled to:

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

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

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

3.4 REFER AND FOLLOW STAFF

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

3.4-1 QUALIFICATIONS

The Refer and Follow staff shall consist of members who:

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

3.4-2 PRIVILEGES

(a) Refer and Follow staff members do not have privileges to admit or otherwise provide patient care but are still required to maintain malpractice insurance;

(b) Will be responsible to pay any annual or reappointment fees.
(c) Has "view only" access to their patient's Health information record, and will not be allowed to enter orders in the patient's health record.
(d) Shall not nominate or vote on any matters presented at general or special meeting of the Medical Staff or any Committee or the Department of which they are members.
(e) May attend a General meeting of the Medical Staff and Department of which they are appointed and any Educational program offerings.

3.5 PROVISIONAL STAFF

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

3.5-1 QUALIFICATIONS

The provisional staff shall consist of all members who:

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

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

3.5-2 PRIVILEGES

The provisional staff member shall:

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

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

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

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

3.5-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

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

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

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

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

results of the observation shall be communicated by the department ~~chairman~~chairperson to the Medical Executive Committee.

3.5-4 TERM OF PROVISIONAL STAFF STATUS

A member shall be eligible to request advancement from provisional staff after a minimum period of six (6) months if the member's proctoring is fully completed and the provider requests to be advanced. Otherwise, a member remains in the provisional staff for a period of 24 months unless that status is extended by the Medical Executive Committee upon determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.5-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

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

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

3.6 HONORARY STAFF

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

3.6-1 PRIVILEGES

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

~~3.7 GENERAL EXCEPTIONS TO PRIVILEGES~~

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

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

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

~~3.8~~3.7 MODIFICATION OF MEMBERSHIP CATEGORY

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

~~3.9~~3.8 ALLIED HEALTH PROFESSIONALS

Refer to Rules and Regulations for Allied Health Professionals.

ARTICLE IV: MEMBERSHIP AND MEMBERSHIP RENEWAL

4.1 GENERAL

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

4.2 BURDEN OF PRODUCING INFORMATION

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

4.3 MEMBERSHIP AUTHORITY

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

4.4 DURATION OF MEMBERSHIP AND MEMBERSHIP RENEWAL

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

4.5 APPLICATION FOR INITIAL MEMBERSHIP AND MEMBERSHIP RENEWAL

4.5-1 APPLICATION FORM

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

(a) The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA (Drug Enforcement Administration) registration, continuing medical education information related to the clinical privileges to be exercised by the applicant, and documentation of the results of a current tuberculosis skin test. The requirement for DEA registration may be

waived on the recommendation of the Credentials Committee to practitioners who do not need such prescriptive authority.

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

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

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

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

(f) Physical and mental health status.

(g) Professional liability insurance coverage as required.

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

4.5-2 EFFECT OF APPLICATION

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

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

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

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

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

(e) Consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information

regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law.

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

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

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

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

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

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

4.5-3 VERIFICATION OF INFORMATION

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

4.5-4 DEPARTMENT ACTION

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

to the Credentials Committee a written report and recommendation as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The ~~chairman~~chairperson may also request that the Medical Executive Committee defer action on the application.

4.5-5 CREDENTIALS COMMITTEE ACTION

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

4.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

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

4.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

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

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

4.5-8 ACTION ON THE APPLICATION

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

(a) If the Medical Executive Committee issues a favorable recommendation, and

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

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

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

(1) If the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Governing Body for final action.

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

4.5-9 NOTICE OF FINAL DECISION

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

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

4.5-10 REAPPLICATION AFTER ADVERSE MEMBERSHIP DECISION

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

4.5-11 TIMELY PROCESSING OF APPLICATIONS

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

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

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

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

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

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

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

4.6-1 APPLICATION

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

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

4.6-2 EFFECT OF APPLICATION

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

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits an application for reappointment, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in depth review to include satisfactory completion of OPPE evaluation(s) and specific requirements/process overview (refer to *Credentialing Policy*,

Processing Medical Staff Reappointments 8710-548), generally following the procedures set forth in Section 4.5-3 through Section 4.5-11.

4.6-4 FAILURE TO FILE MEMBERSHIP RENEWAL APPLICATION

Failure without good cause to timely file a completed application for renewal of membership shall result in the member being deemed to have resigned membership and privileges as of the end of the current staff appointment. In the event membership and privileges terminate for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

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

4.7-2 TERMINATION OF LEAVE

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

4.7-3 FAILURE TO REQUEST REINSTATEMENT

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

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

4.7-4 MEDICAL LEAVE OF ABSENCE

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the

leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

4.7-5 MILITARY LEAVE OF ABSENCE

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

ARTICLE V: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

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

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

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

5.2-2 BASIS FOR PRIVILEGES DETERMINATION

(a) Initial and subsequent ~~R~~requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, current health status, ~~and~~ the documented results of patient care and other quality review and proctoring/OPPE Evaluations *(Refer to Peer Review Process: OPPE and FPPE 8710-509)* which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

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

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

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

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

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

5.3-2 FAILURE TO OBTAIN PROCTORING CERTIFICATION

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

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSION

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

5.4-2 SURGERY

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

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the ~~chairman~~chairperson of the appropriate department(s).

5.5 TEMPORARY CLINICAL PRIVILEGES

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

5.5-1 PATIENT CARE NEEDS

(a) Care of a Specific Patient

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

(b) Locum Tenens

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

(c) Disaster Privileges

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

5.5-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP

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

5.5-3 APPLICATION AND REVIEW

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

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

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

a. Has recently worked with the applicant;

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

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

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

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

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

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

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

5.5-4 GENERAL CONDITIONS

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

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

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

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

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

5.6 EMERGENCY PRIVILEGES

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

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

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

5.7 HISTORY AND PHYSICAL PRIVILEGES

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

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

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

5.8 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

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

5.9 VOLUNTARY WITHDRAWAL OF APPLICATION

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

ARTICLE VI: EVALUATION AND CORRECTIVE ACTION

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

6.1 EVALUATION OF MEMBERS

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

6.1-1 PEER REVIEW CRITERIA

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

6.1-2 REVIEW OF INITIAL MEMBERS

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

6.1-3 REVIEW OF MEMBERS

All members and privilege holders are reviewed for compliance with the relevant department peer review criteria on an on-going basis. In addition to information gathered under routine screening, complaints and concerns are analyzed in light of the department peer review criteria using mechanisms determined by the department. Members are kept apprised of reviews of their performance. Performance monitoring, corrective action or other measures are implemented or recommended.

6.1-4 FOCUSED REVIEW

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

6.1-5 EXTERNAL REVIEW

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

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

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

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

(c) To promote impartial peer review;

(d) Upon reasonable request of the practitioner.

6.2 CORRECTIVE ACTION

6.2-1 CRITERIA FOR INITIATION

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

6.2-2 INITIATION

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

6.2-3 INVESTIGATION

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

6.2-4 MEDICAL EXECUTIVE COMMITTEE ACTION

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

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

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

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

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

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

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

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

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

6.2-5 SUBSEQUENT ACTION

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

6.2-6 INITIATION BY GOVERNING BODY

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

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3-1 CRITERIA FOR INITIATION

Whenever a member's conduct or physical condition, is such that failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff, the Chief of Staff-elect, or the immediate Past Chief of Staff, or Chair of the applicable Department , together with either a member of the Governing Body or the Chief Executive Officer acting in his capacity as an agent of the Governing Body, shall conjointly have the authority to summarily restrict or suspend the Medical Staff privileges of a member and such summary suspension shall become effective immediately upon imposition. The person or body responsible shall promptly give written notice to the member, the Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The summary restriction or suspension may be limited in duration and may be based upon the member's refusal to submit to a blood or urine test to detect the presence of alcohol or chemicals. The summary suspension shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department ~~chairman~~chairperson or by the Chief of Staff, considering where feasible the wishes of the patient in the choice of a substitute member.

6.3-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

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

6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

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

6.3-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension before it becomes reportable to the Medical Board of California or the National

Practitioners Data Bank, the member shall be entitled to the procedural rights afforded by Article VII.

6.3-5 INITIATION BY GOVERNING BODY

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

6.4 AUTOMATIC SUSPENSION OR LIMITATION

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

6.4-1 LICENSURE

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

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

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

6.4-2 CONTROLLED SUBSTANCES

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

(b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medication shall automatically become subject to

the same terms of the probation, as of the date such action becomes effective and throughout its term.

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

6.4-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

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

6.4-4 MEDICAL RECORDS

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

6.4-5 TUBERCULIN TESTING DOCUMENTATION

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

6.4-6 PROFESSIONAL LIABILITY INSURANCE

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

6.4-7 EXCLUSION FROM GOVERNMENTAL HEALTHCARE PROGRAM

In the event a member is excluded from participation in a government healthcare program, the member shall be automatically suspended. Such suspension shall remain in place until the member submits a plan, acceptable to the Medical Executive Committee and the

Governing Body, which permits the member to exercise privileges without subjecting the hospital to sanctions or denial of payment. Failure to submit an acceptable plan within ninety (90) days after written notice of suspension shall result in automatic termination.

6.5 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 6.4, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 6.2.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 EXHAUSTION OF REMEDIES

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

7.1-2 APPLICATION OF ARTICLE

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

7.1-3 SUBSTANTIAL COMPLIANCE

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

7.2 GROUNDS FOR HEARING

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

(a) Denial of Medical Staff membership.

(b) Denial of Medical Staff reappointment.

(c) Suspension of Medical Staff membership.

(d) Revocation of Medical Staff membership.

(e) Denial of requested clinical privileges.

(f) Involuntary reduction of current clinical privileges.

(g) Suspension of clinical privileges.

(h) Termination of all clinical privileges.

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

7.3 REQUEST FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, said person or body shall give the member prompt written notice of the recommendation or final proposed action and that such action, if adopted, shall be taken

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

7.3-2 REQUEST FOR HEARING

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

7.3-3 TIME AND PLACE FOR HEARING

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

7.3-4 NOTICE OF CHARGES

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

7.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee which shall be composed of not less than five (5) members of the Medical Staff who shall gain no direct financial benefit from the outcome, and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. The Medical Executive Committee may appoint members from either staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the ~~chairman~~chairperson. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused and, where feasible, include an individual practicing in the same specialty as the member. All other members shall have M.D. or D.O. degrees. At the discretion of the Medical Executive

Committee, an arbitrator or arbitrators, selected by a process mutually agreeable to the individual and the Medical Staff, may be utilized rather than a judicial review committee.

7.3-6 FAILURE TO APPEAR OR PROCEED

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

7.3-7 POSTPONEMENTS AND EXTENSIONS

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

7.4 HEARING PROCEDURE

7.4-1 PRE-HEARING PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

7.4-2 REPRESENTATION

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

7.4-3 THE HEARING OFFICER

Concurrent with his/her notice of appeal, the member shall submit a list of at least three (3) qualified persons the member would accept as a Hearing Officer. If none of the persons suggested by the member is acceptable to the Chief of Staff, the Chief of Staff shall within seven (7) days provide the member with the names of at least three (3) qualified persons to serve as a Hearing Officer. The member shall have seven (7) days to select a Hearing Officer from one of the names provided by the Chief of Staff. If the member fails to make a selection within the said seven (7) days, the Chief of Staff may select the Hearing Officer from his/her list. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, with prior experience as a Hearing

Officer in a hospital peer review matter, where feasible. Absent stipulation by the Chief of Staff and the member, attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer, nor shall a person who has served as a Hearing Officer at the Hospital in the prior two-year period. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. If a Hearing Officer selected by this process is disqualified for any reason, a replacement will be chosen by repeating the process described in this section.

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

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

7.4-4 RECORD OF THE HEARING

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

7.4-5 RIGHTS OF THE PARTIES

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

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of

law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

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

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

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

7.4-8 ADJOURNMENT AND CONCLUSION

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

7.4-9 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Chief Executive Officer, the Governing Body, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the

decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Medical Board of California and shall state the text of the report as agreed upon by the committee. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

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

7.5-2 GROUNDS FOR APPEAL

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

7.5-3 TIME, PLACE AND NOTICE

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

7.5-4 APPEAL BOARD

The Governing Body may sit as the appeal board, or it may appoint an appeal board, which shall be composed of not less than three (3) members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board shall select a Hearing Officer to assist in the proceeding, if requested by the appeal board. The Hearing Officer for the appeal shall generally have the qualifications and exercise the same duties and powers as set forth in the in Section 7.4-3 of these Bylaws. Any decision of the appeal Hearing Officer that

affects the substantive rights of the parties to the appeal is subject to review and reconsideration by the appeal board.

7.5-5 APPEAL PROCEDURE

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

7.5-6 DECISION

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

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

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

7.5-7 RIGHT TO ONE HEARING

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

7.6 EXCEPTIONS TO HEARING RIGHTS

7.6-1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS

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

7.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

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

7.7 NATIONAL PRACTITIONER DATA BANK REPORTING

7.7-1 ADVERSE ACTIONS

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

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

7.8 DISPUTING REPORT LANGUAGE

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

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

ARTICLE VIII: OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

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

8.2 QUALIFICATIONS OF OFFICERS

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

8.3 ELECTION OF OFFICER

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

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

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

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

8.4 TERM OF OFFICE

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

automatically assume the office of Immediate Past Chief of Staff (Treasurer), and the Chief of Staff-elect shall automatically assume the office of Chief of Staff. At the end of his/her term of office, the Immediate Past Chief of Staff shall automatically assume the office of the Past Chief of Staff (Secretary).

8.5 VACANCIES IN OFFICE

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

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

8.6 DUTIES OF OFFICERS

8.6-1 CHIEF OF STAFF (PRESIDENT)

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

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

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

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

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

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

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

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

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

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

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

(k) Attending all meetings of the Governing Body.

(l) Relieving any staff member, which he has appointed to a committee position for any reason.

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

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

8.6-3 IMMEDIATE PAST CHIEF OF STAFF (TREASURER)

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

8.6-4 PAST CHIEF OF STAFF (SECRETARY)

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

8.7 COMPENSATION OF MEDICAL STAFF

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

8.8 RECALL OF OFFICERS

8.8-1 INITIATION OF RECALL ACTION

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

8.8-2 REPLACEMENT OF OFFICER

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

ARTICLE IX: CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

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

9.2 CURRENT DEPARTMENTS AND DIVISIONS

The current departments and divisions are:

(a) Department of Anesthesiology

(b) Department of Family Medicine

(c) Department of Emergency Medicine

~~(1) Occupational Medicine Division~~

(d) Department of Medicine

(1) Cardiology Division

~~(2) Gastroenterology Division~~

~~(3)~~(2) ~~Internal~~ Medicine Division

a. Allergy & Immunology
b. Dermatology
c. Endocrinology
~~c.~~ d. Gastroenterology
e. Infectious Disease
~~d.~~ f. Internal Medicine
g. Nephrology
h. Neurology
~~e.~~ i. Oncology
j. Physiatry (Physical Medicine & Rehabilitation)
k. Pulmonary
~~f.~~ l. Psychiatry
~~g.~~ m. Rheumatology

~~(4) Oncology Division~~

~~(5) Psychiatry Division~~

~~(6) Pulmonary Division~~

~~(7) Neurology Division~~

(e) Department of Obstetrics-Gynecology

(f) Department of Pathology

(g) Department of Pediatrics

(1) Neonatology Division

(h) Department of Radiology

(i) Department of Surgery

(1) General and Vascular Surgery Division

a. General Surgery
b. Cardiothoracic Surgery ~~Division~~
c. Vascular Surgery

(2) Subspecialty Surgery Division

a. Neurosurgery
b. ~~Plastic and Reconstructive Surgery~~Ophthalmology
~~a.~~c. Orthopedic Surgery
~~b.~~d. Otolaryngology, Head and Neck Surgery
e. Oral and Maxillofacial Surgery and Dentistry
f. Podiatric Surgery
~~c.~~g. Urology

~~(3) Neurosurgery Division~~

~~(4) Ophthalmology Division~~

~~(5) Orthopedic Surgery Division~~

~~(6) Podiatric Surgery Division~~

~~(7) Urology Division~~

9.3 ASSIGNMENT OF DEPARTMENTS AND DIVISIONS

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

9.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting timely patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.5 FUNCTIONS OF DIVISIONS

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

9.6 DEPARTMENT CHAIR

9.6-1 QUALIFICATIONS

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

9.6-2 SELECTION

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

9.6-3 TERM OF OFFICE

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

9.6-4 REMOVAL

After election, removal of department ~~chairmen~~chairperson or vice-~~chairmen~~chairperson from office may occur for valid cause, including, but not limited to, gross neglect or

misfeasance in office, or serious acts of moral turpitude by a two-thirds (2/3) vote of the Medical Executive Committee and a two-thirds (2/3) vote of the department members eligible to vote on departmental matters who cast votes.

9.6-5 DUTIES

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

(a) Acting as presiding officer at department meetings.

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

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

~~(c)~~(d) Being responsible for the oversight of the OPPE Process within the Department for all members with Clinical Privileges.

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

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

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

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

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

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

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

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

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

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

(3) Recommending adequate space, supplies, and other resources needed by the department;

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

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

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

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

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

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

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

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

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

9.6-6 COMPENSATION OF DEPARTMENT CHAIRS

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

9.7 DIVISION CHIEFS

9.7-1 QUALIFICATIONS

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

9.7-2 SELECTIONS

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

9.7-3 TERM OF OFFICE

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

9.7-4 REMOVAL

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

9.7-5 DUTIES

Each division chief shall:

(a) Act as presiding officer at division meetings.

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

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

~~(c)~~(d) Being responsible for the oversight of the OPPE Process within the Department for all members with Clinical Privileges.

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

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

9.8 MEMBER-AT-LARGE, JOB DESCRIPTION

QUALIFICATIONS

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

SELECTIONS

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

TERM OF OFFICE

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

REMOVAL

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

DUTIES

Each Member-At Large shall:

(a) Attend the Medical Executive Committee Meetings
(b) Perform such other duties as may be delegated by the Chief of Staff/MEC

ARTICLE X: COMMITTEES

10.1 DESIGNATION

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

10.2 GENERAL PROVISIONS

10.2-1 TERM OF COMMITTEE

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

10.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if there is valid cause, including but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude, that member may be removed by the Chief of Staff. Removal of the ~~chairman~~chairperson of a committee against the ~~chairman~~chairperson's wishes must be ratified by a majority vote of the Medical Executive Committee.

10.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee may be filled by the Chief of Staff or his/her designee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

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

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

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

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

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

(e) ~~Chairman~~Chairperson of the Department of Anesthesiology

(f) ~~Chairman~~Chairperson of the Department of Emergency Medicine

(g) ~~Chairman~~Chairperson of the Department of Family Medicine

(h) ~~Chairman~~Chairperson of the Department of Radiology

(i) ~~Chairman~~Chairperson of the Department of Medicine

(j) ~~Chairman~~Chairperson of the Department of Obstetrics and Gynecology

~~(j)~~

(k) ~~Chairman~~Chairperson of the Department of Pathology

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

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

(n) ~~Chairman~~Chairperson of the ~~QA/PI/ Quality Peer Revie~~Medical Quality Peer Reviewww Committee

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

(p) Up to two Members-at-Large,

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

(c) Chief Executive Officer of the Hospital

(d) Chief Operating Officer

(e) Chief Nurse Executive

(f) Representative of the Governing Body

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

10.3-2 DUTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Establishing, criteria and standards for Medical Staff membership and privileges, and for enforcing those criteria and standards;

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

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

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

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

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

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

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

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

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

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

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

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

10.3-3 MEETINGS

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

10.4 CREDENTIALS COMMITTEE

10.4-1 COMPOSITION

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

10.4-2 DUTIES

The Credentials Committee shall:

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

(b) Obtain and consider the recommendations of the appropriate departments concerning appointment, reappointment, and clinical privileges.

(c) Submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations to the Medical Executive Committee with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions.

(d) Investigate, review, and report on matters referred by the Chief of Staff, the Medical Executive Committee, or the ~~Quality Assurance/Performance~~

~~Improvement~~Medical Quality Peer Review Committee regarding the qualifications, conduct, professional character, or competence of any applicant or Medical Staff member.

(e) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications for initial appointment, reappointment, and clinical privileges.

10.4-3 MEETINGS

The Credentials Committee shall meet as often as necessary, but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions.

10.5 BIOETHICS COMMITTEE

10.5-1 COMPOSITION

The Bioethics Committee shall be chaired by a member of the medical staff, and shall consist of physicians and such other staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Governing Body, although a majority shall be physician members of the Medical Staff.

10.5-2 DUTIES

The Bioethics Committee may participate in development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; education of the Hospital staff on bioethical matters; and oversee the development and implementation of policies related to patient rights and self-determination.

10.5-3 MEETINGS AND REPORTING

The Bioethics Committee shall meet as often as necessary but at least quarterly and maintain a permanent record of its proceedings and actions. The committee shall report to the Medical Executive Committee.

10.6 BLOOD UTILIZATION REVIEW COMMITTEE

10.6-1 COMPOSITION

The committee shall consist of members of high blood utilization groups, including a surgeon, anesthesiologist, internist/oncologist, obstetrician-gynecologist, and the Transfusion Services Director. Ancillary members may include Transfusion Service Supervisor and a QA representative. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.6-2 DUTIES

Duties: To monitor blood utilization to include:

(a) Observing transfusion and component-utilization practices

(b) Usage, including discard of components, following professional judgement & industry best practices;

(c) Appropriateness of use

(d) Blood Administration Policies

(e) Transfusion Reactions

(f) Ability of Service to meet patient need

(g) Compliance with Focused Practitioner Performance Review recommendations

10.6-3 MEETINGS

The committee shall meet at least quarterly and submit written reports to the ~~Quality Assurance/Performance~~Medical Quality Peer Review Committee ~~Improvement~~ and Medical Executive Committee~~s~~.

10.7 BYLAWS COMMITTEE

10.7-1 COMPOSITION

The committee shall consist of at least two members of the Medical Staff, at least one of whom shall be a prior Chief of Staff. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.7-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) Conducting an annual review of the Medical Staff bylaws, as well as the rules and regulations, policies and forms promulgated by the Medical Staff, its departments and divisions;

(b) Developing and submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect or improve current Medical Staff practices;

(c) Receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a); and

(d) Reviewing the hospital bylaws and policies for inconsistencies and conflicts with Medical Staff documents and reporting issues and recommendations to the Medical Executive Committee for its review.

10.7-3 MEETINGS

The committee shall meet as often as necessary, but at least annually, and report its findings and activities in written form to the Medical Executive Committee.

10.8 CANCER COMMITTEE

10.8-1 COMPOSITION

The committee shall include a general surgeon, a medical oncologist, a diagnostic radiologist, a radiation oncologist, a pathologist, a pain management specialist, and the Cancer Liaison Physician. It shall also include the cancer program administrator, an oncology nurse, a social worker/case manager, a performance improvement/quality management professional, and the certified tumor registrar. Others may be appointed as the Medical Executive Committee or its designee may deem appropriate, and in conformance with the membership requirements of the American College of Surgeons' Commission on Cancer. To assure continuity and to facilitate planning, the members shall be appointed to serve for a period of three (3) years and may serve consecutive terms.

10.8-2 DUTIES

The Cancer Committee shall be responsible for:

(a) Planning, initiating, implementing, evaluating, improving, and setting goals regarding all cancer related activities within the Hospital.

(b) Scheduling and conducting multi-disciplinary educational cancer conferences, the intent of which will be to provide consultative services in the form of a Tumor Board.

(c) Developing and carrying out a system of quality care evaluation with documentation of its operation.

10.8-3 MEETINGS

The committee shall meet at least quarterly . Written minutes of the meetings shall be kept and submitted to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.9 CONTINUING MEDICAL EDUCATION COMMITTEE

10.9-1 COMPOSITION

The committee shall consist of at least five (5) members of the Medical Staff. The members and ~~chairman~~chairperson may be appointed by the Chief of Staff for a term of three (3) years. Two members may be replaced annually. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.9-2 DUTIES

The committee shall:

(a) Submit a budget annually to the Medical Executive Committee for its approval, action, and disbursement of funds.

(b) Assist departments and divisions in planning and scheduling educational programs.

(c) Plan education programs for staff meetings and educational conferences.

(d) Approve all requests for CME credit for educational programs. Each request must include:

(1) Demonstration of need.

(2) Statement of objectives.

(3) Assessment of improvement.

(e) Be responsible for arranging staff education programs for training in cardiopulmonary resuscitation if requested by the Medical Executive Committee.

(f) Keep attendance records and provide each member with a report of credit hours on the member's request.

(g) Publish a monthly schedule of educational programs.

10.9-3 MEETINGS

The committee shall meet ~~quarterly~~ as needed and submit written reports of its activities to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.10 CRITICAL CARE COMMITTEE

10.10-1 COMPOSITION

The committee shall consist of at least one representative of the following specialties: family medicine, internal medicine, infectious diseases, cardiothoracic surgery, neurosurgery, pulmonary medicine, cardiology, general surgery, anesthesia, and gastroenterology. The committee shall also include the pulmonary function laboratory supervisor, the cardiac catheterization laboratory supervisor, the critical care unit head nurse(s), the telemetry unit supervisor, and the critical care education nurse. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.10-2 PURPOSE AND DUTIES

The purpose of the committee shall be to optimize care in the acute cardiac care setting.

The committee shall:

(a) Establish, review and update drug administration protocols.

(b) Establish, review and update standing treatment orders utilized in the critical care unit.

(c) Update and streamline Code Blue carts, including the addition of new and appropriate drugs and the deletion of old and inappropriate drugs.

(d) Establish, update, and revise Medical Staff protocols for various procedures.

(e) Make recommendations concerning nursing personnel utilization, particularly as relates to the manipulation of central lines.

(f) Revise and update admission and discharge criteria from the critical care unit, and revise and update transfer criteria from the critical care unit to outsider care facilities.

(g) Make recommendations concerning bed utilization in the critical care unit.

(h) Make recommendations concerning equipment procurement, utilization, and procedure protocols.

(i) Mediate Medical Staff-Nursing problems.

(j) Perform such other duties as assigned by the Medical Executive Committee.

10.10-3 MEETINGS

The committee shall meet quarterly and submit written reports to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.11 GRADUATE MEDICAL EDUCATION COMMITTEE

10.11-1 COMPOSITION

The Graduate Medical Education (GME) Committee shall consist of at least one supervising Medical Staff Member for each area where residents, medical students and/or fellows serve in rotation. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.11-2 DUTIES

The duties of the GME Committee shall include:

(a) Oversight of residents, medical students and/or fellows who rotate throughout patient care areas per Medical Staff Policy, *Supervision of Residents/ Fellows/Medical Students, 8710-513*, and *Supervision of Residents in Emergency Medicine, 8710-571*.

(b) Maintenance of appropriate schedules and policies and procedures pertaining to the residents, medical students and/or fellows.

(c) Review of quality of care provided to the patients by the residents, medical students and/or fellows.

10.11-3 MEETINGS

The GME Committee shall meet at the discretion of the ~~Chairman~~Chairperson, on an as needed basis or at least annually. The GME shall provide a report to the Medical Executive Committee regarding the safety, quality of care, performance, supervision and ongoing education needs of these practitioners.

10.12 INFECTION CONTROL COMMITTEE

10.12-1 COMPOSITION

The committee shall consist of at least one representative from each department of the Medical Staff, and a representative from each of the following areas: Administration, the nursing service, laboratory microbiology section, environmental services, central supply, engineering, dietary, pharmacy, operating room, and the infection control practitioner. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.12-2 DUTIES

Infections acquired in the Hospital or from the community are potential hazards for all persons having contact with the Hospital. Effective measures must be developed to prevent, identify, and control such infections. The Infection Control Committee shall recommend corrective action based on records and reports of infections and infection potentials among patients and Hospital personnel.

Basic elements of the program shall include:

(a) Definition of nosocomial infections.

(b) A system for reporting, evaluating, and maintaining records of infection among patients and personnel.

(c) Ongoing review of all aseptic and sanitation techniques in the Hospital.

(d) Specific written infection control policies and procedures for all services in the Hospital.

(e) Preventive surveillance and control procedures relating to the inanimate environment.

(f) Input into the content and scope of the employee health program.

(g) Coordination with the Medical Staff on actions relative to the findings from regular review of clinical use of antibiotics.

(h) Orientation and education of all Hospital personnel relative to infection prevention and control.

(i) Action as required to assess the effectiveness of the infection control program.

The committee or infection control nurse, consulting with the ~~chairman~~chairperson, may institute measures or control measures where there is reasonably considered to be a danger to any patient or to Hospital personnel from infectious diseases in hospitalized patients after discussing the action with the attending staff member.

Any patient admitted to the Hospital with a diagnosis requiring isolation, as determined by a previously approved list of isolatable diseases, will be admitted directly to appropriate isolation. Any patient who is found to have an isolatable disease after admission will be placed in appropriate isolation by either the attending physician or the

infection control nurse with the supervision of a physician member of the Infection Control Committee. If there is a disagreement between the attending physician and infection control nurse as to the level of appropriate isolation, arbitration and final decision shall be by the ~~chairman~~chairperson of the committee.

10.12-3 MEETINGS

The committee shall meet not less than quarterly, maintain a record of its proceedings and activities, and report to the ~~Quality Assurance/Performance Improvement~~ Medical Quality Peer Review Committee and Medical Executive Committee~~s~~ quarterly.

10.13 JOINT CONFERENCE COMMITTEE OF THE MEDICAL STAFF

10.13-1 COMPOSITION

The committee shall be composed of: (a) five physician members of the active medical staff to be appointed for terms of two years by the Medical Executive Committee (MEC), and who may be reappointed for additional terms; (b) two members of the Governing Body, to be recommended by the Governing Body Chair for one year terms; and (c) three members of hospital administration to be appointed by, and for a term determined by, the Chief Executive Officer. The medical staff members shall include: (1) a hospitalist, (2) one physician chosen from another hospital-based specialty, and (3) the Chief of Staff. The immediate past Chief of Staff shall serve as an alternate physician member.

10.13-2 DUTIES

The committee shall constitute a forum at which representatives drawn from the medical staff, the Governing Body, and hospital administration shall meet and confer on any issues that are of importance to any of the parties, to allow for open and fruitful discussion of respective positions, and for resolution of differences.

The committee is to have wide scope, and, amongst its other activities, it:

(a) Shall assist in the development of policy;

(b) Shall consider plans for future growth, or changes in hospital organization;

(c) Is intended to facilitate open communication, particularly as it relates to actions contemplated or taken;

(d) Shall discuss quality-of-care issues, or any matters of importance to the delivery of patient care;

(e) Shall discuss problems that may arise among the parties;

(f) Shall function as a liaison to facilitate communication on any matter among the Governing Body, the medical staff, and administration;

(g) Shall satisfy the meet and confer requirements of California Business & Professions Code Section 2282.5.

The committee shall reach its positions by a process of consensus, without the necessity of a formal vote. However, it may elect to do so by a decision of the committee in-toto.

10.13-3 MEETINGS

The committee shall meet as often as necessary to fulfill its responsibilities, but at least quarterly. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee. Any member of the committee may call for a meeting by contacting the Secretary of the committee, who shall then convene a meeting at the earliest opportunity of the members.

At its first meeting, and annually thereafter, the committee by consensus shall appoint a member to serve as its Secretary, who shall (1) anchor the meetings; (2) act as the recorder of its findings; and (3) prepare its written reports. The Secretary shall coordinate meetings, prepare agendas when applicable, and be the committee's contact individual for its members between meetings.

The Secretary shall prepare minutes of meetings when requested, to be later approved by the committee at-large at its next meeting. He/she shall transmit written reports of the committee's activities to the MEC and the Governing Body at the direction of, and with the content specified by, the committee.

10.14 QUALITY REVIEW COMMITTEES

10.14-1 COMPOSITION

With the approval of the Medical Executive Committee, Medical Staff departments may individually or jointly form one or more Quality Review Committees to perform all quality assessment and improvement activities as specified in Section 9.4. Members of a quality review committee shall be appointed from active members of the involved department(s) by the chairperson(s) of the involved department(s), subject to the approval of the Medical Executive Committee. Each Quality Review Committee shall be composed of at least four members. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate. The ~~chairman~~chairperson of each QRC shall serve as its department's representative on the Medical ~~Staff Quality Assurance/Performance Improvement~~Quality Peer Review Committee.

10.14-2 DUTIES

In addition to performing the quality assessment and improvement function specified in Section 9.4, each Quality Review Committee shall:

(a) Involve department members in identifying important aspects of care, including the indicators used to monitor care;

(b) Communicate, at least quarterly to the members of their departments, the relevant and significant findings, conclusions, recommendations, and actions taken by the Quality Review Committee.

10.14-3 MEETINGS

Quality Review Committees shall meet as often as necessary but at least quarterly. The committee shall report to the represented department chairpersons and the Medical Executive Committee through the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee at least quarterly.

10.15 LIBRARY COMMITTEE

10.15-1 COMPOSITION

The committee shall consist of three (3) members of the Medical Staff. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

10.15-2 DUTIES

The committee will identify needed library services, and act as an advocate to assure that these programs are enacted or supported. Committee members will assist the librarian to develop the library's book and periodical collections, identify subject area priorities, and provide expertise in various specialties and disciplines.

10.15-3 MEETINGS

The committee shall meet as needed and transmit written reports of its activities to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.16 NOMINATING COMMITTEE

10.16-1 COMPOSITION

The Medical Executive Committee and the four most recent past chiefs of staff shall serve as the Nominating Committee. The Immediate Past Chief of Staff shall serve as the ~~chairman~~chairperson of the Nominating Committee.

10.16-2 DUTIES

The committee shall nominate, from members of the active staff, a candidate for the biennial election of the Chief of Staff-elect (Vice President) of the Medical Staff.

10.16-3 MEETINGS

The committee shall meet biennially or as needed, and report the nominees for Medical Staff offices for announcement prior to the annual Medical Staff meeting.

10.17 OPERATING ROOM COMMITTEE

10.17-1 COMPOSITION

The committee shall consist of the ~~Chairman~~Chairperson of the Department of Surgery and three other members of the Department of Surgery appointed by the Chief of Staff; the ~~Chairman~~Chairperson of the Department of Anesthesia and one other member of the Department of Anesthesia appointed by the Chief of Staff; a member of the Department of Obstetrics and Gynecology appointed by the Chief of Staff; a

management representative of the Operating Room to be appointed by Administration; and a consultant from Administration to be appointed by the Chief Executive Officer. Other staff members may be appointed as the Medical Executive Committee or its designee may deem appropriate.

~~Chairman~~Chairpersonship of the committee shall be alternated between the Surgery and Anesthesia Departments on alternate years. Members of the committee shall serve for a period of two years. Each physician member shall vote with decisions of the committee effective immediately subject to later ratification, revision, or revocation by the Medical Executive Committee.

10.17-2 DUTIES

The committee shall:

(a) Conduct a periodic review of policies governing the scheduling of elective and emergency procedures, and submit recommendations for change to the Medical Executive Committee.

(b) Investigate and evaluate individual infractions of established policies.

(c) Function as liaison between Operating Room personnel and Medical Staff members in operational matters such as scheduling, equipment, and other matters affecting the proper and efficient functioning of the Operating Rooms.

10.17-3 MEETINGS

The committee shall meet at least every other month in addition to any meetings called by a minimum of two committee members. Written reports shall be transmitted to the ~~Quality Assurance/Performance~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.18 PHARMACY AND THERAPEUTICS COMMITTEE

10.18-1 COMPOSITION

The committee shall consist of at least five (5) members of the Medical Staff, one or more members from (a) the pharmacy service, (b) nursing administration, (c) the Chief Nurse Executive or representative, (d) the Infection Control Practitioner, and (e) the Hospital Chief Executive Officer or representative. Other staff members may be appointed as the Medical Executive Committee or its designee deem appropriate.

10.18-2 DUTIES

(a) Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard.

(b) Assist in the formation of broad professional policies regarding the evaluation, appraisal,

(c) Serve as an advisory group to the Hospital staff and the pharmacist on matters pertaining to the choice of available drugs.

(d) Make recommendations concerning drugs to be stocked on nursing units and by other services.

(e) Develop and periodically review a formulary or drug list for use in the hospital.

(f) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

(g) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(h) Establish standards concerning the use, control, and proctoring of investigational drugs and research in the use of recognized drugs.

(i) Review all significant untoward drug reactions.

(j) Review the appropriateness of empiric and therapeutic use of drugs.

(k) Review of antibiogram and appropriate antibiotics for the formulary.

(l) Responsible for the analysis of individual or aggregate patterns of drug practice.

10.18-3 MEETINGS

The committee shall meet at least quarterly and submit written reports of its activities to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.19 PHYSICIANS' WELL BEING COMMITTEE

10.19-1 PURPOSE

The Medical Staff recognizes its obligation to protect patients, its members, and other persons in the hospital from harm. This Committee is designed to provide education about member health; address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of members who suffer from a potentially impairing condition. The purpose of the process is to facilitate the rehabilitation by assisting a member to retain and to regain optimal professional functioning consistent with the protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a member is unable to safely perform the privileges granted, the matter is forwarded for appropriate corrective action. Refer to Medical Staff Policy, ~~*TCMC*~~ *TCHD Well-Being Policy, 8710-511.*

10.19-2 COMPOSITION

The committee will consist of at least four (4) members of the Medical Staff who are well read and well versed in the problems of the well-being of members, Appointment of a member to the Committee may be done only after consultation with the Chair of the Committee. In so far as possible, members of this committee shall not serve as active

participants on other peer review or quality assessment and improvement committees while serving on this committee.

10.19-3 FUNCTIONS

The committee's functions are to:

(a) Educate members and hospital staff about illness and impairment recognition issues specific to members.

(b) Receive self-referrals by members.

(c) Verify reported problems suggesting member dysfunction, make assessments of the validity of evidence, and as directed by the Well Being Committee ~~Chairman~~Chairperson, report those findings to the Medical Executive Committee when the practitioner is providing or at risk of providing, unsafe treatment. Receive referrals by others and maintain informant confidentiality.

(d) Assure the protection of the public at large, as well as the impaired member. This will be done by making appropriate recommendations to the Medical Executive Committee. Refer members to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

(e) Evaluate the credibility of a complaint, allegation, or concern.

(f) Monitor the member and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

(g) Report quarterly to the Medical Executive Committee and the Governing Body instances in which a member is providing unsafe treatment.

(h) Initiate appropriate actions when a member fails to complete the required program.

10.20 MEDICAL QUALITY PEER REVIEW COMMITTEE

10.20-1 COMPOSITION

The committee shall consist of a physician ~~chairman~~chairperson, selected by the Chief of Staff; and a member and an alternate member elected by each department. The alternate member shall attend Medical Quality Peer Review Committee meetings in the member's absence. All department ~~chairmen~~chairperson, Medical Staff committee ~~chairmen~~chairperson, and the Director of Patient Care Review will be asked to attend and participate in committee functions when appropriate and will serve in an ad hoc capacity.
With the approval of the Chief of Staff, up to two additional physicians may be appointed by the committee chair to promote committee priorities. The Chief of Staff shall have the authority to remove the ~~chairman~~chairperson and appoint a new ~~chairman~~chairperson prior to expiration of the one (1) year term, subject to approval of the Medical Executive Committee.

10.20-2 DUTIES

The Medical Quality Peer Review Committee shall perform the following duties:

(a) Accept responsibility and accountability for that portion of the overall quality assurance/performance improvement program developed by the Governing Body and Administration, which is related to the Medical Staff including but not limited to, evaluation of the accuracy, timeliness and completion of medical records.

(b) Recommend plans for improving and sustaining quality patient care on an ongoing basis within the Hospital to the Medical Executive Committee for approval. These may include mechanisms to:

(1) Evaluate opportunities for improvement in patient care and patient safety (medical errors).

(2) Evaluate priorities for action on opportunities for improvement.

(3) Refer opportunities for improvement for assessment and for corrective action to appropriate departments, divisions, or committees.

(4) Evaluate the results of quality assurance, performance improvement, safety activities, and patient satisfaction throughout the Hospital to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements.

(5) Review and track medical errors and adverse patient events. Causal factors related to the Medical Staff are referred per # 3.

(6) Review and evaluate the activities of subcommittees for department and division quality review and hospital-wide quality assessment and performance improvement activities, directly or through its subcommittee(s).

(7) Evaluate the quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.

(c) Submit regular confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality review activities conducted.

(d) Delegate specific responsibilities to and receive reports from the Quality Assessment/Performance Improvement Committee.

10.20-3 MEETINGS

The committee shall meet as often as necessary at the call of its ~~chairman~~chairperson, but at least ten times annually. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Governing Body, except that routine reports to the Governing Body shall not include Focused Practitioner Performance Review evaluations related to individual Medical Staff members.

10.21 QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT COMMITTEE

10.21-1 COMPOSITION

The committee shall consist of the Medical Peer Review Committee physician ~~chairman~~chairperson with representation from medical staff, nursing, ancillary, and administration as determined by the Medical Quality Peer Review Committee Chair in consultation with the Chief of Staff.

10.21-2 DUTIES

The Quality Assurance/Performance Improvement (QA/PI) Committee shall perform the following duties:

Recommend plans for improving and sustaining quality patient care on an ongoing basis within the Hospital to the Medical Quality Peer Review Committee for approval. These may include mechanisms to:

1) Establish systems to identify opportunities for improvement in patient care and patient safety (medical errors).

2) Set priorities for action on opportunities for improvement.

3) Refer opportunities for improvement.

4) Track, analyze and submit the results of quality assurance, performance improvement, safety activities, and patient satisfaction throughout the Hospital to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements.

5) Review adverse patient events.

6) Coordinate quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.

7) Accept specific responsibilities as delegated by the Medical Quality Peer Review Committee.

8) Submit regular confidential reports to the Medical Quality Peer Review Committee on quality review activities conducted.

10.21-3 MEETINGS

The committee shall meet as often as necessary at the call of its ~~chairman~~chairperson, but at least ten times annually. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Quality Peer Review Committee.

10.22 TISSUE COMMITTEE

10.22-1 COMPOSITION

The committee shall consist of a pathologist, a radiologist, a gynecologist, a general surgeon, and at least two representatives of other surgery subspecialties. Other staff members may be appointed as the Medical Executive Committee or its designee deem appropriate.

10.22-2 DUTIES AND RESPONSIBILITIES

The committee shall be responsible for:

(a) Reviewing all surgical cases in which a specimen (tissue or non-tissue) is removed, as well as all cases in which no specimen is removed.

(b) Evaluating the pre-operative and post-operative diagnosis and referring cases in which discrepancies occur to the appropriate department for review resolution.

(c) Maintaining written evidence of tissue review findings.

(d) Referring pertinent problem cases to the Medical Executive Committee.

10.22-3 MEETINGS

The committee shall meet ~~at least quarterly~~as needed and submit written reports to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.23 UTILIZATION REVIEW COMMITTEE

10.23-1 COMPOSITION

The committee shall consist of at least five (5) members of the Medical Staff.

10.23-2 DUTIES

The duties of the committee shall be to:

(a) Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services, and related factors which may contribute to the effective utilization of services.

(b) Work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital.

(c) Communicate the results of its studies and other pertinent data to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~. It shall make recommendations to these committees for the optimum utilization of Hospital resources and facilities commensurate with maintenance of high quality patient care.

10.23-3 MEETINGS

The committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a quarterly report thereof to the ~~Quality Assurance/Performance Improvement~~Medical Quality Peer Review Committee and Medical Executive Committee~~s~~.

10.24 INTERDISCIPLINARY PRACTICE COMMITTEE

10.24-1 COMPOSITION

The committee shall include as a minimum of the ~~chairman~~chairperson, the Chief Nurse Executive or designee, the Chief Executive Officer or designee and an equal number of physicians appointed by the Medical Executive Committee and registered nurses appointed by the Chief Nursing Executive. Additionally, licensed or certified health professionals who are performing functions requiring standardized procedures may be appointed by the Chief of Staff or his/her designee.

10.24-2 DUTIES

The Interdisciplinary Practice Committee (IDPC) shall perform functions consistent with the requirements of law and regulation. The IDPC shall routinely report to the Governing Body through the Medical Executive Committee and, in addition, shall submit an annual report to the Governing Body and the Medical Executive Committee.

The IPC shall establish written policies and procedures for, but not limited to:

(a) Reviewing and approving standardized procedures in accordance with Section 2725 of the Business and Professions Code.

(b) Approving recommendation from Department(s) and Division(s) for adding Allied Health Professional Categories within their respective rules and regulations.

(c) Reviewing as appropriate any clinical care provided to patients by an Allied Health Professional to ensure competency.

(d) Intended line of approval for each recommendation of the committee.

(e) The committee shall be responsible for identifying functions and/or procedures, which require the formation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by Registered Nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this Section.

(f) The committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to Registered Nurses and to Physician Assistants, whether or not employed by the facility, and to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in a licensed health facility.

10.24-3 MEETINGS

The IDPC shall meet at the call of the ~~chairman~~chairperson at such intervals as the ~~chairman~~chairperson of the Medical Executive Committee may deem appropriate, but at least annually.

10.25 PROFESSIONAL BEHAVIOR COMMITTEE

10.25-1 COMPOSITION

The committee shall act as a sub-committee appointed by the Medical Executive Committee as per the Medical Staff Professional Behavior Policy.

10.25-2 DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Professional Behavior Committee are defined in Medical Staff Policy, ~~*TCMC*~~ *TCHD Professional Behavior Policy, 8710-511*, and include, but are not limited to:

(a) Reviewing all documentation and determining appropriate action(s) regarding issues not resolved by prior interventions as defined in *Professional Behavior Policy, 8710-570*;

(b) Recommending any such appropriate action(s) to the Medical Executive Committee;

(c) Maintaining confidential records of recommendations, and;

(d) Providing non-confidential feedback as appropriate.

(e) Reporting periodically to the Medical Executive Committee.

10.25-3 MEETINGS

The committee shall meet as necessary.

ARTICLE XI: MEETINGS AND ATTENDANCE

11.1 MEDICAL STAFF MEETINGS

11.1-1 REGULAR MEETINGS

An annual staff meeting shall be held within thirty (30) days of the end of the staff year (the staff year ends June 30). The agenda for such meetings shall include reports of review and evaluation of the work done in the clinical departments and the performance of required Medical Staff functions. If the Medical Staff chooses, they may conduct regular meetings on a more frequent basis.

11.1-2 SPECIAL MEETINGS

The Chief of Staff or the Medical Executive Committee may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within fifteen (15) days after receiving a written request for same signed by not less than one-fourth of the members of the active staff and stating the purpose of such meeting. The Chief of Staff shall designate the time and place of any special meeting, after consultation with the Medical Executive Committee. Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the active staff not less than one week nor more than one month before the day of such meeting by, or at the direction of, the Chief of Staff or other persons authorized to call the meetings. If mailed, the notice of the meeting shall be deemed delivered if deposited, postage prepaid, in the United States mail and addressed to each staff member.

11.1-3 QUORUM

The presence of twenty-five (25%) percent of the total membership of the active staff at any regular or special Medical Staff meeting shall constitute a quorum.

11.1-4 VOTING

For regular and special Medical Staff meetings, Medical Staff members entitled to vote may do so either in person or by written proxy executed by the person and filed with the Medical Staff Office, provided, however, that no voting member shall enter into a proxy arrangement with any person other than another licensed physician entitled to vote.

11.2 MEETINGS OF DEPARTMENTS, DIVISIONS AND COMMITTEES

11.2-1 SPECIAL MEETINGS

Special meetings may be called in addition to the regular meetings as provided in the Bylaws. A special meeting of any department, division, or committee may be called by or at the request of the ~~chairman~~chairperson, or by one-third of the members, but not by less than two members. Notice of such meeting shall be as provided above for the Medical Staff meeting notices.

11.2-2 QUORUM

(a) Definition of a Quorum

At special meetings of the Medical Staff and at the General Medical Staff meetings, fifty-one percent (51%) of those Active members present shall constitute a quorum to vote on an action item. Quorum requirements for the MEC and QAPI Committee shall require at least 51% of voting members to vote on an action. Quorum requirement for all other medical staff meeting shall be recognized when at least 3 voting members are present to vote on an action item.

(b) Voting Rights

Persons serving under these Bylaws as ex officio members of a committee have all rights and privileges of regular members except that they shall not be counted in determining the existence of a quorum and shall have no vote.

11.2-3 MINUTES

Minutes of each regular or special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on the matter. The minutes shall be signed by the presiding officer or member secretary and copies thereof shall be submitted to the Medical Staff office and then forwarded to the Medical Executive Committee.

11.2-4 REQUIRED ATTENDANCE

At the discretion of the ~~chairman~~chairperson, when a member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting, with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

11.2-5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference or other electronic communication which shall be deemed to constitute a meeting for the matters discussed in that telephone conference or other electronic communication. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least a simple majority of the members voting.

11.2-6 RIGHTS OF EX-OFFICIO MEMBERS

Except as otherwise provided in these Bylaws, persons serving as ex-officio members of a Committee shall have all privileges of regular members except they shall not vote or be counted in determining a quorum.

ARTICLE XII: CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital an applicant:

(a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.

(b) Authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff.

(c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this Article.

(d) Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

(a) Records and proceedings of all Medical Staff committees have the responsibility for evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article X, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to Section 10.1) or by departments (pursuant to Section 9.4 (i), and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

(b) The Medical Staff shall develop a "Medical Staff Focused Practitioner Performance Review Activity Confidentiality Agreement" and require each member who is asked to participate in Focused Practitioner Performance Review activities on behalf of the Medical Staff to execute such an agreement if, in the opinion of the Medical Executive Committee, such an agreement is necessary to preserve the confidentiality of the Medical Staff information.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective Peer Review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other hospitals, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or Hospital.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

12.3-3 LIABILITY INSURANCE COVERAGE

The Tri-City Hospital District shall, at its expense, provide liability insurance coverage for all acts of duly appointed officers and committee members performed in good faith in an amount not to be less than $1,000,000.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

The confidentiality and immunity provided by this article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

(a) Applications for appointment, reappointment, or clinical privileges.

(b) Corrective action.

(c) Hearings and appellate reviews.

(d) Utilization reviews.

(e) Other department, or division, committee, or Medical Staff activities related to proctoring and maintaining quality patient care and appropriate professional conduct.

(f) Focused Practitioner Performance Review organizations, Medical Board of California, and similar reports.

12.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 INDEMNIFICATION

The Tri-City Healthcare District shall defend, indemnify, and hold harmless the Medical Staff and its individual members from and against attorneys' fees, judgments, settlements (to which the Tri-City Healthcare District has agreed), and court-awarded costs incurred or suffered by reason of or based upon any claim, action, special proceedings, administrative proceeding, or arbitration brought by a third party relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities on behalf of the Tri-City Healthcare District, including, but not limited to, service (1) as a member of or witness for a Tri-City Healthcare District Medical Staff department, service, committee or hearing panel, (2) as a member of or witness for the Tri-City Healthcare District Board of directors or any Tri-City Healthcare District hospital task force, group, or committee, and (3) as a person providing information to any Tri-City Healthcare District hospital or Medical Staff officer or committee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member, past Medical Staff member, or applicant with respect to any Tri-City Healthcare District medical facility or operation. The Medical Staff or member may seek defense and indemnification for such losses and expenses in accordance with this bylaw provision and Tri-City Healthcare District policy. Payment of any losses or expenses as set forth herein by the Medical Staff or member is not a condition precedent to the Tri-City Healthcare District's defense and indemnification obligations hereunder.

The Tri-City Healthcare District's indemnification obligation shall include payment of any part of a judgment that is for punitive or exemplary damages if the Tri-City Healthcare District, acting in its sole reasonable discretion and exercising independent judgment after providing the Medical Staff member a reasonable opportunity to present relevant evidence and information on the issues, finds the following:

(a) The judgment is based on an act or omission of the Medical Staff or member acting within the course and scope of peer review or quality assessment activities as defined above; and

(b) At the time of the act or omission giving rise to the liability, the Medical Staff's or member's act or omission was in good faith, without actual malice and in the apparent best interests of the Tri-City Healthcare District; and

(c) Payment of the claim or judgment would be in the best interests of the Tri-City Healthcare District.

Any dispute between the Medical Staff or member and the Tri-City Healthcare District regarding defense and indemnification under this bylaw provision and/or District policy shall be resolved by binding arbitration pursuant to the laws of the State of California, Code of Civil Procedure § 1280 et. seq. The parties agree that the arbitrator shall interpret this bylaw provision and District policy as a whole and not inconsistent with each other to the greatest extent possible.

ARTICLE XIII: GENERAL PROVISIONS

13.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such rules and regulations as it may deem desirable for the proper conduct of its work and shall review every two years and revise (if necessary) its Rules and Regulations to comply with current Medical Staff practice. Upon the request of (1) the Medical Executive Committee, or the Chief of Staff or the bylaws committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least 10% of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of Medical Staff rules and regulations. Such action shall be taken at a regular or special meeting of the Medical Staff, provided notice of the next regular or special meeting at which action is to be taken included notice that a rules or regulations change would be considered. The notice shall include the exact wording of the existing language of the rule(s) or regulation(s), if any, and the proposed change(s) and that there be a 30-day period for responding to submission of petitions. Following adoption such rules and regulations shall become effective upon approval of the Governing Body, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Rules and Regulations. "Temporary Rules and Regulations" may be put into place by the Medical Executive Committee while waiting for a vote by the Medical Staff. This will allow changes to be made when necessary, but subject to final approval by the Medical Staff.

Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between Bylaws and the Rules and Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations. Members of the Medical Staff shall be given written notice of new adopted Rules and Regulations.

13.2 DUES ASSESSMENTS

Reasonable dues shall be assessed members of the Medical Staff in an amount to be determined by the Medical Executive Committee each year. The Medical Staff will use such dues as appropriate for its purposes. Such dues shall be due and payable at the time of each member's biennial reappointment. Application for reappointment will be considered as incomplete if dues (or other fines or assessments) are not paid within the time frame described in Section 4.6-5 and the member is deemed to be voluntarily resigned without the rights to a hearing as described in Section VII. If a delinquent staff member is voluntarily resigned for non-payment of dues, he will incur the cost and process of a new application should he desire to reinstate his membership.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of the Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

13.4 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

13.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

13.6 NOTICES

Except where specific notice provisions are otherwise provided in the Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof shall be addressed as following:

Name and proper title of addressee, if known or applicable
Name of Department, Division or Committee
c/o Medical Staff Manager / Chief of Staff
Tri-City Medical Center
4002 Vista Way
Oceanside, California 92056

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

13.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of the election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

13.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state and national Hospital Medical Staff sections should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by the Nominating Committee.

13.9 MEDICAL STAFF CREDENTIALS FILES

13.9-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

(a) As stated previously in Section 6.1-1, any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

(b) When a request is made for insertion of adverse information into the Medical Staff member's credentials file, the respective department ~~chairman~~chairperson, and Chief of Staff shall review such a request.

(c) After such review a decision will be made by the respective department ~~chairman~~chairperson and Chief of Staff to:

(1) Not insert the information;

(2) Notify the member of the adverse information by a written summary and offer him the opportunity to rebut this assertion before it is entered into this file; or

(3) Insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Section 6.1-2 of these Bylaws.

(d) If adverse information is inserted into a member's file, the member shall be promptly notified and shall have an opportunity to address the Medical Executive Committee and submit contrary information. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions by a majority vote.

13.9-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

The following applies to the review of adverse information in the Medical Staff member's credential's file at the time of reappraisal or reappointment.

(a) Prior to recommendation on reappointment, the Credentials Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

(b) Following this review, the Credentials Committee shall determine whether documentation in the file warrants further action.

(c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.

(d) However, if an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.

(e) No later than sixty (60) days following final action on reappointment, the Medical Executive Committee shall, except as provided in (g):

(1) Initiate a request for corrective action, based on such adverse information and on the credential's committee's recommendation relating thereto, or

(2) Cause the substance of such adverse information to be summarized and disclosed to the member.

(f) The member shall have the right to respond thereto in writing, and the Medical Executive Committee may elect to remove such adverse information on the basis of such response.

(g) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be

removed from the file and discarded, unless the Medical Executive Committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:

(1) Character;

(2) Competence; or

(3) Professional performance.

13.9-3 CONFIDENTIALITY

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the Governing Body of the Hospital or its appointed representatives—in order that the Governing Body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.

(d) Information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff, professional licensing board, or as required by law.

(e) A Medical Staff member shall be granted access to his own credentials file, subject to the following provisions:

(1) Timely notice of such shall be made by the member to the Chief of Staff or his/her designee;

(2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information-including Focused Practitioner Performance Review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member in writing by the designated officer of the Medical Staff within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized.

(3) The review by the member shall take place in the Medical Staff office during normal work hours, with an officer or designee of the Medical Staff present.

13.9-4 MEMBERS' OPPORTUNITY TO REQUEST CORRECTION/DELETION AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) When a member has reviewed his file as provided under Section 13.8-3(e), he may address to the Chief of Staff a written request for correction or deletion of information in his credentials file. Such request shall include a statement of the basis for the action requested.

(b) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation by a majority vote.

(c) The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

(d) In any case, a member shall have the right to add to his own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

13.10 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

13.10-1 In the event of a disagreement between the Medical Executive Committee and the Hospital regarding an exclusive contract arrangement, the Medical Executive Committee may review and make recommendations to the Governing Body regarding all quality of care issues related to exclusive arrangements for physician and/or professional services. Such arrangements include:

(a) execution of an exclusive contract in a previously open department or service;

(b) renewal or modification of an exclusive contract in a department or service;

(c) termination of an exclusive contract in a department or service; and

(d) the execution, renewal, or termination of any exclusive vendor or prime vendor contract for medical supplies or equipment.

13.10-2 The Medical Executive Committee may conduct a notice and comment hearing to assess the quality of care issues related to such arrangement. The results of any such hearing shall be reported to the Governing Body.

13.10-3 The Governing Body shall give great weight to the recommendations of the Medical Executive Committee on quality of care issues; and

13.11 RETALIATION PROHIBITED

(a) Neither the Medical Staff, its members, committees or department chairs, division chiefs, the Governing Body, its chief administrative officer, or any other employee or agent of the hospital or Medical Staff, may engage in any punitive or retaliatory action against any member of the Medical Staff because that member claims a right or privilege afforded by or seeks implementation of any provision of these Medical Staff bylaws.

(b) The Medical Staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for

medically appropriate health care for his or her patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients. No person, including but not limited to the Medical Staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict, or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.

(c) This section does not preclude corrective and/or disciplinary action as authorized by these Medical Staff bylaws.

13.12 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the Medical Staff, or of the Medical Executive Committee acting on its behalf, the Medical Staff may retain and be represented by independent legal counsel.

ARTICLE XIV: ADOPTION AND AMENDMENT OF BYLAW

14.1 PROCEDURE

Upon the request of the Bylaws Committee, the Chief of Staff, and Medical Executive Committee, or upon timely written petition signed by at least 10% of the members of the Medical Staff in good standing who are entitled to vote at Medical Staff meetings, consideration will be given to the recommendation to the Governing Body regarding the adoption, amendment, or repeal of these Bylaws. Such adoption, amendment, or repeal of the Bylaws may be acted upon following introduction of the proposed action at a Medical Staff meeting or by mail ballot or by electronic method the proposed action to each staff member entitled to vote at least 10 days prior to a scheduled staff meeting. Such introduction shall include the exact wording of existing Bylaws language, if any, and the proposed change(s).

14.2 ACTION OF BYLAW CHANGE

Discussion and vote on adoption, amendment, or repeal of Bylaws shall take place at the next Medical Staff meeting following introduction as outline in 14.1. In this instance, a quorum of voting members must be present for the purpose of enacting a Bylaws change. In addition, and as an alternative method, balloting may occur electronically by the use of a verifiable e-mail sent to the Director of the Medical Staff Office. The change shall require an affirmative majority vote of the members voting at a meeting in person or by electronic ballot.

14.3 APPROVAL

Bylaws changes adopted by the Medical Staff shall become effective following approval by the Governing Body, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Medical Staff Bylaws. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee, and the Bylaws Committee.

14.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 UPDATING BYLAWS AND RULES AND REGULATIONS

At the end of each year the staff secretary shall make certain that all amendments to the Bylaws and Rules and Regulations, which have been made during the year, are added to the Bylaws and Rules and Regulations. Review of the Medical Staff Bylaws and Rules and Regulations should also ascertain that they do not conflict with the Governing Body's bylaws.

14.6 EFFECT OF THE BYLAWS

Upon adoption and approval as provided in Article XIV, in consideration of the mutual promises and agreements contained in these bylaws, the hospital and the Medical Staff, intending to be legally bound, agree that these bylaws constitute part of the contractual relationship existing between the hospital and the Medical Staff members, both individually and collectively.

14.7 SUCCESSOR IN INTEREST/AFFILIATIONS

14.7-1 Successor in Interest

These bylaws, and privileges of individual members of the Medical Staff accorded under these bylaws, will be binding upon the Medical Staff, and the Governing Body of any

successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the Medical Staff shall work together to develop new bylaws, which will govern the combined medical staffs, subject to the approval of the hospital's Governing Body or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

14.7-2 Affiliations

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

TRI-CITY MEDICAL CENTER
RULES AND REGULATIONS

1. Meetings of the Medical Staff shall be held annually in June, unless otherwise designated by the Chief of Staff. There will be one additional General staff Meeting per Medical Staff year, to be held in the month of January.

2. Autopsies shall be performed by the Hospital pathologists at the request of the attending staff member. The following criteria identify deaths in which an autopsy may be encouraged:
   (a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
   (b) Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.
   (c) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
   (d) Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
   (e) All obstetrical deaths.
   (f) All pediatric deaths.
   (g) All cases of unusual death and of medical-legal and educational interest.

   Securing an autopsy will be performed according to the Patient Care Services Policy Manual, policy *Autopsy, Authorization of,* IV.P.4.

   It is the attending physicians responsibility upon notification of death to explain to the family the benefits and rational of an autopsy, the associated cost and offer them the opportunity to request or deny an autopsy.

   Refer to Department of Pathology Rules and Regulations for the Notification guidelines for an autopsy.

3. Patients shall be attended by their own private practitioners, who are members of the Medical Staff. Each attending member shall provide the name of an alternate who shall be a member of the Medical Staff qualified to manage the care/treatment needs of the attending member's patients. Assent of the named alternate will be obtained by the Medical Staff office. Applicants shall name an alternate as part of the application process. Patients requiring admission with no attending member shall be assigned to the physician on Emergency Department call that day. Members are not permitted to sign out to the Emergency Department.

4. Each department shall formulate its own Rules and Regulations, policies and procedures for approval by the Medical Executive Committee.

5. All orders for treatment shall be in writing. Medical Staff Policy *Medical Record Documentation Requirements, 8710-518*, sets forth in detail the standard for this regulation.

6. The Safety Officer will report at least annually, and more often as needed, to the Medical Executive Committee regarding Mass Casualty and/or Disaster Planning. His report will include recommended responsibilities of members of the Medical Staff. The Medical Executive Committee will inform the members of the Medical Staff at least annually of these assignments.

7. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded by the admitting member as soon after admission as possible.

8. Members admitting private patients shall give such information as is necessary to assure the protection of other patients from those who are a source of danger.

9. The Hospital shall admit patients suffering from all types of diseases except for those specifically excluded by state and county laws relative to a general hospital not having facilities for isolation of communicable diseases. Neuropsychiatric patients may be admitted only when proper facilities and care may be available.

10. A.M. admissions and outpatient surgery admissions must be arranged in accordance with the Hospital's Policies and Procedures.

11. Patients shall be discharged only on order of the attending member or his/her designee.

12. The attending member shall be held responsible for the preparation of a complete medical record for each patient as defined by the medical records committee. An abbreviated form, for transient admissions not exceeding 48 hours for minor procedures, may be used. For all other patients, a complete medical record shall include a discharge summary, which shall be completed within two weeks following the patient's discharge.

13. When the history and physical examination are not recorded on the chart before the time stated for the operation, a scheduled operation shall be canceled.

14. All original records are the property of the Hospital and shall not be taken away except for court order, subpoena, or statute. In cases of readmission of a patient, all previous records shall be available for the use of the attending member. This shall apply whether he is attended by the same member or not. When patients request a copy of their medical records, either a copy of the record or a pertinent summary may be provided.

15. Access to medical records for staff members in good standing for bona fide study and research shall be done in accordance with the Hospital's HIPAA policies. Subject to the discretion of the Chief Executive Officer and the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

16. All surgical operations and diagnostic procedures shall be performed with informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title 22.

17. All operations performed shall be fully described by the operating surgeon in his operative report, describing the technical procedures used, findings, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. The operative report shall be written or dictated immediately after surgery and is to be subsequently signed by the surgeon. If the operative report is dictated, a summary progress note must be written in the medical record immediately after the surgery to be available for the next level of care.

18. All tissues, foreign bodies or devices removed at operation shall be sent to the Hospital pathologist, who shall make such examination as he may consider necessary to establish his findings and/or arrive at a diagnosis. His authenticated report shall be made a part of the patient's medical record.

19. One member shall be designated as attending physician for each inpatient. The attending physician has overall responsibility for the medical care of his patient. When clinically appropriate, the attending physician may transfer his responsibilities to another qualified

physician member. The attending physician may also delegate specific aspects of the medical evaluation and treatment of his patient to another member. The attending physician documents the transfer or delegation of these responsibilities by written orders on the medical record. When care is transferred or delegated to a member for the performance of a surgery or procedure, post-operative care is also transferred or delegated. However, anesthesiologists may also appropriately participate in postoperative care.

20. Consultations:

Consultants

(a) A consultant must be qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of individual training, experience, and competence. The consultant must be a member of the Medical Staff or have Temporary Privileges.

(b) Essentials of a Consultation

A satisfactory consultation includes examination of the patient and medical records. An opinion signed by the consultant must be in the medical record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.

(c) Responsibility for Requesting Consultations

The attending member is responsible for requesting consultation when indicated. It is the duty of the Medical Staff, through its committees and departments, to make certain that members of the staff do not fail in the matter of calling consultants when needed. The member requesting consultation shall write his reasons for same on the order sheet or progress notes. If the consultant is to assume management of the case, this must be so designated on the order sheet.

(d) To assure that each patient is treated appropriately the following conditions will require a consultation from a qualified physician who is credentialed:

1. 5150 holds
2. Drug Overdoses
3. Suicide Attempts

Around-the-clock sitters are required for patients in categories (a) through (c) above, unless, in the opinion of the primary member of psychiatric consultant, such sitters are not required.

4. All patients on a ventilator for more than 48 hours must have a consultation by an intensivist or pulmonologist.
5. Hemorrhagic Strokes & Ischemic Strokes

21. Drugs used shall meet the standards of the Pharmacopoeia and National Formulary. New and unofficial drugs, with the exception of drugs for bona fide clinical investigations, may not be used. Exceptions to this rule shall be well justified and approved by the department and the Medical Executive Committee.

22. Rules and Regulations regarding stop orders on dangerous drugs and narcotics shall be formulated by the Pharmacy and Therapeutics Committee, with the approval of the Medical Executive Committee, and shall be found in the standing orders of the Hospital.

23. In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease or when the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

24. The member is in complete charge of the medical care and treatment given to his patient while in the Hospital. The Hospital has set certain guidelines and rules for the member to work within, and these have been established by the physicians themselves to insure a good level of patient care. However, the Hospital also has a responsibility to the patient, to all the doctors, and to the Governing Body to insure that these guidelines are followed for the good of all concerned.

    If a Registered Nurse has concern regarding an attending member's care or treatment of a Hospital patient, or if an attending member cannot be located within a reasonable time, she should notify her Nursing Supervisor or the Nursing Supervisor on duty.

    After notification, the Nursing Supervisor will first discuss this with the attending member if available, or his/her designee. She will then use her judgment as to whether the information should go to the Director of Nursing Service and/or Executive Medical Staff, utilizing the following order:

First:	~~Chairman~~Chairperson of Department(s) involved
Second:	Chief of Staff
Third:	Immediate Past Chief of Staff
Fourth:	Chief of Staff-elect

    The Nursing Supervisor will always notify the Director of Nursing Service of her actions directly or in writing.

25. Each member shall be required to attend 25 hours of CMA Category I education programs and submit a record to the Continuing Medical Education Committee annually as determined by the Credentials Committee.

26. Practitioners sixty (60) years of age or older and with at least 5 years of staff membership, or practitioners with twenty-five (25) years of staff membership at Tri-City Medical Center, may be exempted from the ED call with the approval of the Division Chief, Department Chair and the Medical Executive Committee.

27. Respiratory therapists designated by an associate director of the Cardiopulmonary Division may take telephone orders from staff members related to oxygen administration, inhalation therapy, ventilator adjustments, auctioning, and chest physical therapy. Orders transmitted by phone will be written on the patient order sheet with the respiratory therapist's signature and the printed name of the physician as soon as practical. The charge nurse will be informed of the new order immediately.

28. A member unable to practice because of physical or mental illness will notify his department ~~chairman~~chairperson. Inability to practice for a period of three months will automatically result in a leave of absence status as defined in Section 4.7 of the Medical Staff Bylaws.

29. Non-approved symbols and abbreviations may not be used in patient charts. The Medical Records Department maintains the non-approved listing.

30. Member privileges for treating patients in the intensive care units are identical to their privileges throughout the Hospital. Generally, these admission criteria include patients requiring monitoring, as well as those non-monitored patients who require continuous observation and skilled, specialized nursing care.

31. Daily progress notes must be written by the attending member on all acute patients in the acute care setting. Refer to Medical Staff Policy, *Medical Record Documentation Requirement Policy, 8710-518*, or its successors.

    An exception to the above rule will be mental health unit patients, on whom progress notes will be written six days per week by the attending member.

32. When serving on the Emergency Department call roster, each member shall respond to requests from the Emergency Department as referenced in Medical Staff Policy, *Emergency Room Call: Duties of the On-Call Physician, 8710-520*. Each department/division may specifically define the Emergency Department call for its area of specialty in its own department/division rules and regulations.

33. Sedation shall be a specifically delineated privilege as moderate or deep sedation. Any and all members of the Medical Staff shall be granted and re-granted privileges to perform sedation in accordance with the Medical Staff Policy, *Criteria for Granting Adult and Pediatric Sedation/Analgesia Privileges Policy and Procedure, 8710-517.*

34. Prior to either side asserting its legal rights under section 2282.5 of the Business and Professional Code with respect to any dispute arising under this section, the Medical Staff and the hospital governing board shall meet and confer in good faith to resolve the dispute. Furthermore, if the dispute is not resolved prior to seeking court intervention, the parties will submit the dispute to non-binding mediation, the procedure of which will be explained in supplemental regulations.

35. Maximal sterile precautions will be used during insertion of Central Venous Catheters (including Peripherally Inserted Central Catheters) or guidewire exchanges. Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet.

36. In addition to physicians, the following persons may perform Medical Screening Exam as that term is defined in the Medical Staff Policy *Emergency Room Call: Duties of the On-Call Physicians, 8710-520*:

    (a) In the Emergency Department: by a Physician Assistant who has been determined to be qualified and experienced and as delegated by the supervising physician.
    (b) In the Labor and Delivery Unit: by a Registered Nurse who has determined to be qualified and experienced in obstetrical nursing and who is required to follow standardized procedures as approved by the Medical Staff.

BYLAWS: Revised ~~March 25, 2017~~August 22, 2018
ADOPTED by the Tri-City Medical Staff on:
Date: April 27, 2017
APPROVED by the Governing Body on:
Date: April 27, 2017

Tri-City Medical Center

Delineation of Privileges

Cardiology (Revised 1/19)

Provider Name:

Request	Privilege	Action MSO Use Only

Please check the box next to the privilege bundle(s) you wish to request. Please strike through any procedure within your requested bundle that you do not wish to request.

~~CRITERIA~~**BASIC QUALIFICATIONS:** The Division of Cardiology consists of physicians who are Board Certified in Cardiovascular disease by the American Board of Internal Medicine or are actively progressing toward certification.
Applicants who are progressing toward Board Certification must complete formal training prior to applying for medical staff membership in the Division of Cardiology and must become Board Certified within five (5) years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee.

By virtue of appointment to the Medical Staff, all physicians are authorized to perform occult blood testing and order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

COGNITIVE PRIVILEGES:

Initial Requirement: Must meet basic qualifications as outlined above.
Proctoring Requirement: A minimum of 6 cases proctored resulting in any combination of H&P'sand/or Consultations.
Reappointment Criteria: Documentation of 6 cases within the past two years is required.

___ Admission of a Patient to Inpatient Services ___

___ Performance of a History and Physical Examination, including via telemedicine ___

___ Performance of a Cardiac Consultation, including via telemedicine ___

___ Operation of Fluoroscopy Equipment ___
Prerequisite Criteria: Requires Current Fluoroscopy certificate.

ALLIED HEALTH PRACTITIONER SUPERVISOR PRIVILEGES

___ Supervision of an approved category of Allied Health Practitioner ___

SEDATION/ANALGESIAPRIVILEGES:

___ Moderate Sedation/Analgesia ___

Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

___ Deep Sedation Sedation/Analgesia ___
Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

BASIC INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and have performed at least four (4) of each privilege requested within the previous 24 month period is required.
Proctoring Requirements: One(1) of each privilege requested.
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of four (4)cases of each procedure requested within the previous 24 month period is required.

___ Venous cut-down & Percutaneous Central Venous Pressure Catheters ___

___ Insertion of Temporary Transvenous Cardiac Pacemaker ___

___ Elective Cardioversion ___

Tri-City Medical Center
Delineation of Privileges
Cardiology (Revised 1/19)

Provider Name:

Request	Privilege	Action MSO Use Only

— Swan-Ganz Catheter Insertion & Monitoring —

CARDIAC CATHETERIZATION PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and provide training and show current competency of have performed at least three-hundred (300) cases; if more than 12 months since completion of training, documentation of forty (40) cases within two (2) years prior to application is required.
Proctoring Requirements: Five (5) cases
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of forty (40)cases within the previous 24 month period is required.

— RIGHT Cardiac Catheterization —

— LEFT Cardiac Catheterization —

— Coronary Arteriography —

— **INTERVENTIONAL CARDIOLOGY – PERCUTANEOUS CORONARY INTERVENTIONS (PCI)**
Initial Criteria: Must meet basic qualifications as outlined above and requires training & two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy (75) cases within the two years prior to application.

Proctoring: Five (5) Cases

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of Seventy five (75) cases of which twenty (20) must be done at TCMC within the previous 24 month period

Percutaneous Transluminal Coronary Angioplasty (PTCA)
Thrombectomy
Intra-aortic Balloon Pump Insertion & Removal (IABP)
Temporary Percutaneous Left Ventricular Assist Device (Impella) (Requires Certificate)
Rotational Atherectomy (Requires Certificate)
Orbital Atherectomy (Requires Certificate)

SPECIAL PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and the specific criteria indicated below.

Permanent Pacemaker Insertion (single/dual/biventricular chamber) and/or intra-cardiac defibrillator (ICD) (single/dual/biventricular chamber) requires proof of completion of fellowship training or twenty-five (25) cases.
~~**Percutaneous Angioplasty (PTCA)** requires training & two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy (75) cases within the two years prior to application.~~
Pericardiocentesis: Requires a Fluoroscopy Certificate
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
~~**Rotational Atherectomy** requires meeting PTCA criteria and Boston Scientific Certificate documenting training (FDA requirement).~~
Transesophageal echocardiography (including passing the probe) requires documentation of training or a course.

Tri-City Medical Center
Delineation of Privileges
Cardiology (Revised 1/19)

Provider Name:

Request	Privilege	Action MSO Use Only

Proctoring Requirements:

Permanent Pacemakers/ICDs: two (2)
~~**Percutaneous angioplasty (PTCA):** five (5)~~
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: two (2)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: two (2)
~~**Rotational Atherectomy:** three (3)~~
Transesophageal echocardiography: two (2)

Reappointment Criteria:

Permanent Pacemaker/ICD cases: ten (10)
~~**Percutaneous Angioplasty (PTCA):** seventy five (75) cases of which twenty (20) must be done at TCMC~~
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: Twenty (20)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: Twenty (20)
~~**Rotational Atherectomy:** six (6)~~
Transesophageal echocardiography: ten(10)

___	Permanent Pacemaker/ICD Insertion	___
___	~~Percutaneous Angioplasty (PTCA)~~	___
___	Pericardiocentesis	___
___	Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation	___
___	Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation	___
___	~~Rotational Atherectomy~~	___
___	Transesophageal echocardiography	___

NON-INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and be a cardiologist with fellowship training and is an active reading panel participant and has sufficient case volumes to fulfill reappointment volume requirements as outlined below for each procedure requested.

Proctoring Requirements:

EKG: twenty five (25)
Stress ECHO: two (2)
Thoracic ECHO: two (2)
Holter Monitor: two (2)
Treadmill: two (2)

Reappointment Criteria:

EKG: five hundred (500) or active reading panel member as attested by Division of Chief or designee.
Stress Echo: five (5) Documentation of Stress Echos performed at other facilities (including the physician's office) will count towards this requirement.
Thoracic Echos: two hundred (200) or active reading panel member as attested by Division of Chief or designee.

Tri-City Medical Center
Delineation of Privileges
Cardiology (Revised 1/19)

Provider Name:

Request	Privilege	Action MSO Use Only
	Holter Monitor: forty (40), of which ten (10) must be performed at TCMC or active reading panel member as attested by Division of Chief or designee. **Treadmill:** fifty (50) or active reading panel member as attested by Division of Chief or designee.	
___	EKG	___
___	Stress Echo	___
___	Thoracic Echo	___
___	Holter Monitor	___
___	Treadmills	___
___	**PERIPHERAL VASCULAR INTERVENTIONAL PROCEDURES** (Refer to Medical Staff Policy # 8710-504 for Initial, Proctoring, and Reappointment Criteria)	___
___	Peripheral Angiography - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.	___
___	Carotid	___
___	Cerebral	___
___	Extremity	___
___	Pulmonary	___
___	Thoracic	___
___	Visceral	___
___	Peripheral Intervention - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.	___
___	Angioplasty	___
___	Drug infusion	___
___	Stent graft	___
___	Stent placement	___
___	Thrombolysis	___
___	Venography and Venous Intervention - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.	___
___	IVC filter	___
___	Stent	___
___	Tissue plasminogen activator (tPA)	___
___	Venous Sampling	___

Tri-City Medical Center

Delineation of Privileges

Cardiology (Revised 1/19)

Provider Name:

Request	Privilege	Action MSO Use Only
___	Venous Thrombolysis	___

_____

Print Applicant Name

_____

Applicant Signature

_____

Date

_____

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

ADMINISTRATION REVIEW CONSENT AGENDA
January 3rd, 2019

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
2. Cardiac Cath Lab Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
3. Care of the Newborn Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
4. Droperidol Administration, Monitoring and-or Discontinuing Drug Standardized Procedure	DELETE	Forward to BOD for Approval
5. Identification of Newborns Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
6. Massive Transfusion Protocol Policy	Practice Change	Forward to BOD for Approval
7. Pneumococcal and Influenza Vaccine Screening and Administration Standardized Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
8. Sedation/ Analgesia Used During Therapeutic or Diagnostic Procedure	Practice Change	Forward to BOD for Approval
9. Stroke Code, Emergency Department Procedure	Practice Change	Forward to BOD for Approval
10. Surgical Hand Asepsis Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Outsourcing Sterile Compounding Policy 206	DELETE	Forward to BOD for Approval
Food and Nutrition		
1. Emergency Preparedness Food and Nutrition Disaster Plan Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Mammography Women's Center		
1. Communication of Results Women Center Policy	3 Year Review, Practice Change	Forward to BOD for Approval
2. Completion of Diagnostic Report Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Distribution of Mammography Reports Policy	3 Year Review, Practice Change	Forward to BOD for Approval
4. Film Retention, Check Out and Copying Policy	3 Year Review, Practice Change	Forward to BOD for Approval
5. Mammography Medical Outcomes Audit Policy	3 Year Review, Practice Change	Forward to BOD for Approval
6. Mammography QA Plan DIT Policy	3 Year Review, Practice Change	Forward to BOD for Approval
7. Scheduling of Self Referring Mammography Patients Policy	3 Year Review, Practice Change	Forward to BOD for Approval
8. Screening Mammography Policy	3 Year Review, Practice Change	Forward to BOD for Approval
9. Self Referring & Self Requesting Patients Policy	DELETE	Forward to BOD for Approval
10. Staff & Personnel Listing Women's Center Policy	3 Year Review, Practice Change	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
January 3rd, 2019

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Management		
1. Utilization Review Process Policy	Practice Change	Forward to BOD for Approval
Pharmacy		
1. Antidote Stocking Policy	3 Year Review, Practice Change	Forward to BOD for Approval
2. Restricted Antimicrobials Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Progressive Care Unit		
1. High Profile Patients in Progressive Care Unit (PCU) Policy	NEW	Forward to BOD for Approval with Revisions
Radiology		
1. Imaging Services General Safety Management #128	DELETE	Forward to BOD for Approval
2. MRI After Hours Coverage Procedure #122	3 Year Review, Practice Change	Forward to BOD for Approval
3. MRI Emergency Procedures Procedure #111	3 Year Review, Practice Change	Forward to BOD for Approval
4. MRI Safety Zones Procedure #113	3 Year Review, Practice Change	Forward to BOD for Approval
5. Oral Contrast Administration Procedure #106	3 Year Review, Practice Change	Forward to BOD for Approval
6. Patient Interaction Procedure #126	3 Year Review, Practice Change	Forward to BOD for Approval
7. Patient Procedure Refusal Procedure #127	3 Year Review, Practice Change	Forward to BOD for Approval
8. Radiologists Coverage Non IR Procedure #125	3 Year Review, Practice Change	Forward to BOD for Approval
9. Scope of Service Procedure #121	3 Year Review, Practice Change	Forward to BOD for Approval
Rehabilitation		
1. Physical Therapy Assistant Supervision Policy 613	3 Year Review, Practice Change	Forward to BOD for Approval
Women and Newborn Services		
1. Adoption Policy	3 Year Review, Practice Change	Forward to BOD for Approval
2. Partners in Care for WNS Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Release of Minor to Other than Birth Mother Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
4. Surrogacy Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ADMINISTRATION OF VITAMIN K INJECTION AND ERYTHROMYCIN OPHTHALMIC OINTMENT TO NEWBORNS

I. **POLICY:**

A. Function: To provide guidelines for Women~~'s~~ and Newborn Services (WNS) nurses administering Vitamin K and Erythromycin Ophthalmic Ointment to newborns.

B. Circumstances:

1. Setting: **WNS**~~Labor and Delivery, Newborn Nursery and Neonatal Intensive Care (NICU)~~

~~2. Requires that a Registered Nurse (RN) administer Vitamin K and Erythromycin Ophthalmic Ointment.~~

C. Consent:

1. The RN shall obtain verbal parental consent prior to administration of the Vitamin K- injection and the Erythromycin Ophthalmic Ointment to the newborn.
   i. If the parent or legal guardian declines the Vitamin K- injection and Erythromycin Ophthalmic Ointment refer to documentation guidelines. In the Medication Administration Record (MAR) this will be documented as "refusal".

D. **Administration/**Documentation:

1. The newborn's patient record
   i. Refer to Tri-City Medical Center Patient Care Services (PCS) policy Medication Administration.
   ii. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.
      a. Not required if a screening process triggers the order
   iii. Document given or "refused" in the MAR
      a. If refused complete Refusal of~~r~~ Newborn Eye Prophylaxis and/or Refusal of Vitamin K form(s), original to be kept with the patient chart and one copy to be given to the parent or legal guardian and notify Pediatrician of refusal(s).

II. **PROCEDURE:**

A. The RN will administer Vitamin K 1 mg IM and Erythromycin Ophthalmic Ointment to the newborn within two hours of birth.

III. **REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:**

A. Current **unencumbered** California RN license and working in **WNS**~~Women's and Children's Services/NICU.~~

B. Initial Evaluation: Orientation

C. Ongoing Evaluation: Annually

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Department of Pediatrics	Nurse Executive Committee	Pharmacy and & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/05, 6/07, 9/09, 5/11, 07/13, 06/18	6/07, 9/09, 07/13, 04/15, 07/18	05/15, 08/18	8/07, 11/09, 7/13, 4/15, 07/18	7/07, 12/09, 9/13, 05/15, 09/18	8/07, 12/09, 09/13, 09/15, 10/18	8/07, 2/10, 10/13, 09/15, 11/18	01/19	10/15, n/a	12/05, 8/07, 2/10; 6/11,10/15

B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure

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

A. **Patient Care Services Policy:** ~~PCS~~ Medication Administration
B. **Refusal of Vitamin K Form 6385-1012 English - Sample**
C. **Refusal of Vitamin K Form 6385-1014 Spanish - Sample**
D. **Refusal of Newborn Eye Prophylaxis Form 6385-1011 English - Sample**
~~A.~~E. **Refusal of Newborn Eye Prophylaxis Form 6385-1013 Spanish - Sample**

SAMPLE

I, _____, have been advised and my physician, Dr. _____ (physician's name, printed) has recommended that my newborn receive a single intramuscular injection of .5-1.0 milligrams of vitamin K (phytonadione) within two hours of birth for prevention of vitamin K deficiency bleeding (Hemorrhagic Disease of the Newborn).

Hemorrhagic Disease of the Newborn usually occurs in the first week of life, but can occur up to 3 months of age. Early warning signs of this disease include but are not limited to:

- skin bruising
- blood seepage from any body opening

Upon observing any such symptoms, a physician should be notified immediately.

Very minimal correlations between childhood leukemia and the use of vitamin K in infants have been reported. If the treatment is not provided, the following injuries could occur:

- onset of vitamin K deficiency bleeding (Hemorrhagic Disease of the Newborn)
- intracranial hemorrhage
- seizure
- death

I have read and I understand the above material. My physician has informed me of the nature of this medical treatment, the risks, benefits, and alternatives thereof, and the probable consequences of receiving and declining this treatment. All my questions have been answered. Despite this information, and the recommendation of my physician, I refuse to allow the hospital to administer a vitamin K injection to my infant. **I also understand that no circumcision will be performed on any male infant who has not received the vitamin K injection.**

I accept full responsibility for any detrimental effect my refusal may have on my infant. I, as an individual, and on behalf of my infant child, hereby release, indemnify and hold harmless Tri-City Medical Center, its agents, servants, and employees, including but not limited to anyone involved in my care and the delivery and care of my child, for any and all liability for any injury resulting from my refusal to allow treatment. I have made this decision of my own free will with full understanding and knowledge of the harm that may result to my child as a result of my decision not to allow my child to receive a vitamin k injection.

I understand that the physician named above and other physicians who provide services to me are not employees, servants or agents of the hospital but independent contractors.

Name: Patient/Representative	Signature: Patient/Representative	Date	Time
_____	_____	___/___/___	___:___ AM/PM

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

Witness – TCHD Representative (print name)	Signature • *Firma*	Date • *Fecha*	Time • *Hora*
_____	_____	___/___/___	___:___ AM/PM

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI
☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time
_____	_____	___/___/___	___:___ AM/PM

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

Affix Patient Label

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

6385-1012
(Rev 3/17)

REFUSAL OF VITAMIN K FORM

White - Medical Record Canary - Patient

SAMPLE

Fecha: _____,

Nombre de la madre: _____,

Yo, _____, he sido aconsejada y mi médico, el Dr./la Dra. (imprima/escriba en letra de molde el nombre del médico): _____ ha recomendado que mi recién nacido reciba una sola inyección intramuscular de entre 0.5 a 1.0 miligramos de vitamina K (fitonadiona) dentro de la primera hora de haber nacido para la prevención del sangrado por causa de la deficiencia de vitamina K (Enfermedad Hemorrágica del Recién Nacido). Hay una forma oral disponible de la vitamina K, pero no ha mostrado ser tan efectiva y pone a la criatura en riesgo de tener un sangrado tardío.

La Enfermedad Hemorrágica del Recién Nacido usualmente ocurre en la primera semana de vida, pero puede ocurrir hasta los 3 meses de edad. Las señales de alerta o advertencia temprana de esta enfermedad incluyen pero no se limitan a:

- moretones en la piel
- sangre que filtra (sale) de cualquier abertura del cuerpo

Al observar cualquiera de estos síntomas, se le deberá notificar al médico inmediatamente.

Ha sido mínima la correlación que se ha reportado entre la leucemia infantil y el uso de la vitamina K en los recién nacidos. Si no se proporciona el tratamiento, las siguientes lesiones o daños pueden ocurrir:

- inicio de sangrado por deficiencia de la vitamina K (Enfermedad Hemorrágica del Recién Nacido)
- hemorragia intracraneal
- convulsiones
- muerte

He leído y comprendo el material/información anterior. Mi médico me ha informado acerca de la naturaleza de este tratamiento médico, los riesgos, los beneficios y las alternativas del mismo, y también acerca de las probables consecuencias de recibir y de rehusar este tratamiento. Todas mis preguntas han sido respondidas. A pesar de esta información y de la recomendación de mi médico, rehúso permitir al hospital administrarle una inyección de vitamina K a mi criatura. **Comprendo, además, que no circuncisión se realizará en ningún recién nacido que no haya recibido la inyección de vitamina K.**

Acepto completa y total responsabilidad por cualquier efecto perjudicial que mi rehúso pudiera tener en mi criatura. Yo, como individuo, y en nombre de mi criatura, por la presente libero, indemnizo, y exonero a Tri-City Medical Center, a sus agentes, servidores y empleados, incluyendo pero no limitándose a cualquier persona involucrada en mi atención médica, y en el parto y atención de mi criatura, de cualquier y toda responsabilidad por cualquier lesión/daño que resulte de mi rehúso a permitir el tratamiento. He tomado esta decisión por mi propia voluntad y con la completa comprensión y conocimiento del daño a mi criatura que podría resultar como consecuencia de mi decisión de no permitir que mi criatura reciba una inyección de vitamina K.

Comprendo que el médico mencionado anteriormente y otros médicos que me proporcionan servicios son contratistas independientes y no son empleados, servidores (dependientes) o agentes del hospital.

Firma: _____ **Fecha:** _____ **Hora:** _____ **AM / PM**
(Madre o Padre)

Si se firma por alguien más que no sea la madre o el padre del paciente, imprima su nombre en letra de molde e indique la relación con el paciente:

Nombre: _____ **Relación:** _____.

Testigo: _____ **Fecha:** _____ **Hora:** _____ **AM / PM**

Affix Patient Label

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

6385-1014
(Rev. 01/14)

REFUSAL OF VITAMIN K
REHÚSO A LA VITAMINA K

White - Hospital Yellow - Patient

SAMPLE

I, _____, have been informed by my physician, Dr. _____ (physician's name, printed) that California State law[1] requires both of my newborn infant's eyes to be treated with efficient prophylaxis treatment approved by the California Department of Public Health. Erythromycin is the medication provided at Tri-City Medical Center.

The hospital intends to comply with California State law by administering an approved prophylactic agent to the newborn's eye within two hours after the infant's birth in order to prevent ophthalmia neonatorum and gonorrheal ophthalmia, which most commonly result from Sexually Transmitted Infections. Neither agent stings or otherwise irritates the eyes. If any other symptoms are observed, a physician should be notified immediately.

The most common side effects can last up to 24 hours and include:

- blurred vision
- swelling, redness and/or puffiness to the eyelids

If the treatment is not provided, the following injuries could occur:

- severe eye infection up to and including permanent impaired vision or blindness
- other systemic infection with significant complications

I have read and I understand the above material. My physician has informed me of the nature of this medical treatment, the risks, benefits, and alternatives thereof, and the probable consequences of receiving and declining this treatment. All my questions have been answered. Despite this information, I refuse to allow the hospital to administer a prophylactic agent to my infant's eyes.

I accept full responsibility for any detrimental effect my refusal may have on my infant. I, on behalf of myself and my newborn infant, hereby release, indemnify and hold harmless Tri-City Medical Center, its agents, servants, and employees, including but not limited to anyone involved in my care and the delivery and care of my child, for any and all liability for any injury resulting from my refusal to allow treatment.

I understand that by signing this document I am agreeing not to have the treatment for my infant child and to assume full responsibility for the consequences for any civil or criminal action made against me as a result of my decision not to allow my infant child to undergo prophylactic-efficient treatment.

I understand that the doctor named above and other doctors who provide services to me are not employees, servants or agents of the hospital but independent contractors.

Name: Patient/Representative	Signature: Patient/Representative	Date	Time
_____	_____	___/___/___	_____ AM/PM

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

Witness – TCHD Representative (print name)	Signature • *Firma*	Date • *Fecha*	Time • *Hora*
_____	_____	___/___/___	_____ AM/PM

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI ☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time
_____	_____	___/___/___	_____ AM/PM

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

[1]The Business and Professions Code Section 551 requires the infant's eye be treated within two hours after birth with a prophylactic-efficient treatment to prevent ophthalmia neonatorum and gonorrheal ophthalmia.

Affix Patient Label

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

6385-1011
(Rev. 5/17)

REFUSAL OF NEWBORN EYE PROPHYLAXIS FORM

White - Medical Record Canary- Patient

SAMPLE

Fecha: _____

Nombre de la madre: _____

Yo, _____, he sido informada por mi médico, el Dr./la Dra. _____ (nombre del médico en letra de molde) que la Ley Estatal de California[1] requiere que ambos ojos de mi recién nacido sean tratados con tratamiento profiláctico-eficiente aprobado por el Departamento de Salud Pública de California. Los agentes profilácticos aprobados por el Departamento de Salud Pública de California, incluyen (1) uno porciento de nitrato de plata en ampolletas de cera administradas sin irrigación con solución salina; o (2) pomadas oftálmicas o gotas conteniendo tetraciclina o eritromicina.

El hospital se propone cumplir con la Ley Estatal de California, administrándole un agente profiláctico aprobado a los ojos del recién nacido a menos de dos horas de haber nacido la criatura con el fin de prevenir la oftalmia neonatorum y la gonorrea oftálmica, los que más comúnmente resultan de las Infecciones Sexualmente Transmitidas. Ninguno de los agentes causan ardor o irritan de ninguna manera a los ojos. Si se observa cualquier otro síntoma, se debería notificar inmediatamente a un médico.

Los más comunes efectos secundarios pueden durar hasta 24 horas e incluyen:

- visión borrosa
- inflamación, enrojecimiento y o/hinchazón en los párpados

Si no se provee el tratamiento, los siguientes daños podrían ocurrir:

- infección severa de los ojos hasta llegar e incluir impedimento permanente de la vista o ceguera
- otras infecciones sistémicas con significativas complicaciones

He leído y comprendo el material anteriormente expuesto. Mi médico me ha informado acerca de la naturaleza de este tratamiento médico, los riegos, los beneficios, las alternativas de los mismos, y las probables consecuencias de recibir y de rehusar este tratamiento. Todas mis preguntas han sido respondidas. No obstante esta información, yo rehúso permitir que el hospital administre un agente profiláctico a los ojos de mi criatura.

Acepto completa responsabilidad por cualquier efecto detrimental (que causa daño) que mi rehúso pueda causar en mi criatura. Yo, en mi nombre y en nombre de mi criatura recién nacida, por este medio absuelvo, indemnizo y libero de toda responsabilidad a Tri-City Medical Center, a sus agentes, servidores, y empleados, incluyendo pero no limitándose a cualquier persona involucrada en mi cuidado y en el acto de lar a luz y en el cuidado de mi criatura, de cualquier y toda responsabilidad y obligación por cualquier daño resultante de mi rehúso a permitir el tratamiento.

Comprendo que, al firmar este documento, estoy aceptando a no tener el tratamiento para mi criatura y asumo total responsabilidad de las consecuencias de cualquier acción civil o criminal hecha contra mí como resultado de mi decisión de no permitir que mi criatura se someta al tratamiento profiláctico-eficiente.

Comprendo que el médico nombrado anteriormente y otros médicos que a mi me proveen servicios no son empleados, servidores o agentes del hospital, sino contratistas independientes.

_____

Firma del padre (madre/padre) Fecha / Hora

Si ha sido firmado por otra persona que no sea la madre o el padre del paciente, escriba el nombre en letra de molde e indique la relación o el parentesco con el paciente:

_____ _____

Nombre en letra de molde **Relación con el paciente**

Testigo: _____

Representante del Hospital Fecha / Hora

[1]La Sección 551 del Código de Negocios y Profesiones de California requiere que el ojo de la criatura sea tratado en menos de dos horas de haber nacido con un tratamiento profiláctico-eficiente para prevenir la oftalmia neonatorum y la gonorrea oftálmica.

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

6385-1013
(Rev 12/13)

REFUSAL OF NEWBORN EYE PROPHYLAXIS FORM
REHÚSO A LA PROFILAXIS OCULAR EN RECIÉN NACIDO

White - Medical Record Canary - Patient

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARDIAC CATH LAB PROCEDURES

I. **POLICY:**
- A. Function: Provide care for patients who will be receiving services through the Cardiac Cath Lab.
- B. Circumstances:
  1. Setting: Tri-City Medical Center (TCMC) Cath Lab
  2. Supervision: None required.
  3. Patient contraindications: None.
- C. Expected Outcomes:
  1. To outline personnel and duties involved in procedures in the Cath Lab.
  2. To delineate steps in elective or emergent procedure in the Cath Lab.
  3. To assure that any patient undergoing a cardiac procedure at TCMC will be assessed for pre procedure risk and will be directed to the appropriate level of care.

II. **PROCEDURE:**
- A. Cardiac Catherization **with Possible Percutaneous Transluminal Coronary** Intervention
  1. The **Registered Nurse** (RN) shall order the following if previous results ~~from~~**are** greater than 90 days or no results **are** available:
     - a. Obtain previous lab and history and physical, if available.
     - b. Cardiology:
       - i. ~~Perform~~ **eElectrocardiogram** (EKG). Retrieve and print any previous EKG, if available.
     - c. Labs:
       - i. **Complete blood count** (CBC)
       - ii. Complete Metabolic Panel (Chem 12)
       - iii. PT/PTT/INR
       - ~~iv. Cardiac Troponin (Troponin-I)~~
       - v. ~~CKMB~~ **Lipid Panel**
       - vi. Labs may be drawn prior to procedure.
     - d. Nurses Order:
       - i. Start 22, 20 or 18 gauge **Intravenous** (IV)
       - ii. ~~Intravenous (~~IV~~)~~ Normal Saline (NS) at 20 mL/hour
       - iii. Point of care (POC) blood glucose, if patient diabetic.
     - e. Diet:
       - i. Ensure **nothing by mouth** (NPO) prior to procedure except for small amounts of water to take oral medications.
- B. ~~PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY~~:
  1. ~~The RN shall order the following if previous results from greater than 90 days or no results available:~~
     - ~~a. Obtain previous lab and history and physical, if available.~~
     - ~~b. Cardiology:~~
       - ~~i. Perform EKG, retrieve and print previous EKG, if available.~~
     - ~~c. Labs:~~
       - ~~i. CBC~~
       - ~~ii. Complete Metabolic Panel (Chem 12)~~

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Council	Division of Cardiology	Pharmacy & Therapeutics Committee	Inter-disciplinary Practice Council	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/13, 04/14, 12/17	03/13, 04/14, 01/18	03/13, 05/14, 01/18	02/16, 06/18	05/13, 03/16, 07/18	09/13, 07/16, 10/18	10/13, 09/16, 11/18	01/19	10/16, n/a	10/13, 11/16

~~iii. PT/PTT/INR~~
~~iv. Cardiac Troponin (Troponin I)~~
~~v. CKMB~~
~~vi. Labs may be drawn prior to procedure.~~

~~d. Nurses Order:~~
~~i. Start 22, 20 or 18 gauge IV~~
~~ii. IV NS at 20 mL/hr~~
~~iii. POC blood glucose, if patient diabetic.~~

~~e. Diet:~~
~~i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.~~

C. Elective Cardioversion:
1. The RN shall order the following, if previous results from greater than 90 days or no results available:
   a. Obtain previous lab & history and physical, if available.
   b. Cardiology:
      i. ~~Perform~~ EKG. Retrieve and print any previous EKG, if available.
   c. Labs:
      i. INR, complete metabolic panel (Chem 12), CBC
      ii. Labs may be drawn prior to procedure.
   d. Nurses Order:
      i. Start 22, 20 or 18 gauge IV
      ii. IV NS at 20 mL/hr
      iii. POC blood glucose, if patient diabetic.
   e. Diet:
      i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

D. Pericardiocentesis:
1. The RN shall order the following, if previous results from greater than 90 days or no results available:
   a. Obtain previous lab and history and physical, if available.
   b. Cardiology:
      i. ~~Perform~~ EKG. Retrieve and print any previous EKG, if available.
   c. Labs:
      i. CBC
      ii. Complete Metabolic Panel (Chem 12)
      iii. PT/PTT/INR
      iv. Labs may be drawn prior to procedure.
   d. Nurses Order:
      i. Start 22, 20 or 18 gauge IV
      ii. IV NS at 20 mL/hr
      iii. POC blood glucose, if patient diabetic.
   e. Diet:
      i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

E. Implantable Cardioverter Defibrillator Implant/Change:
1. The RN shall order the following, if needed:
   a. Obtain previous lab and history and physical, if available.
   b. Cardiology:
      i. ~~Perform~~ EKG. Retrieve and print any previous EKG, if available.
   c. Labs:
      i. CBC
      ii. Complete metabolic panel (Chem 12)
      iii. INR/ PT/ PTT

iv. BNP
v. Labs may be drawn prior to procedure.

d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. NS at 20 ml/hr

e. Diet:
i. **Ensure** NPO after midnight, except for small amounts of water to take oral medications.

F. Permanent Pacemaker Insertion/Change:

1. The RN shall order the following, if previous results from greater than 90 days or no results available:

a. Obtain previous lab and history and physical, if available.

b. Cardiology:
i. ~~Perform~~ EKG. Retrieve and print any previous EKG, if available.

c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. PT/PTT/INR
iv. Labs may be drawn prior to procedure

d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose, if patient diabetic.

e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

G. Implantable Loop Device Implant/Explant:

1. The RN shall order the following, if previous results from greater than 90 days or no results available:

a. Obtain previous lab and history and physical, if available.

b. Cardiology:
i. ~~Perform~~ EKG. Retrieve and print any previous EKG, if available.

c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. INR
iv. Labs may be drawn prior to procedure.

d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose, if patient diabetic.

e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

III. REQUIREMENTS FOR REGISTERED NURSE INITIATING STANDARDIZED PROCEDURE:

A. Current unencumbered California RN license.
B. Current Advanced Cardiac Life Support (ACLS) certification.
C. Initial Evaluation: Orientation
~~i.~~D. Ongoing Evaluation: Annually

~~III.~~IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

~~IV.~~**V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All Registered Nurses who have successfully completed orientation are authorized to direct and perform the Cath Lab Standardized Procedure.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARE OF THE NEWBORN

I. **POLICY:**

A. Function: To define the care and immediate treatment post-delivery for the newborn:

1. ~~w~~Weighing greater than or equal to 2000 grams ~~that~~

~~A.~~2. is equal to and are greater than 35 6/7 weeks gestational age.

B. Circumstances:

1. Setting: Labor and Delivery (L&D), Newborn Nursery, and Mother-Baby
2. Supervision: None required. Physician's office/answering service **or well-baby line** will be notified of delivery time and date.
3. Requires that a Registered Nurse (RN) provide immediate care to administer medications, provide nutrition and/or nutritional support, and to perform procedures, laboratory and diagnostic tests that are considered to be routine care to the well born term or near term newborn infant.
4. The Women and Newborn Services (WNS) RN must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**

A. Newborns greater than or equal to 2000 grams and who are **equal to and** greater than 35 6/7 weeks gestational age shall receive:

1. Prophylactic treatment of eyes (Erythromycin ophthalmic ointment) and medication to normalize coagulation (Vitamin K) within 2 hours of delivery time.
   a. Refer to Patient Care Services (PCS) Standardized Procedure (SP): Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to the Newborns.
   b. Exception: Parents who refuse verbal consent.
2. The newborn shall receive Hepatitis B vaccine or Hepatitis B vaccine/HBIG immunoglobulin injection if indicated according to the mother's HBsAg status ~~and within 12 hours of delivery time.~~
   a. Refer to PCS SP: Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) (Hyper B Sd®) to Newborns.
   b. Exception: Parents who refuse verbal consent.

B. Infant nutrition:

1. Breastfeeding
   a. Initiate feedings as soon as possible but no longer than 2 hours following delivery.
      i. If cesarean delivery, as soon as possible (ASAP) when mother and infant are reunited.
      ii. If mother and infant are separated for longer than 3 hours, initiate breast-pumping (even if mother going to NICU to breastfeed).
         1) Refer to WNS Procedure: **Infant Feedings** ~~Breast Milk, Pumping, Handling and Storage of.~~
      iii. Assess and attempt to feed 8-**12** ~~or more~~ times within a 24 hour period **utilizing infant feeding cues as indicators** ~~approximately every 2-3 hours and on demand.~~

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Council	Peri-natal Collab-orative Practice	Dept. of Peds.	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Admin-istration	Professional Affairs Committee	Board of Directors
04/15	08/12, 11/13, 04/15, 06/16	08/12, 11/13, 04/15, 07/16, 03/18	~~08/1605/~~ 18	05/15, 11/16, 05/18	09/12,11/13, 05/15, 11/16, 07/18	11/12, 02/14, 09/15, 01/17, 10/18	04/13, 02/14, 09/15, 02/17, 11/18	01/19	10/15, 03/17, n/a	04/13, 02/14, 10/15, 03/17

iv. **No breastmilk substitute (such as formula) will be given unless by a providers order or per Blood Glucose Newborn Monitoring Standardized Procedure.**

~~iv.~~**1) Alternative feeding methods are preferred per Infant Feedings Policy.** ~~No supplementation of formula unless ordered by provider, requested by mother or as per other procedures where supplementation is required~~.

v. Obtain lactation consult as clinically indicated

1) Refer to WNS Policy: Infant Feedings.

2. **Formula**~~Bottle~~ feeding

a. If mother requests infant to be fed by a breastmilk substitute:

i. Educate on the risks and give the Risks of Formula Supplementation education flyer.

ii. Document informed decision with patient education

iii. Call provider for an order per Infant Feedings Policy

iv. Give patient and significant other ~~**Elsevier Clinical Skills:**~~ **Fformula Ffeeding Eeducation**

~~a. Offer bottle with formula of mother's choice, by 3 hours of age~~

~~i. Assess feeding status every 3-4 hours, offer formula PRN and on-demand.~~

~~ii. Refer to WNS Procedure: Formula Feeding.~~

C. Procedures:

1. Newborn hearing screen
   a. Ensure hearing screen is ordered per WNS Policy: Hearing Screening Program: Newborn and Infants.
2. Obtain Total Serum Bilirubin at approximately 24 hours of age or sooner if baby visually appears to have jaundice.
   ~~a. If greater than or equal to 95th percentile (high risk zone) on Bhutani's curve (per hours of age) notify provider.~~
   a. Notify provider of Total Serum Bilirubin at ~~**higher**~~ **levels above threshold of initiating phototherapy per the phototherapy treatment** ~~**curve**~~**graph.**
   b. Notify provider of Total Serum Bilirubin prior to discharge if he/she is not already aware of the result and the baby will not be rounded on/seen again by a pediatrician prior to discharge.
3. If infant Coombs positive, order CBC with manual differential, retic count, and total serum bilirubin STAT and call provider with results.
   a. Contact physician immediately upon return of test results.
4. All infants meeting criteria will have a car seat challenge performed prior to discharge as per WNS/Neonatal Intensive Care Unit (NICU) Procedure: Car Seat Challenge Test.
5. All infants meeting criteria will have neonatal abstinence scoring performed as per WNS/NICU Procedure: Neonatal Abstinence **Syndrome, Management of**~~Scoring~~.
6. All infants will have pulse oximetry done after 24 hours of life or prior to discharge per PCS SP: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).

D. Laboratory tests:

1. Point of care glucose testing
   a. Perform per PCS SP: Blood Glucose Newborn Monitoring.
2. Toxicology
   a. Obtain a urine specimen if mother has a positive toxicology screen, a positive history of substance use, is suspected of substance use or with diagnosis, has had less than or equal to three prenatal visits, or suspicion of placental abruption.
      ~~i. If positive for cocaine, amphetamines and or opiates, lab will perform a confirmation.~~
   ~~b. Obtain a urine specimen on all babies assigned to Neonatology.~~
3. Cord blood screen (Direct Coombs and blood typing) ASAP
4. Newborn metabolic screen prior to discharge but at least 24 hours following delivery.

a. Refer to PCS Procedure: Newborn Screening, Collection of Specimen.

5. Perform CBC with manual differential and blood culture on newborn between 6 - 12 hours of age if:
   a. If Mother is GBS positive, received no treatment or received a dose of antibiotics less than 4 hours prior to delivery
      i. Infant is either less than 37 weeks estimated gestational age (EGA)
      ii. Infant is greater than 37 weeks EGA , but mother had a rupture of membranes greater than 18 hours:
6. Notify provider of CBC with manual differential results if abnormal
   a. Abnormal CBC for infant, at least one of the following:
      i. WBC greater than 35,000 or less than 9,000
      ii. ANC less than 1500
      iii. Platelet Count less than 120,000

E. Call provider immediately for maternal/infant signs of chorioamnionitis/infection or the following symptoms:
   1. Maternal temperature greater than or equal to 100.4 degrees Fahrenheit plus two or more of the following:
      a. Maternal tachycardia (greater than 100bpm)
      b. Fetal tachycardia (greater than 160bpm)
      c. Uterine tenderness
      d. Foul smelling amniotic fluid
      e. Maternal leukocytosis (greater than 15,000 WBC)

III. **DOCUMENTATION:**

A. Document assessment, actions and provider notification/response in electronic health record (EHR) as appropriate.

B. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the (EHR) as Standardized Procedure.
   ~~1. Not required if a screening process triggers the order.~~
   ~~2. Utilizing Computerized Physician Order Entry (CPOE), select the Standardized Procedure (SP) power plan PCS SP: Newborn Admit.~~
   ~~3. Type in provider's name and select "Standardized Procedure" as the order communication type.~~

~~C. Initiate, sign and refresh Newborn Medications power plan prior to birth in order to readily access medications in Pyxis.~~

~~D.~~C. Prior to administration of vaccines see PCS Policy: Vaccination Administration.

~~E.~~D. Document patient (mother/legal guardian) teaching in the education section of the EHR.

~~F. Total serum bilirubin will be documented in the EHR.~~

IV. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current **unencumbered** California RN license working in Women's and Children's Services
B. Education: Register Nurse
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

VI. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All Registered Nurses **in WNS** who have successfully completed requirements as outlined above are authorized to direct and perform "Care of the Newborn" Standardized Procedure.

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

A. PCS Policy: Vaccination Administration
B. PCS Procedure: Newborn Screening, Collection of Specimen
C. PCS Standardized Procedure: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns
D. PCS Standardized Procedure: Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) (Hyper B Sd®) to Newborns
E. PCS Standardized Procedure: Blood Glucose Newborn Monitoring
F. PCS Standardized Procedure: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD)
G. WNS Policy: Infant Feedings
~~H.~~ WNS Policy: Hearing Screening Program: Newborn and Infants
~~H.~~**I. Elsevier Clinical Skills: Formula Feeding Education**
~~I. WNS Procedure: Formula Feeding~~
~~J. WNS Procedure: Breast Milk, Pumping, Handling and Storage of~~
~~K.~~**J.** WNS/NICU Procedure: Car Seat Challenge Test
~~L.~~**K.** WNS/NICU Procedure: Neonatal ~~Abstinence Scoring~~ **Abstinence Syndrome, Management of**

VIII. **REFERENCE(S):**

A. AWHONN Core ~~c~~Curriculum for Maternal-Newborn Nursing 4th edition. St Louis, Missouri: Elsevier Saunders 2001~~7. pp 427--429.~~
B. Gilstrap, L.C. ed., et al. Guidelines for Perinatal Care, **8th**~~7~~th Edition. AAP & ACOG **2017**~~2012~~.
C. Schrage, S. et al: Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CBC. MMWR, 2010; 59 (no. RR 10): November 19, 2010.
~~D. Thureen, Deacon, Hernandez, Hall. Assessment and care of the well newborn 2nd edition. St. Louis, Missouri: Elsevier Saunders 2005. pp 91-92.~~

Tri-City Medical Center
Oceanside, California

DELETE – droperidol no longer on hospital formulary

STANDARDIZED PROCEDURES MANUAL PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: DROPERIDOL ADMINISTRATION, MONITORING, AND/OR DISCONTINUING DRUG

I. **POLICY:**

A. Function: To provide direction for the use and monitoring of droperidol at Tri-City Medical Center (TCMC).

B. Circumstances:

1. Setting: Cardiac Cath Lab, cardiac monitoring nursing units (Intensive Care Unit (ICU) or Telemetry) Tri-City Medical Center
2. Supervision: None
3. Patient Contraindications: 12 Lead electrocardiogram (ECG) QTc greater than 440 milliseconds

C. Definitions:

1. The safe administration of droperidol requires the QTc interval on the 12 Lead ECG be less than 440 milliseconds.
2. The safe administration of droperidol requires that the patient be monitored continuously for cardiac dysrhythmia for three (3) hours after the drug is given.
3. Current is defined as during the present hospitalization.
4. QTc is the corrected QT interval that is independent of a heart rate.

II. **PROCEDURE:**

A. The attending physician initiates the process by ordering droperidol for the patient.

B. The Registered Nurse (RN) checks the chart for the most recent 12 Lead ECG.

1. RN shall order a 12 Lead ECG, if there is not a recent ECG completed during this hospitalization available on the chart.

C. RN or physician shall check the QTc interval electronically measured and printed on the 12 Lead ECG.

1. Do not administer droperidol if QTc interval is greater than 440 milliseconds.
2. Discontinue droperidol and notify the physician for alternative medication.
3. If physician specifically orders droperidol despite QTc greater than 440, document QTc and physicians awareness of QTc.

D. The RN shall document the QTc interval on the medication record as soon as possible after the order is transcribed.

1. Right click "Comments" and document the QTc interval.

E. The patient shall be monitored for the following for 3 hours after the droperidol has been administered:

1. Cardiac effects (new onset tachycardia, orthostatic hypotension, hypertension, abnormal T waves, prolongation of the QT from baseline and ventricular tachycardia).
   i. If prolongation of the QT from baseline is noted, obtain a 12 lead ECG and check the QTc.
2. Extrapyramidal reactions, seizures or any of the following:
   i. Dystonic reactions (neck rigidity, swollen tongue, and oculogyric crisis).

Patient Care Services Content Expert	Clinical Policies & Procedures	Nurse Executive Committee	Division of Cardiology	Pharmacy and Therapeutics	Inter disciplinary Committee	Medical Executive Committee	Admin-istration	Professional Affairs Committee	Board of Directors
8/06,8/04,3/08 11/10,2/13, 9/15, 06/18	12/10, 2/13, 10/15, 06/18	12/10, 2/13, 10/15, 07/18	1/16, 09/18	1/11, 7/13, 01/16, 09/18	1/11, 10/13, 07/16, 10/18	2/11, 10/13, 09/16, 11/18	01/19	10/16, n/a	8/04,7/03, 9/06, 12/08, 4/09,2/11, 10/13, 11/16

ii. Tardive dyskinesia (repetitive, involuntary, purposeless movements, grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may appear as though the patient is playing an invisible guitar or piano).

iii. Pseudoparkinsonian signs and symptoms.

3. Increased drowsiness and sedation.

F. The RN shall recheck the QTc interval if giving repeated doses of droperidol using the most recent ECG.

1. Repeat process outlined in steps A - E when administering subsequent doses of droperidol.

G. Documentation

1. Notify the physician and document in the medical record the presence of the following:
   i. Cardiac effects
   ii. Extrapyramidal reactions:
   iii. Pseudoparkinsonian signs and symptoms
2. When administering medications or implementing orders from a standardized procedure, the RN shall enter the medication/order into the electronic health record as a standardized procedure.
   i. Not required if a screening process triggers the order.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license.
B. Current Advanced Cardiac Life Support card.
C. Primary RN staff on with continuous cardiac monitoring at TCMC.
D. Initial Evaluation: During Department Orientation.
E. Ongoing Evaluation: Annually during Skills Lab.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform this standardized procedure.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**IDENTIFICATION OF NEWBORNS**
Purpose:	To outline the nursing responsibilities in identification of the mother/baby couplet as required by Title 22 of the California Code
Supportive Data:	All newborns will be identified with the birth mother's last name **(with the possible exception being with Adoption and Surrogacy)** before leaving the room the birth occurred in **Labor and Delivery, and Obstetrical Operating room)**~~(LDR, LDRP, OB Operating Room)~~ to ensure proper identification. Newborns born outside the hospital will be banded on admission to Tri City Medical Center (TCMC)~~before separation of the mother-baby couplet~~. **All infants admitted to the Emergency Department (ED) will be banded per hospital policy.** ~~Newborns less than 2 weeks of age will be banded on admission to TCMC.~~
Equipment:	**Newborn Identification Bands (two for the infant, one for the mother and another for the significant other).** ~~Blank Identification wrist band set with secure closure (set of four with matching numbers)(to be filled in during Cerner downtime only).~~ **In the event of computer downtime a blank identification wrist band set will be utilized in Women's and Newborn Services (WNS). ED will follow the hospital procedure for banding: Identification, Patient Policy.** ~~Aztec infant ID bands (4);~~

A. **POLICY:**

1. All newborns shall be banded before separation from his/her birth mother. ~~(Refer to Patient Care Services (PCS) Policy # IV-A: Identification, Patient)~~
2. All newborns born outside the hospital shall be banded ~~and printed~~ upon admission to the ~~Women's and Children's Services~~ (WN~~C~~S) or Neonatal **Intensive Care Unit** (NICU) ~~TCMC~~.
3. **If infant is admitted to the Emergency Department (ED) it will be banded per the ED Registration process**~~**Identification, Patient Policy**~~**.**
4. For the following situations see these policies:
   a. Safe Surrender: See Administrative Policy New Abandonment #380
   b. Adoption: See **WNS Procedure:** Adoption ~~Policy~~
   c. Surrogacy: See **WNS**~~WCS~~ **Procedure:** Surrogacy ~~Policy~~
   d. Release of Minor to Other **Than** Birth Mother: See **WNS Procedure: Release of Minor to Other Than Birth Mother** Procedure

B. **PROCEDURE:**

1. Following delivery of the infant, ~~-~~a set of four bands with matching Parent/Baby ID numbers will be printed. **They will contain the following information:**
   a. **Mother's last and first name**
   b. **Newborn's Medical Record Number**
   c. **Sex of newborn: BOY or GIRL**
   d. **Date of birth.**
   ~~1.~~**e. Time of birth (24 hour clock)**
2. The identification bands must be verified as complete and accurate **by two staff members along with the mother or support person.**
   a. Identification must be completed before any separation of mother/ baby couplet.
3. Separate and attach the set of four completed bands as follows:
   a. One large band is applied to the mother's wrist next to her admission Aztec bar code band.

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
12/93, 09/09, 07/13, 08/18	08/06; 09/09; 07/13, 09/18	10/06, 11/09; 08/13, 11/18	n/a	n/a	n/a	01/19	11/06, 1/10, 9/13, n/a	12/93, 03/97, 10/97, 07/00, 06/03, 04/04, 12/06, 01/10, 09/13

b. One large band is applied to ~~the father's wrist (or a significant other~~**support person** ~~(SO)~~ identified by the birth mother~~)~~.
c. The two smaller bands will be applied to the newborn extremities ~~:~~
d. When a newborn is transferred to Mother/Baby, all bands must be verified as complete and accurate **by two staff members**. Verify the band number, baby name, MRN, date and time of birth.
e. Whenever a newborn is separated from the mother for any reason, bands must be checked prior to separation and upon returning the newborn to the mother.
f. Should the mother or the newborn, lose a band, a new set of four bands with new identical numbers must be printed and all must be applied and old bands removed.
g. If possible, re-banding should take place with the mother **and/or ~~significant other~~support person** as a witness.
h. If new bands are issued to the mother/baby ~~couple~~**couplet**, one of the newborn's old bands needs to be attached to the Newborn Identification Upon Re-Banding form~~.~~ **and have a parent sign that the information on the bands is correct with the re-banding of the mother, ~~significant other~~support person and baby.**
i. If mother of infant is discharged prior to infant~~,~~ the newborn's mother and/ or support person should continue to wear his/her ID band (with matching numbers) until the infant is released from the hospital.

C. **CERNER DOWNTIME IDENTIFICATION PROCEDURE:**

1. At delivery, complete a set of four bands with matching numbers.
   a. Identification must be completed before any separation of mother/ baby ~~couple~~**couplet**.
2. Complete the following information for placement on the band:
   a. Mother's last and first name
   ~~b. Mother's medical Record Number~~
   ~~c.~~**b.** Newborn's Medical Record Number
   ~~d.~~**c.** Sex of newborn: BOY or GIRL
   ~~e.~~**d.** Date of birth.
   ~~f.~~**e.** Time of birth (24 hour clock)
3. The four bands ***MUST*** have ***IDENTICAL*** numbers and all information must be accurate and legible.
4. Proceed with remainder of procedure for placement of bands.

D. **DOCUMENTATION:**

1. At the time of delivery, document identification numbers~~,~~ on the Labor and Delivery Summary and the Newborn History and Physical.
2. Document presence and accuracy of bands at time of transfer**, in the Mother Baby Unit when mother is separated from the infant and when the mother is reunited with the infant.** ~~to Mother/Baby on Newborn and Maternal medical records.~~
3. If re-banding occurs, document in the patient record in both the mother's and the infant's patient records with the new identification band number and add a comment stating the reason for re-banding.
4. At discharge, identification is verified and one newborn ID band is attached to the Newborn Identification form. **Record the** ~~Also recorded are the~~ mother **or ~~significant other~~support person** and witness signatures **with** ~~and~~ the date.

E. **FORM(S):**

1. **Newborn Identification & Discharge Instructions ~~form~~ English - Sample**
2. **Newborn Identification & Discharge Instructions ~~form~~ Spanish - Sample**
3. **Newborn Identification Upon Re-Banding form English - Sample**
4. **Newborn Identification Upon Re-Banding form Spanish - Sample**

F. RELATED DOCUMENT(S):

1. **Patient Care Services Policy: Identification, Patient~~, Patient Care Services (PCS) Policy #IV-A~~**
2. **Women & Newborn Services Policy: Adoption ~~Procedure~~**
3. **Women & Newborn Services Policy: Surrogacy ~~Procedure~~**
4. **Women & Newborn Services Procedure: Release of a Minor to Other Than Birth Mother**

~~E.~~G. REFERENCE(S):

1. American Academy of Pediatricians, & American College of Obstetricians and Gynecologists (AAP, ACOG). (201~~707~~). *Guidelines for Perinatal Care* (~~86~~th Edition). Washington, DC.
2. Besuner, P. (2007). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): Templates for Protocols and Procedures for Maternity Services (2nd Edition). Washington, DC
~~2.~~3. **The Joint Commission R^3 Report: Distinct newborn identification requirement. Issue 17, June 25, 2018**
4. ~~California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.~~

4-Hole 1/4 1 3/8 c-to-c SAMPLE

CAREPLAN Problems resolved: Yes ☐ No ☐ If No, describe plan_____

DIET
Breast Feeding_____ Frequent feeding - q2 - 3°_____
Formula Feeding_____ Type_____ Frequency_____

TAKE HOME MEDICATIONS Medications (dosage, frequency, indications) Date/Time
Last dose given
Medications Received 1. _____
Prescriptions Given 2. _____
None Ordered 3. _____
Instructions for medication(s) given to Parent ☐ Significant Other / Caregiver ☐
Relationship_____, understands instructions and performed return demonstration.
_____ RN / LVN

BABY: REPORTABLE CONDITIONS
a. Fever 100.4°F or over by rectum
b. Listlessness or restlessness
c. Excessive crying or high pitch shill cry
d. Any unusual rash
e. Loose, watery bowel movements (mucous and foul odor)
f. Vomiting ("not just spitting up") or refusal to eat several times in a row.
g. Jaundice (press gently on tip of nose or cheek, yellow color appears, or yellow coloration of the whites of eyeballs)

f. Ages & Stages taught ☐
Brochure given to parent(s) Eng Spn Other
Pass Refer Waived Diag. Refer
_____ RN / LVN

OTHER SPECIFIC INSTRUCTIONS_____

FOLLOW-UP APPOINTMENTS
Dr. _____ Date/Time_____ Call for appointment_____ Telephone_____
Other_____ Date/Time_____ Call for appointment_____ Telephone_____

I RECEIVED AND UNDERSTAND THE NURSES INSTRUCTIONS.

_____ _____RN/LVN
Parent / Significant Other / Caregiver

_____ Date: _____
RN Validation Signature

NEWBORN IDENTIFICATION **Affix infant's identification band here**
Check appropriate box below
☐ I hereby acknowledge that I have compared the identification band with my own band numbered _____ and I am taking my baby from the hospital
☐ I hereby acknowledge that I have checked the identification and I am taking the appropriate baby from the hospital.

Parent	Witness	Date	Time
Signature if other than parent	Relationship	Identification Verification	

Affix Patient Label

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

7400-1008
(Rev 6/09)

NEWBORN IDENTIFICATION & DISCHARGE INSTRUCTIONS

White - Chart Yellow - Patient

SAMPLE

5-Hole 1/4 1 3/8 c-to-c

CARE PLAN Problems resolved ☐ **Yes** ☐ **No** **If no, describe plan** _____

DIETA

☐ Dando Pecho Cada 2-3 horas (Elbebe debe de orinar 6-8 panales y 2-3 movimuentos del intestino en 24 horas).
☐ Botella Tipo _____ Frecuencia _____

MEDICACIONES PARA LLEVAR A LA CASA (Dosificacion, frecuencia, indicacion)

Fecha/Hora De Uluma Dosis

☐ Medicacion Recibida 1 _____
☐ Prescripciones Entregadas 2 _____
☐ Ninguno Ordenado 3 _____

INSTRUCCIONES POR MEDICACIONES ENTREGADAS ☐ Padre ☐ Significante Otro/Caregiver
Relación _____ Entrende instrucciones y ejecutó demostración del retorno _____ RN
OTROS INSTRUCCIONES ESPECIFICAS _____

BEBE, REPORTABLE CONDICIONES

a. Fiebre de 100.4 F o alto por el recto
b. Vomitar ("no soló escupir") o negar comer varias veces seguidas
c. Llorar en excesivo o chillar en altavoz
d. Decaida o intranquilidad
e. Movimientos del intestino sueltos, acuosos (olor sucio y mucoso)
f. Cualquiera salpullido raro
g. Ictericia (Aprete suavemente en la punta de nariz o mejilla, color amarillo aparece, o colorido amarillo o lo blanco de globo del ojo

OTROAS INSTRUCCIONES ESPECIFICAS _____

CITAS DE LA CONTINUACION

Dr _____ Fecha/Hora _____ Liame por cita _____ Telefonea _____
Otro _____ Fecha/Hora _____ Liame por cita _____ Telefonea _____

He Recibido y verifico comprension de todas las instrucciones dadas por la enfermera.

_____ _____ _____
Padre/ Significante otro/Caregiver Fecha RN/LVN

_____
RN Validation Signature

IDENTIFICACION DE RECIÉN NACIDO

Affix infant's identification band here

Marque caja apropiada abajo

☐ Por lo presente reconozco que he comparado la venda de identificación con mi venda propia numerada y me llevo mi bebe de la clinica.

☐ Por lo presente reconozco que he verificado la venda de identificación y me llevo el bebe apropriado de el hospital.

_____ _____ _____
Paciente Fecha RN/LVN

_____ _____ _____
Signature of other than parent Relationship Identification Verification

ADDRESSOGRAPH

Tri-City Medical Center
4002 Vista Way, Oceanside, California 92056
NEWBORN IDENTIFICATION & DISCHARGE INSTRUCTIONS

7400-4009 (5/05)

White - Chart Yellow - Patient

SAMPLE

NEWBORN IDENTIFICATION UPON RE-BANDING

Baby _____ is being re-banded.

I hereby acknowledge that I have verified the baby band removed and the new bands applied are correct.

Old Band # _____

New Band # _____

Parent Signature	Relationship	Date & Time

If other than parent:

Written Name	Signature	Relationship

Identification Verification (i.e. Driver's License, Passport) _____

Witness Name	Witness Signature	Date & Time

Affix infant's (and Banded Adults if appropriate) identification band(s) below

Affix Patient Label

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

6385-1010
(Rev 11/13)

NEWBORN IDENTIFICATION UPON RE-BANDING

SAMPLE

IDENTIFICATION DEL RECIEN NACIDO AL CAMBIARLE LAS PULSERAS

Al bebé _____ se le están poniendo nuevas pulseras.

Por este medio reconozco que he verificado las pulseras que le han quitado al bebé y que las nuevas pulseras identificativas que le han puesto están correctas.

Número de las pulseras viejas _____

Número de las pulseras nuevas _____

Nombre de uno de los padres _____

Si la persona quien firma no es uno de los padres, indique el nombre y la relación/parentesco:

Nombre _____; Relación/parentesco _____

Verificación de identidad _____

Firma _____ Fecha _____ Hora _____ ☐AM ☐PM

Testigo (Witness): _____
Representante del hospital (Hospital Representative)

Pegue las pulseras de identificación del bebé abajo (affix infant's identification bands below)

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4002 Vista Way • Oceanside • CA • 92056

6365-1010
(Rev. 6/13)

NEWBORN IDENTIFICATION UPON RE-BANDING

Affix Patient Label

SAMPLE

NEWBORN IDENTIFICATION VERIFICATION UPON DISCHARGE

Check appropriate box below

☐ I hereby acknowledge that I have compared the identification band with my own numbered _____ and I am taking my baby from the hospital.

☐ I hereby acknow[illegible] taking the appropriate baby from the ho[illegible]

DELETE

_____	_____	_____
Parent	Witness	Date & Time
_____	_____	_____
Signature if other than parent	Relationship	Identification Verification

Affix infant's (and Mom's if appropriate) identification band(s) below

Tri-City Medical Center
4002 Vista Way ◇ Oceanside ◇ CA ◇ 92058

NEWBORN IDENTIFICATION
7400–1008

Affix Patient Label

SAMPLE

VERIFICACIÓN DEL RECIÉN NACIDO AL DARLE DE ALTA

Marque abajo el cuadrito apropiado

☐ Por la presente reconozco que he comparado la pulsera identificativa con mi propia pulsera número _____ y me llevo a mi bebé del hospital.

☐ Por la presente reco[DELETE]que me llevo al bebé apropiado del

Firma de uno de los padres	Testigo	Fecha y hora
Signature if other than parent	Relationship	Identification

Affix infant's (and Mom's if appropriate) identification band(s) below

Tri-City Medical Center
4002 Vista Way ◇ Oceanside ◇ CA ◇ 92058

NEWBORN IDENTIFICATION
7400-1008

Affix Patient Label

SAMPLE

NEWBORN IDENTIFICATION UPON RE-BANDING

Baby _____ is being re-banded.

I hereby acknowledge that I have verified the baby band removed and the new bands applied are correct.

Old Band # _____

New Band # _____

DELETE

Parent Signature	Relationship	Date & Time

If other than parent:

Written Name	Signature	Relationship

Identification Verification (i.e. Driver's License, Passport) _____

Witness Name	Witness Signature	Date & Time

Affix infant's (and Banded Adults if appropriate) identification band(s) below

Affix Patient Label

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

6385-1010
(Rev 11/13)

NEWBORN IDENTIFICATION
UPON RE-BANDING

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: ~~NEW~~03/16 **SUBJECT: Massive Transfusion Protocol (MTP)**

REVISION DATE(S): ~~05/18~~

Patient Care Services Content Expert Approval:	**05/18**
Clinical Policies & Procedures Committee Approval:	**~~01/16~~10/18**
Nurse Executive Committee Approval:	**~~01/16~~11/18**
Blood Utilization Review Approval:	**~~01/16~~11/18**
Pharmacy & Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**~~03/16~~n/a**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. Protocolized transfusion has been shown to improve clinical outcomes ~~as well as~~**and** transfusion efficiency in trauma patients who require massive transfusion. This document provides guidelines for utilization of the massive transfusion protocol (MTP) at Tri-City Medical Center (TCMC).

B. **DEFINITIONS:**

1. Massive Transfusion (MT): Acute administration of 4 or more **units of** Red Blood Cells (RBC) in 1 hour or 8 or more units in 24 hours. Alternatively: Replacement of 1 or more blood volumes (1 **blood volume equals approximately** ~~=~~ 5000 mL) in 24 hours.
2. Massive Transfusion Protocol (MTP): The coordinated team process **to meet the physician identified need for MT,** led by the ~~MD~~**physician**, between clinical staff, the Blood Bank staff and ancillary staff ~~to meet the MD physician identified need for MT~~. MTP includes collaboratively agreed upon ratios of blood and blood components to be prepared and transfused to meet identified patient's needs.
3. Emergency Release: Due to **the** critical condition of **the** patient, blood and blood products are released for transfusion before all required compatibility testing is completed.

C. **POLICY:**

1. Patients meeting the definition of MT with current, ongoing or impending use should be considered for activation of MTP by the ~~MD~~**physician.**
   a. MTP ~~Activation~~ **activation** should be considered for patients who will/have received greater than 4 RBC units in 1 hour and appear to have an acute on-going requirement for RBC use.
2. MTP may be activated by the order of a physician/Allied Health Professional (AHP) in the Operating Room (OR), Interventional Radiology (IR), Emergency Department (ED), Intensive Care Unit (ICU) or Women and Newborn Services (WNS).
   a. The requesting department should identify a primary contact person for communicating with the Blood Bank when possible.
   b. Multiple people contacting the Blood Bank during MTP are to be discouraged.
3. If the patient needs to have additional RBC on hand at all times but does not need the MTP, order "~~Transfuse~~ **Lab Prepare** RBC" with a comment to "Keep Ahead (X number) of RBC".

D. **PROCEDURE:**

1. Activate MTP upon the order of the ~~Physician~~**physician**/AHP by calling a telephone order to the Blood Bank (x7904). Blood Bank will indicate patient testing status and whether Emergency

Release is necessary for immediate transfusions. Historical ~~Problems~~ **problems** such as antibodies may also be available with the initial call.

2. Include the following information in the **telephone** order **to initiate MTP**:
   a. Patient name, gender and age
   b. Medical Record Number (MRN)
   c. Blood Bank armband number, if available
   d. Diagnosis or source of bleeding
   ~~e. Estimated blood loss/rate of loss~~
   ~~f.~~**e.** Current or intended location—The Blood Bank will contact phlebotomy for STAT draw if necessary for the MTP.
   ~~g.~~**f.** Staff member name and phone number for notifications
3. If not already done, obtain sample and enter a STAT order for type and crossmatch as soon as possible (ASAP).
   a. If possible, the type and cross-match should be collected prior to the start of the transfusion.
   ~~h.~~**b.** Blood Bank staff will notify the physician/AHP if known history of clinically significant antibody and collaborate with pathologist to determine how to proceed.
   ~~i.~~**c.** Turnaround time to issue blood is **approximately**~~expected to be~~ 20 minutes if crossmatch is already completed.

~~2.~~**4.** If necessary, at least two (2) Group O~~)~~ uncrossmatched units are available for emergency release prior to completion of the type and crossmatch.
   ~~j.~~**a.** Call Blood Bank for emergency release units and enter an electronic order for "Emergency O Neg", if possible.
   ~~k.~~**b.** At a minimum, provide ordering physician/AHP name and number of requested units. It is preferred to also provide patient name, MRN, and Blood Bank armband number (if available).
   ~~l.~~**c.** Send a courier to the Blood Bank with a completed Transfusion Request form to obtain the emergency release units.
   ~~m.~~**d.** Blood Bank personnel will dispense requested emergency release units to the courier. ~~To expedite the dispensing process:~~
   ~~n.~~**e.** For all blood products issued as emergency release, the physician/AHP must initial the following statement at the bottom of each Transfusion Record: "Due to critical condition of patient, I accept unit without crossmatch".

~~3.~~**5.** The initial MTP will consist of **releasing two RBC immediately for use without cooler to courier 1. Then units will be** ~~transfusion of~~ **prepared in multiples of** five (5) RBC units and five (5) Thawed Frozen Plasma (FP) units at a 1:1 ratio followed by one (1) unit of Plateletpheresis (PLPH).
   a. 30 minutes are required to thaw and label FP if a second Clinical Laboratory Scientist (CLS) is available in the Blood Bank. Total turnaround time to issue FP is 45 minutes.
   b. One (1) PLPH is normally on hand. The first PLPH will be issued for immediate transfusion, and Blood Bank will keep ahead one (1) PLPH until end of event or alternative physician/AHP instruction.

~~4.~~**6.** The clinical team must ~~place a telephone order~~**send a courier** for subsequent**ly prepared** rounds of blood products ~~if~~ **as long as the MTP event** ~~hemorrhage~~ continues unabated. **Notify Transfusion Service when MTP is discontinued by the physician/AHP**~~MD. See 12. below.~~

~~5. Transfuse 10 units Cryoprecipitate (Cryo) as needed for decreased fibrinogen values, per physician/AHP orders.~~
   ~~a. Cryo units will be set up as ordered by the clinical team.~~
   ~~b. Normally 5 unit pools in single bags are available within 25-30 minutes.~~

~~6. Give Calcium IV for every 2 FP units administered, if corrected serum calcium is less than 2.1mmol/L, or ABG ionic calcium level is less than 1.15mmol/L, per physician orders.~~

~~5.~~**7.** Dispensing Blood Products for use:
   a. Products (including emergency released O Neg uncrossmatched units) are picked up by a designated TCMC staff member presenting a correctly-completed "Transfusion Request Form" for the products.

b. RBC and FP units will be issued in coolers.
c. PLPH and cryo pools are placed in a dual bag delivery system after dispense is completed in Cerner. Do not infuse after expiration date and do not store in coolers.

8. **Transfuse 10 units Cryoprecipitate (Cryo) as needed for decreased fibrinogen values, per physician/AHP orders.**
   a. **Cryo units will be set up as ordered by the clinical team.**
   ~~a.~~b. **Normally 5-unit pools in single bags are available within 10-20 minutes.**

~~6.~~9. Send the following labs STAT after four (4) units of blood products received by patient, per physician/AHP orders:
   a. CBC
   b. **Chem 12**
   c. PTT
   d. PT/INR
   e. Fibrinogen

~~7.~~10. **Calcium administration should be considered and calcium labs be ordered at the discretion of the practitioner during massive transfusion scenarios.**~~Send ionized calcium lab STAT after eight (8) units of blood products received by patient, per physician/AHP orders. (Give calcium instruction here? Yellow highlighted above) check dosing with Pharmacy because IV calcium may would be an antagonist to the calcium binding activity (anticoagulant) of the transfused blood products that may lead to abnormal product clotting if given through same line as blood products.~~

~~8.~~11. Send the following labs STAT as needed, per physician/AHP orders:
   a. Comprehensive metabolic panel
   b. ABG

~~9.~~12. Endpoints/termination
   a. Orders to keep ahead will be maintained until a member of the clinical team notifies the Blood Bank of end-of-event or the physician/AHP updates orders.
   b. Blood Bank staff may call patient location to verify continuation of MTP.
   c. Once stabilized, Blood Bank will keep ahead two (2) RBC units and one (1) FP (2:1 ratio), for 24 hours.
   d. When appropriate endpoints are reached, as judged by the clinical team, the MTP must be discontinued by phone-notification to the Blood Bank, to limit resource wastage.
   e. Most reliable transfusion endpoint is a collaborative decision based on operative field examination, laboratory results, and clinical parameters.
   f. At the completion of the case, the department will be responsible for the return of all unused blood products and coolers to the blood bank.
   g. Any products returned unacceptable for reissue will be discarded.

E. **FORM(S):**
1. Transfusion Request Form - Sample

SAMPLE

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

_____, M.D.

SPECIAL PATIENT REQUIREMENTS: ☐ IRRADIATED

OTHER: _____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)	Quantity
~~O NEG UNCROSSMATCHED RED BLOOD CELL (RBC)'S~~	_____
☐ **EMERGENCY RELEASE RED BLOOD CELLS (RBC)**	_____
☐ RANDOM RBC~~'S~~, LEUKOPOOR	_____
☐ PLATELET PHERESIS**(PLPH)**, LEUKOPOOR	_____
☐ THAWED PLASMA **(TP)**	_____
☐ CRYOPRECIPITATE	_____
☐ AUTOLOGOUS RBC~~'S~~	_____
☐ DONOR SPECIFIC RBC~~'S~~, LEUKOPOOR	_____
☐ OTHER BLOOD COMPONENT: _____	

ADDITIONAL ORDER NOTES:_____

☐ **Massive Transfusion Protocol (5 RBCs:5FP:1PLPH) until ordering physician discontinues/stops**

Transfusion Service Identification Band Number: _____

Order verified by:_____, R.N. Date: _____ Time:_____

Dispensed: Date: _____ **Time:** _____

DO NOT WRITE IN THIS SPACE

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

Affix Patient Label

7500-1009
(Rev. 5/14)

TRANSFUSION REQUEST

White - Chart Yellow - Blood Bank

SAMPLE

Guidelines for Completing Transfusion Request Form
(Add to back of page 1)

1. Attach a current patient chart label to each copy of the form.
2. Record the name of the physician ordering the transfusion on the corresponding line.
3. Check the type of product requested and indicate the number required for the current transfusion.
4. Record the Transfusion Service ID band (BB ID) number in the corresponding area on the form. Use the current band number verified from the patient's BB ID armband.

SAMPLE

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

_____, M.D.

SPECIAL PATIENT REQUIREMENTS: ☐ IRRADIATED

OTHER: _____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)	Quantity
~~O NEG UNCROSSMATCHED RED BLOOD CELL (RBC)'S~~	_____
☐ **EMERGENCY RELEASE RED BLOOD CELLS (RBC)**	_____
☐ RANDOM RBC~~'S~~, LEUKOPOOR	_____
☐ PLATELET PHERESIS**(PLPH)**, LEUKOPOOR	_____
☐ THAWED PLASMA **(TP)**	_____
☐ CRYOPRECIPITATE	_____
☐ AUTOLOGOUS RBC~~'S~~	_____
☐ DONOR SPECIFIC RBC~~'S~~, LEUKOPOOR	_____
☐ OTHER BLOOD COMPONENT: _____	

ADDITIONAL ORDER NOTES: _____

☐ **Massive Transfusion Protocol (5 RBCs:5FP:1PLPH) until ordering physician discontinues/stops**

Transfusion Service Identification Band Number: _____.

Order verified by: _____, R.N. Date: _____ Time: _____

Dispensed: Date: _____ Time: _____

To: _____ Loc: _____ Cooler ID: _____ By: _____

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

Affix Patient Label

7500-1009
(Rev. 5/14)

TRANSFUSION REQUEST

White - Chart Yellow - Blood Bank

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PNEUMOCOCCAL AND INFLUENZA VACCINE SCREENING AND ADMINISTRATION

I. **POLICY:**

A. Function:

1. To provide guidelines to the Registered Nurse (RN) when administering Pneumococcal and/or Influenza Vaccine(s) to the appropriate patient(s) as indicated per criteria set forth by the Pharmacy and Therapeutics Committee and the Medical Executive Committee.
2. To provide guidelines when a physician does not want the patient to receive the vaccine(s).

B. Circumstances for Pneumococcal Vaccine:

1. Setting: Tri-City Medical Center
2. Supervision: None required
3. Exclusions: Immunization in the laboring patient and women currently pregnant will be according to physician orders and not this standardized procedure.
4. Patient indications:
   a. Pneumococcal Vaccine Risk Assessment for all patients 65 years and older.
   b. Prevnar 13 should be given to patients age 65 and older who have never received Prevnar 13, Pneumovax 23, or have unknown vaccination history.
   c. If the patient does not meet criteria above, do not immunize.
5. The Pneumococcal Vaccine should NOT be routinely given without a physician's order if the patient:
   a. Has a contraindication:
      i. Had a previous reaction to the Pneumococcal vaccine.
      ii. Received a bone marrow transplant within the past 6 months.
      iii. Has received chemotherapy or radiation within the last 2 weeks.
      iv. Has received the shingles vaccine (Zostavax) within the last 4 weeks.
   b. Ordered not to have vaccine by physician.
   c. Refuses or advocate refuses.
6. If no exclusion criteria identified, then immunize.

C. Circumstances for Influenza Vaccine:

1. Setting: Tri-City Medical Center
2. Supervision: None required
3. Exclusions: Immunization in the laboring patient will be according to physician orders and not this standardized procedure.
4. Patient indications:
   a. Influenza Vaccine Risk Assessment for all patients 6 months of age and older.
   b. The Influenza Vaccine should be given to patients admitted and/or discharged during the normal flu season until the vaccine is no longer available, if any of the following indications are met:
      i. Age 6 months and older.
      ii. Women who will be pregnant during the influenza season (October through March) NOTE: Influenza vaccine is not contraindicated at any stage of pregnancy.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Infection Control Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
3/06, 1/15, 03/18	12/11, 2/15, 06/15, 01/16, 04/18	12/1, 07/15, 01/16, 04/18	1/12, 07/15, 01/16, 05/18	07/15, 03/16, 10/18	1/12, 09/15, 07/16, 10/18	2/12, 09/15, 09/16, 11/18	01/19	10/15, 10/16, n/a	2/12; 10/15, 11/16

iii. Women who are knowingly pregnant shall receive single-dose preservative free* vaccine (*Not to exceed 1mcg of Thimerosal per 0.5mL dose).
1) Pharmacy to provide single-dose syringe/vial for knowingly pregnant women if available.
iv. Influenza immunization history is unknown by patient or advocate.

5. The Influenza Vaccine should NOT be given if the patient:
   a. Has contraindication
      i. Has allergy to eggs or reaction to prior influenza vaccine (i.e., anaphylactic allergic reaction).
      ii. Had diagnosis of Guillian-Barre Syndrome within six (6) weeks of vaccination (will be left up to the individual healthcare provider to decide if recommended).
      iii. Received bone marrow transplant within past six (6) months.
      iv. Had a previous influenza immunization this flu season.
   b. Ordered not to have vaccine by physician.
   c. Refuses or advocate refuses.
6. If no exclusion criteria identified, then immunize.

II. PROCEDURE:

A. During the initial assessment, the RN will complete the Pneumococcal /Influenza Vaccination Adult Immunization Assessment Screen in Cerner to determine whether or not the vaccinations are indicated according to the following criteria:
   1. If the patient meets any inclusion criteria and no exclusion criteria, the RN will inform the patient/advocate that they are eligible for the vaccination(s), give the patient/advocate the vaccination information sheet(s), and plan to administer the vaccination(s).
   2. If the RN is unsure of whether the patient is a candidate for the vaccine(s), the physician should be contacted for specific orders.
B. Unless the physician has signed an order to withhold the Pneumococcal and/or Influenza vaccine, remove the age appropriate dose assigned by pharmacy from the Pyxis Medication station and administer the vaccine(s).
C. For patients in the Emergency Department, the Pneumococcal and/or Influenza vaccine should be administered at the time the physician order is received.

III. DOCUMENTATION:

A. Document the vaccine administration in the medical record.
B. Document vaccine lot number and site of administration.
C. Document that the Vaccination Information Sheet was given to the patient.
D. Document refusal of immunizations.
E. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record.
   1. Not required if a screening process triggers the order.

IV. PATIENT EDUCATION:

A. If the patient meets inclusion criteria, the RN will review the Pneumococcal and Influenza Vaccine Information sheet(s) with the patient and give the patient a copy.
B. For transfers to skilled nursing facilities and other hospitals, print and send a copy of the Immunization Tab indicating vaccine(s) administered, with a copy of the Medical Record.

V. REQUIREMENTS FOR R.N. INITIATING STANDARDIZED PROCEDURE:

A. Current **unencumbered** California RN license
B. Initial evaluation: Orientation
C. Ongoing evaluation: Annually with Skills Lab/Skills Validation

VI. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every 2 years or review procedure per Hospital policy.

VII. **CLINICIANS AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:**

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Administration of Pneumococcal and/or Influenza Vaccine.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SEDATION/ANALGESIA USED DURING THERAPEUTIC OR DIAGNOSTIC PROCEDURE**
Purpose:	To establish guidance for the safe administration of sedatives used specifically for a level of sedation referred to as moderate sedation/analgesia (previously referred to as "conscious sedation") and deep sedation, delineate required components of care delivery and facilitate comparability of care organization-wide in sedation/analgesia. This procedure does not apply to therapeutic/diagnostic procedures when anesthesiologist is present or NICU setting.
Equipment:	The following equipment/supplies are readily available and functional during sedation and recovery periods: Emergency cart with cardiac monitor/defibrillator and airway management equipment readily available Cardiac Monitor Capnography Monitor Pulse oximeter with alarm Blood Pressure **(BP)** Monitor Suction Equipment Positive-pressure oxygen delivery system available Reversal medications -Naloxone (Narcan) and Flumazenil (Romazicon) - readily available

A. **DEFINITION(S):**

1. Richmond Agitation-Sedation Scale (RASS):

4	Combative	Overly combative or violent, immediate danger to staff
3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
2	Agitated	Frequent non purposeful movement or patient-ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
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	Briefly, less than 10 seconds, awakening with eye contact to voice
-3	Moderate Sedation	Any movement, but no eye contact to voice
-4	Deep Sedation	No response to voice, but any to movement to physical stimulation
-5	Unresponsive	No response to voice or physical stimulation

2. Minimal Sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. This level of sedation is associated with the RASS score of - 2.
3. Moderate Sedation/Analgesia (Previously referred to as "Conscious Sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Note: Reflex withdrawal from painful stimulus is not considered a purposeful response.) No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is usually maintained. Moderate sedation/analgesia may only be administered during therapeutic,

Department Review Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/06, 10/08, 06/11, 02/12, 11/15; **03/18**	08/12, 02/16, 05/16, **4/18**	08/12, 05/16, **07/18**	03/17, **09/18**	03/17, **11/18**	10/12, 04/17, **11/18**	**01/19**	10/12, 06/17, **n/a**	10/12, 06/17

diagnostic or surgical procedures. This level of sedation is associated with the RASS score of –3.

a. Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g. propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.

4. Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. This level of sedation is associated with the RASS score of - 4.
   a. A Registered Nurse (RN) may not administer medications for deep sedation (propofol, ketamine, or etomidate) or provide monitoring for deep sedation.
   b. Medication administration for deep sedation may only be performed by a physician who has been privileged in deep sedation.
   c. Monitoring for deep sedation may be performed by a physician/AHP.
5. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia.
   a. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
6. Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiological consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.
7. Allied Health Professional (AHP): An individual credentialed/privileged to provide specified patient care, treatment and services.
8. End tidal CO_2 ($EtCO_2$): The measuring of End tidal CO_2 ($EtCO_2$) via the Capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.
9. Respiratory depression: can be defined as:
   a. $EtCO_2$ values 10mmHg higher or lower than the patient's baseline with an absolute maximum of 50mmHg
   b. 10% change in $EtCO_2$ values above or below a patient's baseline
   c. Apnea that last for **fifteen (15)** seconds or longer

B. **POLICY**:

1. Tri-City Medical Center (TCMC) provides for the safe administration of sedatives, **to** minimize clinical risks to patients, and assure comparability of care throughout the organization.
2. This policy is intended to discuss the care of patients receiving a specific level of sedation/ analgesia under the care of non-anesthesiologists privileged to administer sedation/analgesia. It has been designated to be applicable to procedures performed in a variety of settings and by various disciplines. These settings may be inpatient or outpatient and include but are not limited to:
   a. Moderate Sedation: Cardiac Catheterization Lab, Critical Care, Telemetry, Diagnostic Imaging, Emergency Department, Operating Room/ Endoscopy/ Bronchoscopy, Post Anesthesia Care Unit, Interventional Radiology.
   b. Deep Sedation: Emergency Department
3. This policy excludes:

a. Patients who are NOT undergoing therapeutic or diagnostic procedures (i.e., preoperative or postoperative sedation, pain management, sedation for insomnia, or seizure management)
b. Emergent procedures
c. Patients undergoing major regional anesthesia or general anesthesia.
d. Situations where it is anticipated that the required sedation analgesia will eliminate purposeful response to verbal commands or tactile stimulation accompanied by partial or complete loss of protective reflexes; such patients require a greater level of care than covered in this policy.
e. Otherwise healthy patients receiving peripheral nerve blocks, local or topical anesthesia.
f. Minimal Sedation/Anxiolytic - *note*: if patient slips into the moderate sedation level, this sedation/analgesia procedure must be implemented.
g. Drug or alcohol withdrawal or prophylaxis.
h. The use of any level of sedation/analgesia in any area of the hospital where an anesthesiologist is present.
i. Single doses of sedatives and narcotics (**oral [PO], intramuscular [IM],** or **intravenous [IV]**) given in usual and customary doses for routine care of patients during procedures such as dressing changes, etc., do not require the provider to follow the sedation policy as long as the RASS score remains at a – 1 or below.
j. The decision to use a single dose of medication for anxiolysis or pain control or to use the sedation policy should be based on the patient's history and planned procedure.

4. Patient Consent:
   a. Pre-procedural education, treatments, and services are provided according to the plan of care
   b. Physician/AHPs shall be responsible for discussing alternatives and risks prior to administration of medication as in any other procedure.
   c. Procedural/Informed consents are required to be signed by all patients before any **invasive** procedures. **See Patient Care Services Policy: Consent for Operative or Other Procedures for complete details.**
      ~~i. Adolescent patients shall participate in the consent process as appropriate.~~
5. The Registered Nurse (RN) will monitor the patient for the presence of pain. Any patient undergoing a procedure who expresses concern regarding unresolved pain management has the right to request pain relief. Any patient request for temporary cessation or termination of the procedure will be honored as expeditiously as possible.
6. Medical Staff Credentialing Requirements:
   a. In order to prescribe and administer moderate or deep sedation/analgesia a physician/AHP must have requisite privilege (physician/AHP privileges available on TCMC Intranet). See Medical Staff Policy: Criteria for Granting Moderate and Deep Sedation/Anesthesia Privileges to Non-Anesthesiologists.
7. RN Training Requirements:
   a. Moderate sedation self-study and test.
   b. Demonstrate competency in basic dysrhythmia recognition
   c. BLS, training including airway management, recognition of cardiovascular and respiratory side effects of sedatives and variability of patient responses with re-certification every **two (2)** years is required.
   d. ACLS, PALS, ENPC, NRP **required (**~~staff member is readily available~~ as appropriate **to patient population).**
      i. Healthcare providers shall use child CPR guidelines for children from **one (1)** year of age to puberty.
         1) Signs of puberty include breast development on the female and underarm, chest, and facial hair on the male. Once a child reaches puberty, healthcare providers shall use adult CPR guidelines for resuscitation.
8. Administering medications:

a. Medication administration for deep sedation may only be performed by a physician~~/~~ who has been privileged in deep sedation.
b. The physician/AHP is present prior to administering any moderate sedation/analgesia medication.
c. ~~Intravenous (~~IV~~)~~ sedation/~~-~~analgesia drugs should be given in small incremental doses that are titrated to the desired endpoints of analgesia and sedation. Sufficient time must elapse between doses to allow the effect of each dose to be assessed before subsequent drug administration. When drugs are administered by non-IV routes (~~oral~~**PO**, rectal, ~~intramuscular (~~IM~~)~~, intranasal), allowance should be made for the time required for drug absorption before supplementation is considered.
d. All medications commonly used in moderate sedation, regardless of their safety profile, produce general anesthesia and may cause cardio~~-~~respiratory arrest.
e. See resource on TCMC Intranet for the list of medications commonly used for moderate sedation/analgesia, reversal agents, and typical dosages for all ages.
f. The RN who is directly responsible to administer medications, monitor and observe the patient's response to medications shall be with the patient at all times and may not engage in tasks that would compromise continuous monitoring during the procedure.
g. Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g., propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.
h. A Registered Nurse (RN) may not administer medications for deep sedation (**e.g.,** propofol, ketamine, or etomidate) or provide monitoring for deep sedation.

9. Required Staff, Equipment and Supplies
   a. Sufficient numbers of qualified staff (in addition to the person performing the procedure) are present to evaluate the patient, assist with the procedure, provide sedation and/or anesthesia, monitor, and recover the patient.
   b. Minimum Staffing Requirements
      i. Moderate Sedation
         1) Physician/AHP to perform procedure
         2) RN to monitor patient
         ~~2)~~**3) Healthcare provider (e.g., RN, Respiratory Therapist, technician) to assist the physician/AHP with the procedure**
      ii. Deep Sedation
         1) Physician/AHP to perform the procedure
         2) Physician/AHP to monitor the patient
         3) RN to assist physician/AHP

C. **PROCEDURE PRE-SEDATION:**

1. Pre-procedure RN:
   a. Reviews the anticipated needs of the patient are assessed to plan for the appropriate level of post~~-~~procedure care.
   b. Ensures a pre-anesthesia/sedation assessment is performed by the physician/AHP and documented in the health record.
   c. Ensures the physician/AHP documents patient's unchanged condition from last History and Physical **(H&P)** or performs a pertinent pre-anesthesia/sedation assessment, to include, but not limited to:
      i. Cardiac, respiratory and/or other major system abnormalities
      ii. Current medications and drug allergies and/or adverse experience **with** sedation/analgesia and anesthesia.
      iii. Airway Assessment: Patient's ability to hyperextend neck, maintain airway and open mouth without difficulty~~, and~~ if teeth are intact **and mallampati score.**
      iv. Time and nature of last oral intake. Recommended guidelines
         1) Patients should be NPO prior to procedure time for:
            a) **Two (2)**~~Six (6)~~ hours after clear liquids

b) Eight (8) hours after solids

2) Oral medications may be taken with small amounts of clear liquids.

3) Patients under **ten** (10) years of age must be NPO for a period of time as indicated below:

a) Infants 0 **to** ~~1~~ **2** years of age:

i) No solids the day of procedure

ii) Formula ~~or~~**until six (6) hours before procedure**

~~ii)~~**iii)** ~~b~~**B**reast milk until four (4) hours before procedure

~~iii)~~**iv)** Clear liquids until **two** (2) hours prior to procedure

~~iv)~~**v)** NPO thereafter until the procedure.

~~b) Ages 1 to 2 years:~~

~~i) No solids the day of procedure~~

~~ii) Full liquids until six (6) hours prior to procedure~~

~~iii) Clear liquids until three (3) hours prior to procedure~~

~~iv) NPO thereafter until the procedure~~

~~c)~~**b)** Ages 3 to 10 years:

i) No solids the day of procedure

ii) Clear liquids until **two (2)**~~four (4)~~ hours prior to procedure

iii) NPO thereafter until the procedure

v. American Society of Anesthesiologists (ASA) Physical Status Classification System

ASA PS Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient.	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with a mild systemic disease.	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease.	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life.	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation.	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction

ASA VI	Patient declared brain dead whose organs are being removed for donor purposes.	

d. Verify physician/AHP orders for sedation.
e. Ensure IV access in place (as ordered by physician/AHP):
   i. Appropriate equipment to administer intravenous fluids and drugs including blood and blood components is available.
f. Review/initiate individualized plan of care.

2. Immediately Pre-Procedure, RN monitoring or assisting **the physician**/AHP shall:
a. ~~Check~~**Verify the procedural** consent **form is accurate and complete**
b. Verify procedure with patient
c. Obtain baseline vital ~~S~~signs: BP, heart rate, respiratory rate, $EtCO_2$, ~~LOC,~~ **Aldrete, RASS, oxygen (~~02~~O_2)** saturation, ~~P~~pain score and document on the Sedation Flowsheet or electronic medical record.
   i. For pediatric patients, include height and weight. Calculate correct dosage of reversal agent for potential administration prior to procedure.
~~d. Assess Level of Consciousness (LOC): Level of alertness and orientation to person/time/place/event (age appropriate).~~
~~e.~~**d.** Ensure a "time out" is completed before starting the procedure as described in the Patient Care Services **Procedure:** Universal Protocol.
~~f. The patient is re-evaluated before moderate or deep sedation.~~

D. **INTRA-PROCEDURE FOR PLANNED MODERATE SEDATION:**

1. Measure/assess on an ongoing basis and document every **five** (5) minutes or more often if significant changes in the patient's condition occurs during the procedure:
a. BP
b. Heart rate
   i. Continuous EKG rhythm is recommended for all patients receiving moderate sedation/analgesia, and REQUIRED for patients with ASA score of III or greater.
c. Respiratory rate
d. Adequacy of ventilation
e. $EtCO_2$ (except for mechanically ventilated patients)
f. O_2 Saturation
g. Level of sedation for adults using the RASS:

4	Combative	Overly combative or violent, immediate danger to staff
3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
2	Agitated	Frequent non purposeful movement or patient-ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
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	Briefly, less than 10 seconds, awakening with eye contact to voice
-3	Moderate Sedation	Any movement, but no eye contact to voice
-4	Deep Sedation	No response to voice, but any to movement to physical stimulation
-5	Unresponsive	No response to voice or physical stimulation

h. Level of sedation for pediatrics using the Aldrete Score:

Activity:	Able to move 4 extremities voluntarily or on command	Score: 2
	Able to move 2 extremities voluntarily or on command	Score: 1
	~~Una~~Able to move no extremities ~~voluntarily or~~ on command	Score: 0
Breathing ~~Respiration:~~	Able to breathe deeply and cough freely	Score: 2
	Dyspnea~~, limited breathing, or tachypnea~~	Score: 1
	Apneic ~~or mechanical ventilator~~	Score: 0
Circulation:	BP **less than or equal to (<)**= 20% of pre-anesthetic level	Score: 2
	BP **is**= 20% to **50~~49~~**% of pre-anesthetic level	Score: 1
	BP **greater than or equal to (>)**= 50% of pre-anesthetic level	Score: 0
Consciousness:	Fully awake	Score: 2
	Arousable ~~on calling~~	Score: 1
	Not responding	Score: 0
Oxygen Saturation (Pulse Oximetry):	**Greater than (>) 92% on room air**	**Score: 2**
	Needs supplemental oxygen to maintain greater than (>) 90%	**Score: 1**
	Less than (<) 90% with oxygen	**Score: 0**

i. Pain level

j. O_2 saturation and heart rate are monitored continuously throughout the procedure. If O_2 saturation is not maintained at or above 90%, (unless baseline was below 90%), obtain an order for supplemental oxygen and/or anesthesia consult. Supplemental oxygen is also recommended during the procedure for the following:
   i. ASA class III or greater patients
   ii. Patients whose O_2 saturation reading is less than 90% pre-procedure while on room air

k. The measuring of ~~End tidal CO_2 ($EtCO_2$)~~ via the ~~C~~capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.
   i. If during the procedure hypoventilation or respiratory depression occurs, intervene immediately by:
      1) Repositioning the patient's head to open up the airway
      2) Verbally or physically stimulate the patient to breathe
      3) If the patient is apneic, start bag/mask ventilation.
   ii. Respiratory depression can be defined as:
      1) $EtCO_2$ values 10mmH~~G~~g higher or lower than the patient's baseline with an absolute maximum of 50mmHg
      2) 10% change in $EtCO_2$ values above or below a patient's baseline
      3) Apnea that last for 15 seconds or longer
   iii. Important: Respiratory depression may occur after the procedure is complete. That is, before the patient returns to a level of consciousness. Continue to monitor the patient with $EtCO_2$ until the patient is fully awake and alert or returns to baseline.

l. Medications and fluids including drugs, dosages, route, times and personnel administering drugs are documented in the medical record.

m. Any unusual occurrences are documented.

E. **INTRA-PROCEDURE PLANNED FOR DEEP SEDATION:**

1. The RN shall document vital signs as requested by physician/AHP.

F. **POST PROCEDURE CARE, DOCUMENTATION AND DISCHARGE:**

1. Patients status is assessed immediately after the procedure and/or administration of moderate or deep sedation and vital signs and pain level are continuously monitored and documented every 5 - 15 minutes according to the patient's condition or until the vital signs return to the pre-procedure baseline (minimum recovery time is 30 minutes), and the following criteria are met:
   a. Patient achieves a score of ~~87~~ or greater (or pre-sedation baseline), on the ~~modified~~ Aldrete scoring system:

Activity:	Able to move 4 extremities voluntarily or on command	Score: 2
	Able to move 2 extremities voluntarily or on command	Score: 1
	~~Una~~Able to move **no** extremities ~~voluntarily or~~ on command	Score: 0
Breathing ~~Respiration:~~	Able to breathe deeply and cough freely	Score: 2
	Dyspnea~~, limited breathing, or tachypnea~~	Score: 1
	Apneic ~~or mechanical ventilator~~	Score: 0
Circulation:	BP **less than or equal to (<)**= 20% of pre-anesthetic level	Score: 2
	BP **is**= 20% to **50~~49~~**% of pre-anesthetic level	Score: 1
	BP **greater than or equal to (>)**= 50% of pre-anesthetic level	Score: 0
Consciousness:	Fully awake	Score: 2
	Arousable~~ on calling~~	Score: 1
	Not responding	Score: 0
Oxygen Saturation (Pulse Oximetry):	**Greater than (>) 92% on room air**	**Score: 2**
	Needs supplemental oxygen to maintain greater than (>) 90%	**Score: 1**
	Less than (<) 90% with oxygen	**Score: 0**

   b. If the patient does not meet the above criteria, the physician/AHP is notified for further orders.
   c. If a reversal agent has been used the patient shall be recovered for an additional **ninety** (90) minutes.
   d. Patients must meet the following discharge criteria prior to being discharged home:
      i. Pre-procedure LOC
      ii. Pre-procedure ~~A~~activity
      iii. Vital signs within pre-procedure values
      iv. Oral fluids ~~retained~~**tolerated**
      v. Pain controlled
      vi. Voided
      vii. Evaluate procedure site
      viii. Dressing clean & dry
   e. Obtain a Physician/AHP order for discharge when all criteria are met.
   f. The patient and/or designated adult receives discharge instructions if outpatient and accompanied home by a responsible adult.
2. Monitoring Outcomes:
   a. Outcome data shall be collected in all areas where moderate or deep sedation/analgesia is performed. Data shall be aggregated by department/service and practitioner specific.

The anticipated needs of the patient are assessed to the plan for the appropriate level of post-procedure care.

3. Pre-procedureal education, treatments, and services are provided according to the plan of care, treatment, and services.
4. Patient Discharge:
   a. Patients are discharged from the recovery area and the hospital by a qualified physician/AHP ~~and-by~~**when they** meeting discharge criteria.
   b. Patients who have received sedation in the outpatient setting are discharged in the company of a responsible, designated ~~adult~~**person per Patient Care Services Policy: Outpatient Post Anesthesia/Procedure Discharge/Transportation Guidelines.**

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

1. Agents Commonly Used for Procedural Sedation
2. ~~Physician Pre-Procedure/Sedation Assessment 8720-1028 - Sample~~
3. Sedation Flow Sheet 8720-1030 - **Sample**
4. ~~Sedation/Analgesia Audit 7420-1030~~
4. **Patient Care Services Policy: Outpatient Post Anesthesia/Procedure Discharge/Transportation Guidelines**

H. **REFERENCE(S):**

1. ~~AORN 2016 Guidelines for Perioperative Practice~~
1. **Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**
2. *ASA Physical Status Classification System*. (2014). Retrieved January 11th, 2016, from American Society of Anesthesiologists: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system
3. In, U. L, S. K, & L. M(2006). *Thelan's Critical Care Nursing Diagnosis and Management* (5th Edition ed., p. 153). St. Louis, Missouri: Mosby Elsevier.
3.4. **Nicholau, T. K. (2015). Postanesthesia Scoring System. In R. D. Miller, *Miller's Anesthesia* (8th Edition, p.2942). St. Louis, Missouri: Saunders Elsevier**
4.5. Rothrock, Jane C. (2015) Alexander's Care of the Patient in Surgery, 15th Edition.

SAMPLE

Physician: _____ Procedure: _____

Allergies _____

Immediately Prior To This Procedure

Ht: _____

❑ History & Physical completed and attached. ❑ Power Note: ED Wt: _____

History of difficulty with anesthesia/Sedation. ❑ Yes ❑ No

❑ Interval Change in patient's status ❑ Yes ❑ No since History & Physical date _____ (explain below)

_____

NPO Status: _____

Airway Assessment WNL

Physician's verification

❑ I have discussed the fo its

and risks and the possible ent's/

Patient legal representati

_____

_____

_____

DELETE – Use electronic documentation

ASA Classification

❑ Class I Normal health patient.

❑ Class II A patient with mild systemic disease.

❑ Class III A patient with severe systemic disease that limits activity but is not incapacitating.

❑ Class IV A patient with an incapacitating systemic disease that is a constant threat to life.

❑ Emergency medical condition

Plan for Sedation

Plan:

❑ Moderate Sedation/Analgesia

❑ Deep Sedation/Analgesia

❑ Supplemental Oxygen

❑ IV _____

❑ Patient is an appropriate candidate for planned sedation

Medication: _____

_____

_____

_____

Post Sedation Plan of Care

❑ PACU/OP-PACU to non-monitored bed ❑ Emergency Department

❑ PACU/OP-PACU to ICU

❑ PACU/SPRA to Telemetry

❑ OP-PACU then discharge home

❑ ICU-TELE direct

❑ ACS/Non-Monitored bed

Comments: _____

_____

_____

Informed Consent

❑ Risks, benefits, and alternatives explained and patient/surrogate accepted plan for sedation/procedure

Re-evaluation

❑ Patient re-evaluated immediately prior to sedation. [See Flow Sheet]

Signature

Attending Physician: _____ **Date:** _____ **Time:** _____

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

8720-1028

(Rev 5/13)

PHYSICIAN PRE-PROCEDURE/ SEDATION ASSESSMENT

SAMPLE

Sedation Flow Sheet

Procedure:_____

Allergies: _____ Date: _____

~~MODIFIED~~ ALDRETE SCORING SYSTEM		Pre	Post	D/C
ACTIVITY				
Able to move 4 extremities voluntarily or on command	2			
Able to move 2 extremities voluntarily or on command	1			
~~Una~~Able to move no extremities ~~voluntarily or on~~ command	0			
BREATHING ~~RESPIRATION~~				
Able to breathe deeply and cough freely	2			
Dyspnea~~, limited breathing or tachypnea~~	1			
Apneic~~ or on mechanical ventilator~~	0			
O_2 SATURATION (PULSE OXIMETRY)				
Greater than (>) 92% on room air	**2**			
Needs supplemental oxygen to maintain greater than (>) 90%	**1**			
Less than (<) 90% with oxygen	**0**			

~~MODIFIED~~ ALDRETE SCORING SYSTEM		Pre	Post	D/C
CIRCULATION				
BP ≤= 20% of pre-anesthetic level	2			
BP is= 20% to 5049% of pre-anesthetic level	1			
BP ≥= 50% of pre-anesthetic level	0			
CONSCIOUSNESS				
Fully awake	2			
Arousable ~~on calling~~	1			
Not responding	0			

Calculate TOTAL SCORE before / immediately after procedure and upon discharge or discontinuing 1:1 Monitoring

Physician Pre-Procedure Sedation Assessment form in chart
☐ yes ☐ no

Time Out Time:_____
Procedure Start: _____
Procedure End: _____

Pre Procedure Target Pain Score: _____

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

Patient Assessment	Time	BP	HR	RR	ETCO2	O2 sat %	RASS (LOC)	Pain Level	Nursing Notes Medications / Cardiac rhythm
Immediate Pre-Procedure vital signs									
Intra-Procedure vital signs Minimally **every 5 minutes** based on patient's condition									
Immediate Post-Procedure vital signs									
Post-Procedure vitalsigns **every 15 minutes** until meets criteria for discharge or discontinue 1:1 monitoring									

SAMPLE

** LOC = Level of Consciousness Score patients using the RASS score as listed below:

0 = Alert and Calm
+1 = Anxious, apprehensive, not aggressive
+2 = Frequent nonpurposeful movement, fights ventilator
+3 = Pulls or removes tube(s), catheters; aggressive
+4= Combative, violent, danger to staff

-1= Awakens to voice (eye opening/contact) >10 seconds
-2= Light sedation, awakens to voice (eye opening/contact) <10sec
-3= Moderate sedation, movement/ eye opening no eye contact
-4= Deep sedation, no response to voice, movement or eye opening to physical stimulation
-5= Unarousable, no response to voice or physical stimulation

Medication Totals

Signature_____ Date/Time _____

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SEDATION FLOW SHEET

8720-1030
(Rev 11/17)

Sedation Flow Sheet

Case Attendees:	Role:
	☐MD ☐PA ☐RN ☐RT ☐Scrub ☐Other_____
	☐MD ☐PA ☐RN ☐RT ☐Scrub ☐Other_____
	☐MD ☐PA ☐RN ☐RT ☐Scrub ☐Other_____
	☐MD ☐PA ☐RN ☐RT ☐Scrub ☐Other_____
	☐MD ☐PA ☐RN ☐RT ☐Scrub ☐Other_____

Patient Position:

Specimen Collected: ☐ No ☐ Yes

Specimen Description	Test Requested	Verified with Physician	Specimen comments
		☐yes ☐no	
		☐yes ☐no	
		☐yes ☐no	

Implants Placed : ☐ No ☐ Yes

Implant ID Description	Catalog number	Manufacturer	Expiration Date	Serial No.	Lot No.	Size	Implant Site	Quantity

Scope used during procedure: _____

Medications given on field:

Medication	Medication Dose	Comment(s)

OUTCOMES: (One selection required/Check all that apply)

- ☐ No Complications, case completed as planned
- ☐ Unplanned escalation to moderate sedation level
- ☐ Unplanned escalation to deep sedation level
- ☐ Patient received reversal medications (i.e Naloxone, Flumazenil)
- ☐ Unplanned respiratory support required in light or moderate sedation (i.e. placement of nasal trumpet or oral airway, supraglottic airway, or ET tube, chin lift/jaw thrust, assisted ventilation with bag-valve-mask)
- ☐ Oxygen saturation < 85% for greater than 3 minutes
- ☐ Hemodynamic instability requiring intervention (e.g. fluid bolus, pressor agents)
- ☐ Patient experienced a serious adverse event (e.g. perforation, anaphylaxis, aspiration, cardiac arrest, death)
- ☐ Unplanned admission/ transfer to a higher level of care
- ☐ Other/Comments_____

DISCHARGE CRITERIA FOR PATIENTS GOING HOME (Complete for Outpatients Only)

Pre-Procedure LOC	Met	Not Met	N/A
Pre-Procedure Activity	Met	Not Met	N/A

SAMPLE

Vital signs within pre-procedure values	Met		Not Met	N/A
Oral Fluids Retained	Met		Not Met	N/A
Pain Controlled	Met		Not Met	N/A
Voided	Met		Not Met	N/A
Evaluate procedure Site	Met		Not Met	N/A
Dressing Clean and dry	Yes	No	N/A	Changed X:

Signature _____ Date/Time _____

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SEDATION FLOW SHEET

8720-1030
(Rev 11/17)

Agents Commonly Used For Procedural Sedation

DRUG	CLASS & MECHANISM OF ACTION	DOSING GUIDELINES (IV ADMINISTRATION	ONSET, PEAK EFFECT, AND DURATION OF ACTION	ADVERSE DRUG REACTIONS	COMMENTS	REVERSAL
Midazolam (Versed)	Benzodiazepine (Binds to GABA receptor resulting in CNS depression)	**IV:** 0.02-0.04 mg/kg **IM:** 0.02-0.1 mg/kg **PO:** 0.5-0.8 mg/kg	Onset(IV): 1-3 min ** allow 15-30 min for effect with PO administration** Peak Effect (IV): 5-7 min Duration of Action(IV): 20-40 min	Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation.	Advantages include quick onset and short duration of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress.	Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses
Lorazepam (Ativan)	Benzodiazepine (Binds to GABA receptor resulting in CNS depression)	**IV:** 0.02-0.04 mg/kg **IM:** 0.5-1 mg	Onset(IV): 3-7 min Peak Effect(IV): 10-20 min Duration of Action (IV): 6-8 hrs.	Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation.	Slower onset and longer duration of action than midazolam. Limited utility in procedural sedation due to slower onset of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress.	Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses
Diazepam (Valium)	Benzodiazepine (Binds to GABA receptor resulting in CNS depression	**IV:** 1-5 mg **IM:** Unreliable absorption **PO:** 5-10 mg	Onset(IV): 1-5 min ** allow at least 30 min for effect with PO administration** Duration of Action (IV/PO): 6-8 hrs.	Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation.	Longer duration of action than midazolam and lorazepam. Limited utility in procedural sedation due to slower onset of action. Reduce dose by 25-30% when combining with opioid to decrease risk of respiratory distress.	Flumazenil (0.2 mg over 15 seconds, may repeat every 1 min with MAX of 4 doses

DRUG	CLASS & MECHANISM OF ACTION	DOSING GUIDELINES (IV ADMINISTRATION	ONSET, PEAK EFFECT, AND DURATION OF ACTION	ADVERSE DRUG REACTIONS	COMMENTS	REVERSAL
Fentanyl (Sublimaze)	Opioid narcotic (Binds to opioid receptor in the CNS)	**IV:** 0.5-1 mcg/kg; *MAX: 2 mcg/kg per procedure or 250 mcg*	Onset: 1-2 min Peak Effect: 10-15 min Duration of Action: 30-60 min	Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash	Quick onset and short duration of action. Reduce dose when combining with benzodiazepines. Less histamine release and hypotension than morphine.	Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed)
Morphine	Opioid narcotic (Binds to opioid receptor in the CNS)	**IV:** 2-4 mg increments; *MAX :15-20 mg/procedure* **IM/SQ**: not recommended due to tissue necrosis with repeat doses (0.1 mg/kg; max 4 mg/DOSE)	Onset: 2-3 min Peak Effect: 20 min Duration of Action: 2-4 hrs.	Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash	Slower onset and longer duration of activity vs. fentanyl. More histamine release and hypotension especially in under resuscitated patients vs. fentanyl. Reduce dose when combining with benzo.	Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed)
Meperidine (Demerol)	Opioid narcotic (Binds to opioid receptor in the CNS)	**IV:** 25-50 mg increments *MAX: 150mg/procedure*	Onset: 5 min Peak Effect: 1 hour Duration of Action: 2-4 hrs.	Seizures, hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash	No major advantage over other opioids. Use is not recommended in the elderly due to increased risk of adverse events including seizures.	Naloxone (0.4mg initially followed by 0.1-0.2mg every 2-3 min as needed)

DRUG	CLASS & MECHANISM OF ACTION	DOSING GUIDELINES (IV ADMINISTRATION	ONSET, PEAK EFFECT, AND DURATION OF ACTION	ADVERSE DRUG REACTIONS	COMMENTS	REVERSAL
Propofol (Diprivan)	Hypnotic/anesthetic phenolic compound (General anesthetic and sedative properties; Structurally unrelated to opioid, barbiturate, and benzodiazepine drugs)	**IV bolus:** 1mg/kg *MAX: 100 mg /procedure*	Onset: 30 seconds Duration of Action: 10-15 min	Hypotension, heart block, asystole, and other arrhythmias, bradycardia, and possible infection from lipid based vehicle. Allergic reactions in patients with a history of an egg allergy	Rapid onset and short duration of action. Bolus doses are restricted to patients monitored for hypotension and bradycardia (ED/ICU). No analgesic effect, caution for respiratory distress when combined with opioids.	NONE
Ketamine (Ketalar)	Dissociative general anesthetic (Produces a cataleptic-like state in which the patient is dissociated from the surrounding environment; Produces intense analgesia and sedation without causing hypotension)	**IV:** 0.2-1mg/kg **IM:** 2-4 mg/kg *MAX: 2mg/kg (per procedure)*	Onset 1-2 min Duration of Action: 15-30 min		Can cause Hypertension and tachycardia. Avoid in patients with aneurysms, elevated ICP, or hypertension. Produces both sedation and analgesia. SLOW IV push to avoid respiratory depression, especially when combined with opioids.	NONE

Pediatric Dosages-IV
(under 12 years of age)

Medication-Pediatric IV/IM	Dose (Pediatric)	Incremental Dose Interval	Reversal
Midazolam (Versed)	0.05-0.1 mg/kg, max total dose 6 mg	Q 3-5 min	Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose: 0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg
Fentanyl (Sublimaze)	0.5-2 mcg/kg, start with 0.5 mcg/kg may repeat every 15 min up to max 3 mcg/kg total for procedure	Every 15-30 min	Naloxone IV: Birth (including premature infants) to 5 years old or < 20 kg 0.1 mg/kg (max of 2 mg) repeat every 2 to 3 minutes if needed. >5 years old or >20 kg 2 mg, if no response, repeat every 2-3 minutes up to 10 mg.
Meperidine (Demerol)	0.5-1 mg/kg, max of 150 mg per procedure	Every 5 min	Naloxone IV: Birth (including premature infants) to 5 years old or < 20 kg 0.1 mg/kg (max of 2 mg) repeat every 2 to 3 minutes if needed. >5 years old or >20 kg 2 mg, if no response, repeat every 2-3 minutes up to 10 mg.
Lorazepam (Ativan)	0.02-0.09 mg/kg (Usual 0.05 mg/dose)	Every 20 min	Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose: 0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg
**** Etomidate** (Amidate)	0.1-0.2 mg/kg	0.05 mg/kg every 5 min	N/A
Ketamine (Ketalar)	IM: 2-5 mg/kg/dose IV: 0.5-1 mg/kg/dose	Every 20 min	N/A

** Dosing information in children less than 10 years old is limited with Etomidate

Pediatric Dosages-PO/Rectal
(under 12 years of age)

Medication-Pediatric IV/IM	Dose (Pediatric)	Comments	Reversal
Midazolam (Versed)	0.25-1 mg/kg; PO or Rectal (usual 0.5 mg/kg) max 20 mg per procedure	Allow 20-30 minutes for effect	Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose: 0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45 seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg
Diazepam (Valium)	0.2-0.3 mg/kg; PO or rectal, max of 10 mg per procedure	Allow 30-60 minutes for	Flumazenil IV: Children >1 year old: Start 0.01 mg/kg (max dose: 0.2 mg) given over 15 seconds; may repeat 0.01 mg/kg (max of 0.2mg) after 45

		effect	seconds. Then every minute (max of 4 doses) to a max total cumulative dose of 0.05 mg/kg or 1 mg whichever is lower. Usual total dose 0.08 to 1 mg
Ketamine (Ketalar)	5-8 mg/kg for 1 dose, mixed in 0.2-0.3 mL/kg of cola or other beverage	Allow 30 minutes for effect	N/A

Cautions:

(1) There is an increased risk of respiratory depression and cardiovascular depression with combinations of benzodiazepines and opioid narcotics
(2) Respiratory depression effects may last longer than analgesic; monitor for respiratory depression and apnea
(3) Use smaller (25-30% decrease) doses in elderly patients (>65 years of age)
(4) Use of naloxone (0.4 mg dose) to reverse narcotics respiratory depression, especially if mild, can result in surge in sympathetic tone, hypertension, and ultimately pulmonary edema, in some cases

References:

Lexicomp Online ®, Lexi-Drugs ®, Hudson, Ohio: Lexi-Comp, Inc.; March 22, 2017 2. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at http://www.micromedexsolutions.com. Accessed March 22, 2017

3. Horn E, Nesbit SA. Pharmacology and pharmacokinetics of sedatives and analgesics. Gastrointestinal Clinics of North America 2004; 14(2):247-268

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**STROKE CODE, EMERGENCY DEPARTMENT**
Purpose:	To outline the procedure for prompt recognition of a patient with signs and symptoms of stroke or worsening stroke and to outline appropriate interventions.
Supportive Data:	Rapid response is critical to obtain required data for a prompt diagnosis and appropriate intervention.
Equipment:	Stroke Admission Packet

A. **POLICY:**

1. A Stroke Code shall be initiated if a patient presents to the Emergency Department (ED) experiencing "stroke-like" symptoms of less than eight (8) hours duration.

B. **PROCEDURE:**

1. Stroke Code Activation:
   a. Patient with "stroke-like" symptoms who are ~~e~~in route to Tri-City Medical Center (TCMC) by Emergency Medical Service (EMS) providers will have a Stroke Code activated by the Mobile Intensive Care Nurse (MICN) prior to arrival by dialing 66 and notifying the operator.
      i. The MICN will notify the ANM/Charge RN as well as the ED Physician.
   b. Patients with "stroke-like" symptoms who present through triage should be immediately placed in an emergency department bed and notify the ED ANM/Charge RN and ED physician.
      i. The Registered Nurse or Unit Secretary will activate a Stroke Code at the direction of the ED Physician by dialing 66 and notifying the operator.
   c. The operator will page the Stroke Team consisting of:
      i. Computed Tomography (CT) Technologist
      ii. Lab Phlebotomist
      iii. Stroke Coordinator
      iv. Radiology Technologist
      v. Lab Technologist
2. Notification of Neurologist:
   a. The Neurologist on call will be notified by the ED ~~P~~physician.
3. Initial Care of the Stroke Patient **per physician orders**:
   a. Initial care of the stroke patient should include immediate stabilization of the airway, breathing, and circulation (ABC's). This is quickly followed **by** an assessment using the ~~NIHSS (~~National Institute Health Stroke Scale~~)~~ **(NIHSS)**.
   b. The ED Physician serves as the Stroke Team Leader and is responsible for initial evaluation and stabilizing treatment, as well as determining eligibility for thrombolytics in collaboration with the Neurologist.
   c. Determine time of symptom onset.
      i. This is defined as when the patient was at his or her previous baseline or symptom-free state. For patients unable to provide this information or who awaken with stroke symptoms, the time of onset is defined as when the patient was last awake and symptom-free or known to be "normal".
   d. Obtain finger stick blood ~~sugar~~**glucose**.
      i. Notify ~~Emergency Department~~ ED ~~P~~physician of result.
   e. Initiate continuous cardiac monitoring
   f. Monitor blood pressure every 15 minutes until thrombolytic eligibility is determined.

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
04/09; 11/11, 01/17, **09/18**	12/11, 4/15, 02/17, **10/18**	12/11; 4/15, 02/17, **11/18**	n/a	02/17, **11/18**	01/12, 02/17, **11/18**	**01/19**	02/12, 03/17, **n/a**	02/12, 03/17

g. Obtain vital signs including: heart rate, blood pressure, respiratory rate, oxygen saturation, and estimated weight.
h. Obtain 12 lead Electrocardiogram (ECG).
i. Obtain Intravenous (IV) access.
   i. Place 18 or 20 gauge IV in antecubital (AC) or forearm.
j. Initiate supplemental oxygen as ordered.
k. Perform NIHSS assessment and Swallow Screen prior to any oral intake.
   i. Notify ED physician of results.

4. Time Parameter goal is to maintain the best practice times listed below **per physician orders**:
   a. Draw STAT labs to include prothrombin time (PT)/international normalized ratio (INR), partial thromboplastin time (PTT), Glucose, and Creatinine –complete within 45 minutes of arrival but not to delay rtPA administration.
      i. Draw labs prior to CT scan.
   b. Obtain STAT CT scan – completed within 25 minutes of arrival.
      i. The Emergency Department RN accompanies all Stroke Code patients to CT scan.
      ii. CT Technologist will notify Radiologist of the Stroke Code CT for STAT read.
      iii. Radiologist will notify the Emergency Department Physician of CT results within 20 minutes of completion.
   c. Obtain portable chest x-ray and ECG – complete within 45 minutes of arrival but not to delay r **Patients** tPA administration.
5. Care of the ~~P~~patients ~~E~~eligible for ~~T~~thrombolytics **per physician orders**:
   a. Continuous cardiac monitoring
   b. Place second peripheral IV.
   c. Place Foley Catheter prior to rtPA administration if ordered by the ED Physician.
   d. Monitor blood pressure Q 15 minutes.
      i. **Acceptable** ~~B~~blood pressure obtained prior to administration of rtPA is a systolic blood pressure **less than (<)** 185 and diastolic blood pressure of **less than (<)** 110.
   e. If patient is eligible for rtPA treatment informed consent will be obtained by ED Physician and/or Neurologist.
      i. Signed consent is not required for administration of rtPA.
6. Administer rtPA per ~~P~~physician ~~O~~order:
   a. Recommended TOTAL dose of rtPA is 0.9 mg/kg, not to exceed 90 mg.
   b. Reconstitute and administer rtPA as follows:
      i. Reconstitute rtPA with 100 ~~ml~~ **mL** of sterile water for injection utilizing the transfer device to create a solution with a concentration of 1 mg/mL.
      ii. With a second Registered Nurse, calculate the weight based dose of rtPA.
      iii. Remove from the vial any quantity drug in excess of that specified for patient treatment, calculate the excess dose and discard 10 ~~ml~~ **mL** less than that dose. This will allow for the complete dose of rtPA to be infused.
      iv. Withdraw the bolus amount (bolus dose is 10% of total dose) and administer IVP over 1 minute.
      v. Program the infusion pump to deliver the remaining dose over 60 minutes.
      vi. rtPA must be double checked by two Registered Nurses and documented in the Medication Administration Record.
7. Monitoring During and Post Thrombolytic Administration:
   a. Continuous cardiac monitoring.
   b. Monitor blood pressure~~-~~:
      i. every 15 minutes ~~times~~ **for** 2 hours~~,~~
      ii. ~~t~~Then every 30 minutes for 6 hours~~,~~
      ~~b.~~iii. ~~t~~Then every 1 hour ~~times~~ **for** 16 hours.
      ~~i.~~iv. Notify ~~Emergency Department~~ **ED** Physician immediately for systolic blood pressure **greater than (>)** 185 and/or diastolic blood pressure **greater than (>)** 110.

c. Monitor neurological status every-:
   i. 15 minutes ~~times~~ for 2 hours~~,~~
   ii. ~~t~~Then every 30 minutes for 6 hours~~,~~
   ~~c.~~iii. **tT**then every 1 hour ~~times~~ for 16 hours.
   ~~i.~~iv. Neurological assessment should include: level of consciousness, orientation, response to commands, motor scoring of upper and lower extremities, language, dysarthria, and pupillary response.
   ~~ii.~~v. If the patient develops a severe headache, acute hypertension, nausea, vomiting or has worsening neurological examination notify ~~Emergency Department~~ **ED** Physician immediately.
   ~~iii.~~vi. Monitor temperature and maintain normothermia.
   ~~iv.~~vii. Monitor blood sugar and maintain euglycemia.

d. Continue monitoring patient upon transport and during diagnostic tests. If unable to perform assessment/vital signs during test, document reason and resume assessment/vital signs as soon as test is completed.
   i. Note: most diagnostic areas have vital sign monitoring capability but staff may not be able to perform assessment during test

8. Care of the ~~P~~patients eligible for ~~T~~thrombectomy

a. Neurology and/ or ~~Emergency Medicine~~ED ~~p~~PhysicianMD ~~D~~ will discuss case with on call Interventional Radiologist

b. The Registered Nurse (RN), Unit Secretary, or designee will activate a Code Thrombectomy at the direction of the Interventional Radiologist and/or ED Physician by dialing 66 and notifying the operator.

c. The operator will page the Code Thrombectomy Team consisting of:
   i. Administrative~~House~~ ~~s~~Supervisor
   ii. Intensive Care Unit (ICU) Charge Nurse
   iii. Stroke ~~c~~Coordinator

d. The operator will also call 5400 and notify ~~o~~Operating ~~r~~Room (OR) desk to gather their team (aAnesthesiologista, aAnesthesia ~~t~~Tech and OR RN)~~,~~. ~~t~~The OR desk will return a call to the private branch exchange (PBX) with OR team names and call response.

e. The operator will call the Interventional Radiology Team (RN, scrub tech, rad tech) as per the on-call schedule

~~a. Emergency Room Registered Nurse will obtain an order to place foley catheter prior to the patient going to Interventional Radiology.~~

~~8.~~**9.** Disposition of Stroke Patient:

a. Monitoring Post Thrombectomy without thrombolytics (tPA):
   ~~b.~~i. Continuous cardiac monitoring, vitals and groin checks:
      1) Every fifteen (15) minutes for one (1) hour
      2) ~~t~~Then every half (½) hour for (1) hour
      3) ~~t~~Then every one (1) hour for four (4) hours~~X4~~~~,~~
      4) ~~t~~Then routine.
   ii. NIHSS ~~Q~~every one (1) hour for ~~x~~ six (6) hours

b. Monitoring Post Thrombectomy with thrombolytics (tPA)
   i. Continuous cardiac monitoring~~,~~
   ~~i.~~ii. Monitor blood pressure, VS and NIHSS:
      ~~ii.~~1) ~~e~~Every fifteen (15) minutes for~~times~~ two (2)-hours
      2) ~~t~~Then every thirty (30) minutes for six (6) hours~~,~~
      3) ~~t~~Then every one (1) hour times sixteen (16) hours~~.~~

~~a.~~c. Stroke patients who have received thrombolytics **and/or Thrombectomy** are admitted to the Intensive Care Unit

~~b.~~d. Stroke patients who do not meet the criteria for admission to the Intensive Care Unit should be admitted to 4 Pavilion or Telemetry.

C. ~~RELATED DOCUMENTS/~~**FORM(S)**:

1. 24 hour rtPA Flow Sheet. Form # 6010-1010 - **Sample**

D. **REFERENCE(S):**

1. Guidelines for the Early Management of Adults with Ischemic Stroke. Stroke, Journal of the American Heart Association, 2007: 1655-1708
2. Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. Volume 44 pages 870-947 (2013)

24 hour rtPA Flow Sheet. Form # 6010-1010 - SAMPLE

Score Table

Level of Consciousness
0=Alert 2=Obtunded
1=Drowsy 3=Coma/Unresponsive

Orientation Questions "What month"/"How old"
0=Answers both correctly
1=Answers one correctly
2=Answers neither correctly

Response to Commands
Open/Close eyes/makes fist
0=Performs both tasks correctly
1=Performs one tasks correctly
2=Performs neither task correctly

Language
0=Normal, no aphasia
1=Mild to moderate aphasia
2=Severe aphasia 3=Coma, mute

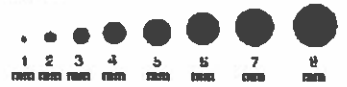
Motor Score-10 sec-arms, 5 sec-legs
0=No Drift 1=Drift
2=Some effort against gravity
3=No effort against gravity
4=No movement

Pupil Reaction
N-Non Reactive S-Sluggish
B-Brisk

Dysarthria
0=Normal articulation
1=Mild to moderate dysarthria
2=Severe dysarthria, coma

Pupil Assessment
Reaction to light: B=Brisk
F=Fixed S=Sluggish

Pupil size:



Abbreviated NIHSS	t-PA Start	15 min	30 min	45 min	1 hr	1 1/4 hr	1 1/2 hr	1 3/4 hr	2 hr	2 1/2 hr	3 hr	3 1/2 hr	4 hr	4 1/2 hr	5 hr	5 1/2 hr	6 hr	6 1/2 hr	7 hr	7 1/2 hr	8 hr	9 hr	10 hr	11 hr	12 hr	13 hr	14 hr	15 hr	16 hr	17 hr	18 hr	19 hr	20 hr	21 hr	22 hr	23 hr	24 hr
Time																																					
Systolic Blood Pressure																																					
Diastolic Blood Pressure																																					
Heart Rate																																					
Pupil Size: Right																																					
Pupil Size: Left																																					
Pupil Reaction: Right																																					
Pupil Reaction: Left																																					
Level of Consciousness																																					
Orientation Questions																																					
Response to Commands																																					
Motor Score Right Arm																																					
Left Arm																																					
Motor Score Right Leg																																					
Left Leg																																					
Language																																					
Dysarthria																																					
TOTAL SCORE																																					
*Groin site ✓ R/L/NA																																					
Initials																																					

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

6010-1010
(Rev. 10/15)

Neuro checks and Vital Signs to be completed.
- 15 Minutes X 2 Hours
- 30 Minutes X 6 Hours
- 1 Hour X 16 Hours

24 Hour t-PA Flow Sheet

Permanent part of the record

Affix Patient Label

Signature Date/Time

Signature Date/Time

Signature Date/Time

Signature Date/Time

Document any site abnormalities in the EHR

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**SURGICAL HAND ~~ASEPSIS~~ANTISEPSIS**
Purpose:	To outline the steps to effectively perform surgical hand ~~asepsis~~**antisepsis**
Supportive Data:	**Surgical hand antisepsis is the primary line of defense to protect the patient from pathogens on the hands of scrubbed team members, whereas sterile surgical gloves are the secondary line of defense.** Surgical hand ~~asepsis~~**antisepsis** is performed by personnel who will be scrubbed for the surgical procedure to remove dirt, skin oil and microbes from the hands and forearms to reduce the microbial count to as near zero as possible and to leave an antimicrobial residue on the skin to prevent growth of microbes for several hours. **All personnel who perform surgical hand antisepsis shall maintain healthy condition of their fingernails and skin of their hands/arms. Unhealthy skin or fingernails may impede removal of microorganisms during hand antisepsis.**

A. **POLICY:**

1. **Surgical hand antisepsis shall be performed prior to donning sterile gowns and gloves for operative or other invasive procedures.**

~~A.~~**B.** **PREPARING TO SCRUB:**

~~1. Equipment:~~

~~a. Hair Cover~~

~~b. Mask~~

~~c. Protective eye wear~~

~~d. Scrub attire~~

1. Personnel ~~should be~~**shall don** ~~in~~ surgical attire prior to beginning surgical hand ~~asepsis~~ **antisepsis** (see **Patient Care Services** [PCS] Policy ~~XI.K "~~Surgical Attire~~"~~).
   a. The scrub shirt should be tucked into pants or fit snugly to the body.
   ~~2.~~**b. All jewelry must be removed or confined within the surgical attire. Hand and wrist jewelry may not be worn.**
   ~~a. All hair is to be confined by the head covering. Earrings should either be removed or completely contained with the head covering.~~

~~b.~~**2.** Don fresh **surgical** mask and adjust snugly over nose and mouth.

~~c.~~**3.** Don protective eyewear, unless eye protection is integrated into mask or user will be wearing **an** orthopedic hood~~s~~.

~~d. Remove rings, watches and bracelets before beginning hand asepis.~~

~~e.~~**4.** Inspect hands and forearms:
   a. Cuticles, hands and forearms should be free of cuts, open lesions or breaks in skin integrity.
      i. **Persons with breaks in skin integrity shall not scrub.**
   ~~ii.~~**b. In addition to Administrative Policy: Dress and Appearance Philosophy - 415,** ~~Natural nails~~**fingernails** should be ~~kept~~ short (less than~~1/4"~~**2mm or 0.08"**) and in good repair. Nail jewelry, artificial nails, nail extenders, nail wraps or any other nail treatments are not allowed. **If nail polish is worn, it must be free of chips or peeling.**
   ~~iii. Nail polish is not to be chipped. Nail polish/enamel must be less than four (4) days old.~~

~~B.~~**C.** **SURGICAL HAND ~~ASEPSIS~~ ANTISEPSIS WITH ~~WATER AND~~ APPROVED ~~ANTIMICROBIAL SOAP~~SURGICAL HAND SCRUB:**

~~1. Equipment:~~

~~a. Sterile scrub brush with nail cleaner~~

Patient Care Services Content Expert	Operating Room Committee	Clinical Policies & Procedures Committee	Nurse Executive Committee	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/12; 07/18	07/18	12/12, 08/18	09/18	10/18	n/a	01/13, 10/18, 11/18	01/19	02/13, n/a	02/13

~~b. Antimicrobial soap~~

~~2. Turn on the faucet via motion in front of automatic sensor.~~

~~a. Be sure the automatic sensor is positioned to effectively turn the water on when hands are underneath the faucet.~~

~~3.~~1. **Surgical hand antisepsis using a surgical hand scrub should be performed according to manufacturer's instructions for use.**~~Open the sterile scrub brush and place it in an accessible area.~~

~~4.~~2. **If hands are visibly soiled, wash hands with soap and water.**~~Perform a hand wash before each surgical scrub.~~

~~a. Apply anti-microbial soap, lather, wash hands and arms thoroughly, and then rinse.~~

3. ~~A surgical hand scrub should be performed by health care personnel before donning sterile gloves for surgical or other invasive procedures~~**Remove debris from underneath fingernails using a disposable nail cleaner under running water.**
4. **Apply the amount of surgical hand scrub product recommended by the manufacturer to the hands and forearms using a soft, nonabrasive sponge. A commercially prepared, pre-moistened surgical scrub brush with approved surgical scrub agent may be used.**
5. **Visualize each finger, hand, and arm as having four sides. Wash all four sides effectively, keeping the hands elevated.**
6. **Scrub for length of time recommended by the manufacturer. The scrub should be timed to allow adequate product contact with the skin.**
7. **Avoid splashing surgical attire.**
8. **Discard sponge, if used.**
9. **Rinse hands and arms under running water in one direction from fingertips to elbows.**
10. **Hold hands higher than elbows and away from surgical attire.**

~~5.~~11. **In the OR or procedure room, dry hands and arms with a sterile towel (drying from fingertips to elbow, while bending forward at the waist) using sterile technique before donning a surgical gown and gloves.**

~~a. Take the sterile scrub brush in one hand, using the other hand to clean underneath the nails with a disposable nail pick. Repeat for the other hand.~~

~~b. Moisten the scrub brush and apply antimicrobial scrub agent according to manufacturer's instructions. Use the soft sponge side of the scrub brush, rather than the hard bristle side, to reduce damage to the epidermis. Scrub along the nails of each hand, holding the hands above the elbows throughout the procedure.~~

~~c. Beginning with the thumb, scrub all four surfaces of each finger, moving on to each finger in the same l manner including web spaces.~~

~~d. Scrub the back of the hand, then palm, and up the forearm to about 2" above the elbow.~~

~~e. Move to the other hand and arm following the same procedures in b - d. Apply more antimicrobial scrub agent as needed.~~

~~6. Scrub shall be 2-6 minutes in duration, according to scrub agents manufacturer's instructions.~~

~~7. When scrubbing of both arms is complete, discard scrub brush and rinse hands with arms from fingertips to elbows, keeping hands higher than elbows. Allow water to drop off at elbows.~~

~~8. Holding hands up and elbows away from body enter the assigned OR bending slightly at the waist.~~

~~C. DRYING THE CLEANSED AREA~~

~~1. Equipment:~~

~~a. Sterile towel~~

~~2. Grasp sterile towel near corner; lift up and away from sterile field to prevent contamination.~~

~~3. Step back from sterile field, bending forward slightly at the waist, and allow towel to unfold to its full length and width.~~

~~a. Prevents contamination of sterile field and towel from brushing against unsterile~~

~~scrub suit.~~

~~4. Holding the top half of the towel, dry the opposite hand, moving up the arm using a rotating motion without returning to a previously dried area.~~

~~5. Reverse the towel and dry the opposite hand and forearm a similar manner.~~

~~6. Discard the towel.~~

D. **SURGICAL HAND ~~ASEPSIS~~ ANTISEPSIS ~~WITH~~ USING APPROVED ~~WATERLESS ALCOHOL BASED~~SURGICAL HAND RUB:**

1. **Perform surgical hand antisepsis using a surgical hand rub according to the manufacturer's instructions for use.**
2. **If hands are visibly soiled, wash hands with soap and water.** ~~Prewash hands and forearms with plain soap and water or anti-microbial agent.~~
3. **Remove debris from underneath fingernails using a disposable nail cleaner under running water.** ~~Clean under nails using a disposable nail stick.~~
4. Rinse hands and forearms under running water and dry hands and forearms thoroughly with a **disposable** paper towel.
5. Apply **the surgical hand rub product to the hands and arms according to the manufacturer's instructions for use, including amount of product to be dispensed for each use, method of application, and time.** ~~alcohol based surgical hand antiseptic agent according to manufacturer's recommendations.~~
   ~~a. Dispense the manufacturer recommended amount of surgical hand rub product.~~
   ~~b. Apply the product to hands and forearms according to manufacturer's instructions.~~
6. Allow hands and arms to dry **completely** before donning gown and gloves, **per manufacturer's instructions for use**. Do not dry with a towel.

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

1. **Administrative Human Resources Policy: Dress and Appearance Philosophy 8610-415**
2. **Tri-City Healthcare District Approved Surgical Scrub Products** ~~**Current OR/L&D/IR/Cath Lab Surgical Scrub/Wash List**~~

~~E~~.F. **REFERENCE(S):**

1. ~~AORN Perioperative Standards and Recommended Practices, 2012 edition. Denver, Colorado 80231.~~ **Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**

~~1. CDC Guidelines – Center for Disease Control & Prevention Guidelines for Hand Hygiene in Health-Care Settings, Recommendations of the Healthcare Infection Control Practices Advisory Committee, & the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 200201 (No. RR-16). Inclusive page numbers.~~

Tri-City Healthcare District
Approved Surgical Scrub Products

~~**Surgery/IR/Cath Lab:**~~

- Ecolab Scrub Stat (2% CHG) "multi-dose dispenser"
- Avagard "multi-dose dispenser"
- Betadine (individually packaged brushes)
- BD E-Z Scrub 116 (3% PCMX – individually packaged brushes)

~~**L&D:**~~

- ~~BD E-Z Scrub 116 (3% PCMX – individually packaged brushes)~~
- ~~Avagard "multi-dose dispenser"~~
- ~~Betadine (individually packaged brushes)~~
-

Note: Approval for all surgical scrub products must be obtained through the Infection Control Committee prior to use.

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual

DELETE – incorporated into Pharmacy Policy: Drug Compounding for Medication Not Commercially Available

ISSUE DATE: 03/15

SUBJECT: Outsourcing Sterile Compounding

REVISION DATE:

POLICY NUMBER: 8610-206

Administrative Content Expert Approval:	09/18
Administrative Policies & Procedures Committee Approval:	~~11/14~~09/18
Pharmacy and Therapeutics Committee Approval:	~~01/15~~11/18
Medical Executive Committee Approval:	~~02/15~~11/18
Administration Approval:	01/19
Professional Affairs Committee Approval:	~~03/15~~n/a
Board of Directors Approval:	03/15

~~A. PURPOSE:~~

~~1. To establish guidelines for selection and quality review of outsourced sterile compounding services.~~

~~B. PERSONNEL:~~

~~1. Pharmacy Management~~
~~2. Hospital Administration~~
~~3. Medical Staff~~

~~C. BACKGROUND:~~

~~1. There are various environmental influences and market forces that may contribute to a facility's decision to consider outsourcing sterile compounding services. Tri City Health Care District (TCHD) when considering outsourcing should at a minimum conduct an internal needs assessment, a cost analysis, and a comprehensive review of prospective compounding facilities/vendors for regulatory compliance, quality and patient safety measures. The organization should examine the long term consequences of outsourcing and the short term outcome expectations during a contract's performance period.~~

~~D. POLICY:~~

~~1. Pharmacy Services in collaboration with key hospital stakeholders will assess the organizational needs and capabilities for sterile compounding.~~
~~2. If the organization deems it necessary to contract with an outsourced sterile compounding vendor for services, Pharmacy Services will contact prospective compounding facilities with a request for proposal (RFP).~~
~~3. Based on the compounding vendor's assessment results and the nature of the product(s), the medical staff (via the Pharmacy and Therapeutics Committee or equivalent), in conjunction with hospital leadership, determines when and if disclosure of the compounding source prior to medication administration is required.~~
~~4. The organization will not contract to outsource the preparation of copies of commercial products available on the current market unless drug is in shortage or becomes unavailable.~~
~~5. The organization will establish contract service expectations and at a minimum perform annual management reviews of selected indicators to ensure that services provided are safe and effective and comply with all applicable state, federal and regulatory requirements for licensure, labeling and patient confidentiality.~~
~~6. The contract agreement to outsource sterile compounding services and the sterile compounding vendor is reviewed and approved by medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.~~

E. **PROCEDURE:**

1. Proposals and Required Documents:
   a. The prospective compounding vendor will submit the following information with their proposals:
      i. A brief history of the compounding vendor and service, including its mission, vision, and values.
      ii. The location of the compounding vendor's offices and other facilities that would provide services to the organization.
      iii. The compounding vendor's regular business hours or hours of operation and emergency and after-hours contact information.
      iv. Assurance that all pharmacists employed at the compounding facility are licensed and competent as required by state and federal rules and regulations
      v. Evidence of the following documentation regarding the compounding vendor:
         1. Proof of current liability insurance.
         2. Current accreditation or certification certificates, if applicable.
         3. State pharmacy and/or wholesaler licensure and other appropriate licenses.
         4. Licensure documents if the compounding facility is registered with FDA as a drug manufacturer or device manufacturer.
         5. Current DEA registration as a manufacturer or wholesaler.
         6. Licensure of pharmacists employed and verification that there is documented training and competency assessments on file and available for review.
         7. Registration of pharmacy technicians employed and verification that there is documented training and competency assessments on file and available for review, if applicable.
         8. Pharmacist and pharmacy technician training manuals on file and available for review.
         9. Standard operating procedures manual on file and available for review.
         10. Policies and procedures for sterility testing on file and available for review
         11. Policies and procedures for pyrogen and endotoxins testing on file and available for review, if applicable
         12. Examples of the quality control reports include trending reports for the last year as well as detailed reports for the last quarter.
         13. Stability and sterility documents and clinical references, as well as any materials that are used to determine beyond-use dates
      vi. A history of the results of all accreditation or regulatory surveys conducted of the compounding vendor's sites, including copies of significant regulatory actions.
      vii. Experience (e.g., years of experience in providing sterile compounding services, total number of clients served current number of clients).
      viii. A list of the services that the compounding vendor can provide and the normal terms of service, including but not limited to delivery cycles, availability and cost of emergency preparation and delivery, remedies for failure to perform to the contract and the infrastructure available for electronic ordering.
      ix. A list of the sterile compounding services that the compounding vendor cannot provide and the reasons for its inability to provide them.
      x. Disclosure as to whether the compounding vendor has had product liability lawsuits filed against it for preparations it compounded. If so, the vendor's disclose of the suites and the outcome (e.g. favorable for or against the company).

xi. A description of the compounding vendor's formal procedures for conducting recalls and a listing or their product recall history to include date of recall, description on preparations, and reason for the recall.

b. Site Visit and Compounding Vendor Assessment
   i. An organization representative with current knowledge of USP 797 sterile compounding requirements will make a site visit to the compounding vendor's facility (ies), initially and periodically, to assess and evaluate regulatory and quality requirements, the compounding environment as well as compounding and medication safety procedures.
   ii. An audit check list is used to evaluate outsource vendors of compounded sterile products.

c. Evaluation and Selection
   i. Proposals and site visit findings are evaluated and compared with respect to services, experience, quality and safety standards, references and cost. The compounding vendor must at a minimum be able to:
      1. Provide assurance that each compounded sterile preparation meets applicable state and federal labeling requirements and is sterile and free of pyrogens, endotoxins and unintended particulate matter, according to professionally established and accepted quality monitoring data.
      2. If compounding high risk level preparations, provide documentation of the end product testing processes used to determine that compounded sterile preparations are sterile and free of pyrogens, endotoxins, and unintended particulate matter.
      3. Deliver preparations in tamper resistant packaging and in containers that will maintain proper storage temperature and (when required) protection from light during delivery and storage.
      4. Provide, upon request, batch records for any compounded sterile preparation.
      5. Provide quarterly information on its compliance with contract requirements and other quality assurance programs.

d. Contract Negotiation and Agreement
   i. The contract clearly describes all aspects of the outsourcing agreement and is executed as defined by organizational policy.
   ii. Review of the proposal and clarification of contract provisions includes the Director of Pharmacy Services and, as indicated, the organization's risk management and legal counsel.
   iii. The contract agreement and sterile compounding vendor is reviewed and approved by medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

e. Evaluation of Sterile Compounding Vendor's Performance
   i. On a regular basis as part of the organization's quality assurance program, the sterile compounding vendor's performance and compliance with the terms of the contract are evaluated.
   ii. Based on quarterly quality reports submitted by the vendor, Pharmacy Services in collaboration with other key hospital leadership will perform objective and subjective evaluations of the measurable standards of performance specified in the contract.
   iii. Annually, or more frequently if indicated by performance outcomes, a summary of the sterile compounding vendor's performance expectations and outcomes are reported to and reviewed by the medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

F. **REFRENCES:**

1. American Society of Health System Pharmacists ASHP Guidelines on Outsourcing

~~Sterile Am J Health System Pharm.2010; 67:757-65 (Accessed November 2012)~~

2. ~~Pharmacy Compounding Accreditation Board (PCAB) Accreditation Manual (Accessed November 2012)~~
3. ~~American Society of Health System Pharmacists Sterile Compounding Resource Center (Accessed November 2012)~~
4. ~~ISMP Medication Safety Alert: Moving Forward for Safer Sterile Compounding, November 1, 2012 Volume 17 Issue 22~~
5. ~~The Joint Commission Standards MM.02.01.01 EP1; LD.04.03.09~~
6. ~~Center for Medicare and Medicaid Services (CMS) §482.25(b)(9); §482.12(e)~~
7. ~~Healthcare Facility Accreditation Program (HFAP) 25.01.11~~
8. ~~DNV National Integrated Accreditation for Tri-City Health Care District (TCHD) (NIAHO - DNV) MM.2;~~
~~GB.3~~

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: 05/88

SUBJECT: Emergency Preparedness: Food & Nutrition Plan

REVISION DATE: 12/09, 01/10, 10/11, 02/12

Food and Nutrition Department Approval:	03/18
Medical Staff Department or Division Approval:	n/a
Environmental Health & Safety Committee Approval:	11/18
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/12

A. **PURPOSE:**

1. **Tri-City Medical Center will have the means** ~~T~~to insure efficient Food & Nutrition services and to maintain adequate availability of personnel in the event of disaster; to establish **the means to provide nutritional assistance to staff and patients,** ~~supervise,~~ and maintain proper management of food, supplies~~,~~. ~~and personnel in the event of an emergency/disaster~~.

B. **DEFINITION(S):**

1. **An emergency as "unexpected or sudden event that that significantly disrupts the organizations ability to provide care, or the environment of care itself, or that results sudden, significantly changed or increased demand for the organization's services".**

~~B. INTRODUCTION:~~

~~1. Due to the varying types and magnitudes of emergency events, Tri City Medical Center has adopted the command structure of Hospital Incident Command Systems (HICS). Once the decision has been made to activate the disaster plan, HICS becomes the standard operating procedure. The complete plan is located in the TCMC Disaster Plan Manual located in the Patient Food Services Supervisors' office and the main Food & Nutrition Services office~~.

C. **POLICY:**

1. **The facility maintains at least (7) days staple and (2) days perishable foods in inventory. Within our supply, we maintain a minimum of (4) days (96 hour) diaster meals, bottled water and disposable supplies in the facilities secured warehouse area.**
2. **A Nutrition Service Disaster and emergency plan is prominently posed in the food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences and emergency/disaster. It is possible that any or all of these services may be interrupted.**
3. **The Nutrition Service Director, Dietitian, or Food Service staff member in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration. If needed, all or part of the emergency meal plan will be implemented to ensure provisions of nutritious meals to patients despite the limitations of the disaster. The Meals for All Emergency Solution menu may be used during and emergency/disaster at the discretion of the Food and Nutrition Service Department, House Supervisor, or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the Registered Dietitian will be notified.**

~~C.~~D. **NOTIFICATION:**

~~2.~~1. Food & Nutrition Services will be notified of the disaster plan activation from the PBX operator announce~~sing~~ "CODE ORANGE" or "CODE YELLOW" ~~using~~ **utilizing** the overhead page.

~~3.~~2. **Food Service Supervisor/**Charge Responsibilities ~~(food service supervisor)~~

~~1.~~a. ~~Read~~**Locate** the Unit Leader Responsibilities found in the Department Disaster **binder** ~~packet (usually kept in the Disaster Manual)~~. **The** ~~C~~charge duty **responsibilities** will transfer to the ~~m~~**M**anager/~~d~~**D**irector **of Food and Nutrition Services upon their arrival to the facility and briefing with the Command Center.** ~~after one arrives~~.

~~a.~~b. **A** ~~C~~**c**ompleted **staff** ~~and send one employee with the personnel~~ inventory form ~~or~~ **and** emergency incident message form **will be delivered** to the Incident Command Center **via staff**. These **forms can be located** ~~are found~~ in the **Department** Disaster ~~manual~~ **Binder** ~~-~~located in the patient food service supervisors' office and in the main Food & Nutrition Services office.

~~b.~~c. The Incident Command Center is located in the French rooms. If the Incident Command Center is not set up, **then staff is to notify** ~~contact~~ the Emergency Department **for further instructions**.

~~c.~~d. **All Food Service staff will be** ~~R~~**r**ecalled staff from breaks for standby to report to disaster priority areas **when assigned.** ~~(Staff should return immediately if they hear the overhead page activating the disaster plan.)~~

~~2.~~ ~~Contact director and begin call-in procedure. Relay as much information as possible to the Incident Command Center~~.

~~D.~~E. ~~**FOOD & NUTRITION RESPONSIBILITIES:**~~ **PROCEDURE**

~~1. The Vice President of Support Services will be contacted by the Command Center and will alert the Director of Food & Nutrition as appropriate.~~

1. The ~~d~~**D**irector **of Food and Nutrition Services** will initiate the departmental **disaster** call-**in roster, if the situation warrants it and requested by the Incident Command Center.** ~~tree, if necessary (Appendix A).~~

~~2.~~a. In the event of a major disaster **situation**, all off duty personnel are **required** to report to the **designated** ~~l~~**L**abor pool for further direction.

~~3.~~2. All on-duty employees are to report immediately to the department for instructions.

a. Information regarding staffing levels and available staff resources is completed on the ~~l~~**i**ncident ~~e~~**E**mergency ~~m~~**M**essage form and taken to the ~~i~~**I**ncident ~~c~~**C**ommand ~~c~~**C**enter in the French rooms.

~~4.~~3. **Staff will begin to inventory and document all** ~~F~~**f**ood **products** and disposable supplies ~~will be inventoried~~. **They will report their findings to the Director of Food and Nutrition or their designee**

~~5.~~4. Meals will be served in the cafeteria when possible **unless circumstances prevent the use of that area. If this occurs, then.** ~~If necessary,~~ other serving areas **and times** will be designated by the **Food and Nutrition** ~~d~~**D**irector or designee.

5. In the event the **emergency/**disaster **situations** affects the normal operation of patient food service, the **Director of Food and Nutrition or designee**

6. ~~director or designee~~ will be responsible for any changes necessary to serve food to the patients and will notify **all the affected departments.** ~~the units.~~ **The Command Center shall also be notified of the changes as well.**

7. **Disposable ware will be utilized** ~~i~~**I**n the event the **emergency/**~~disaster~~ **disaster situation when normal food service operations are disrupted.** ~~interrupts the normal operations of food service such as power failure, disposable ware may be used~~.

8. ~~A~~**The** list of current vendors who can provide emergency refrigeration, water, and food supplies is kept on file (Appendix B) **in the Department Disaster Binder**. Emergency phone numbers for contacting vendors at night or on weekends for all of the vendors is **in the Department Disaster Binder as well.** ~~on file.~~

~~4.~~9. In the event that the kitchen can not be accessed or utilized, **one option may be the Meals for All (Nutricopia) which has an inventory of 7800 meals as well as 1950 snacks for patients, staff and visitors. Refer to Meals for All Implementation procedures .** ~~3000 meals ready to eat (MRE's) will be provided to patients, employees, and visitors. Enough MRE's are on hand to last for at least 72 hours. A "Confidential Disaster Information Form" is on file with the primary vendor, details of which would be initiated in the event of a natural disaster. MRE's are available for use by patients, staff and visitors. Enteral formulas are stocked for patients who are fed via tube. Supplements and alternative supplies (i.e. pureed foods) are available for patients on pureed and full liquid diets. See Appendix D for further details~~

~~5.~~10. **The Director of Food and Nutrition or designee** ~~As changes occur, an hourly update report will be sent to the Command Center, via department status form~~ **will update the Command Center on an hourly basis, unless extreme circumstances warrant and immediate notification.**

~~6.~~11. A beverage station will be set up, upon request, for the Command Center.

~~7.~~12. The **Food and Nutrition** ~~d~~Departmental **Disaster Plan** ~~procedures on disaster control~~ will be updated and reviewed **on an annual basis** ~~annually~~.

13. **The Food and Nutrition Department maintains an emergency water supply which is kept in the basement storage and disaster cage. This includes:**
    a. **80 five gallon jugs or approximately 400 gallons**
    b. **9500 gallons of canned water**

~~8.~~14. Water may be accessed from the City of Oceanside. In the event that this water is inaccessible, water from the City of Vista would be accessed. Water may also be accessed from two 10,000 gallon drums located on the roof of the medical center. Details of how this water would be accessed are found in the Disaster Manual Engineering specific policy (Failure of H20 Distribution). ~~Additional provisions of bottled water (2000 twelve ounce bottles) and 80 five gallon jugs of water are stored with disaster supplies in the basement under the operating room suites.~~ Alternative sources for water include commercial water suppliers, i.e. Rayne and Arrowhead.

~~a.~~15. Disaster supplies and food designated for disaster use are stored separately from Food and Nutrition Services, in a room in the basement under the Operating Room Suites.

16. In the event that the kitchen cannot be utilized for meal preparation, alternative sites are available,
    a. ~~i.e. the~~ Occupational Therapy kitchen,
    b. ~~the~~ Pavilion kitchen.
    ~~9.~~**c. Disaster** A tents may be set up and utilized as needed ~~in the parking lot~~.

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

1. Food & Nutrition Services Disaster Call Tree
2. Disaster Call List for Vendors

Appendix A

Procedure for Disaster Control

A. Procedure for Handwashing Dishes
   1. Use two (2) lanterns
   2. Strip and stack dirty trays, etc.
   3. Handwash dirty trays, etc., in portable sinks as follows:
      a. Sink #1 (WASH) - add **Pantastic Detergent according to manufacturer's instructions** ~~4 pumps disinfectant~~ to hot water (at least 110 degrees F)
      b. Sink #2 (RINSE) - plain hot water (at least 110 degrees F)
      c. Sink #3 (SANITIZE) - add **Quat sanitizer solution according to manufacturer's instructions**~~3 pumps sanitizer~~ to hot water (at least 110 degrees F)
      d. Dry on rack

B. Waste Disposal
   1. Garbage will be placed in closed containers and removed since garbage disposals could not be used. If garbage and trash could not be removed, they would need to be buried in a pit on the property.

C. Emergency Power
   1. **If** ~~O~~on emergency power, most equipment is still functioning. If pilot gas is available, gas grills, gas ovens, convection ovens (without blowers), gas stoves, deep fat fryers and boilers can be **utilized**~~used~~.
   2. Food items that can be prepared include any type of frozen entree, grill items, frozen items that are fried, soups, frozen vegetables and gravies that could be cooked on the stove.
   3. If boiler gas only is available, steamers and steam kettles could be used. Food items that can be prepared include frozen entree, frozen vegetables, fish potatoes, dehydrated potatoes, soups and gravies, and freeze-dried coffee.
   ~~3.~~**4.** Flashlights are kept in the supervisors' office. Battery-operated lanterns are kept in the storeroom.

D. Reserve Water
   1. Using the reserve water supply, all china, glassware and utensils would be replaced by disposable paper goods, and we would handwash only the essential items such as serving utensils and pots and pans.

E. Communications
   ~~E.~~**1.** Food Service would rely on telephones in-house to keep updated on the discharge and admissions of patients to the nursing floors and would modify the diets according to the foods available under the circumstances.

F. Security
   1. Only Supervisors have the keys to the refrigerators and freezers. All would be locked except for those in use.
   2. The doors to the kitchen would be locked to prevent outsiders from coming into the kitchen.
   3. The walk-in freezer and the walk-in refrigerator would be locked until a freezer truck and a refrigeration truck could be obtained from Hollandia, if necessary. However, most freezers and refrigerators are on emergency power.
   ~~1.~~**4.** Supervisors would only allow authorized personnel into the walk-ins and the storeroom.

G. Employees
   1. The manager will initiate the departmental call tree if necessary (Appendix A).
   2. ~~Method of call in:~~ If telephone service is available, they would be called.
   ~~2.~~**3.** If phone service is out, an employee would be sent to the homes of those living nearest the hospital.
   4. ~~If not access in or out:~~ Shifts would be arranged for people to work and rest out in the cafeteria, take naps and sleeps when needed.
   ~~3.~~**5.** Moderate amounts of water and towels would be provided for washing.

H. Concerns
   1. The most immediate concern is proper sanitation and handling and storage of perishable food items, disposal of refuse and the comfort and well being of the patients and employees.

Appendix B

Disaster Menu - the following food supplies will last **a minimum** ~~96~~72 hours and are located in the OR basement or in the Disaster Storage Container. The menu is planned for a census of **180 patients, 400 staff, 85 visitors.** ~~200~~ for each meal.

If food within the department is not available, ~~**MRE's**~~**Meals for all are available as a supplement to foods within the department;** ~~**300**~~**7800 meals are kept on site in the OR basement or in the Disaster Storage Container. These meals may be utilized as needed for patients on all regular and therapeutic diets, staff, and the community. Patients on liquid diets are to be provided** ~~**Carnation Instant Breakfast Plus or**~~ **Boost Plus 1 can/meal and one snack with bottled water – to provide 1420 kcal, 56 gm protein.** ~~**Replete**~~**Boost Glucose Control is provided for insulin dependent diabetics on full liquids (10 cases/25 pack); Resource Fruit Beverage is provided for clear liquids (3 cases/24 pack); Nepro is available as an appropriate supplement for renal patients.** ~~**"Thick and Easy Pureed" meals are available for patients on pureed diets.**~~ **Patients on a puree diet** ~~**These patients**~~ **will also receive supplemental** ~~**Carnation Instant Breakfast Plus or**~~ **Boost Plus with each meal. Thickened juices (1 case) and thickener (1 case) are available for those patients with dysphagia who require thickened liquids.**

Type of Diet	Type of "Disaster Food" Provided/meal
Regular, soft, mechanical soft	**Meals for All** ~~MRE~~
Cardiac	**Meals for All** ~~MRE~~
Low sodium, NAS	**Meals for All** ~~MRE~~
Renal	~~MRE~~ **Meals for All** with Nepro
Pureed	1 Thick & Easy Puree meal with 4 oz pureed fruit ~~and~~ 1 can ~~CIB Plus or~~ Boost Plus
Full liquid	**Boost Plus** ~~CIB Plus~~ (diabetic FL receive 1 can ~~Replete~~ **Boost Glucose Control**)
Clear liquid	Resource fruit beverage
Enteral feedings	Fibersource, Nepro are available

A. Procedure for Food Preparation and Service for Disaster Where No Power Available:
   1. Dietitians' Office - Use one (1) lantern
   2. Diet Clerks' Office - Use one (1) lantern
   3. Patient Food Service
      a. Pour HOT water into 5 - 2 1/2 gallon Containers, using individual tea bags and freeze-dried coffee for beverages.
      b. Trayline - push trays manually.
      c. Use disposable ware for patient tray service with regular tray.
      d. Supervisors: Check temperature of hot water.
   4. Cooks
      a. Boil water for coffee and tea for patient food service and cafeteria.
      b. Keep foods warm in ovens.
      c. Dish up small amounts of food to be served on trayline and in cafeteria.
      d. Replenish foods frequently.
   5. Dishroom - Using 2 lanterns, handwash dirty trays, etc., in portable sinks:
      a. SINK #1 (WASH) Add **Pantastic Detergent accourding to manufacturer's instructions** ~~4 pumps Solitaire~~ to hot water (at least 110 degrees F)
      b. SINK #2 (RINSE) Plain hot water (at least 110 degrees F)
      c. SINK #3 (SANITIZE) Add **quat sanitizer solution according to manufacturer's instructions** ~~4 pumps Stor-bac~~ to hot water (at least 110 degrees F)

B. Procedure for Specific Disaster, Mass Casualties and for Disruption of Service
   1. There shall be controlled traffic through flooded area.
      a. Outside of the department, Environmental Services personnel will reroute traffic away from flooded areas.

b. Within the department, all employees will be required to leave and relocate to an uncontaminated area as designated by the supervisor.
c. If it is impossible to relocate traffic, area will be sanitized with a sanitizing agent to prevent contamination.

2. There shall be communication to all departments regarding contaminated area.
   a. The switchboard shall notify all departments to discourage employees from going to the cafeteria, and/or to notify them of alternate routes.
   b. The department will call the nursing units if patient tray service will be interrupted. Patients who require food before trays can be sent from the kitchen will be served food from the supply available on the nursing units.
3. All food processing preparation and delivery shall be halted in contaminated areas.
   a. All food carts and related equipment should be relocated to an uncontaminated area, if possible.
   b. Coffee service may be provided to employees.
4. There shall be an orderly and organized plan of clean up and enough personnel so that the most vital areas are cleaned first.
   a. Environmental Services and Facilities Management personnel will assist designated Food & Nutrition Services personnel to clean the kitchen areas, hallways to elevators, hallways to stairwells, cafeteria area, restrooms and offices, respectively.
   b. Within the kitchen and cafeteria, the areas shall be cleaned in the following order: Patient food service area, food production, receiving area, diet office, dishroom, cafeteria serving area, cafeteria, storerooms and dietary offices.
5. All contaminated equipment and floors shall be cleaned and sanitized using appropriate disinfectant. All personnel should be extra conscious of hand washing techniques.
6. Once clean up in the kitchen is complete, food preparation and processing may resume. Food carts may be delivered to the floors when hallways are free of contamination. Staff will call nursing floors to notify them of delivery of patient trays.
7. The switchboard will notify all departments when contaminated hallways have been cleaned and sanitized.

Food & Nutrition Services Disaster Call Tree

STANDING ORDER 9.1 CALL LIST (DISASTER AND MASS CASUALTIES)*

AREA	POSITION	NAME	PHONE
OFFICE	Director**	Marty Acevedo	760-941-5841
	Clinical Dietitian	Linda Gastelum	760-758-4904
	Clinical Dietitian(Alt)*	Kelli Gecewicz	760-715-8744
FOOD PRODUCTION	Cook	Maurilia Parra	760-945-2250
	Buyer (Purchasing)	Gloria Breault	760-480-9380
	Receiving Clerk	Andres Carachure	760-726-3798
DISHROOM	Food Service Supervisor	Lisa Van Poelmann	760-822-0027
	Food Service Worker	Jesus Tello	760-216-6130
	Food Service Worke	Rolando Guiterrez	760-643-9142
	Food Service Worker (Alt)*	Michael Adams	760-277-7002
DIET OFFICE	Diet Clerk	Paul Riecke	760-224-1008
	Diet Clerk	Mary Lou Grose	760-757-4330
	Diet Technician	Terry Odfina	760-758-2825
PATIENT FOOD SERVICE	Food Service Supervisor	Eric Clemens	760-842-5988
	Food Service Worker	Marily Carachure	760-724-0846
	Food Service Worker (Alt) *	Josefina Blancas	760-724-1901
CAFETERIA	Cafeteria Supervisor	Jeff Pigza	760-721-1078
	Food Service Worker	Maria Elena McKeag	760-758-8104
	Food Service Worker (Alt) *	Tina Fucci	760-727-8516

* Indicates the person to be called only when more than 25 casualties are expected.
** These employees are to be called first and they will then call others, as needed.

Food & Nutrition Services Disaster Call List for Vendors

A. Emergency Refrigeration and Freezers

Hollandia Dairy maintains standby refrigerator and freezer trucks. Contact Ken May.

USFoods also will provide standby refrigerator and freezer trucks. Contact **Jennifer Weir**~~Dave Sherako~~.

B. Procedure for obtaining food and related supplies - refer to the following vendors' list:

ITEM — VENDOR

Water — *Arrowhead Bottling Company
(Contact Facilities Department first at Ext. 7148)
~~Hollandia Dairy maintains standby stainless steel water bins~~
which are available for emergency situations.

Dairy Products — Hollandia Dairy - contact:
Ken May 760-744-3222 (office) or 728-2108

~~Food & Supplies — US Foodservice/Joseph Webb Foods (closest supplier) - contact~~
~~Kim Jones 760-745-4200 (office), Ext. 351~~

~~US Foodservice/Alliant~~
~~Dave Sherako 800.888.3147 ext 8765~~
~~619.204.0879 (cell)~~

Primary - US Foodservice Emergency Contact List – Corona Division
(800) 888-3147 +

Name	Ext.	Mobile	Pager	Home
Andrzejczyk, Paul – ~~V.P. Healthcare and Multi-Unit Sales~~ **Populus, Phillip – Manager, Healthcare**	8983	(858) 354-6994**(714)552-7574**	-	-
Garcia, Alex – Account Executive	**8783**	**(909)292-8326**		
Hess, Emily – Account Executive	8740	(714) 747-7452	-	(951) 734-3396
Koya, Julie – Account Executive**Stratton, Jessica – Account Executive**	8765~~8746~~	(562) 572-1567**(909) 315-0773**	-	-
Nix, Colleen – Account Executive	8139	(805) 407-9764	-	(805) 921-1587
Sherako, Dave **Jennifer Weir** - Account Executive	87658733	(619)~~-204-0879~~**(909) 921-9456**	-	-
Stappas, Shanti – Account Executive	8758	(704) 953-1845	-	-
Truong, Nam – Account Executive	84568733	(626) 236-3956	-	(951) 817-0543
Sands, Anne – Account Executive	**8777**	**(949) 322-5197**		
Larrabure, Maria – Account Executive		**(818) 585-4604**		
Burns, Seamus – Account Executive		**(805) 720-0626**		

Secondary - US Foodservice Emergency Contact List - Corona Division
(800) 888-3147 +

Name	Ext.	Mobile	Pager	Home
MacFall, Graylon – President	8935	(714) 343-4480-**(619) 218-1376**	-	-
McLain, Jeff – Vice President, Operations	8973	(951) 505-7380	-	-
Miller, Lee – Transportation Manager	8944**8973**	(951) 204-3037	-	-
Spencer, Lonnie **Loc, Warren** – Operations Manager	8992**8944**	(714) 904-6637 **(626) 664-5398**	-	-
Stappas, Shanti – Vice President	**3678**	**(704) 953-1845**		

National Sales				

Produce Sunrise Produce
Danny Calvillo ~~951-347-6076~~**760-994-3379**

Meat Tip-Top Meats - contact
~~John/Diane Haedrich~~**Steve** —760-438-2620 (office)
~~760-729-5753 (home)~~

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 11/99

SUBJECT: Communication of Results – Women's Center

REVISION DATE(S):

~~STANDARD NUMBER:~~
~~CROSS REFERENCE:~~

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Radiologists and Records Techs

B. **PURPOSE:**
1. To meet **Mammography Quality Standard Act** (MQSA) standards to ensure that reports/results are sent to patients and referring physicians in a timely way .

C. **POLICY:**
1. The Mammography Center will provide patients with written results within thirty (30) days. Self-referring patients will receive the written report as well as the summary.
2. Results that are "suspicious" or "highly suggestive of malignancy" will be communicated directly by the interpreting Radiologist or designee ASAP to the referring MD or, if self-referred, to the patient. Self- referred patients will be given the Breast Help Line phone number, 940-5100, for a list of physicians for follow-up.
3. Patients that are called back to ~~our~~ **the** facility for additional views will be scheduled within ten (10) working days. ~~Our~~ **The** department's scheduler will make several attempts to contact the patient. If the patient cannot be reached, a letter will be sent to the referring physician reporting our request for follow-up. If ~~we~~ **the mammography department** receives no response within five (5) working days, a certified letter will be sent to the patient's residence signifying the importance of breast imaging follow-up. A copy of receipt of letter will be filed with the patient's records.

D. **EXTERNAL LINK(S):**
1. **Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf**
2. **Mammography Clinical Experience Requirements (2017) https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-requirements-2017.pdf?sfvrsn=4**

E. REFERENCE(S):

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
~~3.~~2. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 10/97

SUBJECT: Completion of Diagnostic Report

REVISION DATE(S):

~~**POLICY NUMBER:**~~
~~**CROSS REFERENCE:**~~

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **RESPONSIBILITY:**
1. Transcriptionists, Radiology Records Techs

B. **PURPOSE:**
1. To expedite the finalization of the diagnostic report.

C. **POLICY:**
1. The diagnostic report will be dictated, transcribed, printed, and distributed to the referring physicians in a timely manner.

D. **PROCEDURE:**
1. The transcription department will transcribe the diagnostic report in a timely manner.
2. The Radiologist will review the report and make corrections.
3. The Radiologist will finalize the report.
4. Periodically, throughout the day, the signed reports are printed for distribution.

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: ~~05/12~~	**SUBJECT: Distribution of Mammography Reports**
REVISION DATE(S):	~~**STANDARD NUMBER:**~~
Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**~~11/18~~01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Radiologists and Radiology records techs

B. **PURPOSE:**
1. To expedite the finalization and timely distribution of the of the mammography reports to the Requesting physicians.

C. **POLICY "A" FOR MAMMOGRAPHY EXAMS**
~~C.~~1. Requiring no prior films from outside facilities
- ~~1.~~**a.** Scheduled returning patients will have their images loaded from the PAC's system and available at their appointment time.
- ~~2.~~**b.** Radiologist will interpret mammogram and compare with previous images.
- ~~3.~~**c.** Report will be transcribed and Radiologist wi ll finalize the report.
- **d.** Reports will be automatically faxed to the referring physician within 24 hours of Transcription.
- **e. Normal result letters will be mailed to patients within 30 days.**
- **f. Self referred patients, if a health provider (or a responsible designee) is not named or is unavailable, then the report must be provided to the patient.**
- ~~4.~~**g. Communications to the patient, if there is no health care provider, it must include:1) the complete report of findings referenced above 2) the summary written in lay terms that is required for all patients.**

~~D.~~2. ~~POLICY "B" for mammography exams n~~Needing comparison films from outside facilities
- a. The patient's current mammogram ~~will be placed~~ **study will be flaged** in ~~our~~ **the** "hold-pending prior films" box for no longer than 10 working days
- b. If outside images have not arrived within ~~this~~ **a** I 0-day period, images will be dictated And results faxed to referring physician within 24 hours
- c. When and if images arrive from outside facilities~~y~~, ~~our~~ **the** mammography ~~films~~ **study** will be ~~pulled~~ **flaged for the radiologist** and an addendum comparison report will be dictated, ~~transcri bed~~ **transcribed** ~~and sent out~~ **and finalized by the radiologist. The final result will be faxed to the referring physician through the automated fax server application.**

~~2.~~3. ~~POLICY "C" m~~Mammograms with "suspicious or highly ~~suspicious~~ **suggestive malignancy"** assessment~~)~~
- a. The interpreting Radiologist will ~~phone~~**dictate and finalize the report** ~~to~~ **and faxed to**

the referring physician with **their**~~his~~ findings within 24- hours of mammography **study**.

i. A letter will be mailed to the patient indicating the need to follow-up with their physician any abnormality seen on their mammogram within 5 working days.

ii. If a biopsy or surgical intervention is attained, then the pathology report is collected from the ~~J~~lab and these findings are entered into ~~our~~ **the mammography tracking** program for statistical computation.

~~ii.~~**iii. The interpreting Radiologist will add an addendum to the report documenting the pathology findings. The addended report is refaxed to the referring physician with the addended results.**

~~iii. The pathology reports are given to the lead radiologist's assistant who will correlate this Information with the patient's mammogram~~.

~~E.~~**D. PROCEDURE:**

1. Twice daily **Remote Installation Service** (RIS) will automatically transmit a facsimile to the requesting physician after the Radiologist approves the diagnostic report.

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 6/93	**SUBJECT:** Mammography Image/Data~~Film~~ Retention, Check-Out and Copying
REVISION DATE(S):	
Mammography Department Approval:	10/17
Department of Radiology Approval:	~~06/18~~10/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	11/18
Administration Approval:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/11

A. **AUTHORIZED TO PERFORM:**
1. Radiology records technician, radiologic technologist.

B. **PURPOSE:**
1. To ensure that all original films and reports are retained in accordance with **Joint Commission (JC)**~~JCAHO~~ and hospital policies; to ensure that all appropriate requests for films and/or reports are handled in the proper manner to maintain patient confidentiality and legal requirements.

C. **POLICY:**
1. All employees are responsible to maintain the files, films, and reports in good order.

D. **PROCEDURE:**
1. Retention:
   a. **Images**~~Films~~ and reports are filed by the Imaging Services Department using the patient's medical record number and a terminal digit and most recent year of visit.
   b. All **images/data**~~films~~ and reports are retained for ten (~~10~~ **5**) years by the Imaging Department.
      i. Films on all minors (under age 18) are retained until 25 years of age.
      ii. Mammographs are retained ~~for~~ **10 years or 5 years if a new set of images are performed at the facility** ~~.~~

~~2. Check Out of Films (Only After Dictation Complete by Radiologist)~~
~~a. To Surgery.~~
~~i. All original films taken to surgery must be returned to the department at the end of the day.~~
~~b. To Emergency Department~~
~~i. Films are not to be taken to the ER until they are requested by the physician. Films are then to be left with the ER physician making the request, and retrieved in a timely manner.~~
~~ii. If films are unread, copies must be made before an ER patient is transferred and films sent to another facility.~~
~~iii. The ER is to alert Radiology when sending films with the patient. Film library personnel will then prepare the films for transport according to department policy.~~
~~c. To Other Departments:~~
~~i. Nuclear Medicine films may be taken to Radiology for review if the file has been bar-coded to that location.~~

~~ii. Radiology films may be taken to Nuclear Medicine for review if the file has been bar- coded to that location.~~

~~d. To a Physician's Office:~~

~~i. The physician's office must call to request the films in a reasonable time frame (24 hours is suggested).~~

~~ii. A written request must be received through the mail or delivered by the patient if the requesting physician is not on staff at Tri-City or if films are to be mailed.~~

~~e. By Patients:~~

~~i. Patients may check out original films only if they present a written request from a physician or the Imaging Services staff makes telephone confirmation of the request from the physician's office.~~

~~ii. A signature is necessary before release. If a minor, the signature of the parent/legal guardian must be obtained.~~

~~iii. Proper identification (i..e., driver's license) must be presented when films are picked up.~~

~~f. *By* Attorneys:~~

~~i. **Copies only** may be released to an attorney's office upon presentation of a subpoena unless the subpoena specifies **Originals.**~~

~~1) If originals are specified, COPIES must first be made to be retained in our files.~~

~~ii. These cases are considered **LEGAL CASES** and should be bar coded into the legal file and remain there. Jackets can be filed back into main file for storage purposes only.~~

~~g. *By Copy Service:*~~

~~i. **Copies only** may be released if a subpoena is submitted and the fees are paid prior to release.~~

~~1) If originals are specified, COPIES must first be made to be retained in our files.~~

~~ii. Ask for sufficient time to duplicate the films before pick-up.~~

~~h. *To other Hospitals:*~~

~~i. A written release form signed by the patient or guardian must be received prior to releasing films to another facility.~~

~~i. *Return:*~~

~~i. All originals must be returned to the Imaging Services Department within seven *(7)* days.~~

~~ii.~~iii. ~~Monthly all overdue films will be traced and notices sent to the offices or facilities in possession.~~

E. **REQUEST COPY OF REPORTS/MAMMOGRAMS/ULTRASOUND~~COPYING~~:**

1. Requests for copies of **report/images on a disc**~~films~~ should be directed to the Film Library.
2. **Requests by patients:**
   a. **Patients may check out their original reports/mammograms only if they complete the authorization form for disclosure of individually identifiable health information, as set forth and consistent with California and Federal law concerning the privacy of such information.**
   b. **Patients need to fill out the Authorization for Use or Disclosure from and sign the form by presenting their identification documents.**
3. **Requests by Mammography from outside facilities:**
   a. **Women's Diagnostic Center may request a copy of reports/mammograms/ultrasounds through Medical Record Department Fax Transmittal Sheet.**
   b. **Patient needs to sign and fill out the authorization form to authorize the release of medical records, mammograms and reports to Tri-City Medical Center Women's Diagnostic Center.**

c. **Mammographer needs to send the release of authorization request by finding the fax number from Mammography Centers Directory.**

~~2. Fees for copies are charged for films requested by attorneys' offices. Films will not be released or mailed until payment is made. This process is handled by the SMART Corporation. They collect all fees.~~

~~3. All mammography films must be copied. Originals may then be released upon request.~~

~~4. Copies should be made whenever a request for release is made.~~

~~5. Note: original films should not be released if "unread",~~

~~a. Original films must never be released to copy services or attorneys unless the subpoena specifies "originals". Original films must not be mailed to an attorney.~~

~~6. Charges for copying are as follows:~~

~~0 – 5 films~~	~~$30~~	~~134080068~~
~~6 – 10 films~~	~~$45~~	~~134080076~~
~~11 – 20 films~~	~~$60~~	~~134080084~~
~~21 + films~~	~~$75~~	~~134080092~~

F. **FACSIMILE TRANSMISSI ON (FAX):**

1. In accordance with Administrative **Compliance** Policy: **Faxing Protected Health Information** 522~~ and Procedure #342~~, confidentiality of all patient records must be maintained at all times, and is not to be discussed with any person not directly associated with the case.
2. Facsimile machines may be used to transmit confidential information (e.g., reports), but reasonable care must be taken to assure the information reaches its destination (e.g., confirmation form) and is kept confidential.
3. **Per Administrative Information Technology Policy: Fax Transmissions 616** Aa FAX transmittal sheet must accompany any records that are sent via facsimile machine and maintained as a permanent part of the patient's file. ~~See attached form.~~

G. **DISCIPLINARY ACTION:**

1. Failure to follow these guidelines for film retention and release will result in disciplinary action.

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

1. **Administrative Compliance Policy: Faxing Protected Health Information 8610-522**
2. **Administrative Compliance Policy: Patient Access to Protected Health Information in the Designated Record Set 8610-516**
3. ~~1.~~**Administrative Information Technology Policy: Fax Transmissions 8610-616**

I. **REFERENCE(S):**

~~2.~~1. **U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~Women's Diagnostic Center – Policies and Procedures~~

ISSUE DATE:	**05/11**	**SUBJECT:**	**Mammography Medical Outcomes Audit**
REVISION DATE(S):	**03/13**		

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Computer data input and output coordinated by Mammography supervisor. Pathology reports and mammography exams are correlated ~~by the Breast Health Nurse Navigator~~ and presented to the lead interpreting Radiologist for review and presentation at the Radiology Division meeting.

B. **PURPOSE:**
1. To statistically aggregate patient mammography data outcomes for physician analysis and to comply with **Mammography Quality Standard Act** (MQSA) standards.

C. **POLICY:**
1. Medical Audit analysis will be prepared, reviewed and presented semi-annually at the Radiology Division meeting. Audit analysis must be retained for 36 months.

D. **PROCEDURE:**
1. Tri-City Medical Center's system for tracking positive mammograms is as follows:
   a. Mammograms with "suspicious" or "highly suggestive of malignancy" assessment:
      i. The interpreting radiologist will explain the results to the patient.
      ii. The radiologist will ~~phone~~**dictate and finalize the report.**
      ~~ii.~~iii. ~~t~~The **report**~~results~~ **will automatically be sent** to the referring physician ~~with his/her findings~~.
      iv. **Mammography department's patient coordinator will phone the referring physician office to follow up radiologist's request for new findings.**
      ~~iii.~~v. The letter will be mailed to the patient, within 5 working days, indicating the need to follow-up with their physician on any abnormal finding.
      ~~iv.~~vi. ~~Nurse navigator~~**Mammography supervisor** tracks pathology results for all breast biopsies. The pathology report is verbally called and faxed to the ordering physician by **the mammography supervisor** ~~Breast Health Nurse Navigator~~ within 24-48 hours of result.
      vii. Once pathology report has been called into ordering **physician**~~MD~~ the report is then scanned into PAC system for radiology-pathology correlation by lead interpreting radiologist. The pathology reports are given to the Mammography Supervisor who will ~~correlate~~ **document** this information ~~with the~~ **into** patient's mammogram**'s chart** ~~in the~~ **through** computerized mammography medical

audit.

viii. **Women's Diagnostic tracking system for "positive mammography findings" as "suspicious or highly suggestive Malignancy":**

ix. **1) Determines whether biopsies are done on the patient by tracking the list of Birads 4&5 through Discern Analysis on Cerner**

x. **2) Determines whether the biopsy specimen was benign or malignant by tracking pathology on patient's power chart and directing the report to lead interpreting physician for correlation.**

~~v.~~xi. **3) Facility provides list of any non-compliant patients who were recommended biopsy but not result were obtained. Facility documents all attempts to provide this information.**

~~vi. Nurse navigator tracks radiology-pathology correlation to ensure patient has recommended surgical intervention or recommended radiologic surveillance as appropriate.~~

E. **TO RETRIEVE CLINICAL OUTCOMES DATA:**

1. Log on to ~~Cemer~~ **Cerner** application mammography
2. Select Medical Audit icon
3. Select date range and run reports
4. Print rep011and submit to lead interpreting radiologist for review and presentation
5. Place report in Medical Audit Binder for documentation.

F. **REFERENCE(S):**

~~5.~~1. **U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~Diagnostics, Imaging & Therapeutics Policies & Procedures~~

ISSUE DATE: 12/99

SUBJECT: Mammography Quality Assurance (QA) Plan

REVISION DATE(S):

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **PURPOSE:**

1. To ensure the safety, reliability, clarity and accuracy of mammography services performed at Tri-City Medical Center (TCMC).

B. **POLICY:**

1. The Edgar and JoAnne Jones Mammography Quality Assurance Program will meet the **Mammography Quality Standard Act** (MQSA) standards and those of other appropriate regulatory bodies. The program will be reviewed bi-annually by the responsible mammography interpreting physician as mandated by California Code of Regulations, Title 17, Section 30317.20. The program will consist of multiple parts and be supported by a system that incorporates the following:
   a. Audit of Results
      i. Whereby positive results are entered into the system
      ii. System in place to obtain all pathology results
      iii. System in place to compare pathology results with physician interpretations
      iv. Analysis data kept for at least 24 months following the analysis
   b. Reporting of Results - communication of results to patients and physicians.
   c. Appropriate procedures to ensure consistency and safety in performance and procedures.
   d. Defined processes/responsibilities to support the service
   e. Monitoring of important aspects of care
   f. Patient satisfaction data
   g. Competent staff - orientation, training, and continuing education
   h. Equipment - Quality Control testing and corrective actions followed up when results not acceptable
   i. Annual Medical Physicians Survey performed in a timely and complete manner, with results and recommendation reviewed by the facility
   j. Performance improvement

C. **RESPONSIBILITIES :**

1. Responsible individuals shall:
   a. Be qualified for assignments.
   b. Know the specifics of their assigned tasks.
   c. Have adequate time to perform duties.

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

~~c.~~1. **Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf**

~~D.~~E. **REFERENCE(S):**

1. California Code of Regulations, Title 17, Section 30317.20
~~1.~~2. **Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE:	**01/00**	**SUBJECT:**	**Scheduling of Self-Referring Mammography Patients**
REVISION DATE(S):		~~**POLICY NUMBER:**~~ ~~**CROSS REFERENCE**~~	

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **DEFINITIONS:**
1. **Self-Referred: comes for a mammogram but has no personal health care provider or the provider declines responsibility.**
2. **Self-Requesting: has taken the initiative to come for a mammogram, can name health care provider, but does not have a referral.**

~~A.~~B. **PURPOSE:**
1. To clarify the Women's' Center self-referral process for screening versus diagnostic exams.
2. **To clarify follow up for the self-requesting and self-referring patients.**

~~B.~~C. **POLICY:**
1. The **Women's** Center will perform self-referral exams for screening only. Self-referring patients with breast symptoms must have a physical exam by a~~n~~ **physician**~~M.D.~~ prior to mammogram scheduling.
2. ~~TCMC~~ **The** Women's Center will ensure that follow up for self-referring and self-requesting patients meet MQSA standards.

~~C.~~D. **PROCEDURE:**
1. **Scheduling:**
   - ~~1.~~**a.** The scheduler will confirm whether the exam is for screening or diagnostic purposes.
   - ~~2.~~**b.** The scheduler will ask for referring **physician**~~M.D.~~ for all patients.
   - ~~3.~~**c.** The scheduler will inform the self-referring patient with breast symptoms of this Policy (Diagnostic Exam) and provide the Breast Help Line number, 940-5100 for physician referral information.
2. **Interpretation:**
   - **a. Self-referred: The interpreting physician will assume responsibility for women's breast care; including education and physical exam, communication of results (see Mammography Policy: Communication of Results).**
   - **b. Self-requesting: The Women's Center will document that the designated provider accepts responsibility for follow up, or the interpreting physician will assume responsibility for women's breast care ~~treat the patient as above in 4.1~~, if physician declines.**

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

4.1. **Mammography Policy: Communication of Results**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE:	**SUBJECT: Screening Mammography**
REVISION DATE(S):	~~**POLICY NUMBER:**~~ ~~**CROSS REFERENCE:**~~
Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**

1. Licensed Radiologic Technologist processing certification from the **American Registry of Radiology Technologists** (~~A.R.R.R.~~) and the California **Certified Radiologic Technologist** (~~C.R.T.~~) in Mammography. Must have performed 200 mammograms in a 24-month period.

B. **PURPOSE:**

1. To provide consistent guidelines for screening mammograms to detect unsuspected breast cancer in symptomatic women and meet all **Mammography Quality Standard Act** (~~M.Q.S.A.~~) and **American College of Radiology** (~~A.C.R.~~) accreditation requirements

C. **POLICY:**

1. Screening Mammography is indicated in symptomatic (including patients with a family history of breast cancer) women at least 40 years of age, with or without referring **physician**~~M.D.~~ order.

~~1.~~**a.** Exception: Screening mammography will not be done on pregnant or lactating women unless ordered by physician.

D. **PROCEDURE:**

1. Standard views to be done:
   ~~2.~~**a.** Craniocaudal (cc)
   ~~3.~~**b.** Mediolateral (mlo)

~~4.~~**2.** If the patient is a symptomatic and/or something abnormal is seen on mammogram, show films to Radiologist for recommendations for additional imaging studies. The Radiologist will complete an "Additional Evaluation Required" form, which constitutes a diagnostic order from **physician**~~M.D~~.

~~5.~~**3.** If a breast abnormality is identified on the same date of service prior to the patient leaving, and additional films are performed, the patient's screening mammogram will be edited by the technologist to a diagnostic mammogram as per Radiologist's orders.

~~6.~~**4.** If this breast abnormality is identified after the patient has left our facility, the patient will be billed for the screening mammogram on the original date of service and will be billed for a diagnostic mammogram on the return visit.

5. One copy of this order will be given to the registrar in the Women's Diagnostic Center and a second copy to the Billing Department.

E. **EXTERNAL LINK(S):**

~~Pol-proc/patient care serv.pp/screening mammogram.10-03~~

1. Mammography Clinical Experience Requirements (2017) https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-requirements-2017.pdf?sfvrsn=4

F. REFERENCE(S):

~~7.~~1. AART (2017, July 1) Updated Mammography Content Specifications, Clinical Experience Requirements, and Task Inventory. Retrieved from https://www.arrt.org/news/2017/03/22/updated-mammography-content-specifications-clinical-experience-requirements-and-task-inventory-effective-july-1-2017

Tri-City Medical Center
Oceanside, California

DELETE - incorporated into Scheduling of Self-Referring Mammography Patients

Mammography
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 01/00

SUBJECT: Self-Referring & Self-Requesting Patients

REVISION DATE(S):

~~**POLICY NUMBER:**~~
~~**CROSS REFERENCE**~~

Mammography Department Approval ~~Date(s)~~:	10/17
Department of Radiology Approval ~~Date(s)~~:	~~06/18~~10/18
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	11/18
Administration Approval:	01/19
Professional Affairs Committee Approval ~~Date(s)~~:	n/a
Board of Directors Approval ~~Date(s)~~:	08/11

~~A. **DEFINITIONS:**~~
~~1. Self-Referred: comes for a mammogram but has no personal health care provider or the provider declines responsibility.~~
~~2. Self-Requesting: has taken the initiative to come for a mammogram, can name health care provider, but does not have a referral.~~

~~B. **PURPOSE:**~~
~~1. To clarify follow-up for the self-requesting and self-referring patients.~~

~~C. **POLICY:**~~
~~1. TCMC Women's Center will ensure that follow up for self-referring and self-requesting patients meet MQSA standards.~~

~~D. **PROCEDURE:**~~
~~1. Self-referred: The interpreting physician will assume responsibility for women's breast care; including education and physical exam, communication of results (see Mammography Policy: Communication of Results).~~
~~2. Self-requesting: The Women's Center will document that the designated provider accepts responsibility for follow-up, or the interpreting physician will assume responsibility for women's breast care , if physician declines.~~

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 11/99	**SUBJECT:** Staff & Personnel Listing Women's Center
REVISION DATE(S):	
	~~**POLICY NUMBER:**~~
	~~**CROSS-REFERENCE:**~~

Mammography Department Approval:	**10/17**
Department of Radiology Approval:	**~~06/18~~10/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/11**

A. **PURPOSE:**

1. In addition to **quality control** (QC) test records, a **quality assurance** (QA) program includes clearly assigned personnel responsibilities. The QA program should identify the person responsible for overall quality assurance and compliance with the quality standards at the facility. It should also identify the QC technologist and the medical/ physicist and describe their responsibilities within the QA/QC program

B. **PERSONNEL:**

1. The Edgar and JoAnne Women's Center has an actively involved lead interpreting radiologist to oversee the program. The program also includes a physicist and a Mammography Diagnostic Specialist who serves as the facility's Quality Control technologist. Other technologists and ~~darkroom~~ personnel help with testing. ~~but T~~the Diagnostic Specialist ensures that the program is ~~being~~ run according to MQSA standards. All personnel associated with mammography services must meet the MQSA qualifications, training and continuing education requirements.
2. **See the Mammography Staff and Responsibilities List**

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

~~2.~~1. **Mammography Staff and Responsibilities List**

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

1. **Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf**
2. **The Mammography Quality Standards Act Final Regulations: Preparing for MQSA Inspections; Final Guidance for Industry and FDA (2001) https://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm094441.pdf**

E. **REFERENCE(S):**

1. **Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).**

~~3.~~2. **U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm**

Mammography Staff and Responsibilities List

	Name	Pgr/Ext/Telephone	Primary Responsibilities
Responsible Radiologist	Dr. ~~William Johnson~~ **Jennifer Mayberry**	~~Pgr: 760-926-0964~~ ~~Ext: 4055~~ **Hm: Communication desk: 760-940-7815** Mobile: 503-330-5719	Lead Interpreting Physician Clinical/Medical Oversight of Mammography Program Auditing Interpreting Physician
Responsible Technologist	**Margaret Patterson** Nazita Sanders	Pgr: Ext: 5573 **Hm: 760 758-0007** Work mobile phone: **760-696-7964**	QC/QA program, ensure MQSA standards
QC Technologists	Karen Niggli Connie George	Pgr: Ext: 5572 Hm:	Daily Calibrations, Mammography
Physicist	Glen Deacon**Fady Khassem**	**619 421-7670** 562-234-7664	Radiation Safety QC, Program Validation, Equipment
Imaging Operations Manager	**Lou Bello** Bucky Basaez	Cell: 760 802-7299 Ext: ~~3963~~ **7225** **Work Mobile phone number:**~~Hm:~~ 760-277-0422	Daily Operations
Imaging Director	Steve Young	Cell: 760 208-7442 Ext: 3980 Mobile~~Hm~~: 760 757-8969	Administrative Oversight, Budget, QA/QC/PI Programs for departments

Tri-City Medical Center
Oceanside, California

PATIENT CARE MANAGEMENT

ISSUE DATE: 10/09 **SUBJECT: Utilization Review Process**

REVISION DATE(S): 04/10, 02/12, 02/13

Case Management Department Approval ~~Date(s)~~:	**~~11/15~~10/18**
Utilization Review Committee Approval ~~Date(s)~~:	**~~11/15~~11/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Staff Department or Division Approval:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~01/16~~11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~02/16~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**02/16**

A. **PURPOSE:**
1. To establish criteria for utilization review process.

B. **POLICY:**
1. Case Management staff will utilize hospital approved (InterQual®) Severity of Illness/Intensity of Service (SI/IS) guidelines to perform and document admission reviews, observation status and continued stay reviews, discharge disposition review and retroactive review for all patients as stated in this procedure.
2. Case Management staff will identify appropriateness of level of care (i.e. ICU/CCU, DOU/Telemetry, Acute Care, Monitored Med/Surg, ~~Pediatrics~~, NICU, and Women's Care Services).
3. Case Management staff shall ~~identify~~ **review** admission criteria for Observation vs. Inpatient.
4. Every reasonable effort shall be made ~~so that~~ **for** appropriate admission criteria ~~are~~ **to be** documented ~~in the appropriate EMR~~ within 24 business hours of admission.

C. **PROCEDURE:**
1. Admission Review
   a. All new Tri-City Medical Center (TCMC) Admissions (Inpatient & Observation Service) and transfers ~~within~~ **to**TCMC ~~(example: 2-P to ICU)~~ shall have an initial InterQual® review performed not later than 24 business hours following admission to TCMC~~, seven (7) days per week, "~~to determine appropriateness of an admission to a Level of Care~~"~~.
      i. Priority of Initial Review:
         1) Medicare
         2) Medi-Cal & Cash
         3) Commercial Insurance
      ii. Every reasonable effort shall be made to complete Initial CM Reviews within 24 calendar hours of admission to TCMC
      iii. EXCEPTIONS: Routine postpartum, newborn care.
         1) Vaginal Delivery – provide review 48 hours following delivery
         2) Cesarean Section Delivery – provide review 96 hours following delivery
   b. Admission Review shall include a "Patient Status Reconciliation" – the physician order must match the correct level of care- Inpatient vs Outpatient / Observation,
      i. Case manager shall contact the admitting physician to discuss any discrepancy and clarify the physician's intent. The Case Manager shall contact the ~~UM Medical Director~~ **PhysicianPhysician Advisor** as needed.
   c. Clinical review findings shall be documented in Allscripts (InterQual®)~~,~~ within 24 business hours of admission.

i. The following medical groups' Utilization Management staff will perform utilization review for their capitated patients per contractual agreement.
   1) PCAMG (Primary Care Associates Medical Group)
   2) GTCIPA (Greater Tri-City Independent Physician Association)
   3) Graybill Medical Group (except CHG)

ii. TCMC Case Management staff and the medical groups' utilization management staff will have ongoing communication regarding cases, issues, problems, on an as-needed basis.

2. California Children's Services (CCS)
   a. Identify all patients under the age of 21 and screen for potential CCS eligible diagnosis (refer to CCS approved diagnoses).
   b. Review all patients under 21 for changes in clinical condition representing a potential California Children's Services (CCS) -eligible condition. If the patient appears to meet the eligibility criteria, a referral is made to the Social Worker and communication is made to the Business Office to generate a referral to CCS.
   ~~c. If patient appears to meet the eligibility criteria, a referral is made to the Social Worker and communication is made to the Business Office to generate a CCS referral.~~
3. California Department of Correction (CDCR):
   a. Clinical updates shall be provided daily Monday through Friday via pre-scheduled conference call
   ~~b. 1-888-232-0366, participant code 381347~~
4. Continued Stay Review
   a. All inpatients will be reviewed for Continued Stay-, Monday – Friday, utilizing InterQual® guidelines' Intensity of Service (IS) and appropriateness of level of care and medical necessity ~~as follows~~ (unless Payor has been granted electronic health record (EHR) Access by TCMC for the purposes of performing their own clinical reviews)~~:~~.
      ~~i. Daily Reviews with comments: (Do NOT attach any other documentation unless requested)~~
         ~~1) Aetna, BC/BS, Care First, CHG, Molina~~
         ~~2) "Out of Area" Commercial payers (Kaiser, Sharp, Scripps for example)~~
      ~~3) Medi-Cal, CMS, LIHP & Cash patients – IQ Review with comments re: daily events~~
      ~~ii. Medicare – Initial then every four (4) hospital days~~
      ~~iii. Other Commercial Payers – as per request and / or contractual agreement~~
   ~~b. Next Review date:~~
      ~~i. Daily Reviews for all cases in rule out, work up status (Observation Service)~~
      ~~ii. Daily Reviews for all CHG, Molina, Care First, Aetna, BC/BS patients~~
         ~~1) Exceptions: Routine postpartum, newborn care.~~
            ~~a) Vaginal Delivery – provide review after 48 hours following delivery~~
            ~~b) Cesarean Section Delivery – provide review after 96 hours following delivery~~
         ~~2) Clinical reviews shall be provided within one (1) business day of the request.~~
   ~~c.~~**b.** If Continued Stay criteria are not met or the current level of care is no longer appropriate, ~~discuss~~ case **is discussed** with the attending/treating physician ~~to determine the plan of care~~.
      i. NOTE: If attempts to contact/discuss the case with the attending/treating physician are unsuccessful, refer case to the Physician Advisor.
   ~~d.~~**c.** InterQual® reviews shall be provided to the payer / review organization via Allscripts or in manner requested by the payer.
      i. The payer information (including authorization number and days authorized) will be documented in Affinity under the PA notes for the specific patient.
   ~~e.~~**d.** When a patient is transferred to another area of the hospital, the transferring case manager / social worker is responsible for:
      i. Hand-Off Communication to accepting Case Manager / Social Worker utilizing SBAR format as adopted by TCMC, and documented in Allscripts

ii. Completing all electronic medical record documentation.

~~5. Discharge Disposition Review~~

~~a. All patients are required to have a discharge disposition review, utilizing InterQual© Criteria except for those patients in Maternal Child, Pediatrics, and NICU.~~

~~b. Discharge disposition reviews should be completed, including reviews of patients that are admitted and discharged the same day of admission, and weekend admissions that were discharged prior to Monday.~~

~~c. Discharge Disposition Reviews shall be documented in appropriate EMR application, no later than 48 hours after the patient is discharged.~~

~~d. The discharge disposition (Example: SNF, Rehab, HHA or Hospice) will be entered in the Appropriate Case Management System (Allscripts), and shall include the name of the after hospital provider as applicable~~

~~e. The weekday case manager assigned to the unit from which the patient was discharged is responsible for performing the discharge review.~~

~~f. Weekend case managers should perform Discharge Disposition Review as time and workload permits, documenting in the Appropriate EMR.~~

D. **REFERENCE(S):**

1. InterQual Level of Care Criteria, Acute Care - Adult (Annual Edition as appropriate & updated)

Tri-City Medical Center
Oceanside, California

PHARMACY MANUAL

ISSUE DATE:	**05/94**	**SUBJECT:**	**Antidote Stocking**
REVISION DATE(S):	**04/97, 08/00, 05/02, 02/03, 07/06, 07/09, 01/12**	**~~POLICY NUMBER: 8390-10002~~**	
Pharmacy Department Review:		**~~10/17~~09/18**	
Medical Staff Department or Division Approval:		**n/a**	
Pharmacy & Therapeutics Committee Approval:		**~~02/03, 07/06, 07/09, 1/12, 11/14~~09/18**	
Medical Executive Committee Approval:		**~~02/03, 07/06, 07/09, 1/12,01/15~~11/18**	
Administration Approval:		**01/19**	
Professional Affairs Committee Approval:		**~~02/15~~ n/a**	
Board of Directors Approval:		**~~02/03, 07/06, 07/09, 1/12,~~ 2/15**	

A. **DEFINITION(S):**
1. Antidote: a substance which can counteract a form of poisoning

B. **PURPOSE:**
1. To ensure supply of antidotes are consistently available, controlled, and secured

C. **POLICY:**
1. Antidote medications will be primarily stocked in the Pharmacy Department
2. Antidote medications that require immediate administration upon patient arrival shall be stored in the Emergency Department
3. Pharmacy will supply a minimum of an 8 hour supply of antidotes unless mechanisms for more rapid resupply or transfer is in place
4. Pharmacy will supply up to 24 hours for patients likely to be maintained for longer periods or when definitive care is planned
5. A list of antidotes stocked and approved for use at Tri-City Medical Center shall be reviewed and maintained at least annually; available via the Intranet (see attachment)
6. The telephone number of the Poison Control Center shall be posted in the Pharmacy, Emergency Department, and all other patient care areas

D. **RELATED DOCUMENT(S):**
1. Antidote Information Chart

E. **REFERENCE(S)**

1. Dart RC et al. Expert Consensus Guidelines for Stocking of Antidotes in Hospitals that Provide Emergency Care. Annals of Emergency Medicine. ~~2009; 54(3): 386-394~~**2017 doi: 10.1016/j.annemergmed.2017.05.021. [Epub ahead of print]**
2. California Poison Control System. Antidote Chart. Last Updated ~~October 14, 2014~~**March 2017**. Available from: http://www.calpoison.org/hcp/home.html. Date Assessed: ~~October 31, 2014~~**October 11, 2017.**

Antidote Information Chart

Antidote Information Chart				
Generic/Brand	**Toxin**	**Notes**	**Stocking Recommendation***	**Stocking Location**
Acetylcysteine/Mucomyst (oral)	Acetaminophen poisoning	Use orally. Dilute at least by 3:1 ratio	**8 hours:** 28 g or 5 x 30ml (20%) vials **24 hours:** 56g or 10 x30 ml (20%) vials	Pharmacy
Acetylcysteine/Acetadote (IV)	Acetaminophen poisoning	Loading dose should be infused over 45-60 minutes. Generic N-acetylcysteine can be used if Acetadote is unavailable (consult with poison control and administer via a micropore filter)	**8 hours:** 24g or 4 x 30ml (20%) vials **24 hours:** 30g or 5 x 30ml (20%) vials	Pharmacy
Antivenom Crotalidae Polyvalent Immune-FAB (ovine)/ CroFab	Rattlesnake venom		**8 hours:** 18 vials **24 hours:** 36 vials	Pharmacy
Antivenom Black Widow Spider/Antivenom (Latrodectus Mactans)	Black Widow Spider venom	Risk of allergic hypersensitivity (equine).	**8 hours:** 1 vial **24 hours:** 1 vial	Drop ships from Merck only if case presents due to limited availability. Call 800-672-6372
Atropine Sulfate	Organophosphate/carbamate insecticide and other cholinesterase inhibitors (i.e. warfare agents); bradycardia induced by a variety of toxin	May require large amounts in severe cholinesterase inhibitor poisoning. Also stocked in the Strategic National Stockpile but will need supplies for first 48 hours. Coordinate with local Homeland Security Office	**8 hours:** 100mg or 13 vials (0.4mg/ml, 20ml each) **24 hours:** 200mg or 26 vials (0.4mg/ml, 20ml each) Use preservative free product	ED and Pharmacy
Calcium Chloride	Calcium channel blocker poisoning; hypocalcemia induced by various agents	Can cause severe tissue necrosis if extravasation occurs. Central administration recommended or give calcium gluconate	**8 hours:** 10 g or 10 vials (10%, 10ml) **24 hours:** 10g or 10 vials (10%, 10ml)	ED and Pharmacy
Calcium Gluconate	Hydrofluoric acid skin exposure or poisoning; hypocalcemia induced by a variety of agents		**8 hours:** 30g or 30 vials (10%, 10ml) **24 hours:** 30g or 30 vials (10%, 10ml)	ED and Pharmacy
Carnitine (L-Carnitine)/Carnitor	Hyper ammonemia from valproic acid toxicity		**8 hours:** 10g or 10 x 1g vials **24 hours:** 10 x 25g tubes	Pharmacy
Cyanide Antidote Kit/Cyanokit	Cyanide; sodium nitroprusside toxicity	Newer, safer, and easier to use than conventional cyanide kit. Contains hydroxycobalamin. May cause red discoloration of urine and skin. May cause laboratory test interference	**8 hours:** 10g or 2 kits **24 hours:** 10g or 2 kits	ED and Pharmacy
Dantrolene	Malignant hyperthermia		**8 hours: 1000 mg or 50x 20 mg vials** **24 hours: 1300 mg or 56 vials**	Surgery/OB OR MH Carts and Pharmacy
Deferoxamine/Desferal	iron poisoning	IV use only	**8 hours:** 12g or 6 x 2g vials **24 hours:** 36g or 18 x 2g vials	ED and Pharmacy
Digoxin Immune FAB(ovine)/ DigiFab	digoxin poisoning; other cardiac glycosides (i.e. oleander, foxglove)	Consult with poison center regarding dosing, especially for cardiac glycosides than digoxin	**8 hours:** 15 vials **24 hours:** 20 vials	Pharmacy
Dimercaprol/ BAL in oil 10%	Heavy metal poisoning	IM administration only	**8 hours:** 600mg or 2 amps (100mg/ml, 3ml each) **24 hours:** 1800mg or 6 amps (100mg/ml, 3ml)	Pharmacy
DMSA (Succimer)/Chemet	Heavy metal poisoning		**8 hours:** 1g or 10 x 100mg capsules **24 hours:** 3g or 30 100mg capsules	Pharmacy

Antidote Information Chart				
EDTA-Calcium/Versenate	Heavy metal poisoning		**8 hours:** 1g or 1 x 1000mg/5ml amp **24 hours:** 3g or 3 x 1000mg/5ml amp	Drop shipment from Amerisource Bergen Specialty only

Generic/Brand	Toxin	Notes	Stocking Recommendation	Stocking Location
Flumazenil/Romazicon	Benzodiazepine overdose	Primarily used for iatrogenic over sedation. Use in patients on chronic benzodiazepines may cause withdrawal seizures. Caution with seizure disorders and head injury. Use small doses initially to avoid abrupt awakening/delirium.	**8 hours:** 6mg or 6 x 1mg/1ml vials **24 hours:** 12mg or 12 x1mg/10ml vials	ED, Pharmacy, Crash Carts
Fomepizole/Antizol	ethylene glycol toxicity or methanol poisoning	Manufacturer will replace expired stocks	**8 hours:** 1.5g or 1 x 1.5ml (1g/ml) vials **24 hours:** 4.5 g or 3 x 1.5 ml (1 g/ml) vials	Pharmacy
Glucagon	beta blocker/calcium channel blocker toxicity	Anticipate nausea and vomiting	**8 hours:** 90mg or 90 x 1mg kit **24 hours:** 250mg or 250 x 1mg kits	ED and Pharmacy
Idarucizumab	Monoclonal antibody that binds to dabigatran and its acylglucuronide metabolites and neutralizes their anticoagulant effects	Specific only for dabigatran; not effective for other oral anticoagulants	**8 hours:** 5g or 2 x (2.5g/ 50 mL) vials **24 hours:** 10 g or 4 x (2.5g/ 50 mL) vials	Pharmacy
Leucovorin	Folic acid antagonist		8-24 hours: 300 mg or 3 (100 mg) vials	Pharmacy
Levocarnitine	Acute valproic acid toxicity		8 hours: 9 g or 9 x 1 g (200 mg/ml) vials **24 hours:** 15 g or 15 x 1g (200 mg/ml) vials	Pharmacy
Lipid emulsion 20%/ Intralipid	Lipophilic cardiotoxic drugs	Immediately after administration severeal lab tests of patient serum/blood may be interpretable	**8-24 hours:** 3000 mL or 12 bags (250 ml each)	Pharmacy
Methylene Blue	methemoglobinemia		**8 hours:** 400mg or 4 x 10ml (10mg/ml) amps or 8 x 10 ml (0.5 mg/ml) amps **24 hours:** 600mg or 6 x 10ml (10mg/ml) amps or 12 x 10 ml (0.5 mg/ml) amps	Pharmacy
Naloxone/Narcan	opiate overdose	Use small initial doses to avoid abrupt awakening/withdrawal	**8 hours:** 20mg or 50 x 0.4ml/2ml amps or10 x 2mg/2 ml syringes **24 hours:** 40mg or 20 x 2mg/2ml syringes	ED, Pharmacy, Crash Carts
Octreotide acetate/Sandostatin	oral sulfonylurea poisoning	Do not use long-acting depot products	**8 hours:** 200 mcg or 2 x 1ml (0.1mg/ml) amps **24 hours:** 1000mcg or 1 x 5ml (0.2mg/ml) multidose vial	Pharmacy
Physostigmine/Antilirium	anticholinergic poisoning, especially antimuscarinic delirium	Administer at low dose (0.5mg) and slowly, over 2-5 minutes to avoid severe adverse reactions including bradycardia, asystole, and seizures. Contraindicated in TCA or similar poisoning with prolonged QRS intervals	**8 hours:** 4mg or 2 x 2ml (1ml/ml) amps **24 hours:** 20mg or 10 x 2ml (1mg/ml) amps	ED and Pharmacy

Generic/Brand	Toxin	Notes	Stocking Recommendation	Stocking Location
Pralidoxime (2-PAM)/Protopam	cholinesterase inhibitor poisoning (organophosphate or "nerve gas")	Also stocked in the Strategic National Stockpile but will need supplies for first 48 hours. Coordinate with local Homeland Security Office	**8 hours:** 7g or 7 x 1g (20ml) vials **24 hours:** 18g or 18 x 1g (20ml) vials	Pharmacy
Pyridoxine (Vitamin B6)	isoniazid (INH) poisoning	Large amounts needed for poisoning: 5g is the minimal antidotal dose used in an ingestion of unknown amount. Note: the 100mg in 1 ml vials contain the preservative chlorobutanol. A 5g dose requires 50 of these vials and will deliver a toxic dose of preservative. The 30ml vials may only be available from compounding pharmacies	**8 hours:** 9g or 3 vials (100mg/ml, 30ml each) or the equivalent **24 hours:** 24g or 8 vials (100mg/ml, 30ml each) or equivalent. **Use preservative free product**	Pharmacy
Phytonadione (Vitamin K)	warfarin, warfarin-based rodenticide poisoning	If patient has life threatening bleed, use in combination with prothrombin complex concentrate (PCC) or fresh frozen plasma	**8 hours:** 50mg or 5 x 10mg/ml amps **24 hours:** 200mg or 20 x 10mg/ml amps	Pharmacy
Protamine	Heparin reversal	May also partially neutralize low-molecular weight heparins	**8-24 hours:** 500 mg or 2 vials (10 mg/ml, 25 ml each)	Pharmacy and Surgery
Prothrombin Complex Concentrate (Profilnine)	warfarin, alternative oral anticoagulants (rivaroxaban/Xarelto, apixaban/Eliquis))	There have been no studies evaluating the effect of PCCs on bleeding in humans receiving the new oral anticoagulants. Data is limited but can be considered. See Pharmacy Anticoagulation Protocol for more information	**Min:** 5000 units or 5 x 1000 unit/vials	Pharmacy
Sodium bicarbonate	sodium channel blocker toxicity & urinary alkalinization	IV bolus dosing for reversal of sodium channel blocker toxicity; continuous infusion used for alkalinization of the urine (aspirin overdose). Monitor for alkalemia.	**8 hours:** 63g (750 mEq) or 750ml of 8.4% solution **24 hours:** 84g (1000 mEq) or 1 liter of 8.4% solution	ED and Pharmacy
Uridine triacetate/Vistogard	5-FU, capecitabine poisoning	Recommended for use within 96 hours of last dose where toxicity is evident or expected	**8 hours:** 20 g or 2 x 10 g packets **24 hours:** 40 g or 4 x 10 g packets	Cardinal Health Specialty Division (SPD) available 24/7 for urgent delivery (1-866-677-4844)

* Suggested Stocking Recommendation is based on dose to treat a single 100kg patient for 8 hours and for 24 hours for antidote purposes only). Subject to availability. Twenty-four hour supply may not be sufficient for entire treatment course

Dart RC et al. Expert Consensus Guidelines for Stocking of Antidotes in Hospitals that Provide Emergency Care. Annals of Emergency medicine. 2017: doi: 10.1016/j.annemergmed.2017.05.021. [Epub ahead of print]

California Poison Control System. Antidote Chart. Last Updated March 2017. Available from: http://www.calpoison.org/hcp/home.html. Date Assessed: October 11, 2017.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 10/10 **SUBJECT: Restricted Antimicrobials**

REVISION DATE(S):

Pharmacy Department Approval:	**~~03/15~~09/18**
Medical Staff Department or Division Approval:	
Pharmacy & Therapeutics Committee Approval:	**~~10/10, 03/15~~09/18**
Medical Executive Committee Approval:	**~~10/10, 06/15~~10/18~~11~~/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**~~07/15~~ n/a**
Board of Directors Approval:	**~~10/10,~~ 07/15**

A. **PURPOSE:**

1. To provide a list of restricted antimicrobials where prescribing of such medications is limited to specific indications or medical specialty in order to improve clinical outcomes, reduce rates of emerging resistance, and reduce the incidence of adverse events.
2. To provide restriction criteria and outline requirements for prescribing and dispensing of restricted antimicrobials
3. To provide a process that streamlines the approval of restricted antimicrobials

B. **POLICY:**

1. Restriction criteria shall be reviewed and revised at least annually by Pharmacy and the Infectious Disease (ID) Physician based on usage patterns, microbiology data, and cost-effective analyses.
2. Restriction Criteria shall be approved by the Pharmacy & Therapeutics (P&T) committee.
   a. Use of antimicrobials that do not meet criteria shall require ID approval.
   b. The Infectious Disease Physician shall collaborate with those who fail to comply with the restriction guidelines set forth by P&T.
3. All restrictions apply to inpatient and emergency room patients with the exception of patients enrolled in investigational antibiotic drug studies.

C. **PROCEDURE:**

1. The clinical pharmacist and/or Pharmacy Clinical Manager shall review all requests for restricted antimicrobials.
2. If the patient meets criteria for use of the agent (see Antimicrobial Agents Requiring Approval: Criteria For Use), the clinical pharmacist will approve the request.
3. If the patient fails to meet criteria, the prescriber will be notified that continued use of restricted antimicrobials requires approval by the Infectious Disease Physician, **and/or Intensivist as indicated by criteria use guidelines.**~~.~~
4. If the prescriber insists on using a restricted antimicrobial, the patient will be provided with enough doses (i.e. up to 24 hours, or through the weekend) to allow enough time for the prescribing physician to contact the Infectious Disease Physician and obtain approval. The prescriber will be notified of how many doses will be dispensed pending approval.
5. The Infectious Disease Physician will determine if the antimicrobial is indicated and provide approval if continued use of restricted antimicrobial is deemed appropriate.
6. ~~The Infectious Disease physician shall notify pharmacy regarding status of approval.~~**It is the ordering physician's responsibility to follow-up with a maintenance order for the antimicrobial after approval from the Infectious Disease Physician has been obtained**

~~6.~~**7. In addition to Infectious Disease Physician approval, all non-formulary agents require approval from the Clinical Pharmacy Manager**

~~7. If the antimicrobial is approved by the Infectious Disease Physician, the pharmacist shall update the order comments; otherwise the order shall be discontinued by the prescriber.~~

D. **~~FORMS/~~RELATED DOCUMENT(S):**

1. Antimicrobial Agents Requiring Approval: Criteria For Use

ANTIMICROBIAL AGENTS REQUIRING APPROVAL: CRITERIA FOR USE

ANTIBIOTICS:

1. **Amikacin**
   a. **All use restricted to Infectious Disease Physicians**
2. **Aztreonam (Azactam)**
   a. **Treatment of documented aerobic gram-negative bacilli infections in which beta-lactams are contraindicated due to a true anaphylactic penicillin or cephalosporin allergy (any prescriber)**
      i. **Monotherapy should be used only when cultures and sensitivities have been reported**
   b. Empiric therapy is **restricted to Intensivists or Infectious Disease Physicians**

~~1. Ceftazidime (Fortaz®)~~
   ~~a. For treatment of documented *Pseudomonas aeruginosa, Serratia or Acinetobacter* species (any prescriber)~~
   ~~b. Empiric therapy restricted to Oncologists, Pulmonology, Critical Care, or Infectious Disease specialists~~

~~2.~~3. Cefepime (Maxipime)
   a. For treatment of documented *Pseudomonas aeruginosa*~~, Serratia or Acinetobacter species~~ (any prescriber)
   b. For empiric treatment of febrile neutropenia (any prescriber)
   c. **Other** ~~E~~empiric therapy restricted to Oncologists, ~~Pulmonology, Critical Care,~~**Intensivists,** or Infectious Disease ~~specialists~~ **Physicians**

4. **Ceftaroline (Teflaro)**
   a. **Non-formulary agent restricted to Infectious Disease Physicians**
5. **Ceftolozane-tazobactam (Zerbaxa)**
   a. **Non-formulary agent restricted to Infectious Disease Physicians**
6. **Ceftazidime (Fortaz)**
   a. **For treatment of documented *Pseudomonas aeruginosa* (any prescriber)**
   b. **Empiric therapy restricted to Oncologists, Intensivists, Infectious Disease Physicians, or Nephrologists**
7. **Ceftazidime-avibactam (Avycaz)**
   a. **Non-formulary agent restricted to Infectious Disease Physicians**
8. **Colistin/colistimethate**
   ~~1.~~a. Non-formulary agent restricted to Infectious Disease **Physicians**

~~3. Amikacin & Tobramycin - Aminoglycoside antibiotics that retain activity to PSA.~~
   ~~2. Restrict tobramycin/amikacin to documented or highly suspected PSA infections or other MDRO pathogen (any prescriber)~~

~~4. Aztreonam (Azactam®)~~
   ~~a. For treatment of gram-negative infections in patients with a documented allergic reaction to penicillins or cephalosporin (any prescriber)~~
      ~~i. Monotherapy should be used only when cultures and sensitivities have been reported.~~
   ~~b. For empiric treatment of febrile neutropenia in a patient with anaphylactic allergy to penicillin (any prescriber)~~

9. **Dalbavancin (Dalvance) & oritavancin (Orbactiv)**
   a. **Non-formulary agent restricted to Infectious Disease Physicians**
   b. **Should not be dispensed unless ordered by Infectious Disease Physician and approved by pharmacy Clinical Manager**
10. **Daptomycin (Cubicin)**
   a. **For treatment of serious infections (except involving the urinary tract or lungs) with confirmed vancomycin resistant *Enterococcus faecalis/faecium* (any prescriber)**

b. **Empiric therapy or UTI is restricted to Intensivists or Infectious Disease Physicians**

11. Ertapenem (Invanz)

a. **Non-formulary agent restricted to Infectious Disease Physicians**

12. Fidaxomicin (Dificid)

a. **Non-formulary agent restricted to Infectious Disease Physicians**

~~5.~~**13.** Linezolid ~~(Zyvox®)~~ **(Zyvox)**

a. For treatment of ~~documented~~ serious infections (except involving the urinary tract) with confirmed vancomycin resistant *Enterococcus faecalis/faecium* (any prescriber)

b. **Empiric therapy or UTI is** ~~restricted to Pulmonology, Critical Care~~**Intensivists**, or Infectious Disease ~~specialists~~**Physicians**

14. Fosfomycin (Monurol)

~~b.~~**a.** Non-formulary agent restricted to Infectious Disease **Physicians**

~~6. Quinupristin/ Dalfopristin (Synercid®)~~

~~a. For treatment of documented serious infections with confirmed vancomycin resistant *Enterococcus faecium* only (restricted to Infectious Disease Physician only and Pharmacy Clinical Manager approval)~~

~~i. Patient must have a central line~~

~~ii. *Enterococcus faecalis* is inherently resistant to quinupristin/dalfopristin~~

~~7.~~**15.** Meropenem (Merrem)~~®~~

a. For treatment of serious infections due to documented multi-drug resistant gram negative bacilli that are only sensitive to the carbapenem class of antibiotics (any prescriber)~~.~~

b. For treatment of extended-spectrum beta-lactamase (ESBL) producing Enterobacteriacae.

c. **Empiric therapy restricted to Oncologists,** ~~Pulmonology, Critical Care~~**Intensivists**, or Infectious Disease ~~specialists.~~**Physicians**

16. Meropenem/vaborbactam~~)~~

a. **Non-formulary agent restricted to Infectious Disease Physicians**

17. Quinupristin/dalfopristin (Synercid)

a. **Non-formulary agent restricted to Infectious Disease Physicians**

~~c.~~

~~d. NOT indicated for necrotizing pancreatitis (recommend piperacillin/tazobactam for this indication).~~

~~8. Voriconazole (V-Fend®)~~

~~a. For treatment of documented invasive aspergillus infections (any prescriber)~~

~~b. Treatment of probable mold infections (exception: NOT indicated for Zygomycetes)~~

~~c. Empiric therapy or other fungal infections is restricted to Pulmonology, Critical Care, or Infectious Disease specialists.~~

~~9. Micafungin (Micamine®)~~

~~a. For treatment of documented non-albicans candidemia (any prescriber)~~

~~b. Empiric therapy of febrile neutropenia (any prescriber)~~

~~c. Other empiric therapy is restricted to Pulmonology, Critical Care, or Infectious Disease specialists~~

~~10. Doripenem (Doribax®) & Imipenem (Primaxin®)~~

~~a. Restricted to Infectious Disease Physician and Pharmacy Clinical Manager approval.~~

~~11. Daptomycin (Cubicin®)~~

~~a. For treatment of documented bacteremia with confirmed vancomycin resistant Enterococcus faecalis/faecium or treatment of any other documented vancomycin-resistant Enterococcus faecium infections except lung or UTI (any prescriber)~~

~~b. Empiric therapy is restricted to Pulmonology, Critical Care, or Infectious Disease specialists.~~

~~12.~~**18.** Tigecycline ~~(Tygacil®)~~ **(Tygacil)**

a. Non-formulary agent restricted to Infectious Disease ~~Physician~~ **Physicians**

~~13. Ceftaroline (Teflaro®)~~

~~a. Restricted to Infectious Disease Physician only and Pharmacy Clinical Manager approval~~

~~14. Dalbavancin (Dalvance®) & oritavancin (Orbactiv®)~~

~~a. Non-formulary agent restricted to Infectious Disease Physician only and Pharmacy Clinical Manager~~

~~b. Doses should not be administered unless ordered by Infectious Disease Physician~~

ANTIFUNGALS:

1. Amphotericin B liposomal (Ambisome)
   a. All use restricted to Oncologists, Intensivists, or Infectious Disease Physicians
2. Micafungin (Mycamine)
   a. For treatment of documented invasive candidiasis (not urine or respiratory), pending species identification (any prescriber)
   b. Empiric therapy is restricted to Oncologists, Intensivists, or Infectious Disease Physicians
3. Posaconazole (Noxafil)
   a. IV formulation: All use restricted to Infectious Disease Physicians
   b. PO formulation: All use restricted to Oncologists or Infectious Disease Physicians
4. Isavuconazonium (Cresemba)
   a. Non-formulary agent restricted to Infectious Disease Physicians
5. Voriconazole (Vfend)
   a. For treatment of documented invasive aspergillus infections (any prescriber)
   b. Empiric therapy or other fungal infections restricted to Oncologists, Intensivists, or Infectious Disease Physicians

Tri-City Medical Center
Oceanside, California

PROGRESSIVE CARE UNIT

ISSUE DATE: **NEW**

SUBJECT: **High Profile Patient (HPP) Admission Process**

REVISION DATE(S):

~~**POLICY NUMBER: (Optional)**~~

Progressive Care Unit Department Approval:	**07/18**
~~**Division of Cardiology Approval:**~~	~~**n/a**~~
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/18**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **DEFINITION:**

1. **A Law Enforcement Agency such as the California Department of Corrections and Rehabilitation (CDCR) or the San Diego County Sheriff (SDSD) will alert the Progressive Care Unit (PCU) Manager of the custodial status of the patient prior to admission.**

~~1.~~**2.** **A High Profile Patient (HPP) may be identified as a person who is easily recognized by either name or appearance. These patients will have notoriety in the public either through media or gang affiliation. Outside of the incarcerated setting, these patients pose an increased risk to the security of Tri-City Healthcare District (TCHD)~~~~TCMC~~.**

B. **PROCEDURE:**

1. Tri-City Medical Center (TCMC) Security, ~~Manager of~~ **Patient Access Manager, Director of Medical Records,** ~~Senior~~ Director of Risk and Chief Nurse Executive (CNE) will be notified immediately upon receiving information of incoming ~~High Profile Patient (~~HPP~~)~~ to the Progressive Care Unit (PCU) by the PCU management team or designee.

~~a.~~**2.** The HPP will be admitted to room 300 or 314 to ensure that there is a reduction in foot traffic outside of the patient door

~~2.~~**3.** Only PCU core staff will be assigned to provide care for the HPP.

~~2.~~**4.** The Patient Access Manager for Admitting or designee will be notified by PCU staff to register the HPP.

~~3.~~**5.** ~~**The Patient Access Manager or their designee**~~**Risk Management will register the patient.**

~~4.~~**a.** The HPP will be registered as "John or Jane Doe" per TCMC's policy.

~~5.~~**b.** **The HPP will be directly admitted to the PCU unless emergency care is required.**

~~6.~~**c.** **The HPP will be registered at bedside.**

~~7.~~**6.** **The Patient Access Manager will inform the Director of Medical Records of patient's identification number so unauthorized chart access can be periodically monitored.**

~~a.~~**7.** Off unit test or procedures will be scheduled as either the first or last patient of the day as long as it does not pose any problem to the health and wellbeing of the HPP. Examples of test or procedure and locations are as follows: (this list is not inclusive).

~~b.~~**a.** X-ray

~~c.~~**b.** Intervention Radiology

~~d.~~**c.** Computed Tomography (CT)

~~8.~~**d.** MRI

~~9.~~**8.** Nursing staff on the PCU will be educated daily about the TCMC privacy policy.

~~10.~~9. If the HPP becomes critical or deemed to be actively dying, visitation will follow the California Department of Correction and Rehabilitation/San Diego Sheriff Department visitation guidelines as well as the following PCU guidelines:
   a. All visitations must be known 24 hours in advance.
   b. The names of all visitors will be given to the TCMC Security department
   c. All visitors will check in with Security. Visitors will not be allowed to check in at the main visitor desk.
   d. Visitors will be escorted to the PCU by a TCMC Security Officer and then handed over to the appropriate custody personnel
   e. Visitors will not be allowed to carry any personal items into the PCU
   f. Jackets, coats, and vests must be removed prior to entering the patient room and these items are to be placed into a locker provided by the PCU.
   ~~11.~~g. Visitations will be limited to one hour.
   ~~a.~~h. After the visitation has ended, TCMC Security will be notified and will escort the visitor into the main lobby area.

~~12.~~10. The PCU management team will monitor the HPP chart for unauthorized access

~~13.~~11. **HIPAA violations and unauthorized chart access will lead to immediate disciplinary actions up to and including immediate suspension of the employee pending investigation.**

~~3.~~12. Once the HPP is discharged, Security, Risk, and the CNE will be notified by the PCU management team or designee.

~~B.~~C. **RELATED DOCUMENT(S):**

1. **Patient Care Services Policy**: In-Custody Patients
~~4.~~2. **Patient Care Services Policy:** Unidentified or Confidential Patient

Tri-City Medical Center	Distribution

DELETE – no longer needed. Content covered in Hospital Policies and orientation.

PROCEDURE: GENERAL SAFETY MANAGEMENT

~~Purpose:~~	~~Establish and maintain a safe environment for visitors, patients, hospital staff and physicians~~
~~Supportive Data:~~	
~~Nursing Implications:~~	
~~Equipment~~	

PROCEDURE:

~~A. Team members are expected to participate in the identification of hazards and potential hazards to patients, visitors and hospital staff and physicians.~~

~~1. Report unsafe conditions or equipment promptly.~~
~~2. Report defective or malfunctioning equipment immediately. Place a "Red Defective Equipment" tag on the equipment, remove the equipment from the work area, and contact the Bio-medical department.~~
~~3. Assist in the completion of Safety Inspections.~~
~~4. Use the body slide boards to help transfer patients from beds/gurneys to procedure table. Use coworkers to transfer patients.~~
~~5. Use appropriate body mechanics.~~
~~6. Floors should be dry and litter free.~~
~~7. Remember your environment is your responsibility.~~

~~B. Fire safety~~

~~Department members are expected to know and follow the medical center's fire plan. In addition, they should know the location of all fire equipment in the department and the evacuation routes from the departments. The following are department specific and should be initiated at the sound of the fire alarm or announcement of CODE RED.~~

~~a) Outpatients and visitors should be directed to the imaging waiting room.~~
~~b) Any patient with an exam in progress should stay in the exam room and be monitored.~~
~~c) Monitor any inpatients not in an exam room shall be monitored.~~
~~d) Close all doors.~~

~~C. Patient Safety~~

~~1. Crash Cart Locations~~

~~a) Main department and one pediatric cart~~
~~b) CT 64 Slice~~
~~c) CT Inpatient~~
~~d) IR Suite~~
~~e) MRI three carts on for PET/CT on Saturday and one pediatric cart~~

~~D. All clinical patient caregivers, employed by TCMC, will maintain a current CPR card.~~

~~E. Use proper body mechanics and assistance from co-workers when helping patient onto and off of imaging equipment, wheelchairs and stretchers.~~

~~F. A footstool shall be available for assisting patients to elevate procedure tables.~~

~~G. Use compression devices, when available if the patients are restless, disorientated or incoherent. If unable to immobilize such patients, get a co-worker to watch the patient. Never leave patients unattended.~~

~~H. Pick up fallen articles and clean up minor spilled liquid. Contact Environmental Services if there is a major spill.~~

~~I. Avoid leaving equipment in the hall or where someone may stumble over it.~~

~~J. When pushing a patient in a wheelchair or on a gurney, look ahead to avoid collisions. Utilize overhead mirrors for the same preventative measures. Do no push faster then a safe speed to allow time to avoid obstacles.~~

Radiology Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
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K. Always interview patients for their allergy history and follow the contrast screening tool prior to injections of contrast media.
L. Remove the patient from an x-ray table before you shut down the generator.
M. All footboards, shoulder rests holders should be checked for positive locking prior to use.
N. All wheelchair and gurney wheels should be stabilized when helping a patient on or off.
O. Make sure that a patient's fingers are free of the edge of the exam table before engaging the tabletop float option.
P. Be cautious when transferring a patient to the x-ray table to avoid skin tears.
Q. Fluoroscopy will only be performed by a licensed practitioner of the healing arts with a valid fluoroscopy license.

B. APPROVAL PROCESS
   a. Division of Imaging
   b. Medical Executive Committee
   c. Professional Affairs Committee
   d. Board of Directors

Tri-City Medical Center	~~Distribution: Imaging Services 7633-122~~Radiology
PROCEDURE:	~~AFTER HOUR'S~~ MAGNETIC RESONANCE IMAGING (MRI) AFTER HOURS STUDIES ~~to be performed after 21:00 utilizing MRI.~~7633-122
Purpose:	The following guidelines have been established in an effort to provide access **to** ~~magnetic resonance imaging (~~MRI~~)~~ services and ensure a safe environment during off-hours (on-call).
~~Supportive Data:~~ ~~Nursing Implications:~~	
Equipment:	MRI Scanner

A. **PROCEDURE**:

1. After hour's exam list. The only procedures to be performed after **the department closes (after hours)** ~~21:00~~ are listed below. ~~Prior to 10PM all MRI services are available.~~
   a. Pregnant patient to rule out appendicitis
   b. Spinal Epidural hematoma/abscess
   c. Cauda equina
   ~~c.~~**d. Magnetic resonance angiography (MRA) of the brain for stroke code follow-up**
   e. For other procedure, ~~T~~the ordering physician ~~of the MRI procedure requested after hours~~ must contact the radiologist ~~on staff, after 9 pm, the radiologist~~ "on call", to discuss the medical necessity of performing an MRI exam during off-hours.
      ~~2.~~**i.** The ordering physician shall notify the radiologist if the patient is unconscious, unresponsive, cannot provide reliable history and there is no family that can provide information.

~~3.~~**2.** The emergent nature of the exam requested will be determined by the radiologist. If the exam is deemed necessary, the radiologist will contact the Film Library and ask the records staff to call in the MRI technologist on call duty.

~~4.~~**3. After hours safety** ~~**(after 21:00)**~~

a. A ~~security officer~~**second staff member trained in MRI safety** shall be present during procedures done after hours due to the remote nature of the MRI building. Under no circumstances shall an MRI technologist be allowed to perform a MRI exam on a patient without another MRI screened hospital member in attendance.

~~5.~~**4. MRI Services Hours of Operations**

a. MRI department hours of operation:
   i. Monday – Friday **0730**~~7:00am~~ to **2000**~~21:00~~.
   ii. Saturday – **Sunday 0730** ~~8:00am~~ **to 1800** ~~4:00pm On-Call at end of routine shift.~~
   ~~iii. Sunday On-call only~~

b. MRI **staff on call when department is closed** ~~after hour's on-call hours of operation:~~
   ~~i. Monday – Friday 9:00pm – 7am~~
   ~~ii. Saturday 7pm – 7am~~
   ~~iii. Sunday 8am – 7am~~

~~6.~~**c.** ~~Note: MRI services are offered 24/7 if the normal hours of operation are reduced due to reduced patient volume the MRI technologist will cover the service on-call earlier than posted to ensure access to MRI services.~~

~~7.~~**5. Physician's Responsibility**

~~8.~~**a.** Ordering the MRI test and obtaining approval from the radiologist on duty. Ordering an IV or IV lock on all inpatients to be placed prior to transport for MRI. Assist with completion of the MRI Medical History Questionnaire for Patient's who are unable to do so.

~~9.~~**6. Nursing Staff's Responsibility**

a. Supply the MRI Medical History Questionnaire to the patient for completion if the patient is coherent and an accurate historian.

Radiology Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
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b. Notify MRI personnel if the patient is unconscious, unresponsive, can not provide reliable history and there is no family that can provide information.
c. The nursing staff is responsible for placement of an IV or IV lock and assuring that the MRI Medical History Questionnaire is complete prior to transporting the patient to MRI.

~~10.~~7. **Unable to Perform Test**
a. Patients who are severely claustrophobic, above the weight limit of 350 pounds or body habitus (body shape) prohibits entry into magnet's bore.

~~11.~~8. **Emergency Department**
a. Nursing or hospital transport personnel shall transport a patient from the emergency department to and from MRI. MRI requires a health care professional to remain with the patient during after hour's procedures because of the remote nature of the MRI building.

~~12.~~9. **Critical Care Patients**
a. Nursing personnel from one of the critical care units shall transport critically ill patients to and from MRI. MRI requires a health care professional to remain with any unstable or critically ill patient.

~~13.~~10. **General Care Unit**
a. Nursing or hospital transport personnel shall transport a patient from a general care unit to and from MRI. MRI requires a health care professional to remain with the patient during after hour's procedures because of the remote nature of the MRI building.

~~14.~~11. **Conscious Sedation**
a. Certain instances, such as conscious sedation, require that an RN (or MD) who is competent to manage conscious sedation accompany the patient to MRI and remain with the patient during the procedure. If the unit which houses the patient has no nurse on duty that is competent to manage conscious sedation, the unit nursing supervisor shall locate a qualified RN.

~~15.~~12. **Ventilated Patients**
a. If a patient requires continuous mechanical ventilation, a MRI compatible ventilator is available and is housed in MRI zone 4. The Respiratory Therapist will determine if the MRI compatible ventilator will be used or if the patient will be manually ventilated.

~~16.~~13. **Patients Experiencing Emergency or Code in MRI**
a. Full resuscitation cannot occur in MRI zone 4 (the scan room) because of safety issues.
b. MRI level 2 personnel will initiate basic life support and move the patient from the scan room to a safe location where full resuscitation can continue.

~~B. APPROVAL PROCESS~~
~~1. Division of Imaging~~
~~2. Medical Executive Committee~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center	Radiology ~~Distribution: Imaging Services 7633-111~~
PROCEDURE:	**MAGNETIC RESONANCE IMAGING (MRI) EMERGENCY PROCEDURES 7633-111**
Purpose:	To provide emergency MRI Magnetic Safety Guidelines to MRI personnel and other staff.
~~Supportive Data:~~ ~~Nursing Implications:~~	
Equipment:	MRI Scanners

A. **MEDICAL EMERGENCIES**

1. Only trained MRI personnel may enter the magnet rooms without supervision. All other staff must be directly supervised by trained MRI personnel.
2. In case of a ~~M~~medical emergency;
   a. Dial 66 to report the nature of the emergency along with the location to the response team.
   ~~1.~~b. Inform the operator the emergency is located in the MRI building and ~~a magnetic safety alert~~ must be communicated to the emergency responders.
~~2.~~3. Under no circumstances shall emergency medical response procedures be administered in the magnet rooms. Emergency responders are not allowed to enter the MRI magnet rooms without supervision of trained MRI personnel.
~~3.~~4. If the emergency is related to a patient complication, MRI personnel shall remove the patient immediately from the magnet room and transport to the inpatient staging area in MRI Safety Zone 3.
~~4.~~5. The magnet room door shall be closed upon removal of the patient to avoid entry of any unsupervised staff. This precaution is to prevent the possibility of exposure of metallic objects to the strong magnetic field and generate the missile effect.
~~5.~~6. During an emergency event MRI personnel **or designee** shall be posted outside the entrance door to the MRI building and shall monitor all emergency responders **in order** to prevent non-approved equipment from entering the MRI building. All MRI emergency medical equipment is located within the MRI building and is labeled MRI magnetic safe or MRI not magnetic safe.
~~6.~~7. If not already responding, the ~~supervising Radiologist and the~~ **Imaging Director or** Operations Manager shall be contacted and informed of the nature of the emergency.
~~7.~~8. All adverse events shall be documented on the Quality Review Report (QRR). The Safety Officer, **Imaging**~~Radiology~~ Director, and Operations Manager shall be notified immediately via telephone and within 48 hours in writing.

B. **FIRE EMERGENCIES**

1. In case of a Fire emergency;
   a. Dial 66 to report the nature of the emergency along with the location to the response team.
   ~~2.~~b. Inform the operator the emergency is located in the MRI building and ~~a magnetic safety alert~~ must be communicated to the emergency responders.
~~1.~~2. MRI personnel shall immediately remove the patient and other MRI personnel from the magnet room and the building.
~~2.~~3. If the fire occurs in the magnet room, the fire shall be extinguished using a non-ferrous fire extinguisher (the fire extinguisher near the outside door of the control room is non-ferrous).
~~3.~~4. All doors shall be closed to contain the fire.
~~4.~~5. Emergency responders may only enter the magnet rooms under the direct supervision of trained MRI personnel.
6. The ~~senior~~ MRI Technologist shall supervise all emergency fire procedures
7. **In the event that MRI trained personnel are not on duty, Tri-City Healthcare District (TCHD) Security will control access for emergency personnel to enter the building.**

~~Department Review~~	Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
–	08/18	10/18	n/a	11/18	01/19	n/a	08/11

C. CRYOGEN QUENCH EMERGENCIES:

~~5.~~**1. A quench of superconducting magnet refers to a sudden conversion of liquid helium or nitrogen to vaparous gas. This is usually preceded by a visual or audible warning of a quench resulting in a loss of oxygen within the scan room. The MRI machine is equipped with a sensor and audible alarm system located adjacent to the operator's console which senses changes with oxygen levels within the scan room. In the unlikely event of a supeconducting magnet quench, the major efforts must be directed to evacuating all patients, TCMC staff and members of the public away from areas that vaporized gasses may reach. Patient and personnel safety is the first concern. Equipment safety is secondary.**

2. Types of quench emergencies:

a. **Small leaks:** These would lead to small clouds of fog that clearly remains above the head level and are visibly removed by the heating and air conditioning system (White fog like plumes that sink to the floor). They consist of cold air and do not lead to suffocation. In this case, overpressure is not present. There is not risk of suffocation for either the patient or personnel. The patient can be removed in an orderly process. Contact with cryogenic parts is prohibited.

b. **Partial or complete failure of the quench line:** large fog-like clouds including impaired visibility are present. These clouds spread at the level of a person's head. In this case, the pressure in the RF-room will increase as well. Open all doors (the control room door first, and then the RF-room) and evacuate patients and personnel immediately. Depending on the extent of the leak, patients, personnel and rescue responders may be endangered. As a rule, rescue responders should not work alone, but rather in groups of two or more members.

c. Usually, the strongest gas flow occurs only after several minutes and will subsequently subside. However, the course of gas flow is not fully predictable since at the time of occurrence, the type of error in the quench line is generally not fully known.

~~3.~~D. PROCEDURES:

~~4.~~**1. In the event of a superconducting magnet quench with patients and personnel in the area the following procedure must be followed:**

~~5. If patients and personnel are present in the magnet rooms: follow steps below.~~

~~c.~~a. MRI personnel and patients should be evacuated in an orderly manner.

~~d.~~b. ~~In case of a Quench emergency, d~~Dial 66 to report the nature of the emergency along with the location to the response team. Inform the operator the emergency is located in the MRI building and ~~a magnetic safety alert~~ must be communicated to the emergency responders.

~~e. Standard Scenario: Quench line is working as planned.~~

c. MRI personnel should initiate the quench procedure in the event of catastrophic fire event near the cryogen storage area or threat to life/safety:

- **i. Push quench button located in the MRI control room**

~~6.~~**d. In the event that MRI trained personnel are not on duty, ~~hospital~~ the ~~Security~~ Department will be notified to ~~will~~ make the decision to quench the magnet and to secure the area.**

~~B. APPROVAL PROCESS~~

~~1. Division of Imaging~~
~~2. Medical Executive Committee~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center	RadiologyDistribution: Imaging Services 7633-113
PROCEDURE:	**MAGNETIC RESONANCE IMAGING (MRI) SAFETY ZONES 7633-113**
Purpose:	Establish MRI safety zones defined by the American College of Radiology safety guidelines. Establish rules for the general public, unscreened MRI patients, screened MRI patient/personnel, screened MRI patients under constant direct supervision by trained MRI personnel.
Supportive Data: Nursing Implications:	
Equipment:	MRI Scanners

A. **PROCEUDRE:**

1. MRI Safety Zone rules as defined by the American College of Radiology safety guidelines.
   a. **Zone 1** is unrestricted for the general public and patients. This area is the main lobby, reception desk, registration desk, janitor's closet, MRI office, outpatient waiting area and the outpatient waiting area bathroom.
   b. **Zone 2** is restricted access, for dressing rooms and immediate hallway, North hallway outside scanner control room #1, side entrance and hallway located on the North end of the building. No one is allowed in this zone unless accompanied by safety trained MRI personnel. A verbal screening for pacemakers **metallic screening of the patient or visitor** will be performed prior to **for** admittance to this zone.
   c. **Zone 3** consists of the scanner control rooms and inpatient waiting/staging area. Anyone entering this area shall be required to remove all loose ferrous metal from their persons and secure such in the lockers provided for this purpose. This includes physicians, nursing staff and any other staff accompanying the patient.
   d. **Zone 4** consists of the MRI magnet rooms. No one may be brought into this area without having completed the MRI **metallic** screening form. This form will have been reviewed and signed by the patient and the safety trained MRI personnel **technologist** and include a double screening by a trained MRI staff member. This includes physicians, nursing staff and any other staff accompanying the patient. Nothing may be brought into this area without the direct authorization/supervision of the MRI technologist. MRI magnet room doors must remain closed at all times.
2. MRI **All** Technologist, Imaging Aid/**Lift Team**, Reception, **Environmental Staff** Registration, **Registration/ Reception, pharmacy staff, Nursing, Engineers, Materials Supply workers, Security, S**staff requirements.:
3. All **staff working in** MRI, EVS, lift team and security staff are required to complete a MRI safety in-service upon hire and annually thereafter. All MRI personnel are required to complete initial MRI safety training and competencies prior to working in the department.
4. MRI Technologist, Imaging Aid, Reception, Registration staff are required to sign both the subject screening form and the scan session form prior to working in the MRI department.
5. There must be a minimum of a **two (2)** one to one ratio of safety trained MRI personnel **when scanning** to patients. and anyone who may be accompanying these subjects (i.e. parent, other family member). In the instances where a family member accompanies the **patient**subject into the restricted area, safety trained MRI personnel will be assigned the role of Safety Monitor for that person. Only one additional family member will be allowed into the restricted area at a time. This rule is in effect at all times.
6. Scans being performed outside of regular business hours (Mon-Fri, 8am-5pm, Non-holiday) are required to have a **A** minimum of two safety trained MRI personnel **must be** present during the scan session.
7. All personnel must have a working knowledge of, and a willingness to follow all safety requirements.

B. **APPROVAL PROCESS**

Department Review	Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
--	07/18	10/18	n/a	11/18	01/19	n/a	08/11

~~1. Division of Imaging~~
~~2. Medical Executive Committee~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center	RadiologyDistribution: Imaging Services 7433-106
PROCEDURE:	**ORAL CONTRAST ADMINISTRATION 7433-106**
Purpose:	To assure safe practice when administrating oral contrast media.
Supportive Data:	
Nursing Implications:	
Equipment	

A. **PROCEDURE**

1. The radiology technologist or RN shall review the outpatient physician order prior to taking patient back to procedure area or administrating oral contrast.
2. Procedures normally performed without the radiologist present in the room, which requires oral contrast, shall be protocoled by the radiologist prior oral contrast administration.
3. Prior to administering the oral contrast the radiology technologist or RN shall confirm the patient has properly followed the correct bowel preparation for the procedure to be done.

B. **LABELING**

1. A standardized method for labeling all medications will minimize errors. Anytime medications are prepared but are not administered immediately, the medication will be labeled with medication name, strength, date, time and secured in such a way that it can be readily determined that the contents are intact and have not expired.
   a. At a minimum, all medications are labeled with the following:
   b. Medication name, strength, and amount (if not apparent for the container)
   c. Single dose medication shall be discarded

C. **APPROVAL PROCESS**

1. Division of Imaging
2. Medical Executive Committee
3. Professional Affairs Committee
4. Board of Directors

Department Review	Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
–	08/18	10/18	n/a	11/18	01/19	n/a	08/11

Tri-City Medical Center	RadiologyDistribution: Imaging Services 7633-126
PROCEDURE	**IMAGING SERVICES PATIENT INTERACTION 7633-126**
Purpose:	Guidelines for general conduct expected during patient interactions designed to assure our patients are treated with dignity, compassion and respect.
Supportive Data:	
Nursing Implications:	
Equipmen	

A. **PROCEDURE:**

1. Always address your patient by their last name
2. Confirm two patient identifiers
3. **Review patient gender identity preference**
4. Always introduce yourself to your patient and state your role. Educate the patient in terms that are clear to the patient. Be sure to observe communication queues that the patient understands you're exploitation **explanation**.
5. Always obtain the patients permission prior to any intervention. Instruct the patient as to what steps you are about to take and ask the patient if it is ok to proceed. Communicate to the patient each step/task you are going to take to complete the procedure as those tasks are being performed.
6. When it is necessary to change a patient for artifact free imaging, explain the need for artifact removal to the patient. Only have the patient remove clothing or jewelry that would cause an artifact in the area of the exam.
7. Be aware that people can feel very vulnerable in a patient gown and make every attempt to keep the patient properly covered. Offer a blanket to the patient to provide additional coverage.
8. If your patient appears to be uncomfortable, for any reason, acknowledge their concern and ask what you can do to help the situation.
9. If the patient requests another person in the room, at any time, for any reason, get an escort or second technologist immediately.
10. Male technologist shall never perform an endovaginal exam on a patient without a female chaperone.

B. APPROVAL PROCESS

1. Division of Imaging
2. Medical Executive Committee
3. Professional Affairs Committee
4. Board of Directors

Department Review	Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
--	07/18	10/18	n/a	11/18	01/19	n/a	08/11

Tri-City Medical Center	RadiologyDistribution: Imaging Services 7633-127
PROCEDURE:	PATIENT PROCEDURE REFUSAL 7633-127
Purpose:	To guidelines to follow when a patient refuses to complete the imaging study.
Supportive Data:	
Nursing Implications:	
Equipment	

A. **PROCEDURE**

1. Any patient can refuse an imaging procedure at any time.
2. Technologist should make every effort to ensure the patient is educated regarding the procedure.
3. If the patient refuses further testing after an imaging procedure has been started, the technologist should submit any images for interpretation with a complete explanation of the incomplete study.
4. The technologist should **requesthave** the charges adjusted according to what was actually completed, taking any questions to their immediate supervisor.
5. All imaging partial studies shall be interpreted and archived to **Picture Archiving Computer System** (PACS) and reported in the **elentronic health record (EHRher)** by the radiologist even if the study is incomplete.

B. **APPROVAL PROCESS**

1. Division of Imaging
2. Medical Executive Committee
3. Professional Affairs Committee
4. Board of Directors

Radiology Department Reviewed	Department Revised	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approved
6/09; 6/11 07/18	6/11	10/18	n/a	11/18	01/19	n/a	6/09; 6/11

Tri-City Medical Center	RadiologyDistribution: Imaging Services 7633-125
PROCEDURE:	**RADIOLOGIST'S COVERAGE NON-INTERVENTIONAL RADIOLOGY 7633-125**
Purpose:	To ensure efficient physician oversight/coverage of procedures performed in diagnostic radiology service areas to reduce waiting times
Supportive Data:	
Nursing Implications:	
Equipment	

A. **PROCEDURE:**

1. The Radiologists scheduled specialty assignments will be posted in the reading room. Their daily schedule, including information on days off will be posted. The schedule board will be updated daily.
2. In order to minimize patient waiting times, a technologist should not wait more than 15 minutes for a radiologist to arrive in the procedure area. If the radiologist assigned to the area is unavailable, the technologist shall then seek another radiologist to perform the needed service.
3. If a technologist has waited more than the 15 minutes and cannot find another radiologist to perform the case, then the technologist should immediately **contact**page the supervisor of the area or contact the department manager or director for assistance.

B. **APPROVAL PROCESS**

1. Division of Imaging
2. Medical Executive Committee
3. Professional Affairs Committee
4. Board of Directors

Department Review	Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
–	06/18	10/18	n/a	11/18	01/19	n/a	02/11

Tri-City Medical Center	RadiologyDistribution: Imaging Services 7633-121
PROCEDURE:	**SCOPE OF SERVICES 7633-121**
Purpose:	The department of Imaging Services provides diagnostic and therapeutic services to all referred patient populations; i.e., neonatal, pediatric, young adult, adult and geriatric. A referred patient population includes inpatients, outpatients and emergency services patients.
Supportive Data: Nursing Implications:	N/A
Equipment	N/A

A. **PROCEDURE**:

1. Routine imaging services are performed 24 hours a day with specialty areas on-call as needed for emergency procedures at the main hospital campus. Outpatient services are provided at the main hospital facility and off campus at the outpatient imaging center. Imaging services include:
   a. Diagnostic Imaging
   b. Fluoroscopy
   c. Mammography
   d. Nuclear Medicine – Including Iodine Therapy
   e. Epidural Injections
   f. Interventional Radiology
   g. Computed Tomography
   h. Medical Sonography
   i. Bone Densitometry
   j. Magnetic Resonance **Imaging** (MRI)
2. Limited outpatient procedures are provided at 2095 W. Vista Way, Vista CA 92083. Hours of service 07:00 to 18:00 weekdays. This includes IVP, and GI studies with contrast.
3. Imaging Services is staffed by board certified radiologist, clinical nurse manager, certified physician assistants, licensed technologist and registered or registry eligible medical professionals including, registered general radiographer, registered diagnostic medical sonographers, registered vascular technologist, registered nurses, registered nuclear medicine technologist, registered MRI technologist, registered interventional technologist and registered **Computerized Tomagraphy Tomography** (CT) Technologist. Support personnel include radiology records techs, transcriptionist, billing coordinator.
4. Each member of the imaging team is responsible for identification of opportunities for improvement of the process and services. Select team members may be involved in data collection and results outcome. All team member support accurate and effective data collection for effective quality improvement.
5. Imaging services are integrated with medical and nursing services by referrals, consultations and reporting results of therapeutic interventions and diagnostic procedures. The department interacts with all hospital departments and with multiple outside interests including: vendors, service engineers, physicists, schools, sales representatives, other clinical trainees, couriers, and inspectors from **the Joint Commission, California Department of Public Health** (CDPH), **American College of Radiology** (ACR), and **Food and Drug Administration** (FDA).
6. Imaging services team members participate in process improvement teams, continued quality improvement teams and other multidisciplinary teams in accordance with the quality management plan and **Tri-City Health Care District**TCMC's governance model.
7. **APPROVAL PROCESS**
   a. Division of Imaging
   b. Medical Executive Committee
   c. Professional Affairs Committee
   d. Board of Directors

Department Review	Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
--	07/18	10/18	n/a	11/18	01/19	n/a	08/11

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**2/97**	**SUBJECT:**	**Physical Therapy Assistant Supervision**
REVISION DATE(S): 01/06, 01/09, 04/12, 05/15		**POLICY NUMBER: 613**	
~~**REVIEW DATE: 3/00, 1/03**~~			

Rehabilitation Department Approval ~~Date(s)~~:	~~05/14~~05/18
Department of Medicine Approval ~~Date(s)~~:	n/a
Pharmacy & Therapeutics Committee Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~01/15~~11/18
Administration Approval:	01/19
Professional Affairs Committee Approval ~~Date(s)~~:	~~05/15~~n/a
Board of Directors Approval ~~Date(s)~~:	05/15

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

~~☑ 510 Hacienda Drive 108A, Vista, CA~~

~~☑ 3861 Mission Avenue B25, Oceanside, CA~~

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

1. To comply with the Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44 for adequate supervision of Physical Therapy Assistants.

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

~~1.~~2. The Physical Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the physical therapy assistant does not function autonomously.

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

1. Adequate supervision shall include all of the following:
   a. The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapy assistant at all times while the physical therapy assistant is treating patients. The supervising physical therapist shall provide supervision of the assigned patient care rendered by the physical therapy assistant.
   b. The supervising physical therapist shall initially evaluate each patient and document in the patient's record, along with his or her signature, the evaluation and the plan of care.
   c. The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available. This information shall be communicated verbally or in writing by the supervising physical therapist to the physical therapy assistant prior to initiation of treatment by the physical therapy assistant. The supervising physical therapist shall determine which elements of the treatment plan may

be assigned to the physical therapy assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education, and training of the physical therapy assistant.

d. The supervising physical therapist shall re-evaluate the patient if necessary, and modify the treatment goals and plan as needed. The re-evaluation shall include treatment to the patient by the supervising physical therapist. The re-evaluation shall be documented and signed by the supervising physical therapist in the patient's record and shall reflect the patient's progress toward the treatment goals and when the next re-evaluation shall be performed.

e. The physical therapy assistant shall document each treatment in the patient's record, along with his or her signature. The physical therapy assistant shall document in the patient's record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a re-evaluation by a supervising physical therapist before further treatment by the physical therapy assistant.

D. **REFERENCE(S):**

1. Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

ISSUE DATE: 06/14 **SUBJECT: Adoption**

REVISION DATE(S):

Women and Newborn Services Department Approval:	**12/18**
Department of OB/GYN Approval:	**~~12/13~~n/a**
Perinatal Collaborative Practice Approval:	**n/a**
Department of Pediatrics Approval:	**~~12/13~~n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/14**

A. **DEFINITIONS:**

1. Adoption: A legal process that creates a new, permanent parent-child relationship where one did not exist. This adoption is coordinated through one of 3 options:
   a. Agency adoption:
   b. Independent adoption
   c. State Department of Social Services
2. Adoption Letter of Intent: a ~~legal document~~ **professional document (letter)** outlining the adoption agreement between the Birth Mother and adoptive parent(s). It should include the following:
   a. Name of natural/biological mother (Birth Mother)~~ and~~
   ~~a.~~b. ~~d~~Date of birth ~~(DOB)~~ **(not required)**
   ~~b.~~c. Name of natural mother's physician **(preferred-not required)**
   ~~c.~~d. Expected date of confinement **(preferred-not required)**
   ~~d.~~e. Adopting couple's legal names, address, telephone number and identification numbers
      i. Driver's license
      ii. Social security number (last 4 digits) or other identification
         1) (Authorized forms of additional ID can include: Passport, Military ID, Bank Card with photo, Social Security card with last 4 digits provided in letter,
         2) One form of picture ID is always required.
   ~~e.~~f. If it is an agency adoption the Letter of Intent should include above information on Agency Designee (to whom baby will be released) with an agency adoption.
   ~~f. A statement of financial arrangements for hospital expenses.~~

B. **POLICY:**

1. **Tri City Health Care District (TCHD)** ~~TCMC Women's and Children's~~**Women and Newborn** Services **(WNS)** ~~including NICU~~ provides comprehensive, quality, family-centered care within an interdisciplinary framework. Situations regarding the appropriate discharge of minors ~~(e.g., newborns)~~ for ~~Infant~~**baby(s)** being placed for adoption may arise at any time.
2. ~~Women's and Children's Services'~~ **WNS** personnel discharging ~~infant~~**baby(s)**s within the context of adoptions shall adhere to the following (including but not limited to):
   a. **TCHD** ~~Tri-City Medical Center~~ policies and procedures
   b. Governmental regulations and laws
   c. Court orders

3. Prior to admission:
   a. When a Letter of Intent is received concerning a planned adoption, the social worker will place a copy in the Perinatal Watch List Book and in the identified file in the Social Worker office
   ~~b. The patient will be asked to provide billing information and shall declare the responsible party (e.g. adoption agency, independent adoption)~~
4. Upon Admission if a Letter of Intent is **present**~~received~~:
   a. A copy of the Letter of Intent will be placed on the Birth Mother and baby's charts.
   b. Nursing will place a social service order.
   c. If any questions or confusions arise **concerning**~~with~~ the Letter of Intent, first contact information shall be the birth mother.
5. If a Letter of Intent is not on file, **with mother of baby consent** the social worker **will**~~shall~~:
   a. Notify the agency/private attorney identified by the mother of the baby that ~~TCMC~~**TCHD** must have specific information on letterhead stationary to consider this an adoption. Social worker will obtain verbal consent from mother of the baby prior to the call.

~~6. Insurance information for agreements that require the adopting couple to assume financial responsibility of hospital stay for mother and infant, including NICU costs if applicable,~~

~~7.~~6. All hospital charges to mother and baby will be charged to the Birth Mother unless other arrangements were made.

~~8. The hospital financial counselor(s) shall be alerted about the planned adoption and will contact the identified adoption agency or private attorney and the intended legal parents to discuss contractual obligations including base costs for all care for the Birth Mother (if applicable) and baby (babies) in the neonatal intensive care if required. They will also be advised that the physician charges are not included in the hospital charges.~~

~~9.~~7. ~~Admissions will pre-verify all insurance coverage to ensure adoption is a covered benefit. Should additional financial arrangements be needed, admissions will process them accordingly. They will forward this information to the hospital financial counselor and the perinatal case manager (to ensure that the intended parent(s) have also signed the Conditions of Admission (COA)).~~

~~10.~~8. Social Work:
   a. A hospital social worker evaluation for all parties involved in the adoption process will be completed.

~~11.~~9. Admitting/ID Banding: (~~TCMC~~**TCHD Patient Care Services** (PCS) Procedure: Identification/Banding of Newborns)
   a. The newborn ~~infant~~**baby** will be banded as per the guidelines for the Birth Mother keeping her ~~infant~~**baby**
      i. The Birth Mother and support person (if any) will receive matching baby bands immediately after delivery. The Birth Mother retains all rights to the ~~infant~~**baby** until discharge and may see, hold and feed the ~~infant~~**baby** as often as she wants, or designate any other person to do so. At any time the Birth Mother has the right to change her mind regarding the adoptive couple's involvement.
      ii. The last name of the ~~infant~~**baby** shall remain that of the Birth Mother throughout the hospitalization
      iii. If the intended birth parent(s) are to be the primary providers while in the hospital, they will be given an additional baby band (and baby an additional **downtime** set of bands) with the consent of the mother. All consent will be clearly documented in the ~~infant~~**baby**'s chart, and a note documented with the ~~infant~~**baby** band information.
   b. In the event the adoptive parent(s) are not banded the down time bands may be utilized in the event of rooming in.
      i. Legibly hand write information: Name, Medical Record Number (MRN), Date and time of birth
      ii. Document in Cerner the adoptive parent band numbers

•c. On Discharge both bands will be attached to the Newborn Identification form.

C. **RELEASE OF INFORMATION/CONSENT:** (~~TCMCTCHD~~ **Reference** Administrative **Compliance** Policy: Disclosure of Protected Health Information (PHI) 8610-513)

1. Release of information regarding the ~~infant~~**baby**(s) shall be provided by the Birth Mother whose **electronic** ID bands match those of the ~~infant~~**baby**(s) only.
   a. The intended adoptive parents may receive any information regarding the ~~infant~~**baby**(s) condition or care when the Birth Mother signs the Authorization for Use or Disclosure form.
      i. Written information from the baby can be given to the intended Adoptive Parents at discharge (depart instructions or education)
      ii. Other chart documentation beyond the discharge or education must be obtained from medical records
   b. The Birth Mother shall sign all consents for care/procedures.
2. **If Adoptive Parents request written information regarding the baby's medical history, diagnosis and treatment, this can be provided via medical records.**
3. **Verbal information to the Adoptive Parents can only be released with the written permission of the Birth Mother utilizing the Release of Patient Information form.**

D. **VISITATION:**

1. (Reference **WNS** Policy: ~~6070-115~~ Visitation in NICU, ~~TCMCTCHD Administrative~~**PCS** Policy: ~~8610-301~~: Visiting Guidelines, ~~Policy 7400-100 WCS~~**WNS Policy:** "Partners in Care" for ~~WCS~~**Women and Newborn Services**). In the case of adoption ~~infant~~**baby** visitation will be determined by the written permission via the hospital form Authorization for Visitation and/or Release of Patient Information.
2. Intended Adoptive Parents may not visit ~~infant~~**baby**(s) independently unless granted written permission (such as the hospital form Authorization for Visitation and/or Release of Patient Information) by the Birth Mother, or has been "banded" by the Birth Mother as the significant other.
3. Birth Mother has the option to request that the ~~newborn~~**baby** to be non-couplet care.

E. **BIRTH CERTIFICATE:**

1. The birth certificate worksheet shall be filled out by the Birth Mother and may include the following:
   a. A temporary name
   b. All medical information entered on the birth certificate worksheet shall pertain to the pregnancy, including the labor and delivery information of the Birth Mother
2. All legal changes of the birth certificate for the intended specified adoptive parents will take place in a court of law when the adoption process is completed and finalized according to California law, refer to the San Diego County Vital Records and Statistics manual or call the vital records department.

~~F. BANDING/NEWBORN IDENTIFICATION BANDS:~~

~~1. The baby will be banded per the Birth Mothers request~~
~~• In the event the adoptive parent(s) are not banded the down time bands may be utilized in the event of rooming in.~~
~~• Legibly hand write information: Name, Medical Record Number (MRN), Date and time of birth~~
~~• Document in Corner the adoptive parent band numbers~~
~~• On Discharge both bands will be attached to the Newborn Identification form.~~

~~G.~~F. **PROCEDURE for NEWBORN DISCHARGE in an ADOPTIVE STATUS (LETTER OF INTENT PRESENT):**

1. Nurse to obtain discharge order for ~~newborn~~**baby**.
2. Social Worker (SW) to verify intent of Birth Mother to proceed with adoption and ensure Letter of Intent is on chart.
   a. If there is no Letter of Intent prior to the mothers discharge, the Birth Mother will be discharged with her ~~infant~~**baby** and will make arrangements outside the hospital. This rule may be waived if a state licensed adoption agency provides disposition plans verbally to social worker and this is documented in the medical record.
3. AD 22 is to be completed and obtain Birth Mother's signature, indicating her permission to release the ~~newborn~~**baby** to Adoptive Parent(s) or Identified Party. If Birth Mother is unable to sign the social worker will assist to determine the best next of kin (such as the first next of kin to arrive to the hospital) on a case by case basis..
   a. RN or Charge Nurse to fill out Part I
   b. RN or Charge Nurse to have Birth Mother sign release of ~~infant~~**baby** on Part II and witness the signature to include the date (all copies must be legible)
   ~~c. If infant is on a CPS hold, the birthmother's signature is not required. CPS Hold must be written across part II~~
   ~~d.~~**c.** Have person(s) designated to receive the child sign the remaining copies of AD22 Part III.
      i. Verify receiver has two forms of identification (at least one with a photo and identification information):
         1) Picture ID, which may include Driver's License
         2) Social Security Number or Other Identification
   ~~e.~~**d.** RN or Charge Nurse to witness receiver signatures, including date. Offer copy to the person receiving the ~~newborn~~**baby**.
      i. If copy refused-write on the bottom "Refused Copy"
   ~~f.~~**e.** Make 3 copies of the AD 22. one copy to Adoptive Parents and send original and extra copy to Perinatal Data Coordinator.

~~4. RN or Charge Nurse to obtain signatures for the following forms: Authorization for Release of a Minor and Acknowledgement of Release of a Minor~~
   ~~a. Authorization for Release of a Minor: Birth Mother, guardian or legally authorized caregiver fills out the form and who they want the hospital to release the minor to~~
   ~~b. Acknowledgement of Release of A Minor will be filled out by the person receiving the minor.~~

~~5.~~**4.** **RN** ~~Nurse~~ to collaborate with Social Services to help arrange and coordinate date and time of ~~newborn~~**baby**'s discharge to the Adoptive Parents.

~~6.~~**5.** RN ~~or Charge Nurse~~ to verify identity of person(s) baby being release to the ~~newborn~~**baby** prior to discharge and document appropriate information on AD 22 form. ID must match information provided on Letter of Intent.

~~7.~~**6.** RN ~~or Charge Nurse~~ to verify identity of ~~newborn~~**baby** being released for adoption planning.
   a. One newborn identification bracelet is left on the ~~newborn~~**baby**.
   b. One newborn identification bracelet is taped to the newborn identification discharge instructions.
      i. This form must be signed by the person(s) receiving the ~~newborn~~**baby** and witnessed by the nurse completing the form.
      ii. Verification of ID is to be noted in the appropriate place.

~~8. If Adoptive Parents request written information regarding the newborn's medical history, diagnosis and treatment, this can be provided via medical records.~~

~~9. Verbal information to the Adoptive Parents can only be released with the written permission of the Birth Mother utilizing the Authorization for Visitation and/or Release of Patient Information form.~~

~~10.~~**7.** Mother continues to sign for all consents for treatment for the baby until the AD22 is signed. After it is signed she may still visit the baby and remain involved in the care of the ~~infant~~**baby**.

~~11.~~**8.** The Birth Mother retains all rights to the ~~infant~~**baby** until discharge and may see, hold and feed the ~~infant~~**baby** as often as she wants, or designate any other person to do so. She is

responsible for signing any necessary consents for the ~~infant~~**baby**. At any time the Birth Mother has the right to change her mind regarding adoptive couple's involvement.

~~12.~~**9.** If Letter of Intent present and AD22 signed:

a. Intended Adoptive Parents or agency designee will assume care of the ~~infant~~**baby**, all regular discharge procedures will occur to include all ~~newborn~~**baby** care and discharge teaching and ~~infant~~**baby** will be discharged to the person identified on the Letter of Intent and AD22.

b. Discharge must be cleared by admissions/finance before the ~~infant~~**baby**(s) is released from the hospital. **Call finance if the discharge is planned or prior to discharge.** ~~(refer to signed TCMC financial agreement).~~

c. There will be no "boarder" status of term ~~infant~~**baby**(s) meeting discharge criteria in the Neonatal Intensive Care Unit.

~~H.~~G. PROCEDURE for ~~NEWBORN~~BABY DISCHARGE WITHOUT A LETTER OF INTENT PRESENT:

1. If no Letter of Intent and no AD22 signed:
   a. The Birth Mother assumes care of ~~infant~~**baby** when cleared for discharge (refer to signed waiver of liability).
   b. The Birth Mother shall follow standard discharge procedures including discharge teaching.
   c. Discharge must be cleared by admissions/finance before the ~~infant~~**baby**(s) is released from the hospital. ~~(refer to signed TCMC financial agreement).~~ **Call finance if the discharged is planned or prior to discharge.**
   d. The ~~infant~~**baby** will be discharged to the arms of the Birth Mother
   ~~e. Transfer of the infant to the intended Adoptive Parents shall occur after the discharge~~

~~I.~~H. DOCUMENTATION:

1. Document in the Birth Mother and ~~newborn~~**baby** patient care records.
   a. That the ~~newborn~~**baby** was discharged for the purpose of adoption planning

~~J.~~I. BONDING PROVISIONS OF INTENDED PARENTS:

1. If space allows the intended Adoptive Parents may room in to allow for bonding (if and when permitted by Birth Mother)
2. The intended Adoptive Parents with ~~infant~~**baby**(s) in the **Neonatal Intensive Care Unit** (NICU) will need to make arrangements for overnight stay(s) outside of Tri City Medical Center. NICU rooming in will be the exception.

~~K.~~J. FETAL DEATH/DEMISE:

1. The Birth Mother will follow standard procedures for release of remains.

K. FORM(S):

1. **Newborn Identification & Discharge Instructions 7400-1008 – Sample**
~~1.~~**2.** **Health Facility Minor Release Report AD 22 Form – Sample (available via external link: http://www.cdss.ca.gov/cdssweb/entres/forms/English/AD22.PDF)**

L. RELATED DOCUMENT(S):

1. ~~Tri-City Medical Center Administrative Policy #8610-301~~**PCS Policy**: ~~"~~Visiting Guidelines~~."~~
2. ~~Tri-City Medical Center~~ Administrative Policy ~~#8610-513~~: ~~"~~Disclosure of Protected Health Information (PHI)~~."~~ **8610-513**
3. ~~Tri-City Medical Center~~ **WNS** NICU Policy ~~#6070-115~~: ~~"~~Visitation in the NICU~~."~~
~~3.~~**4.** **WNS Policy: Partners in Care for Women and Newborn Services**
5. ~~Tri-City Medical Center~~ PCS Procedure: ~~"~~Identification of Newborns~~."~~
~~Newborn Identification Form~~
~~4. AD 22 Form from the California Department of Social Services~~

~~5. Tri-City Medical Center Women's and Children's Services Policy "Breast Milk, Pumping, Handling and Storage of."~~

~~6. Tri-City Medical Center Women's and Children's Services Procedure: "Release of a Minor to Other Than Birth Mother"~~

SAMPLE

CAREPLAN Problems resolved: Yes ☐ No ☐ If No, describe plan_____

DIET
Breast Feeding_____ Frequent feeding - q2 - 3°_____
Formula Feeding_____ Type_____ Frequency_____

TAKE HOME MEDICATIONS Medications (dosage, frequency, indications) Date/Time
Last dose given
Medications Received 1. _____
Prescriptions Given 2. _____
None Ordered 3. _____
Instructions for medication(s) given to Parent ☐ Significant Other / Caregiver ☐
Relationship,_____, understands instructions and performed return demonstration.
_____ RN / LVN

BABY: REPORTABLE CONDITIONS
a. Fever 100.4°F or over by rectum
b. Listlessness or restlessness
c. Excessive crying or high pitch shill cry
d. Any unusual rash
e. Loose, watery bowel movements (mucous and foul odor)
f. Vomiting ("not just spitting up") or refusal to eat several times in a row.
g. Jaundice (press gently on tip of nose or cheek, yellow color appears, or yellow coloration of the whites of eyeballs)

f. Ages & Stages taught ☐
Brochure given to parent(s) Eng Spn Other
Pass Refer Waived Diag. Refer
_____ RN / LVN

OTHER SPECIFIC INSTRUCTIONS_____

FOLLOW-UP APPOINTMENTS
Dr. _____ Date/Time_____ Call for appointment_____ Telephone_____
Other_____ Date/Time_____ Call for appointment_____ Telephone_____

I RECEIVED AND UNDERSTAND THE NURSES INSTRUCTIONS.

_____ _____RN/LVN
Parent / Significant Other / Caregiver

_____ Date: _____
RN Validation Signature

NEWBORN IDENTIFICATION **Affix infant's identification band here**
Check appropriate box below
☐ I hereby acknowledge that I have compared the identification band with my own band numbered _____ and I am taking my baby from the hospital
☐ I hereby acknowledge that I have checked the identification and I am taking the appropriate baby from the hospital.

Parent	Witness	Date	Time
Signature if other than parent	Relationship	Identification Verification	

Affix Patient Label

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

7400-1008
(Rev 8/09)

NEWBORN IDENTIFICATION & DISCHARGE INSTRUCTIONS

White - Chart Yellow - Patient

SAMPLE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

HEALTH FACILITY MINOR RELEASE REPORT

Prepare original and 3 copies: one copy each for hospital file, birth parent, and person receiving minor. **SEE INSTRUCTIONS ON REVERSE SIDE**

Send original to: California Department of Social Services
744 P Street, M/S 19-67
Sacramento, California 95814

(Within 48 hours as required by Health & Safety Code Section 1283)

IMPORTANT NOTICE

THIS HEALTH FACILITY RELEASE FORM IS NOT A RELINQUISHMENT FOR OR CONSENT TO ADOPTION.

IN CALIFORNIA, A BIRTH PARENT MAY PLACE A CHILD FOR ADOPTION BY AN:

1) Agency Adoption: The birth parent relinquishes the child to a licensed private or public adoption agency for the agency to place the child with a family that has been approved for adoption. If the birth parent and agency agree, the relinquishment may name the prospective adoptive parents. Before the relinquishment is filed with the California Department of Social Services, the birth parent may cancel the relinquishment and reclaim the child. After the relinquishment is filed with the California Department of Social Services, the birth parent will no longer have any right to the custody of the child, unless either (1) the agency agrees to allow the birth parent to cancel the relinquishment and arrange to return the child to the birth parent, or (2) the relinquishment named the prospective adoptive parents and the adoption is not completed.

2) Independent Adoption: The birth parent selects and places the child directly with the prospective adoptive parents. If the prospective adoptive parent is an adult not related to the child, the birth parent must first be advised of his or her rights regarding an independent adoption by an Adoption Service Provider and then sign an Independent Adoption Placement Agreement. The Independent Adoption Placement Agreement becomes an irrevocable consent to adoption after 30 days. During the 30-day period, the birth parent may revoke the agreement and reclaim the child or may waive the right to revoke the agreement. The birth parent must be interviewed by a representative of the California Department of Social Services or a delegated county adoption agency before signing a waiver of the right to revoke the Independent Adoption Placement Agreement.

A birth parent may place a child in foster care with an agency or with a person. Within six months, the birth parent must either sign a relinquishment, consent, an Independent Adoption Placement Agreement, or reclaim the child. If the birth parent fails to take any of these actions, the court could find the child has been abandoned and issue an order terminating the birth parent's parental rights to the child and order a plan of adoption for the child.

I. IDENTIFYING INFORMATION

Child's Name_____ Birthdate_____ Gender ☐ Male ☐ Female

II. PARENT'S AUTHORIZATION (Fill out completely before parent signs. Alterations or deletions invalidate form).

A. I, _____, the parent of _____
authorize _____ Hospital to release my child to
_____ residing at (complete address)_____
for the purpose of ☐ Independent Adoption by (full names)_____ residing
at (address)_____ who has/have my permission to care for my child in
his/her/their home, ☐ Agency Adoption planning, ☐ Foster Care, ☐ Other, Explain_____. This
authorization only releases my child from the hospital. It is not a consent to or relinquishment for adoption. I retain all parental rights to the custody and control of my child. If the child is placed for Independent Adoption, I will be interviewed by a social worker from the California Department of Social Services or a delegated county adoption agency after the prospective adoptive parents file the adoption petition with the Superior court.

B. **MEDICAL AUTHORIZATION**
I authorize and empower the person(s) named in Section II A above to make any provisions for medical and surgical care for my child identified on this report, including anaesthesia, which may be deemed necessary or advisable by any licensed physician, for a period not to exceed six months from the date of my child's release from this hospital.

_____ (Witness) _____ (Date) _____ (Signature of parent, or person having legal custody of child)

III. ACKNOWLEDGEMENT BY PERSON(S) RECEIVING CHILD

On (date) _____ I/we received (child's name) _____ for the purpose of ☐ Independent Adoption, ☐ Agency Adoption planning, ☐ Foster Care, ☐ Other, as explained above. If the child is released for Independent Adoption and an adoption petition is not filed within 30 days, the California Department of Social Services will begin an investigation to determine if a foster care licensing law is being violated.

I/we understand that this authorizes only the release of this child from the hospital. This is not a consent or relinquishment of this child for adoption.

_____ (Witness) _____ (Date) _____ (Signature of persons receiving child)

_____ (Organization - If Applicable)

_____ (Address)

Identification of person(s) receiving child (two ID's required):

Driver's license number_____ State_____

Social Security number or other identification_____

Telephone number (_____)_____

IV. REPORT OF HOSPITAL

_____ (Name of Hospital)

_____ (Address)

_____ (Name of Attending Physician)

_____ (Mother's Admission Date) _____ (Discharge Date)

_____ (Mother's Name) (DOB)

_____ (Mother's Address)

_____ (Father's Name) (DOB)

_____ (Father's Address)

_____ (Signature of Administrator or Designated Representative)

AD 22 (7/02)

INSTRUCTIONS FOR COMPLETING THE HEALTH FACILITY MINOR RELEASE REPORT

This form shall be completed for each child under 16 years of age who is discharged from a health facility to a person other than the child's parent, relative by blood or marriage, or person having legal custody unless the child is transferred to another health facility or comes within Sections 300, 601 or 602 of the Welfare and Institutions Code and is released to an agent of a public welfare, probation or law enforcement agency.

Section I. Enter the child's name, birthdate and sex (as shown on the "Record of Live Birth" (VS 10) if the child is a newborn).

Section II.. The name and address of the person(s) or agency authorized by the parent or guardian to remove a child from the health facility and, if an independent adoption, the name and address of the person(s) with whom the child will be placed must be entered in the appropriate space before the parent or guardian signs the authorization.

Section III. The person(s) or agency receiving the child shall be the same as the person or agency designated by the parent or guardian in Section II.

Section IV. Complete the entire section. If the father's name is unknown or withheld, this should be indicated.

A copy of the Health Facility Minor Release Report shall be offered to both parent or guardian and the person(s) removing the child from the health facility as all persons are entitled to copies of any documents they may sign. If the copy is refused, this should be noted and retained in the health facility file with the health facility copy.

CALIFORNIA LAW REGARDING RELEASE OF MINOR FROM HEALTH FACILITY

Section 1283 of the Health and Safety Code states:

"(a) No health facility shall surrender the physical custody of a minor under 16 years of age to any person unless such surrender is authorized in writing by the child's parent, the person having legal custody of the child, or the caregiver of the child who is a relative of the child and who may authorize medical care and dental care under 6550 of the Family Code.

"(b) A health facility shall report to the California Department of Health Services, on forms supplied by the department, the name and address of any person and, in the case of a person acting as an agent for an organization, the name and address of the organization, into whose physical custody a minor under the age of 16 is surrendered, other than a parent, relative by blood or marriage, or person having legal custody. This report shall be transmitted to the department within 48 hours of the surrendering of custody. No report to the department is required if a minor under the age of 16 is transferred to another health facility for further care or if this minor comes within Section 300, 601, or 602 of the Welfare and Institutions Code and is released to an agent of a public welfare, probation, or law enforcement agency."

CALIFORNIA LAW REGARDING PLACEMENT OF CHILDREN

Section 8609(b) of the Family Code states:

"Any person, other than a birth parent, or any organization, association, or corporation that, without holding a valid and unrevoked license to place children for adoption issued by the department [of Social Services], places any child for adoption is guilty of a misdemeanor."

CALIFORNIA LAW REGARDING TERMINATION OF PARENTAL RIGHTS

Section 7820 of the Family Code in part states:

"A proceeding may be brought under this part for the purpose of having any child under the age of 18 years declared free from the custody and control of either or both parents if the child comes within any of the following descriptions set out in this chapter."

Section 7822 of the Family Code in part states:

"(a) A proceeding under this part may be brought where the child . . . has been left by both parents or the sole parent in the care and custody of another for a period of six months . . . without any provision for the child's support, or without communication from the parent or parents, with the intent on the part of the parent or parents to abandon the child."

"(d) If the parent has placed the child for adoption and has not refused to give the required consent to adoption, evidence of the adoptive placement shall not in itself preclude the court from finding an intent on the part of that parent to abandon the child. If the parent has placed the child for adoption and has refused to give the required consent to adoption but has not taken reasonable action to obtain custody of the child, evidence of the adoptive placement shall not in itself preclude the court from finding an intent on the part of that parent to abandon the child."

Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN~~CHILDREN'S~~ SERVICES (WNS) ~~POLICY MANUAL~~

ISSUE DATE:	**10/94**	**SUBJECT:**	**Partners In Care for Women's and Newborn~~children's~~ Services**
REVISION DATE(S):	**01/00, 06/03, ~~7/09~~08/09, ~~3/10~~07/10, ~~06/14~~**		

Women and Newborn Services Department Approval:	**11/18**
Department of OB/GYN Approval:	**~~12/13~~n/a**
Department of Pediatrics Approval:	**~~12/13~~n/a**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**~~06/14~~ n/a**
Board of Directors Approval:	**~~6/03, 8/09, 7/10,~~ 06/14**

A. **PURPOSE:**

1. The staff of Tri–City Medical Center **(TCMC)** for Women's and **Newborn**~~Children's~~ Services are committed to supporting the strength and integrity of families as they adapt to the physical and psycho/social changes brought about by childbirth. We promote a patient and family centered care philosophy that is a mutually beneficial partnership between healthcare providers, patients, and their families. In order to address special circumstances, exceptions may be made by the Charge RN and/or the Assistant Nurse Manager on duty. The healthcare team supports the presence of family and friends as "Partners in Care" and encourages their ongoing participation during their stay at ~~Tri-City Medical Center~~ **TCMC**

B. **PROCEDURE:**

1. **All Partners In Care:**
   - a. **Will be issued a visitation sticker for safety and security purposes.**
   - b. **Will need to perform thorough hand hygiene prior to entering and exiting the patient room.**
   - c. **Will have a restriction of visitation for those children 14 and below during the influenza or RSV season as restricted throughout the community.**
   - d. **Children must be over the age of one and need to be accompanied by an adult other than the patient when they are visiting.**
     - i. **They cannot be accommodated overnight.**
     - ii. **Strollers must be occupied.**
     - iii. **Car seats are not allowed on the unit for safety reasons.**
   - e. **Will need to wait in the waiting room if an emergency occurs or if there is need for patient privacy.**
   - f. **In order to provide a confidential environment for patients and a safe environment for everyone, waiting in the hallways is not permitted.**
   - ~~B.~~g. **Still photography/cameras are encouraged of the baby and/or mother and family, but not of the delivery or~~,~~ procedures.~~, Physicians/Midwives nor hospital staff.~~ In some situations it may be requested that no photography is performed.**

~~1. Antenatal testing area / triage:~~

- ~~a. The antenatal testing/triage is a semi-private area for testing and evaluating expecting mothers.~~
- ~~b. In order to respect the privacy of our patients only one support person is recommended in the room during this short term observation.~~

2. **Exceptions to Family Presence or Visitors:**

a. **Except when the patient, staff or provider chooses to restrict family and other "Partners in Care," limitations on the presence of these individuals may be appropriate in exceptional circumstances, such as when:**
   i. **A legal reason (e.g., a restraining order, the patient is in legal custody or a court order this will prohibit all visitors).**
   ii. **Behavior is disruptive to maintaining a therapeutic environment on the patient care unit.**
   iii. **A family member or visitor who is actively coughing, sneezing or has had a fever in the last 24 hours is requested to not visit. This may jeopardize the patient's and baby's health.**

~~2.~~3. **Labor and Delivery:**

a. "Partners in Care" are welcome in the patient's room, 24 hours/day, at the discretion of the patient. Visiting may be limited by the healthcare team if the patient's medical condition warrants. Waiting lounges are available during –those occasions. The patient's spouse/significant other is encouraged to stay overnight while on the Labor and Delivery unit.

~~b. All family and friends will be issued a badge for safety and security purposes.~~
   ~~i. Our staff will notify security services of any visitation restrictions that develop.~~

~~c. In order to provide a confidential environment for patients and a safe environment for everyone, waiting in the hallways are not permitted.~~

~~d. Visiting children under the age of 12:~~

b. To ensure their comfort and safety, children **14 and below** must be accompanied by an adult who is not the patient's primary support person while in labor.

c. **Antenatal testing area / triage:**
   i. **The antenatal testing/triage is a semi-private area for testing and evaluating expecting mothers.**
   ii. **In order to respect the privacy of our patients only one support person is recommended in the room during this short term observation.**

d. **Operating Room/PACU:**
   i. **One support person is welcome to attend a cesarean birth. Observation may be denied in the event of an emergency.**
   ii. **For Cesarean births, one visitor (usually the banded person) will be invited to the Recovery Room after initial stabilization of the patient.**
      ~~i.~~1) **Other friends and family may wait comfortably in the waiting lounge.**

~~3. Operating Room/PACU:~~

~~a. One support person is welcome to attend a cesarean birth. Observation may be denied in the event of an emergency.~~
   ~~b. For Cesarean births, two visitors per patient will be invited to the Recovery Room after initial stabilization of the patient. Other friends and family may wait comfortably in the waiting lounge.~~

~~c. Still photography/cameras are encouraged of the baby and/or mother but not the procedure, physicians, nor operating room staff.~~

4. **Postpartum:**

a. **"Parenters in Care" are welcome to visit between 9a.m. and 9p.m. The number of guests may be limited in semiprivate rooms.**

~~a. The "banded" primary support person is welcome to visit at any time.~~

~~b. "Partners in Care" are welcome to visit between 9am and 9pm. The number of guests may be limited in semiprivate rooms. During "Baby Bonding Hours" (2pm- 4pm), guests are able to wait in our lobby so that our new families can take advantage of this special time together.~~

~~c. All children must be over the age of 1 and be accompanied by an adult other than the patient, at all times. Strollers must be occupied and for safety reasons, no car seats are allowed on our unit.~~

b. As long as the patient doesn't have a "suite-mate", the spouse/significant other is encouraged to stay overnight so they can participate in providing care and support to their new family.

i. The support person must be over the age of 18, unless the father of baby is a minor.

ii. Chairs are provided; the second bed is reserved for possible admission.

~~d.~~**c. If the patient does have a "suite-mate" then all guests and significant others would need to go home by 9 p.m., when visiting hours are over, to ensure privacy for all involved.**

5. **Transition ~~Newborn~~ Nursery:**

a. **At the discretion of the healthcare team~~T~~**the "banded" primary support person is welcome in the **Transition**~~Newborn~~ Nursery.~~ at any time~~.

~~b. Other family members may see the baby for brief periods of time at the discretion of the health care team. If a banded person is not with them the health care team will utilize the Authorization for Visitation and/or Release of Patient Information form.~~

~~6. **Exceptions to Family Presence or Visitors:**~~

~~a. Except when the patient chooses to restrict family and other "Partners in Care," limitations on the presence of these individuals may be appropriate in exceptional circumstances, such as when:~~

~~i. A legal reason (e.g., a restraining order, the patient is in legal custody or a court order prohibiting visitors).~~

~~ii. Behavior is disruptive to maintaining a therapeutic environment on the patient care unit.~~

~~iii. A family member or visitor who has a contagious illness or has had a known exposure to a communicable disease that may jeopardize the patient's health.~~

~~iv. An infectious disease outbreak, such as a pandemic, which requires severe access restrictions throughout the community.~~

~~b. A patient that requires immediate intervention by the healthcare team (e.g. resuscitation) or when a sensitive/private discussion needs to occur. In these instances, those present with the other patient may be asked to temporarily step out of the room or area~~

Tri-City Medical Center	Distribution:	Women's and Newborn~~Children's~~ Services (WN~~C~~S)
PROCEDURE:	**RELEASE OF A MINOR TO OTHER THAN BIRTH MOTHER**	
Purpose:	To outline the proper steps required to release a minor to a person other than the birth mother. ~~for: foster care, adoption, when birth mother is a surrogate, or when mother remains hospitalized in Women's and Children's Services including NICU.~~	
Supportive Data:	On occasion, **babies are placed in Child Protective Services (CPS) custody and placement is arranged by CPS. In these instances, it is necessary to have the California Department of Social Services Health Facility Minor Release Report (AD 22) completed and proper identification of the foster parent or agency representative verified prior to release of baby. On occasion, babies are discharged while their mother remains hospitalized. In these instances it is necessary for the baby's mother to completed Authorization for Release of Minor form.**~~newborns are mandated to foster care per a court's ruling. In these instances, it is necessary to have the California Dept. of Social Services *Health facilities Minor Release Form (AD-22)* completed and the proper identification of the foster parent or agency representative provided and verified prior to releasing the newborn. On occasion, birth mothers elect to relinquish their newborns to individuals or agencies for the purpose of adoption planning. In these instances, it is necessary to have the California Dept. of Social Services *Health facilities Minor Release Form (AD-22)* completed and the proper identification provided and verified before releasing a newborn to the legal parents. On occasion newborns are discharged from the hospital while their birth mother remains hospitalized. In these instances, it is necessary for the birth mother to complete *Authorization for Release of Minor.*~~	
~~Equipment:~~	~~Newborn identification and discharge instructions~~ ~~Required forms: Health Facilities Minor Release Form (AD-22), Authorization for Release of Minor Form and Acknowledgement of Release of a Minor.~~ ~~Black pen~~	

A. **PROCEDURE**

1. ~~On Admission or w~~When it is known that a child is to be released to someone other than a birth mother a Social Service Consult needs to be ordered.
~~1.~~2. All ~~infant~~**baby** bands will be applied as per the Identification/Banding of Newborns procedure.
~~2.~~3. All hospital charges to mother and baby will be charged to the birth mother unless other arrangements are made.
~~3.~~4. **Release of Information/Consent~~RELEASE OF INFORMATION/CONSENT:~~** (~~TCMC~~**TCHD** Administrative Policy: Disclosure of Protected Health Information (PHI) #8610-513)
   a. Release of information regarding the ~~infant~~**baby**(s) shall be provided by the birth mother whose ID bands match those of the ~~infant~~**baby**(s) only.
      i. The foster parents may receive any direct information regarding the ~~infant~~**baby**(s) condition or care after the birth mother, parent or guardian signs the Authorization for Use or Disclosure form. If it is a Child Protective Service (CPS) hold the form is not required.
      ii. Written hospital discharge information summarizing the minor's medical history, diagnosis and treatment that may be required for the continuity of care and treatment shall be provided at discharge.
      iii. If a complete medical record is requested this may be done by referring the requester to medical records.
   b. The birth mother or parent shall sign all consents for care/procedures.
   c. When a baby is being released to someone other than the mother, the mother still retains rights to obtain information and be kept informed of baby's status.

Women and Newborn Department Review	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/14, 12/18	12/13, n/a	n/a	12/13, n/a	n/a	n/a	01/19	06/14, n/a	06/14

d. If a baby remains in the hospital for medical reasons a birth mother or parent can visit the baby and remain involved even if she has already signed the AD22.

~~4.~~5. **Discharge to Foster Care or Someone Other Than the Birth Mother:**

a. Verify discharge order for ~~newborn~~**baby**. ~~(Refer to WCS/NICU Policy # 6385-400: Infants to Foster Care, Mother Remains Hospitalized)~~

b. Validate if there is an active Child Protective Services (CPS) hold on ~~newborn~~**baby**.
   i. If CPS places a hold on baby, Social Worker will place Court Hold Form inside baby's chart in the front and inform nurse. Unless the Hold is released by CPS, SW will coordinate with CPS re: placement of baby. Pertinent information re: assigned foster parent(s) will be provided to nurse for purpose of completion of AD 22; however, foster parent(s) information will not be documented on permanent record.

c. Nurse will coordinate the ~~newborn~~**baby**'s discharge planning with the Social worker who will communicate the plan with the assigned Foster Parent(s) or guardian.
   i. The date and time of pick-up should be arranged

d. AD 22 is to be completed when a child is going to someone other than a legal parent. The hospital staff is to obtain birth mother's or parent signature, indicating her permission to release the ~~newborn~~**baby** to a person other than a parent or Identified Party. If birth mother or parent is unable to sign the social worker will assist to determine the best next of kin (such as the first next of kin to arrive to the hospital) on a case by case basis..
   i. RN ~~or Charge Nurse~~ to fill out Part I
   ii. RN ~~or Charge Nurse~~ to have birth mother or parent sign release of infant on Part II and witness the signature to include the date (all copies must be legible)
   iii. If infant is on a CPS hold, the birthmother's or parent's signature is not required. CPS Hold must be written across part II
   iv. Have person(s) designated to receive the child sign the remaining copies of AD22 Part III.
      1) Verify receiver has two forms of identification (at least one with a photo and identification information):
         a) Picture ID, which may include Drivers License, passport, military ID, bank card with photo ID. Record type of ID verified -and corresponding numbers from the two (2) identifications provided by the foster parent in the appropriate place on the AD 22 form.
         b) Social Security Number or Other Identification
   v. RN ~~or Charge Nurse~~ to witness receiver signatures, including date. Offer copy to the person receiving the ~~newborn~~**baby**.
      1) If copy refused-write on the bottom "Refused Copy"
   vi. Make 3 copies of the AD 22. one copy to person or people receiving the ~~newborn~~**baby** and send original and extra copy to Perinatal Data Coordinator. Copy does not go to birth mother.

e. RN ~~or Charge Nurse~~ to obtain signatures for the following forms: Authorization for Release of a Minor and Acknowledgement of Release of a Minor
   i. Authorization for Release of a Minor: birth mother, guardian or legally authorized caregiver fills out the form and who they want the hospital to release the minor to
   ii. Acknowledgement of Release of A Minor will be filled out by the person receiving the minor.

f. Verify the identity of the ~~newborn~~**baby** being released to foster care per newborn identification protocol.

g. All discharge teaching and paperwork will be done with the person(s) that the baby is to be relased to.

h. One ~~newborn~~**baby** ID bracelet is left on the ~~newborn~~**baby** and one is taped to the ~~newborn~~**baby** identification and discharge instructions.
   i. The foster parent, witnessed by hospital personnel, must sign this form.

ii. Have foster parent sign AD 22 before newbornbaby is released. Make 3 copies of the AD 22. Give one copy to foster parents, and send original and extra copy to Perinatal Data Coordinator.

i. Assess concerning safety issues and coordinate with security and social service as indicated.

B. **ADOPTION PROCEDURE for NEWBORNBABY DISCHARGE in an ADOPTIVE STATUS:**

1. See WCSWNS Adoption Policy

C. **BIRTH MOTHER IS A SURROGATE**

1. See WCSWNS Surrogacy Policy

D. **WHEN CPS HAS CUSTODY OF BABY**

1. **Prior to discharge, when CPS has custody of baby, SW will have placed in baby's chart either completed Court Hold Form or Letter from CPS documenting that CPS has custody of baby.**
2. **SW will coordinate with CPS re: CPS plan for placement of baby. Pertinent information such as assigned foster parent(s)/placement will be provided to RN by SW. However, foster parent identifying information will not be documented in permanent records.**
3. **SW will make initial contact with foster parent(s). Follow up with foster parent(s) to coordinate logistics of baby's discharge will be facilitated by either RN or SW.**
4. **All normal discharge protocol will be completed with foster parent(s)/designated placement person.**
5. **Should safety concerns emerge, Neonatal Intensive Care or Mother Baby team, SW and Security will collaborate to address concerns and implement safe discharge plan.**

D.E. **SPECIAL CIRCUMSTANCES:**

1. **When reasons emerge (i.e. MOB remains a patient in the hospital or is incarcerated) that prevent the baby from being discharged to MOB:**
2. **Baby can be released to Father of Baby (FOB), as identified on Birth Certificate, if circumstances prevent baby from being discharged to MOB.**
3. **RN or SW will discuss MOB's wishes with her and will obtain signature on completed Authorization for Release of a Minor form, reflecting MOB's wishes. Form is to be placed on baby's chart.**
4. **Upon baby's discharge, RN will verify that identity of person to whom baby will be discharged matches the person named in Authorization for Release of Minor form.**
   a. **A picture ID must be provided by the person picking up baby.**
5. **RN will complete Acknowledgement of Release of a Minor form and have it signed by the person to whom baby will be discharged home with.**

A.6. **RN will proceed with normal discharge protocol to Identified Person named in the Authorization for Release of Minor form.**

MOTHER REMAINS HOSPITALIZED (i.e. medical reason not a surrogate, hold or adoption)
Verify discharge order for newborn. (Refer to WCS/NICU Policy # 6385-400: Infants to Foster Care, Mother Remains Hospitalized)
RN or Charge Nurse to obtain signatures for the following forms: Authorization for Release of a Minor and Acknowledgement of Release of a Minor. If birth mother or parent is unable to sign the social worker will assist to determine the best next of kin (such as the first next of kin to arrive to the hospital) on a case by case basis.

Authorization for Release of a Minor: birth mother, guardian or legally authorized caregiver fills out the form and who they want the hospital to release the minor to

Acknowledgement of Release of A Minor will be filled out by the person receiving the minor.
Before releasing the newborn, verify the identity of the person(s) named on the authorization to receive newborn.

~~A picture ID with name that matches the name of the authorization MUST be provided by the person(s) picking up the newborn.~~

~~E.~~F. DOCUMENTATION

1. Document in the birth mother and ~~newborn~~**baby** electronic medical records.:
   a. That the ~~newborn~~**baby** was discharged to foster care, or
   b. That the ~~newborn~~**baby** was discharged for the purpose of adoption planning, or
   c. That the ~~newborn~~**baby** of a surrogate was discharged to the intended legal parent(s)
   d. That the ~~newborn~~**baby** was discharged to the legal parent(s) as verified by the declaration of maternity/paternity

~~F.~~G. ~~REFERENCE~~FORM(S):

~~1. Health Facility Minor Release Report (Form AD 22), State of California Health and Welfare Agency, Department of Social Services.~~

1. Authorization for Release of a Minor - **Sample**~~. California Association of Hospitals and Health Systems (CAHHS), Form 10-1.~~
2. **Acknowledgement of Release of a Minor – Sample**~~. California Association of Hospitals and Health Systems (CAHHS), Form 10-2.~~
3. **Health Facility Minor Release Report AD 22 Form – Sample (available via external link: http://www.cdss.ca.gov/cdssweb/entres/forms/English/AD22.PDF)**
~~2.~~4. **Newborn Identification & Discharge Instructions 7400-1008 – Sample**

SAMPLE

I, (*insert name*) _____, the

☐ parent

☐ guardian

☐ Legally authorized caregiver

of (*child's name*)_____, authorize Tri-City Medical Center to release my child to:

_____ _____
(name) *(area code and telephone number)*

_____ _____
(address) *(city, state, zip)*

I retain all parental rights to his/her custody and control. This authorization authorizes only the release of my child from the hospital to the person named above.

_____ _____ ___/___/___ ____:____AM/PM
Name: Patient/Representative **Signature**: Patient/Representative **Date** **Time**

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

_____ _____ ___/___/___ ____:____AM/PM
Witness – TCHD Representative (print name) **Signature** **Date** **Time**

INTERPRETATION / INTERPRETER'S STATEMENT

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI

☐ Face-to-face ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

_____ _____ ___/___/___ ____:____AM/PM
Interpreter ID number or Name **Interpreter Signature (if present)** **Date** **Time**

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

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

XXXX-XXXX

Authorization for Release of a Minor

Affix Patient Label

_____ Example - Patient Copy Example – Medical Records
(Rev. xx/xx)

BOD Approval:_____

SAMPLE

I/we have on this date, *(insert date)* _____, received *(name of child)* _____.

I/we understand that the signature below authorizes only the release of this child from the hospital. This is not a consent or relinquishment of this child for adoption.

Signature: _____
(person receiving child) *Date / Time*

Print name: _____
(person receiving child)

_____
(organization)

_____
(address)

Signature: _____
(witness) *Date / Time*

Print name: _____
(witness)

*** This form is not to be used in the case of adoption (use AD-22) and is not for Surrogate with a Judgment ***

COMPLETE THE FOLLOWING:

IDENTIFICATION OF PERSON(S) RECEIVING CHILD

Name: _____

Address: _____

_____

Phone Number: _____

Driver's License No: _____ State: _____

Other: _____

_____

Affix Patient Label

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

6385-1017
(Rev. 9/14)

ACKNOWLEDGMENT OF RELEASE OF A MINOR

White - Hospital Yellow - Patient

SAMPLE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

HEALTH FACILITY MINOR RELEASE REPORT

Prepare original and 3 copies: one copy each for hospital file, birth parent, and person receiving minor. SEE INSTRUCTIONS ON REVERSE SIDE

Send original to: California Department of Social Services
744 P Street, M/S 19-67
Sacramento, California 95814

(Within 48 hours as required by Health & Safety Code Section 1283)

IMPORTANT NOTICE

THIS HEALTH FACILITY RELEASE FORM IS NOT A RELINQUISHMENT FOR OR CONSENT TO ADOPTION.

IN CALIFORNIA, A BIRTH PARENT MAY PLACE A CHILD FOR ADOPTION BY AN:

1) Agency Adoption: The birth parent relinquishes the child to a licensed private or public adoption agency for the agency to place the child with a family that has been approved for adoption. If the birth parent and agency agree, the relinquishment may name the prospective adoptive parents. Before the relinquishment is filed with the California Department of Social Services, the birth parent may cancel the relinquishment and reclaim the child. After the relinquishment is filed with the California Department of Social Services, the birth parent will no longer have any right to the custody of the child, unless either (1) the agency agrees to allow the birth parent to cancel the relinquishment and arrange to return the child to the birth parent, or (2) the relinquishment named the prospective adoptive parents and the adoption is not completed..

2) Independent Adoption: The birth parent selects and places the child directly with the prospective adoptive parents. If the prospective adoptive parent is an adult not related to the child, the birth parent must first be advised of his or her rights regarding an independent adoption by an Adoption Service Provider and then sign an Independent Adoption Placement Agreement. The Independent Adoption Placement Agreement becomes an irrevocable consent to adoption after 30 days. During the 30-day period, the birth parent may revoke the agreement and reclaim the child or may waive the right to revoke the agreement. The birth parent must be interviewed by a representative of the California Department of Social Services or a delegated county adoption agency before signing a waiver of the right to revoke the Independent Adoption Placement Agreement.

A birth parent may place a child in foster care with an agency or with a person. Within six months, the birth parent must either sign a relinquishment, consent, an Independent Adoption Placement Agreement, or reclaim the child. If the birth parent fails to take any of these actions, the court could find the child has been abandoned and issue an order terminating the birth parent's parental rights to the child and order a plan of adoption for the child.

I. IDENTIFYING INFORMATION

Child's Name_____ Birthdate_____ Gender ☐ Male ☐ Female

II. PARENT'S AUTHORIZATION (Fill out completely before parent signs. Alterations or deletions invalidate form).

A. I, _____, the parent of _____
authorize _____ Hospital to release my child to
_____ residing at (complete address) _____
for the purpose of ☐ Independent Adoption by (full names) _____ residing at (address) _____ who has/have my permission to care for my child in his/her/their home, ☐ Agency Adoption planning, ☐ Foster Care, ☐ Other, Explain _____. This authorization only releases my child from the hospital. It is not a consent to or relinquishment for adoption. I retain all parental rights to the custody and control of my child. If the child is placed for Independent Adoption, I will be interviewed by a social worker from the California Department of Social Services or a delegated county adoption agency after the prospective adoptive parents file the adoption petition with the Superior court.

B. MEDICAL AUTHORIZATION
I authorize and empower the person(s) named in Section II A above to make any provisions for medical and surgical care for my child identified on this report, including anaesthesia, which may be deemed necessary or advisable by any licensed physician, for a period not to exceed six months from the date of my child's release from this hospital.

_____ (Witness) _____ (Date) _____ (Signature of parent, or person having legal custody of child)

III. ACKNOWLEDGEMENT BY PERSON(S) RECEIVING CHILD

On (date) _____ I/we received (child's name) _____ for the purpose of ☐ Independent Adoption, ☐ Agency Adoption planning, ☐ Foster Care, ☐ Other, as explained above. If the child is released for Independent Adoption and an adoption petition is not filed within 30 days, the California Department of Social Services will begin an investigation to determine if a foster care licensing law is being violated.

I/we understand that this authorizes only the release of this child from the hospital. This is not a consent or relinquishment of this child for adoption.

_____ (Witness) _____ (Date) _____ (Signature of persons receiving child)

_____ (Organization - If Applicable)

_____ (Address)

Identification of person(s) receiving child (two ID's required):

Driver's license number _____ State _____

Social Security number or other identification _____

Telephone number (_____) _____

IV. REPORT OF HOSPITAL

_____ (Name of Hospital)

_____ (Address)

_____ (Name of Attending Physician)

_____ (Mother's Admission Date) _____ (Discharge Date)

_____ (Mother's Name) (DOB)

_____ (Mother's Address)

_____ (Father's Name) (DOB)

_____ (Father's Address)

_____ (Signature of Administrator or Designated Representative)

AD 22 (7/02)

INSTRUCTIONS FOR COMPLETING THE HEALTH FACILITY MINOR RELEASE REPORT

This form shall be completed for each child under 16 years of age who is discharged from a health facility to a person other than the child's parent, relative by blood or marriage, or person having legal custody unless the child is transferred to another health facility or comes within Sections 300, 601 or 602 of the Welfare and Institutions Code and is released to an agent of a public welfare, probation or law enforcement agency.

Section I. Enter the child's name, birthdate and sex (as shown on the "Record of Live Birth" (VS 10) if the child is a newborn).

Section II. The name and address of the person(s) or agency authorized by the parent or guardian to remove a child from the health facility and, if an independent adoption, the name and address of the person(s) with whom the child will be placed must be entered in the appropriate space before the parent or guardian signs the authorization.

Section III. The person(s) or agency receiving the child shall be the same as the person or agency designated by the parent or guardian in Section II.

Section IV. Complete the entire section. If the father's name is unknown or withheld, this should be indicated.

A copy of the Health Facility Minor Release Report shall be offered to both parent or guardian and the person(s) removing the child from the health facility as all persons are entitled to copies of any documents they may sign. If the copy is refused, this should be noted and retained in the health facility file with the health facility copy.

CALIFORNIA LAW REGARDING RELEASE OF MINOR FROM HEALTH FACILITY

Section 1283 of the Health and Safety Code states:

"(a) No health facility shall surrender the physical custody of a minor under 16 years of age to any person unless such surrender is authorized in writing by the child's parent, the person having legal custody of the child, or the caregiver of the child who is a relative of the child and who may authorize medical care and dental care under 6550 of the Family Code.

"(b) A health facility shall report to the California Department of Health Services, on forms supplied by the department, the name and address of any person and, in the case of a person acting as an agent for an organization, the name and address of the organization, into whose physical custody a minor under the age of 16 is surrendered, other than a parent, relative by blood or marriage, or person having legal custody. This report shall be transmitted to the department within 48 hours of the surrendering of custody. No report to the department is required if a minor under the age of 16 is transferred to another health facility for further care or if this minor comes within Section 300, 601, or 602 of the Welfare and Institutions Code and is released to an agent of a public welfare, probation, or law enforcement agency."

CALIFORNIA LAW REGARDING PLACEMENT OF CHILDREN

Section 8609(b) of the Family Code states:

"Any person, other than a birth parent, or any organization, association, or corporation that, without holding a valid and unrevoked license to place children for adoption issued by the department [of Social Services], places any child for adoption is guilty of a misdemeanor."

CALIFORNIA LAW REGARDING TERMINATION OF PARENTAL RIGHTS

Section 7820 of the Family Code in part states:

"A proceeding may be brought under this part for the purpose of having any child under the age of 18 years declared free from the custody and control of either or both parents if the child comes within any of the following descriptions set out in this chapter."

Section 7822 of the Family Code in part states:

"(a) A proceeding under this part may be brought where the child . . . has been left by both parents or the sole parent in the care and custody of another for a period of six months . . . without any provision for the child's support, or without communication from the parent or parents, with the intent on the part of the parent or parents to abandon the child."

"(d) If the parent has placed the child for adoption and has not refused to give the required consent to adoption, evidence of the adoptive placement shall not in itself preclude the court from finding an intent on the part of that parent to abandon the child. If the parent has placed the child for adoption and has refused to give the required consent to adoption but has not taken reasonable action to obtain custody of the child, evidence of the adoptive placement shall not in itself preclude the court from finding an intent on the part of that parent to abandon the child."

~~Triple~~ 1/4 1 3/8 c-to-c SAMPLE

CAREPLAN Problems resolved: Yes ☐ No ☐ If No, describe plan_____

DIET
Breast Feeding_____ Frequent feeding - q2 - 3°_____
Formula Feeding_____ Type_____ Frequency_____

TAKE HOME MEDICATIONS Medications (dosage, frequency, indications) Date/Time
Last dose given
Medications Received 1. _____
Prescriptions Given 2. _____
None Ordered 3. _____
Instructions for medication(s) given to Parent ☐ Significant Other / Caregiver ☐
Relationship_____, understands instructions and performed return demonstration.
_____ RN / LVN

BABY: REPORTABLE CONDITIONS
a. Fever 100.4°F or over by rectum
b. Listlessness or restlessness
c. Excessive crying or high pitch shill cry
d. Any unusual rash
e. Loose, watery bowel movements (mucous and foul odor)
f. Vomiting ("not just spitting up") or refusal to eat several times in a row.
g. Jaundice (press gently on tip of nose or cheek, yellow color appears, or yellow coloration of the whites of eyeballs)

f. Ages & Stages taught ☐
Brochure given to parent(s) Eng Spn Other
Pass Refer Waived Diag. Refer
_____ RN / LVN

OTHER SPECIFIC INSTRUCTIONS_____

FOLLOW-UP APPOINTMENTS
Dr. _____ Date/Time_____ Call for appointment_____ Telephone_____
Other_____ Date/Time_____ Call for appointment_____ Telephone_____

I RECEIVED AND UNDERSTAND THE NURSES INSTRUCTIONS.

_____ _____RN/LVN
Parent / Significant Other / Caregiver

_____ Date: _____
RN Validation Signature

NEWBORN IDENTIFICATION **Affix infant's identification band here**
Check appropriate box below
☐ I hereby acknowledge that I have compared the identification band with my own band numbered _____ and I am taking my baby from the hospital
☐ I hereby acknowledge that I have checked the identification and I am taking the appropriate baby from the hospital.

Parent	Witness	Date Time
Signature if other than parent	Relationship	Identification Verification

Affix Patient Label

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

7400-1008
(Rev. 8/99)

NEWBORN IDENTIFICATION & DISCHARGE INSTRUCTIONS

White - Chart Yellow - Patient

Tri-City Medical Center
Oceanside, California

~~WOMEN'S AND CHILDREN'S~~ WOMEN AND NEWBORN SERVICES (WNS) ~~MANUAL~~

ISSUE DATE: 06/03 **SUBJECT: Surrogacy**

REVISION DATE(S): ~~8/09~~12/09, ~~06/10~~07/10~~, 12/13~~06/13~~, 06/14~~

Women and Newborn Services Department Approval:	**12/18**
Department of OB/GYN Approval:	**~~12/13~~n/a**
Department of Pediatric Approval:	**~~12/13~~n/a**
Administration Approval:	**01/19**
Professional Affairs Committee Approval:	**~~06/14~~ n/a**
Board of Directors Approval:	**~~6/03, 12/09, 7/10,~~ 06/14**

A. **DEFINITIONS:**

1. Surrogate: A pregnant woman who has agreed to carry a~~n infant~~**baby**(s) for another person(s).
2. Intended/Legal Parents: Person(s) identified in a Judgment of maternity and paternity as the ~~legal~~**Intended/Legal Parents** parent(s) with all parental rights. ~~, or legal guardians.~~
3. Judgment of Maternity and Paternity (herein after Judgment): A court order signed by a superior court judge with an official court seal that specifies the **i**Intended/~~legal~~**Legal Parents** parent(s) of **the** ~~an infant~~**baby**(s) born or to be born via a **s**Surrogate and states that the **s**Surrogate is not the ~~legal~~**Intended/Legal Parents** parent. This document indicates the names that must be used on the birth certificate(s).
   a. Note: If there is not a Judgment, the **s**Surrogate will be given full custodial and legal rights and the ~~infant~~**baby** **s**(s) will be kept under the **s**Surrogate's last name. The **s**Surrogate will also sign all consents for herself and the ~~infant~~**baby**(s) if the Judgment has not been received by the hospital.

B. **POLICY:**

1. Tri-City Medical Center (TCMC) ~~Women's and Children's~~ **Women and Newborn's** Services **(WNS)** including **Neonatal Intensive Care Unit** (NICU) provides comprehensive, quality, family-centered care within an interdisciplinary framework. Situations regarding the appropriate discharge of minors (e.g., newborns) may arise at any time.
2. ~~Women's and Children's Services'~~ **WNS'** personnel discharging **baby(s)** ~~infants~~ within the context of a **s**Surrogate ~~birth mother~~ and the **i**Intended ~~legal~~/**Legal Parents** parent(s) shall adhere to the following (including but not limited to):
   a. Tri-City Medical Center policies and procedures
   b. Governmental regulations and laws
   c. Court orders
3. In all cases, the Judgment shall be used as a guide to determine who has legal authority for the newborn baby (~~babies~~).
4. TCMC Social Services shall act as the primary contact and referral coordinator for the **s**Surrogate and associated parties.
5. Prior to admission when a **s**Surrogate is identified she shall be referred to the hospital perinatal **s**Social **w**Worker**(SW)**.

C. **PROCEDURE:**

1. The ~~social worker~~**SW** shall:
   a. Request a copy of Judgment (faxed or mailed to the hospital) and instruct patient to bring original certified copy of Judgment to hospital upon admission for delivery **or prior to discharge**.

b. Notify Obstetrical (OB) Pre-admitting clerk of the surrogacy and provide any paperwork or information collected, including copy of the Judgment, when available.
c. When available, place copy of Judgment in the Perinatal Watch List Book and in designated folder in ~~Social Worker (~~SW~~)~~ office.
d. Upon admission provide original certified copy of Judgment to Birth Clerk (when received).
e. Ensure that copy of Judgment is on baby's chart.

2. The OB admission clerk shall:
   a. Provide the Surrogate with the surrogacy packet, this packet may include but is not limited to:
      i. Pre-registration form
      ii. Insurance information request (requiring photocopy of responsible party's insurance card(s))
      iii. The TCMC financial agreement for surrogate, ~~i~~Intended/~~-l~~Legal ~~p~~Parent(s) and Surrogacy Agency or Private Attorney (Refer to Financial Responsibility Agreement for Hospital Care Provided to Baby Born of Surrogacy Agreement and to a Surrogate Mother)
      iv. Request for copy of Judgment ~~document per infant (~~all pages, may be faxed or sent as a xeroxed copy), with instructions to bring the certified legal Judgment(s) to the hospital upon admission for delivery
   ~~b. Develop a file for the new surrogate using the surrogacy check list to track and to document the returned and completed required documents as defined above (Refer to Surrogacy Information Form)~~
   ~~c.~~**b.** Provide copies of received completed, or required documents to the admitting clerk for creating the pre-admission record
   ~~d.~~**c.** Provide identifying information, (i.e., Judgment) regarding the pregnancy and surrogacy arrangements to:
      i. The birth clerk
      ii. The OB admitting clerk
      iii. Labor and Delivery shall receive a copy of the Judgment to keep on a file in the Perinatal Watch List Binder
      iv. Social Worker **(SW)**
      v. Copies shall also be attached to the ~~s~~**S**urrogate and ~~infant~~**baby**(s) charts when admitted and newborn delivered
   ~~e.~~**d.** Enter the pre-registration information into the system and shall scan all documents, including a copy of the received Judgment into the computer system during normal business hours. During other business hours the regular admissions office or during non-business hours the Emergency Department Clerk will be able to assist and act as the OB admitting clerk.
   ~~f.~~**e.** Pre-verify all provided insurance information to ensure that it is an active account to ensure surrogacy is a covered benefit. Should additional financial arrangements be needed, admissions shall process them accordingly.

3. The Patient Financial Information:
   a. The TCMC financial agreement for ~~s~~**S**urrogate, ~~i~~Intended/~~-l~~**L**egal ~~p~~**P**arent(s) and Surrogacy Agency or Private Attorney will be given to the Patient Financial Services by the person that pre-admits or admits the patient
   b. This information shall be forwarded to Patient Financial Services (PFS)/hospital financial counselor to ensure that the ~~i~~Intended/**Legal** ~~p~~**P**arent(s) have also signed the Conditions of Admission (COA)
   c. Insurance information for agreements that require the ~~s~~**S**urrogate couple to assume financial responsibility of hospital stay for mother (if applicable) and ~~infant~~**baby(s)**, including NICU costs if applicable. In all cases, the Judgment shall be used as a guide to determine who has legal authority for the baby.
   d. ~~All hospital charges to mother and baby will be charged to the birth mother unless other arrangements were made as per the Judgment.~~ The hospital financial counselor(s) shall

be alerted about the planned surrogacy and will contact the identified agency or private attorney and the ~~i~~Intended/~~-l~~Legal ~~p~~Parent(s) to discuss contractual obligations including base costs for all care for the ~~birth mother~~**Surrogate** (if applicable) and **the** baby (~~babies~~) in the **NICU** ~~neonatal intensive care~~ if required. They will also be advised that the physician charges are not included in the hospital charges.

e. Admissions will pre-verify all insurance coverage to ensure surrogacy is a covered benefit. Should additional financial arrangements be needed, admissions will process them accordingly. They will forward this information to the hospital financial counselor (to ensure that the ~~i~~Intended/**Legal** parent(s) have also signed the COA).

f. Upon delivery, the original **certified copy of the** Judgment ~~of maternity and paternity~~ will be given to the birth clerk for processing of the birth certificate. Copies shall also be attached to the ~~birth mother~~**Surrogate** and ~~infant~~ **the baby**(s) charts and the ~~p~~Perinatal **Social Worker** ~~case manager~~ notified.

4. The admitting Labor and Delivery RN/or Unit Secretary upon the ~~s~~Surrogate's admission for delivery shall:
   a. Obtain the legal Judgment on file for the ~~s~~Surrogate and ~~i~~Intended/~~-l~~Legal ~~p~~Parent(s) in the Perinatal Watch List book, and place copies of the documents on the ~~s~~Surrogate and ~~infant~~ **the baby(s)** charts
   b. Notify the OB admission clerk/or designee upon the arrival of the ~~s~~Surrogate for admission to labor and delivery, and then upon birth of baby for admission into the system
      i. The OB admission clerk/or designee shall contact **Patient Financial Services** (PFS) (ext**ension**~~.~~ 3160), who shall contact the insurance company of the ~~s~~Surrogate's admission and obtain authorization for hospital care for the ~~s~~Surrogate and the newborn ~~infant~~**baby(s)**.
   c. Enter a ~~s~~Social ~~w~~Work referral in Cerner:
      i. This will initiate the process for a ~~s~~Social ~~w~~Worker evaluation for all parties involved in the ~~s~~Surrogate pregnancy after admission of surrogate
5. Admitting/ID Banding: (~~TCMC~~ **Patient Care Services** (PCS) Procedure: Identification ~~/Banding~~ of Newborns)
   a. **Signed or certified** Judgment present:
      i. If there is a Judgment present at the time of birth, the baby shall be admitted by an admissions staff member under the ~~i~~Intended/~~-l~~Legal ~~p~~Parent(s)' last name. All of the four plastic bands will be printed per **PCS Procedure:** Identification~~/Banding~~ of Newborns ~~procedure~~. This information shall include:
         1) The last name, and first name of the legal parent identified on the legal Judgment as the legal mother
         ~~2) The intended legal parent(s) driver license number and state/country of issue shall be written on each of the 2 larger bands~~
         ~~3~~)**2)** At the time of birth, include the sex of the newborn, date of birth and time of birth (24-hour clock) on all of the four bands
      ii. Separate and attach the set of four completed bands as follows: (Refer to PCS Procedure: ~~"Infant~~ Identification~~/Banding~~ of Newborns~~"~~). The two smaller bands will be applied to the newborn.
         1) One large band will be placed on the ~~i~~Intended/~~-l~~Legal ~~m~~Mother's wrist or the **Intended/l**Legal father's wrist if there is no legal mother.
         2) The fourth (large) band labeled as above, will be placed on the other **Intended/l**Legal ~~p~~Parent's wrist (if applicable) or can be placed on the identified significant other's wrist per the discretion of the legal parent.
         ~~3) Repeat this process for multi-fetal pregnancies (twins).~~
   b. Absence of **signed or certified** Judgment:
      i. If there is no Judgment present, the baby will be admitted under the ~~s~~Surrogate name and all bands will be made in that name. (Refer to PCS Procedure: ~~"Infant~~
      ~~i.~~ Identification ~~/Banding~~ of Newborns~~"~~)

1) **The Intended/Legal Parent(s) will be banded with 1 of the adult baby bands containing the surrogate name.**

ii. When the **Intended/l**Legal **p**Parents arrive with the **signed** Judgment papers:

~~1) The infant(s) name and medical record number will not change for the duration of the admission visit.~~

~~2) The original surrogate bands will be cut off and placed in the infant(s) chart except for one on the baby that will need to be utilized for the scanning of breastmilk, glucometer and medications.~~

~~a) Utilize Infant re-banding form and document band change in Cerner~~

1) **Social Worker will verify the Judgement.**
2) **Unit Secretary will have baby name changed by main admission office utilizing a communication notice.**
   a) **The name change will be corrected on the Medical Record hard chart documents**
   b) **The name change will be reflected in the Electronic Health Record (EHR).**
   c) **The main admissions office will update insurance and emergency contact information as needed.**
   d) **Newborn identification bands will be made to reflect the name change. Refer to PCS Procedure: ~~Newborn~~ Identification of Newborns~~procedure~~.**
   e) **The Newborn Metabolic Screening form will be updated to reflect the name change utilizing the comment box.**
3) The **i**Intended/~~l~~Legal **p**Parent(s) and ~~infant~~**baby**(s) will be banded with **one** ~~downtime~~ ID bands containing the surrogate name and the following information:
   ~~a) surrogate name (this will not be changed during hospitalization if baby is born prior to a Judgment being present).~~
   ~~b) Infant's medical record number, date of birth and time of birth (24 hour clock) of birth and sex of the newborn.~~
   ~~c) The legal mother/parent's driver license number and state/country of issue shall be written on each of the 2 larger bands (may use passport/visa number)~~
   ~~d) Remove the 2nd infant band at time of discharge and place in infant's chart .as per infant banding procedure along with one of the downtime bands.~~
4) ~~Documentation will cross-reference the ID bands in the infant(s) and surrogate's charts.~~
4) **Unit Secretary will have baby name changed utilizing the main admission office by utilizing a communication notice.**
   a) **The name change will be corrected on the Medical Record hard chart documents**
   b) **The name change will be reflected in the Electronic Health Record (EHR).**
   c) **The main admissions office will update insurance, patient data and emergency contact information as needed.**
   d) **Newborn identification bands will be made to reflect the name change. Refer to PCS Procedure: ~~Newborn~~ Identification of Newborns~~procedure~~.**
   e) **The Newborn Metabolic Screening form will be updated to reflect the name change.**

~~6. Labor and delivery will notify the lab/blood bank at extension 7391 for cord blood identification, upon admission of the surrogate.~~

~~a. The NICU will notify the lab/blood bank for the blood band, if typing and screening is needed for the newborn admitted to NICU.~~

~~E~~.D. **RELEASE OF INFORMATION/CONSENT:** (~~TCMC~~ Administrative Policy: Disclosure of Protected Health Information (PHI) #8610-513)

1. **Signed or certified** Judgment present:
   a. Release of information regarding the ~~infant~~**baby**(s) will be provided by the hospital staff in person or via telephone **to** ~~by~~ the **Intended/**~~I~~Legal ~~p~~Parents. (All consents for care/procedures will be signed by the Intended/~~I~~Legal ~~p~~Parents).
2. Absence of **signed or Certified** Judgment:
   a. Release of information regarding the ~~infant~~**baby**(s) will be provided in person or via telephone ~~to~~**by** the ~~s~~Surrogate whose ID bands match those of the ~~infant~~**baby**(s) only. The **Intended/**~~I~~Legal ~~p~~Parents will not receive any information regarding the ~~infant~~**baby**(s) until a Judgment is present or written permission granted by the ~~s~~Surrogate is present in the ~~infant~~**baby**(s) chart. ~~utilizing the Authorization for Visitation and/or Release of Patient Information form.~~ The ~~s~~Surrogate will sign all consents for care/procedures.

F. **VISITATION:** (Reference **WNS** Policy: ~~6070-115~~ Visitation in NICU, ~~TCMC Administrative~~**PCS** Policy: ~~#8610-301;~~ Visiting Guidelines, **WNS** Policy: ~~7400-100~~ Partners in Care for **Women and Newborn Services** ~~WNSWCS~~)

~~1. Judgment present:~~
   ~~a. surrogates may not visit infant(s) independently unless intended/legal parents grant permission . utilizing the Authorization for Visitation and/or Release of Patient Information form. The legal parents will be banded with identically numbered bands matching the infant(s) safety/security bands for/during NICU visitation.~~
   ~~b. If the surrogate is providing breast milk and has not been granted visitation rights by the legal parents., the breast milk will be turned in, to the nursing staff.~~
~~2. Absence of Judgment:~~
   ~~a. legal parents may not visit infant(s) independently unless granted written permission by the surrogate utilizing the Authorization for Visitation and/or Release of Patient Information form, or has been "banded" by the surrogate mother as the significant other.~~

G. **BIRTH CERTIFICATE:**

1. If there is a Judgment present, the names of the **Intended/**~~I~~Legal ~~p~~Parents will be listed on the original birth certificate.
   a. A certified copy of the Judgment must be given to the birth clerk to attach to the birth statistics. –For the multi-fetal pregnancy, an original certified copy of the Judgment must be attached to each ~~infant~~**baby**'s birth certificate for submission to the county.
   b. The birth certificate is filled out by the **Intended/**~~I~~Legal ~~p~~Parents~~.~~ according to the Judgment, although medical information in the birth certificate pertaining to the pregnancy and labor and delivery shall pertain to the ~~s~~Surrogate.
   ~~c.~~ For other surrogacy details regarding the birth certificate, refer to the San Diego County Vital Records and Statistics manual or call the vital records department.

~~H. OVERNIGHT STAY OF LEGAL PARENT(S):~~

~~1. legal parents with infant(s) in the NICU will need to make arrangements for over-night stay(s) outside of Tri-City Medical Center. NICU rooming in will be the exception.~~
~~2. The legal parents with infant(s) in the Newborn Nursery may request to stay in the medical center to assist in caring for their child.~~
   ~~a. This will be possible only if there is room available, and the census allows.~~
   ~~b. If the census increases and the room is needed, the legal parents will be requested to leave and make other arrangements.~~
~~3. The mother/baby couplet care unit staff will work with the legal parents to grant this request if possible.~~

~~I~~.H. **DISCHARGE:**

1. "Original ~~Notarized~~**Certified copy**" Judgment present at TCMC
   a. ~~legal parents will follow standard discharge procedures including discharge teaching.~~ Discharge must be cleared by admissions/PFS – financial counselor (ext.3160) before the ~~infant~~**baby**(s) is released from the hospital **with the Intended/Legal Parents.**
   ~~a.~~**b. Discharge process for the unit will be followed.**
2. Absence of "Original ~~Notarized~~**Certified copy**" Judgment
   a. ~~s~~**S**urrogate assumes care of infant when cleared for discharge. ~~(refer to signed waiver of liability).~~
   b. Surrogate must follow standard discharge procedures including discharge teaching.
   ~~a.~~**c.** Discharge must be cleared by admissions/PFS – financial counselor (ext.3160) before the ~~s~~**S**urrogate and the infant(s) can be released from the hospital ~~(refer to signed TCMC financial agreement). There will be no "boarder" status of term infant(s) meeting discharge criteria in the Newborn Nursery or Neonatal Intensive Care Unit.~~
3. ~~Verify discharge order for newborn.~~
4. ~~Check mother's chart for the legal Judgment for declaration of maternity/paternity of the legal parents to receive the newborn.~~
5. ~~Verify identity of person(s) receiving newborn prior to discharge.~~
   a. ~~Identifying information must match that provided on written documentation found on the Judgment~~
6. ~~Record type and numbers from two (2) sources of identification used to verify the identity of the person(s) receiving the newborn in a note in the medical cord.~~
   a. ~~One form of identification must be the a photo identification, and the name of the state/country issuing the identification (i.e. drivers license, passport or via)~~
7. ~~Verify identity of newborn per newborn identification protocol.~~
8. ~~Verify that the billing office has cleared the newborn for discharge.~~
9. ~~All discharge teaching and education will be completed and given to the person(s) who will be leaving the hospital with the minor/newborn.~~
10. ~~Discharge newborn.~~
    a. ~~All newborns discharged from TCMC must be in the arms of an adult who is transported out of the medical center in a wheelchair.~~

~~J.~~I. FETAL DEATH/DEMISE:

1. Judgment present
   a. **Intended/l**Legal ~~p~~**P**arents will follow standard procedures for release of remains.
2. Absence of Judgment
   a. ~~s~~**S**urrogate will follow standard procedures for release of remains.

~~K.~~J. RELATED DOCUMENT(S):

1. ~~Tri-City Medical Center~~ **Administrative** Policy ~~#8610-513~~: Disclosure of Protected Health Information (PHI) **8610-513**
2. ~~Tri-City Medical Center~~ **WNS** NICU Policy ~~#6070-115~~: Visitation in the NICU
~~2.~~3. **WNS Policy: Infant Feedings**
3. ~~Tri-City Medical Center Women and~~ **Newborn** ~~Infant Services~~ **Infant Feeding** ~~Policy Breast Milk, Pumping, Handling and Storage of~~
4. ~~Tri-City Medical Center Administrative Policies #86100301~~**Patient Care Services Policy**: Visiting Guidelines
5. ~~Tri-City Medical Center WNCS Procedure # 7400-100~~**WNS Policy:** Partners in Care for ~~Women's and Children's~~ **Women and Newborn** Services
6. ~~Tri-City Medical Center~~ PCS Procedure: "Identification of Newborns~~/Banding of Newborn~~
7. ~~Financial Responsibility Agreement for Hospital Care Provided to Baby Born of Surrogacy Agreement and to a Surrogate Mother.~~
8. ~~Surrogacy Information Form~~

~~L.~~K. REFERENCE(S):

1. ~~1.~~ **California Consent Manual 2018**

~~Scripps Memorial Hospital Maternal Child Health Manual (2005). Surrogacy: Identification and Release of Infant(s).~~
2. ~~Sharp Hospital (2008). Surrogacy Policy.~~
3. ~~UCSD Medical Center (2008). Surrogacy Policy.~~

Community Healthcare & Alliance Committee (No meeting held in January, 2019)

Tri-City Medical Center
Finance, Operations and P[illegible]ning Committee Minutes
January 24, 2019

Members Present	Director Julie Nygaard, Director Leigh Anne Grass, Director Rocky Chavez, Dr. Gene Ma, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Jack Cumming
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Sharon Schultz, Carlos Cruz, CCO, CNE, Susan Bond, General Counsel
Others:	Jane Dunmeyer, Miava Sullivan, Jeremy Raimo, Mark Albright, Maria Carapia, Thomas Moore, Kristy Larkin, Eva England, Lisa Stroud, Rebecca Bloom, Chris Miechowski, Candice Parras, Barbara Hainsworth
Members Absent:	Dr. Marcus Contardo, Wayne Lingenfelter

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 8:32 am.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Ferber, Dr. Yamanaka seconded, and it was unanimously approved to accept the agenda of January 24, 2019.** **Members:** **AYES: Nygaard, Grass, Chavez, Ma, Yamanaka, Ferber, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Contardo, Lingenfelter**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Chair
4. Ratification of minutes of December 4, 2018		Minutes were ratified. **MOTION** **It was moved by Dr. Yamanaka, Mr. Cumming seconded, and the minutes of December 4, 2018 were unanimously approved, with Director**	

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Grass abstaining	
5. Old Business	None		
a. Revised 2019 Meeting Schedule • Finance, Operations & Planning Committee		Director Nygaard encouraged the members of the Committee to make note of the revised 2019 Finance, Operations & Planning Committee meeting dates on their respective calendars.	Chair
6. New Business			
a. Introduction of New Committee Member • Director Rocky Chavez	Director Nygaard welcomed Director Rocky Chavez, and introduced him to the members of the committee.		Chair
b. Community Member Recognition: • Mr. Wayne Lingenfelter	Due to a previous commitment, Mr. Lingenfelter was unable to attend today's meeting. Director Nygaard, however, conveyed the committee's gratitude for his numerous contributions during his two terms. She advised that a certificate of appreciation would be mailed to him. Also at this time, Director Nygaard acknowledged that Sharon Schultz, Chief Nurse Executive will soon be retiring. She conveyed the Committee's appreciation for her participation and wished her much happiness in her retirement.		Chair
7. Consideration of Consent Calendar:	It was requested that the following items be pulled for discussion: <u>Director Grass:</u> 7.b. Rady Children's Specialists Agreement for NICU ROP Testing – Rady Children's Specialists of San Diego	**<u>MOTION</u>** **It was moved by Director Grass, Director Chavez seconded, and it was unanimously approved to accept the agenda of January 24, 2019.** **<u>Members:</u>** **AYES: Nygaard, Grass, Chavez, Ma, Yamanaka, Ferber, Cumming**	Chair

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	7.f. Sub-Lease Agreement Proposal – Kenneth Carr, M.D. Dr. Yamanaka: 7.c. Carlsbad Wellness Center MOB Lease Agreement Proposal – Ohana Medical Services Organization, Inc. Director Nygaard: 7.e. Cerner Community Works Proposal – Cerner	**NOES: None** **ABSTAIN: None** **ABSENT: Contardo, Lingenfelter**	
a. Physician EKG / Echocardiogram Panel Agreement Renewal for Coverage • Dr. Anitha Rajamanickam		**Approved via Consent Calendar**	
b. Rady Children's Specialists Agreement for NICU ROP Testing • Rady Children's Specialists of San Diego	Director Grass questioned whether the staff from Rady Children's Specialists provides this testing on the TCMC campus. Sharon Schultz clarified that the patients are seen for this testing post-discharge at Rady Children's Specialists.	**MOTION** **It was moved by Director Grass, seconded by Mr. Cumming to authorize the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning January 1, 2019, and ending December 31, 2019, for a cost of $3,200 per month, for a total cost for the term of $38,400.** **Members:** **AYES: Nygaard, Grass, Chavez, Ma, Yamanaka, Ferber, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Contardo, Lingenfelter**	
c. Carlsbad-Wellness Center MOB Lease Agreement Proposal • Ohana Medical Services Organization, Inc., ("Tenant")	Dr. Yamanaka asked the nature of the services to be provided at the leased location. Jeremy Raimo conveyed that an urgent care facility would be established at this site.	**MOTION** **It was moved by Director Grass, Mr. Cumming seconded, to authorize the agreement for the Lease Agreement for Suite 101 in the Carlsbad**	

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	Director Grass queried the purpose of the 5-month's rent abatement. Jeremy reported that the rent conversion was in lieu of tenant improvements.	**Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Ohana Medical Services Organization, Inc., for a ten-year, five-month term (125 months), at the rate of $7,971 per month, increasing base rent 3% yearly and with a total credit from the landlord not to exceed $239,609.** **Members:** **AYES: Nygaard, Grass, Chavez, Ma, Yamanaka, Ferber, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Contardo, Lingenfelter**	
d. Physician Agreement for ED On-Call Coverage – Interventional Radiology (IR) • Cyrus Shabrang, M.D.		**Approved via Consent Calendar**	
e. Cerner Community Works Proposal	Director Nygaard requested that more information be provided about this proposal. Scott Livingstone and Mark Albright provided a comprehensive overview of the many enhanced elements that the Cerner Community Works proposal will provide to the facility. In addition, they answered a wide range of questions that were posed. Significant discussion ensued.	**MOTION** **It was moved by Mr. Cumming, Director Chavez seconded, to authorize the agreement with Cerner for Community Works for a term of 120 months (10 years), beginning February 2019 and ending January 2029 for an average annual cost of $6,140,113, and a total cost for the term of $61,401,130.** **Members:** **AYES: Nygaard, Grass, Chavez, Ma, Yamanaka, Ferber, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Contardo, Lingenfelter**	
f. Sub-Lease Agreement Proposal	Director Grass solicited the reason for this agreement reflecting only 4	**MOTION** **It was moved by Director Chavez,**	Sherry Miller

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
• Kenneth Carr, M.D., ("Tenant")	months in duration. Steve Dietlin conveyed that this write-up is to be amended to reflect the statement "not to exceed 4 months, from February 1, 2019 through May 31, 2019" will be revised to read "month-to-month lease, commencing February 1, 2019".	**Director Grass seconded, to authorize the Sub-Lease Agreement for Suite 160 at 2067 W. Vista Way, Vista, CA 92083, with Kenneth Carr, M.D. for a month-to-month term commencing February 1, 2019, at the rate of $2,169.76 per month.** **Members:** **AYES: Nygaard, Grass, Chavez, Ma, Yamanaka, Ferber, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Contardo, Lingenfelter** **Barbara Hainsworth to amend the write-up.**	
g. Physician Agreement for Supportive / Palliative Care Program Medical Director • Dr. Nicholas Jauregui		**Approved via Consent Calendar**	Lisa Stroud
8. Financials:	Ray Rivas presented the financials ending December 31, 2018 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 176,615 Operating Expense $ 179,666 EBITDA $ 8,104 EROE $ 352 **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 152 Adjusted Patient Days 50,111 Surgery Cases 3,282 Deliveries 1,096 ED Visits 28,179 **TCHD – Financial Summary** **Current Month**		Ray Rivas

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Operating Revenue $ 29,704 Operating Expense $ 29,962 EBITDA $ 1,544 EROE $ 236 **TCMC – Key Indicators** **Current Month** Avg. Daily Census 153 Adjusted Patient Days 8,069 Surgery Cases 519 Deliveries 166 ED Visits 4,629 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 43.2 Days in Net A/R Avg. 51.3 **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:			
a. Wellness Center	Scott Livingstone gave a brief verbal presentation on the Wellness Center which included the following information: • No new financial information from the December report • Dues increase as planned effective January 1, 2019 for new members: o Individual Membership now $105 / month		Scott Livingstone

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	○ Senior Membership now $90 / month • Dues increase for current members planned to begin May 1, 2019 • For review – at previous dues, Wellness would need approximately 8,000 members per month to break even; previous dues, realizes a loss of about $20 -$25 / member per month.		
b. Construction Report	Chris Miechowski gave a brief verbal presentation of the following information: • Parking lot expansion has been completed & opened for use. • Lights & video for OR #4 to be completed soon. • Pharmacy USP 800 upgrade estimated to be finished in June 2019. • Retail pharmacy is projected to open in May 2019.		Chris Miechowski
c. ED Throughput	Candice Parras gave a single PowerPoint slide presentation for ED Throughput. She emphasized both the enhanced triage process and the "In Quicker" online appointment scheduling option continues to improve patient satisfaction. The "left without being seen" (LWBS) patient population was 1.97% for 2018, well below the 3% goal. The "No Wall Time" for paramedic providers continues to be extremely successful, and remains the		Candice Parras

Topic	Discussions, Conclusions, Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	best in San Diego County.		
d. IT Physician Liaison	Mark Albright gave a brief PowerPoint presentation created by Dr. Scott Worman, emphasizing the following: • Completed & Ongoing Projects • Strategic Priorities		Mark Albright / Dr. Scott Worman
e. PRIME Update	Scott Livingstone gave a brief verbal presentation, updating the Committee on the current status of PRIME. He emphasized the metrics are being met, and they are preparing for the next reporting period, March 2019. Brief discussion ensued.		Scott Livingstone
f. Dashboard	No discussion		Ray Rivas
10. Comments by committee members			
11. Date of next meeting	Tuesday, February 21, 2019		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 9:38 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 24, 2019
PHYSICIAN EKG/ECHOCARDIOGRAM PANEL AGREEMENT RENEWAL for COVERAGE

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

Physician's Name: Dr. Anitha Rajamanickam

Area of Service: Cardiology

Term of Agreement: 36 months, Beginning, July 1, 2018 – Ending, June 30, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES (within 25%)
Adding physician to existing panel; no increase in expense

Weekly Cost Not to Exceed	Annual Cost Not to Exceed	Total Term Cost Not to Exceed
$4,160	$216,320	$648,960

Position Responsibilities:

- Panel Physician shall interpret echocardiographic studies of unassigned patients for which the attending physician does not specify an interpreting cardiologist.
- Electrocardiograms are to be interpreted twice daily on weekdays (Monday-Friday) and at least once per day on weekends (Saturday, Sunday or holidays).
- The final report for all echocardiograms is to be dictated within 24 hours of the performance of the study.
- For exercise of pharmacological stress test, if the scheduled panel physician cannot be available within 15 minutes of the scheduled start time to personally supervise the test, it is that panel physician's responsibility to assure that another cardiologist will do so. The final report shall be dictated on the day of the study.

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Service Line Administrator / Scott Livingstone, Chief Operating Officer

Motion:

Move that Finance Operations and Planning Committee recommend that TCHD Board of Directors approve the agreement to add Dr. Anitha Rajamanickam to the currently existing Cardiology Physician EKG and Echocardiology Panel Agreement for a term of 36 months, beginning July 1, 2018 and ending June 30, 2021.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 24, 2019
Rady Children's Specialists Agreement for NICU ROP Testing

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

Vendor's Name: Rady Children's Specialists of San Diego

Area of Service: NICU - Retinopathy of Prematurity Testing

Term of Agreement: 12 months, Beginning, January 1, 2019 - Ending, December 31, 2019

Maximum Totals:

	Monthly Cost	Annual Cost	Total Term Cost
ROP Services	$3,200	$38,400	$38,400
		Total:	**$38,400**

Description of Services/Supplies:

- Ophthalmic Consultation Services for NICU - Retinopathy of Prematurity (ROP) Testing
- Requested increase of $123 per month, $1,476 for the term

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

Person responsible for oversight of agreement: Cynthia Kranz, Director-Nursing, Women & Newborn Services / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning January 1, 2019, and ending December 31, 2019, for a cost of $3,200 per month, for a total cost for the term of $38,400.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 24, 2019
Carlsbad-Wellness Center MOB Lease Agreement Proposal

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

Tenant Name: Ohana Medical Services Organization, Inc. ("Tenant")

Term: 10 Year, 5 month Lease (125 Months), beginning at commencement date of completion of tenant improvements;
3% Yearly Rent Escalator
Option for (1), five year extensions at FMV

Premises: 6260 El Camino Real, Suite 101, Carlsbad, CA 92009 (2,657 sq. ft.)

Rental Rate from Ohana Medical Services Organization, Inc.:

Rental Rate:	Revenue per Month
Rental Rate of $3.00 NNN per square foot, per month, (2657 sq. ft.)	$7,971
Total Monthly Revenue:	**$7,971**

City Healthcare District Base Rent Credit to Lessee:

District ("Landlord) to Provide:	Rent Credit Not to Exceed
Base Rent Credit of $75 per square foot per rentable area, (2657 sq. ft.) credited on a Monthly basis over the first five year term (60 months)	$199,275
5 months' rent abatement	$40,334
Total Credits from Landlord:	**$239,609**

Within Fair Market Value: YES (FMV was determined by lease comparables)

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Steve Dietlin, Chief Executive Officer

Motion:
I move that the Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Lease Agreement for Suite 101 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Ohana Medical Services Organization, Inc., for a ten-year, five-month term (125 months), at the rate of $7,971 per month, increasing base rent 3% yearly and with a total credit from the landlord not to exceed $239,609.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 24, 2019
Cerner Community Works Proposal

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

Vendor's Name: Cerner

Area of Service: All Clinical & Financial Departments

Term of Agreement: 120 months, Beginning, February 1, 2019 – Ending, January 31, 2029

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$511,676	$6,140,113	$61,401,130

Description of Services/Supplies:

- Cerner Community Works is a prescriptive/cloud based deployment of Cerner's traditional Millennium IT platform providing a fully integrated acute care and ambulatory electronic health record (EHR) and revenue cycle management system, tailored to support community health care organizations. This Community Works proposal includes the entire portfolio of available applications/solutions to include the data warehouse, population health, and single sign-on.
- The Community Works platform includes Cerner's Application Management Services (AMS) which provides operational monitoring and support ensuring the system is always current with updates and code upgrades.
- Community Works is a 12 – 15 month implementation. Execution of this proposal ensures the system will go live at the expiration of the current Cerner Millennium contract in March 2020.

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

Person responsible for oversight of agreement: Mark Albright, Vice President, IT / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Cerner for Community Works for a term of 120 months (10 years), beginning February 2019 and ending January 2029 for an average annual cost of $6,140,113, and a total cost for the term of $61,401,130.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 24, 2019
Sub-Lease Agreement Proposal

Type of Agreement		Medical Directors		Panel	X	Other: Office Sub-Lease
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Tenant Name: Kenneth Carr, M.D. ("Tenant")

Term: Month-to-Month Lease, commencing February 1, 2019

Premises: 2067 W. Vista Way, Suite 160, Vista, CA 92083 (1,558 sq. ft.)

Rental Rate:

Rental Rate from Kenneth Carr, M.D.:	**Revenue per Month**
Rental Rate of $3.53/sq. ft. for 12 days per month @$180.81/day	$2,169.76
Total Monthly Revenue:	**$2,169.76**

Within Fair Market Value: YES (FMV was determined by Lease Comparables)

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Steve Dietlin, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Sub-Lease Agreement for Suite 160 at 2067 W. Vista Way, Vista, CA 92083, with Kenneth Carr, M.D. for a month-to-month lease, commencing February 1, 2019, at the rate of $2,169.76 per month.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 24, 2019
PHYSICIAN AGREEMENT for Supportive/Palliative Care Program Medical Director

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

Physician's Name: Dr. Nicholas Jauregui

Area of Service: Supportive / Palliative Care

Term of Agreement: 12 months, Beginning, February 1, 2019 – Ending, January 31, 2020

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

Rate/Hour	Average Hours per Month	Hours per Year Not to Exceed	Average Monthly Cost	Annual Cost Not to Exceed	12 month (Term) Cost Not to Exceed
$200	16	200	$3,200	$40,000	$40,000

Position Responsibilities - Supportive / Palliative Care Medical Director Services:

- This service will effectively reduce readmissions, lower length of stay, and improve patient care
- Physician shall serve as the Supportive Care Medical Director and assume education responsibility for Physicians and Nurses for these services
- Physician shall serve as the Leader for SC and PC education quarterly and participate in activities as mutually agreed upon with the TCHD Director of Case Management.
- Provides clinical education oversight to nurses
- Mentor and provide guidance to physicians
- Interface with community partners including Tri-City Medical Center leadership, physicians & employees

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

Person responsible for oversight of agreement: Lisa Stroud, Director - Case Management /Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Nicholas Jauregui, to provide medical oversight for the TCHD Supportive / Palliative Care Program for a term of 12 months beginning February 1, 2019 and ending January 31, 2020. Not to exceed an average of 16 hours per month, and maximum of 200 hours annually, at an hourly rate of $200 for a term cost not to exceed $40,000.

Professional Affairs Committee
(No meeting held in January, 2019)

Audit, Compliance & Ethics Committee (No meeting held in January 2019)

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

December 13, 2018 – 2:30 o'clock p.m.
Classroom 7 – 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 December 13, 2018.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Tracy M. Younger

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Sharon Schultz, Chief Nurse Executive
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Acting Board Chairperson, Leigh Anne Grass, called the meeting to order at 2:30 p.m. in Classroom 7 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Nygaard to approve the agenda. Director Schallock seconded the motion. The motion passed (6-0-0-1) with Director Younger absent.

3. Public Comments – Announcement

   Acting Chairperson Grass read the Public Comments section listed on the November 8, 2018 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Acting Chairperson Grass made an oral announcement of the items listed on the December 13, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee and approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Nygaard to go into Closed Session. The motion passed (6-0-0-1) with Director Younger 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, Acting Chairperson Grass announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

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
Aaron Byzak, Chief Governmental Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Acting Chairperson Grass reported no action was taken in closed session.

10. Director Reno led the Pledge of Allegiance.

11. Acting Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24. Acting Chairperson Grass requested that speakers adhere to the three minute time allotment.

12. Welcome and Introduction of New Board Members:

a) Rocky J. Chavez
b) George W. Coulter
c) Tracy M. Younger

Acting Chairperson Grass introduced and welcomed newly elected Board Members Rocky J. Chavez, George W. Coulter and Tracy M. Younger who was not in attendance today.

13. Special Award Presentation:

a) Honoring James J. Dagostino, DPT, PT and Laura E. Mitchell, RN for their service on the TCHD Board of Directors

Chairperson Grass reported former Directors James Dagostino and Laura Mitchell were unable to attend today's meeting however she wanted to publicly acknowledge their service on the Tri-City Healthcare District Board of Directors and honor them with a plaque. Former Director Dagostino served on the Board for five years and served as Chair two of those years. Former Director Mitchell served on the Board for four years.

14. Report from TCHD Foundation – Jennifer Paroly, Acting Chief Development Officer

Ms. Jennifer Paroly, Acting Chief Development Officer welcomed newly elected District Board members Chavez, Coulter and Younger. She invited them to stop by the Foundation and get acquainted.

Ms. Paroly reported over 680 guests attended the Diamond Ball and there were over 150 local sponsors. The event raised approximately $450,000. Ms. Paroly expressed her appreciation to all who supported the Diamond Ball.

Ms. Paroly reported Director of Facilities Chris Miechowski was honored at the North County Philanthropy luncheon. She stated Chris has been very helpful to the Foundation in so many ways.

Mr. Paroly reported the annual Employee Giving Holiday Luncheon is scheduled for tomorrow. She stated there are many employees who contribute every month to the Foundation as well as contribute in their own with the Denim pass, raffle tickets and the Diamond Ball. Ms. Paroly stated it is encouraging to feel their support and an honor to thank them.

Looking ahead, the 2019 Diamond Ball has been scheduled for November 16th. She encouraged everyone to "save the date". Discussion is still underway for the date of the Annual Golf Tournament.

In closing, Ms. Paroly expressed her appreciation for everyone's support and encouraged everyone to enjoy the holiday season and time of gratitude.

No action taken.

16. Report from Chief Financial Officer

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

- Net Operating Revenue – $118,267
- Operating Expense – $120,455
- EBITDA - $4,942

- EROE – ($225)

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

- Average Daily Census – 153
- Adjusted Patient Days – 34,382
- Surgery Cases – 2,221
- Deliveries – 745
- ED visits – 19,050

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

- Operating Revenue - $29,558
- Operating Expense - $29,796
- EBITDA - $1,561
- EROE –$254

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

- Average Daily Census – 159
- Adjusted Patient Days – 8,277
- Surgery Cases – 590
- Deliveries – 187
- ED Visits – 4,590

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

- Net Patient Accounts Receivable - $42.4
- Days in Net Accounts Receivable - 49.8

Director Nygaard commented that we are headed in the right direction. Mr. Rivas stated we have had a strong start in the new fiscal year.

No action was taken.

16. New Business

1) Consideration and possible action to elect Board of Director Officers for calendar year 2019

Acting Chairperson Grass explained the election process.

Acting Chairperson Grass requested nominations for the office of Chairperson. Nominations were made as follows:

Director Coulter:	**Pass**
Director Chavez:	**Pass**
Director Schallock:	**Pass**
Director Reno:	**Director Grass**
Director Nygaard:	**Pass**
Director Grass:	**Pass**

The vote on the motion to elect Director Grass to office of Chairperson was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

Acting Chairperson Grass requested nominations for the office of Vice Chairperson. Nominations were made as follows:

Director Coulter:	**Director Nygaard**
Director Chavez:	**Director Schallock**
Director Schallock:	**Pass**
Director Reno:	**Director Schallock**
Director Nygaard:	**Director Schallock**
Director Grass:	**Pass**

Director Nygaard stated she would not be willing to accept the nomination if elected.

The vote on the motion to elect Director Schallock to office of Vice Chairperson was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

Acting Chairperson Grass requested nominations for the office of Secretary. Nominations were made as follows:

Director Coulter:	**Director Younger**
Director Chavez:	**Pass**
Director Schallock:	**Director Nygaard**
Director Reno:	**Director Younger**
Director Nygaard:	**Pass**
Director Grass:	**Pass**

Acting Chairperson Grass stated Director Younger is not here to accept this nomination. Director Nygaard stated she was willing to accept the nomination if elected.

Director Chavez called for point of order. He questioned if Director Younger could be considered for the office of Secretary since she is not present. Board Counsel stated the risk is that Director Younger would not want to accept the position however there is no law on whether an absent Board member can be nominated for a position. Director Chavez suggested as a new Board there should be an element of respect for all and suggested Director Younger be considered. The majority of the Board agreed to give Director Younger the opportunity to be considered for Secretary.

Director Nygaard commented on Director Younger's absence. Director Reno stated Director Younger had travel plans for this week prior to the election. It was noted that the Board's

meeting schedule is approved by the Board in December of each year and therefore Director Younger had the opportunity to view the meeting schedule on the website and make travel plans accordingly prior to running for election.

Acting Chairperson Grass requested the Board members vote on their choice for office of Secretary by indicating Director Younger or Director Nygaard.

Director Coulter:	**Younger**
Director Chavez:	**Nygaard**
Director Schallock:	**Nygaard**
Director Nygaard:	**Nygaard**
Director Reno:	**Younger**
Director Grass:	**Nygaard**

Director Nygaard was elected Secretary.

Acting Chairperson Grass requested nominations for the office of Treasurer. Nominations were made as follows

Director Coulter:	**Director Reno**
Director Chavez:	**Pass**
Director Schallock:	**Pass**
Director Reno:	**Director Reno**
Director Nygaard:	**Pass**
Director Grass:	**Director Reno**

Director Reno stated she would be willing to accept the nomination if selected.

The vote on the motion to elect Director Reno to office of Treasurer was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

Acting Chairperson Grass requested nominations for the office of Assistant Secretary. Nominations were made as follows:

Director Coulter:	**Director Chavez**
Director Chavez:	**Pass**
Director Schallock:	**Pass**
Director Reno:	**Director Chavez**
Director Nygaard:	**Director Chavez**
Director Grass:	**Pass**

The vote on the motion to elect Director Chavez to office of Assistant Secretary was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**

ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

Acting Chairperson Grass requested nominations for the office of Assistant Treasurer. Nominations were made as follows:

Director Coulter:	**Director Coulter**
Director Chavez:	**Director Coulter**
Director Schallock:	**Pass**
Director Reno:	**Director Coulter**
Director Nygaard:	**Pass**
Director Grass:	**Pass**

The vote on the motion to elect Director Coulter to office of Assistant Treasurer was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

Acting Chairperson Grass noted Director Younger would hold the position of "at large" by default.

To recap, Acting Chairperson Grass stated the slate of officers is as follows:

- Chairperson: Director Grass
- Vice Chairperson: Director Schallock
- Secretary: Director Nygaard
- Treasurer: Director Reno
- Assistant Secretary: Director Chavez
- Assistant Treasurer: Director Coulter
- At Large Member: Director Younger

Director Reno suggested Director Chavez be appointed as the CHA Representative due to his background and experience. Director Grass stated the item is not on today's agenda for consideration however it could be added to a future agenda.

2) Consideration to certify a recognized Employee Organization as the exclusive bargaining representative

Ms. Anna Aguilar, Senior Human Resources Director stated SEIU requested to be recognized as the exclusive majority representative for all regular, part time and per diem employees in the following classifications employed at 4002 Vista Way:

- **Physical Therapists**
- **Occupational Therapists**
- **Occupational Therapists Assistants**
- **Social Workers**
- **Engineers**

On November 16, 2018 a card check was conducted by a neutral party who verified the authorization cards and determined that SEIU met or exceeded the majority designation. In accordance with Board Resolution 706 Ms. Aguilar requested a motion to accrete these into the existing contract.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors certify the results of the card count, by the neutral party, to determine the majority of employees within the technical classification voted to be represented by SEIU-UHW to include the following classifications of employees employed at 4002 Vista Way, Oceanside, CA 92056 and to accrete those classifications into the existing SEIU-UHW contract.

- **Physical Therapists**
- **Occupational Therapists**
- **Occupational Therapists Assistants**
- **Social Workers**
- **Engineers**

Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

3) Consideration to nominate Board Member to serve on the San Diego Local Agency Formation Commission (LAFCO) as a Regular Special District Member or Alternate Special District Member whose term will expire 2023.

Director Nygaard stated she currently sits on the LAFCO Redevelopment Committee and does not believe it is necessary that the Board nominate a second individual to serve on LAFCO.

There was no motion to nominate a Board member to serve on the San Diego Local Agency Formation Commission (LAFCO) as a Regular Special District Member or Alternate Special District Member.

4) Consideration of proposed 2019 Board Meeting Schedule

It was moved by Director Reno to approve the proposed 2019 Board Meeting Schedule as presented. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

17. Old Business - None

18. Chief of Staff

a. Consideration of November 2018 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on November 26, 2018.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve the November 2018 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on November 26, 2018. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

b. Rules & Regulations - AHP

It was moved by Director Schallock to approve the AHP Rules & Regulations as recommended by the Medical Executive Committee on November 26, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

c. Privilege Card

1) Cardiology

It was moved by Director Nygaard to approve the Cardiology Privilege Card as recommended by the Medical Executive Committee on November 26, 2018. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

19. Consideration of Consent Calendar

It was moved by Director Nygaard to approve the Consent Calendar. Director Schallock seconded the motion.

Director Nygaard stated she would be abstaining from the vote on the minutes.

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

The vote on the motion to approve the Consent Calendar was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

20. Discussion of items pulled from Consent Agenda

There were no items pulled from the Consent Calendar.

21. Reports (Discussion by exception only)

There were no comments or questions on the reports.

22. Comments by Members of the Public

There were no comments from members of the public.

23. Comments by Chief Executive Officer

Mr. Dietlin expressed his appreciation to former Directors Dagostino, Mitchell and Kellett for their service on the Board and welcomed incoming Board members Chavez, Younger and Coulter. Mr. Dietlin also congratulated the Board members on their new offices.

24. Board Communications

Reports from Board Members

Director Coulter stated he hopes the Board can all work together and make Tri-City the best place to come for healthcare.

Director Chavez expressed his appreciation to the voters and supporters in the recent election and stated he is honored to be here. He stated the tenor of this meeting speaks well of the Board and reflects we are all here for one reason – for our community and good healthcare.

Director Schallock welcomed Directors Chavez, Coulter and Younger. He echoed Director Chavez's comments and hopes we can work together well and keep moving the hospital forward. Director Schallock also wished everyone happy holidays.

Director Reno welcomed and congratulated new Board members Chavez, Coulter and Younger. She wished a Merry Christmas to all employees.

Director Reno stated that she is deeply concerned. She stated she has repeatedly asked the Executive Secretary to add her name to the list of notices that are sent to Board members and is still receiving those notices with her name hand-written. Director Reno alleged there is a double standard because her name is only hand-written and Coulter and Younger's names are not even included, however Chavez's name is included.

Director Nygaard welcomed Directors Chavez, Coulter and Younger. She stated she is looking forward to an exciting year ahead and moving the hospital forward. Director Nygaard wished everyone a happy holiday season.

Director Reno stated she had additional comments to make. She stated she expects this problem to be resolved immediately and provided her written comments to the Acting Chairperson Grass, the Executive Assistant and the CEO.

The Executive Assistant requested permission to address Director Reno. Ms. Donnellan stated that she has explained to Director Reno a number of times that her name cannot be included at the top of an e-mail communication because she does not have an email and Director Reno has declined to have an e-mail account set up. The Executive Assistant further explained that past practice was to carbon copy Director Reno on all communications and at her request that method was stopped and her name was added to the line where all Directors names appear and was handwritten as that was the only option without an e-mail account.

With regard to Directors Coulter and Younger, Ms. Donnellan explained their names are in fact included on the copy of the e-mail/fax you provided to Mr. Dietlin and Ms. Donnellan. Director Younger's email is tracy@alchemehealth.com and Director Coulter's e-mail is dreamergeo@aol.com.

Director Reno stated that is a poor excuse. She also commented that she doesn't know who is running this Board and it seems to her it is the Administration and the Executive Secretary.

29. Report from Chairperson

Chairperson Grass wished everyone happy holidays. She congratulated SEIU on the recent card count and congratulated new Board members, Chavez, Coulter and Younger. Chairperson Grass also congratulated the Administrative team as the financials are great. In closing Chairperson Grass stated she appreciates the vote of confidence that the Board has placed in her.

34. There being no further business Chairperson Grass adjourned the meeting at 4:35 p.m.

_____
Leigh Anne Grass, Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

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503270000074111940 R95109GG8
LARRY SCHALLOCK
PO BOX 428, SAN LUIS REY, CA 92068
7411194 EXPIRES MAY 2019 1 COPY 51 ISSUES $76.00

YES	~~NO~~

503270000366527374 R95109GG8
~~CYRIL F KELLETT, TRICITY MEDICAL CENTER~~
~~2829 HIGHLAND DR, CARLSBAD, CA 92008~~
~~36652737 EXPIRES MAY 2019 1 COPY 51 ISSUES $76.00~~

YES	~~NO~~

503270000386774335 R95109GG8
~~JAMES DAGOSTINO~~
~~3456 CAMDEN CIR, CARLSBAD, CA 92008~~
~~38677493 EXPIRES MAY 2019 1 COPY 51 ISSUES $76.00~~

YES	~~NO~~

503270000394681567 R95109GG8
~~LAURA MITCHELL~~
~~104 POLK ST, OCEANSIDE, CA 92057~~
~~39468156 EXPIRES MAY 2019 1 COPY 51 ISSUES $76.00~~

~~YES~~	NO

503270000403108336 R95109GG8
LEIGH ANNE GRASS
2882 WOODRIDGE CIR, CARLSBAD, CA 92008
40310833 EXPIRES MAY 2019 1 COPY 51 ISSUES $76.00

~~YES~~	NO

503270000901044116 R95109GG8
ROSEMARIE V RENO, TRICITY MEDICAL CENTER
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TCMC ADMINISTRATION
4002 VISTA WAY
OCEANSIDE, CA 92056-4506

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(Please print)

Name Rocky J. Chavez
Address 4985 Calle Arquero [✓] Home [ ] Business
City Oceanside State CA Zip 92057
Email Address chavezrj@tcmc.com
(Email required for online access and email communications from us.)

Name George W. Coulter
Address 1501 Anza, Space 46 [✓] Home [ ] Business
City Vista State CA Zip 92054
Email Address coultergw@tcmc.com
(Email required for online access and email communications from us.)

Name Tracy M Younger
Address 3436 Rich Field Dr [✓] Home [ ] Business
City Carlsbad State CA Zip 92010
Email Address
(Email required for online access and email communications from us.)

Name
Address [ ] Home [ ] Business
City State Zip
Email Address
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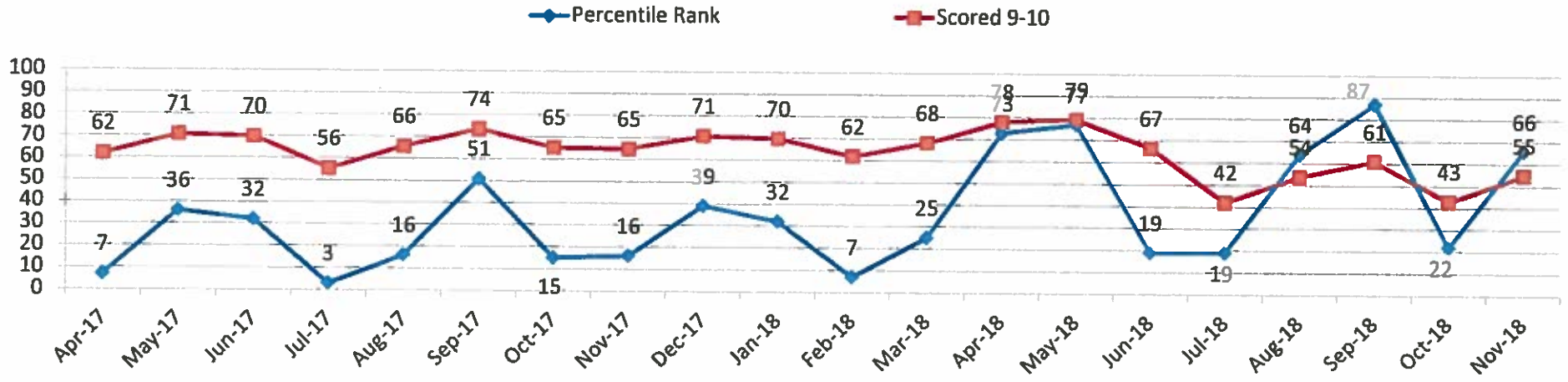
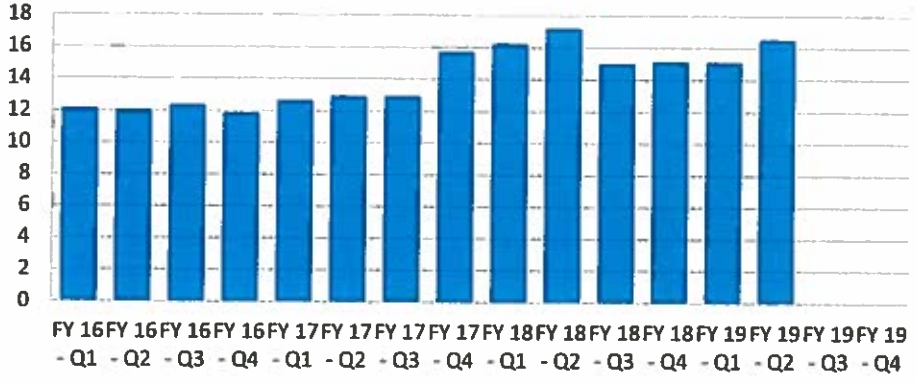
Stakeholder Experiences

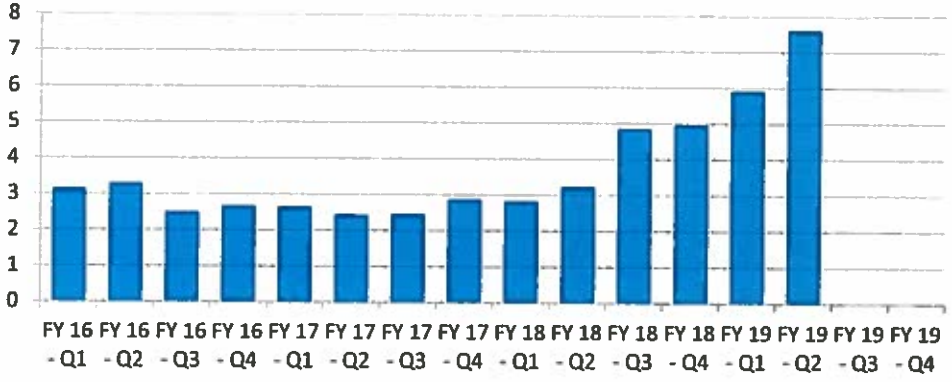
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



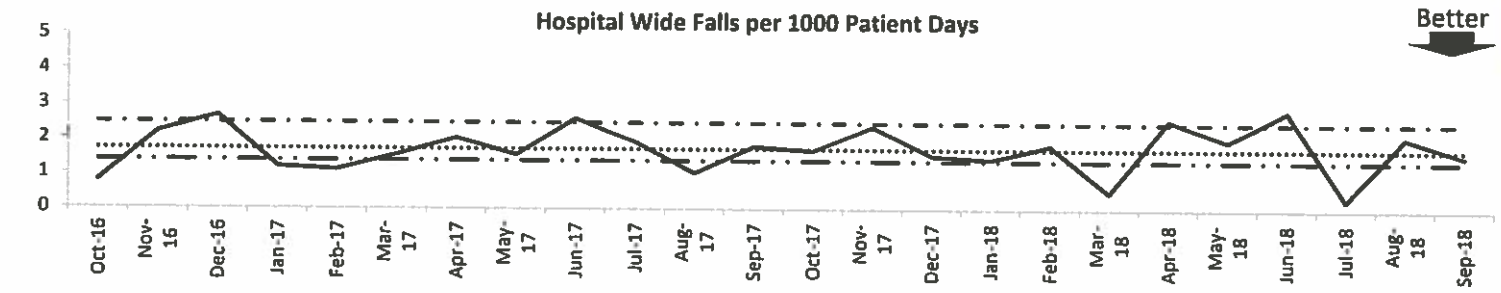
Involuntary Employee Turnover Rate



Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

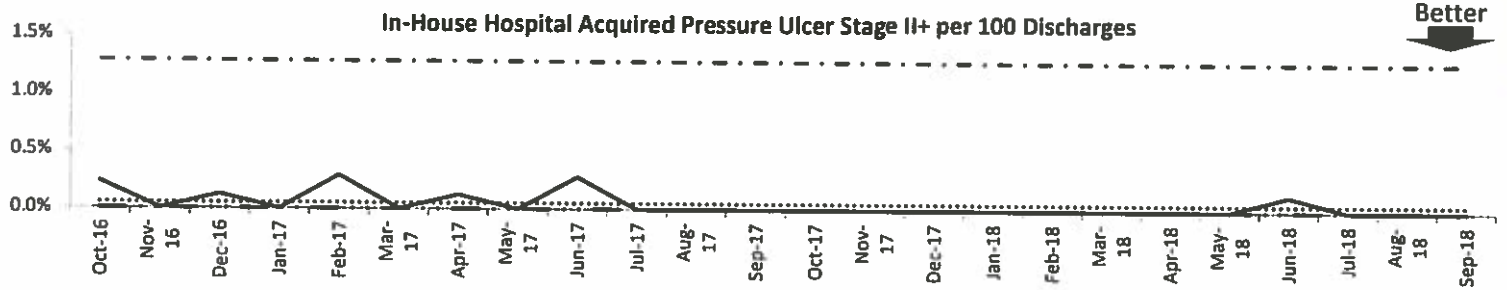
Hospital Wide Falls per 1000 Patient Days



Action Plan

Continue to increase fall awareness and monitor hourly rounding compliance. September rate is at is between our mean and target. Performance is better than state mean. No action necessary at his time. Continue to monitor.

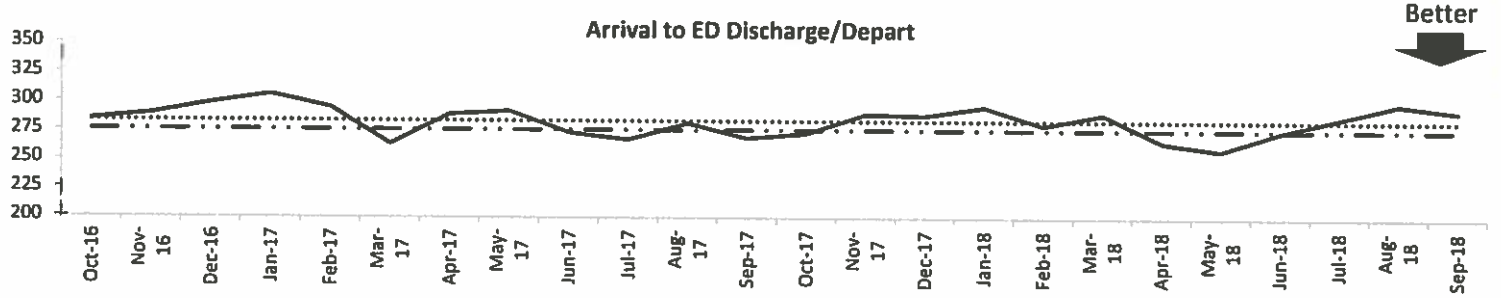
In-House Hospital Acquired Pressure Ulcer Stage II+ per 100 Discharges



Action Plan

Performance below goal. No action plan necessary. Continue to monitor.

Arrival to ED Discharge/Depart



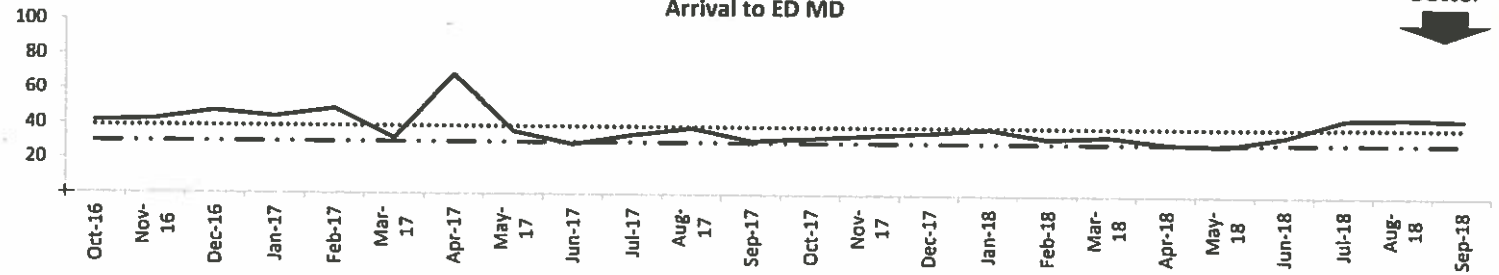
Action Plan

MD coverage reduced due to ED volume decrease. Admits and discharges continue taking longer as each provider has more patients. Adding doctor hours at peak times being assessed.

Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target

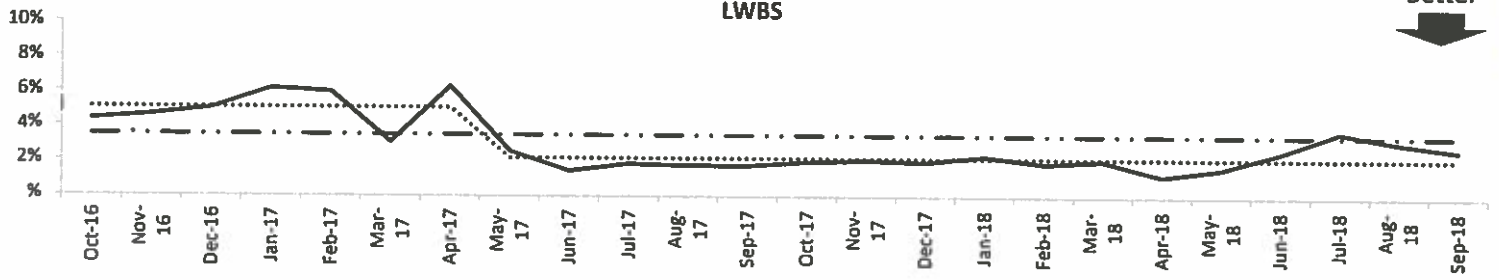
Arrival to ED MD



Action Plan

Triage MD hours reduced causing longer waiting times to be seen and in the main ED. Earlier MD coverage was expecte dto be added by 10/1. Too early to determine if change will affect the times.

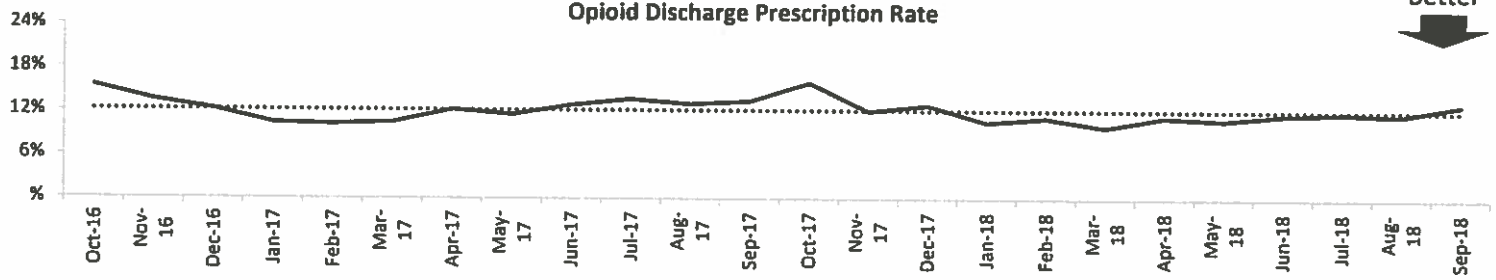
LWBS



Action Plan

LWBS were previously increased due to longer waits and increase in ED Psych volume. Station F opened and more MD hrs added. September data shows a decrease from July and August. Continue to monitor.

Opioid Discharge Prescription Rate

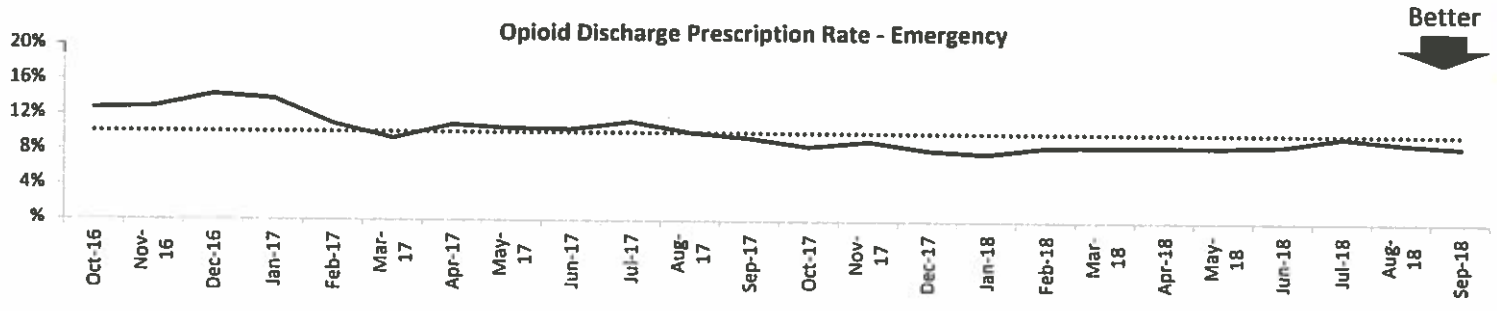


Action Plan

Performance continues to be consistant with the mean. No action necessary at this time. Continue to monitor

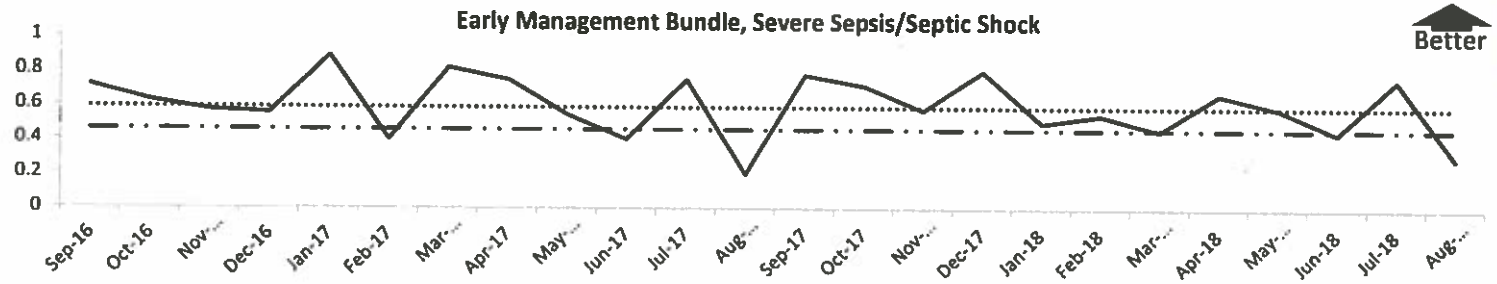
Current Trending Measures

TCMC Rate | Mean | CA Mean | TCMC Target



Action Plan

Performance continues to be better than the mean. No action necessary at this time. Continue to monitor.

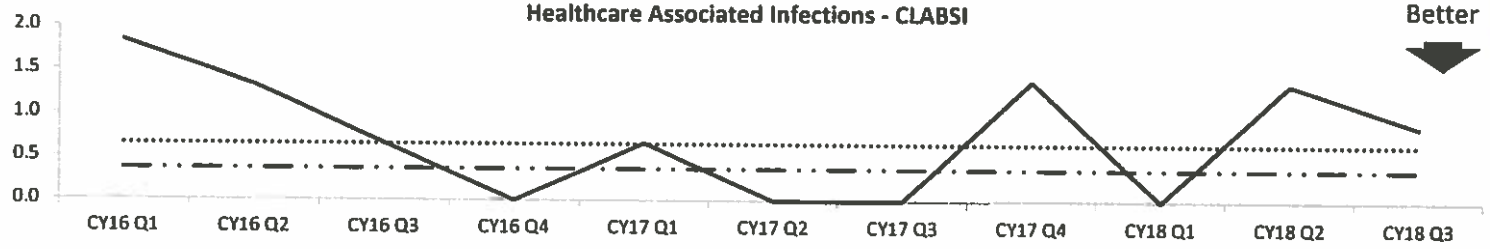


Action Plan

Sepsis Predictive Platform Go-Live anticipated early Oct 2018. All sepsis resources have been allocated to this project. Implementation on MedTele live 10/2018 to determine roll-out plan. Data remains above the state and national averages. Continue to monitor.

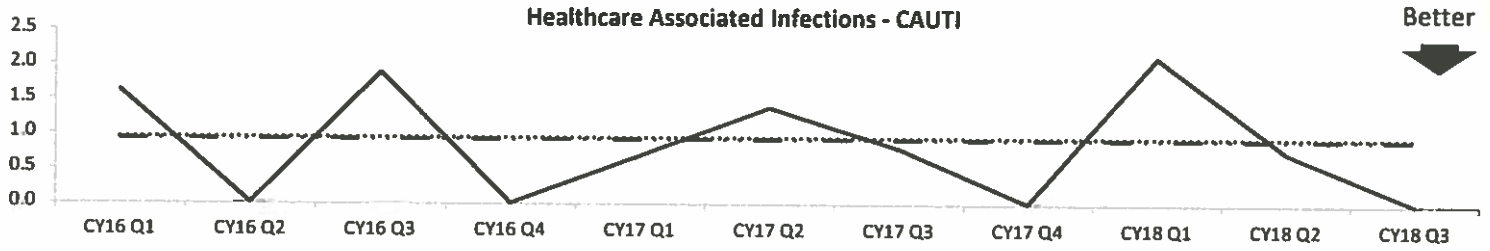
Current Trending Measures

TCMC Rate — Mean — CA Mean — TCMC Target



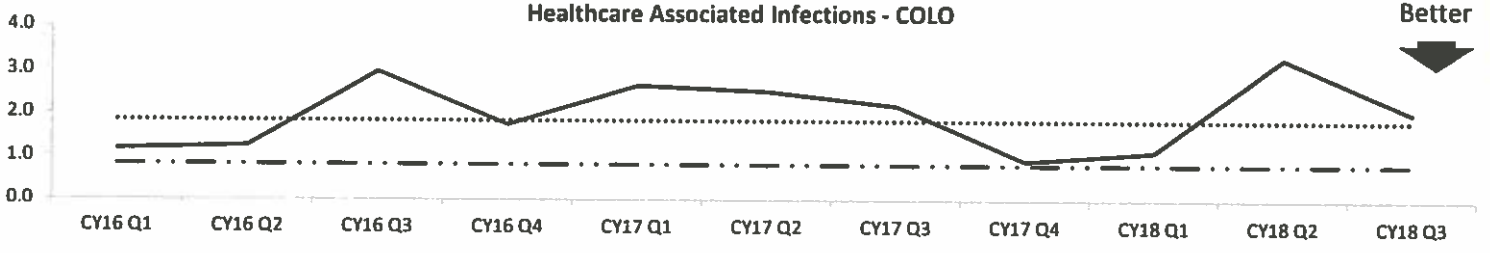
Action Plan

Continue CLABSI bundle. Real time feedback for new cases.



Action Plan

No CAUTI's indentified in CY18 Q3- continue real time feedback for new cases.

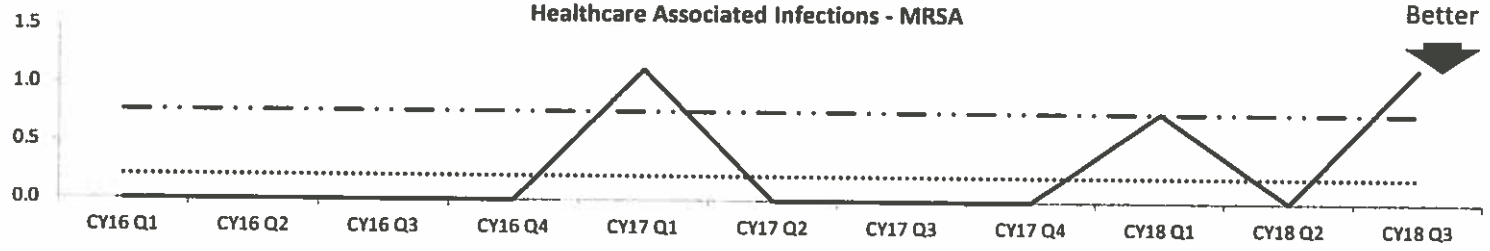


Action Plan

Create audit tool for drill down & follow up. Peer review of all COLO Cases.

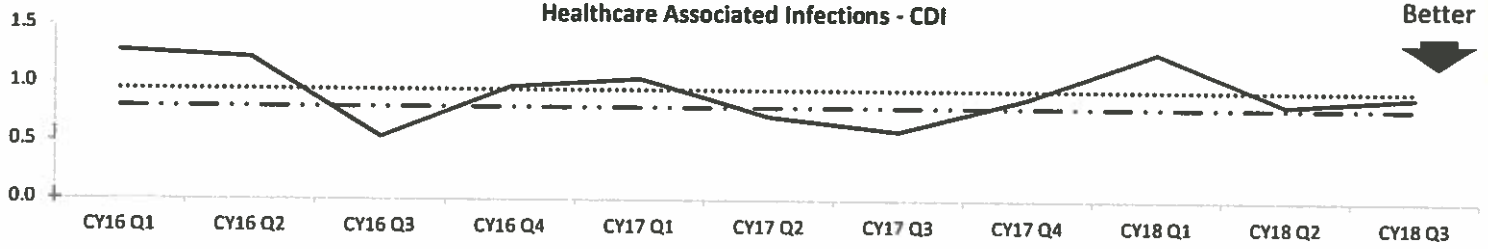
Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target



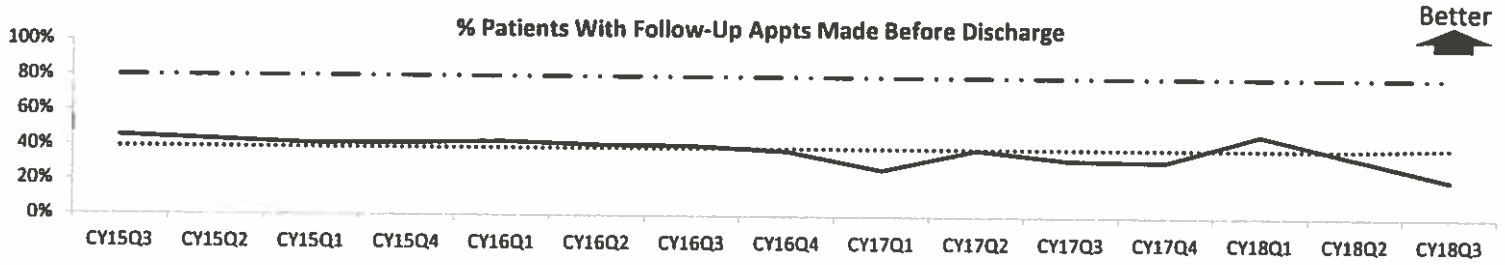
Action Plan

Continue Contact precautions and environmental cleaning.



Action Plan

Antimicrobial stewardship, Contact precautions, Hand soap & water, realtime feedback & deep dive of positive HO cases.



Action Plan

CY 18 Q3 the metric changed within to only include A1c>9. Updating the graph back to original A1c>7 for data capture and break out in a separate graph A1c>9 for a focus area to drive improvement for the new metric.

Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	18	29	19	27	18	24							135
FY18	26	23	23	20	27	27	22	23	24	20	20	28	146

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	10	14	3	7	7	9							50
FY17	14	6	7	13	7	15	14	8	12	7	10	6	62

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	19	16	12	16	12	16							91
FY18	11	12	12	14	16	18	23	12	15	15	16	20	83

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	20	23	18	22	17	21							121
FY18	15	20	20	16	23	15	15	19	23	11	20	17	109

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	31	31	27	35	38	31							193
FY18	48	37	33	32	26	38	29	24	30	38	33	38	214

Performance compared to prior year: Better | Same | Worse

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	10.8	11.3	9.7	-	-	-							5.3
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7	13.8	13.0	11.9	14.5

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	7.4	9.1	6.5	4.7	5.7	5.3							6.4
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	7.8

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	11.4	9.8	10.0	11.0	11.6	8.7							10.4
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	13.0

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	160.3	155.9	146.4	149.6	143.7	153.2							151.6
FY18	169.7	181.9	163.4	173.4	160.9	172.5	210.7	185.8	186.4	163.2	161.9	165.9	170.4

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	186	202	170	187	185	166							1,096
FY18	210	222	194	206	184	166	209	169	186	156	163	188	1,182

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	10	6	8	3	15							50
FY18	12	11	11	11	11	18	16	5	7	16	15	20	74

Performance compared to prior year: Better | Same | Worse

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	3	4	3	13	13	6							42
FY18	4	7	7	3	4	3	2	4	8	2	7	8	28

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	8	6	8	4	14							48
FY18	8	7	7	11	3	14	11	10	4	10	8	5	50

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	1.79	1.83	1.9	1.78	1.78	1.7							1.79
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	1.78

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY19	51.0	48.5	50.3	49.5	52.3	56.5							51.3	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	49.0	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY19	84.9	86.5	90.2	91.4	92.5	87.8							88.9	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	82.1	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	($478)	($121)	$119	$254	$342	$236							$352	$98
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)	$3,118	($4,173)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	-1.64%	-0.39%	0.41%	0.86%	1.19%	0.79%							0.20%	0.06%
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%	-2.33%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	$796	$1,168	$1,417	$1,561	$1,618	$1,544							$8,104	$8,122
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900	$4,407	$3,619	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	2.73%	3.81%	4.90%	5.28%	5.65%	5.20%							4.59%	4.72%
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%	12.82%	2.02%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	6.73	6.70	6.75	6.98	7.82	6.50							6.91	6.65
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	6.41	

TCHD Liquidity $ in Millions (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	$48.1	$37.5	$29.5							
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	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending December 31, 2018

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm 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	(a)	26,311.35	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	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 V#83025	Approx 4,995	$2.58	(a)	15,640.35	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Elfin 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	12/31/20	**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)	10,736.58	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 Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.24	(a)	26,713.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Total				$ 180,808.40			

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending December 2018

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
6150	CNO ROUNDTABLE - PATIENT EXPERIENCE	1116182	629.96	81883	MEREBETH RICHINS
6185	ONS/ONCC CHEMOTHERAPY BIOTHERAPY CERTIFICATE	111718	103.00	80795	MARIA FATIMA MERCADO
6185	ONS/ONCC CHEMOTHERAPY BIOTHERAPY CERTIFICATE	112118	279.00	77286	LYNETTE HWANG
6185	ONS/ONCC CHEMOTHERAPY BIOTHERAPY CERTIFICATE	112818	279.00	82274	ANNA SOUTH
7320	SUICIDAL RISK TRAINING	121718	135.00	80311	JASON FARMER
8390	340B WINTER COALITION	121318 BALL	825.00	80052	LAURA BALL
8390	340B WINTER COALITION	121918 HONG	825.00	80052	TORI HONG
8510	1099 WEBINARS - ALL ACCESS	112618	400.00	82623	WINITA PHOGNSAMRAN
8610	DHLF BOARD RETREAT	112018	341.80	81508	STEVEN DIETLIN
8615	CAPM CERTIFICATION EXAM PREP	111218	1,890.00	78401	JESSICA SHRADER
8650	HR TRAINING CONFERENCE	121718	149.00	79802	NATALIE GREKO
8740	HOAG NUEROSCIENE NURSING CONFERENCE	111618	125.00	77841	WILLIE BLINSTON
8740	SCANN CONFERENCE CHANGING TIDES - NEONATAL	111618	140.00	77765	KIMBERLY GRITMAN
8740	SCANN CONFERENCE CHANGING TIDES - NEONATAL	121418	140.00	78614	MARINNEE CHOMPA
8740	SCANN CONFERENCE CHANGING TIDES - NEONATAL	120718	140.00	80743	LISA GAGNE
8740	AHA ACLS RECERTIFICATION	120718	150.00	41537	LORNA M. MARTINEZ
8740	SCANN CONFERENCE CHANGING TIDES - NEONATAL	111618	165.00	82725	KENDRA AROOJI-SZYMANSKI
8740	PALS COURSE	111618	170.00	79113	JANINE YOUNG
8740	ACLS FULL COURSE	112618	175.00	28741	LORI FISHER
8740	ACLS CERTIFICATION	121418	195.00	83227	GEMMA-ELIZABETH MARIE JOHNSON
8740	ECHO WEB CARDIAC CME'S	111618	200.00	79856	COLLEEN FOSTER
8740	IN PATIENT OB REVIEW	120718	200.00	83375	LESLIE LUCERO
8740	RN TO BSN	120718	2,500.00	82610	CHARLINE TARR
8740	MSN - LEADERSHIP & MANAGEMENT	112618	4,245.00	83374	SANDI KOBIE
8756	CHA POST ACUTE CARE	112618 HUNTER	495.00	14364	JACQUELINE HUNTER
8756	CAHQ CPHQ EXAM PREP	112618	660.00	83373	JULIE DANIELS

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.