**TRI-CITY HEALTHCARE DISTRICT**
**AGENDA FOR A REGULAR MEETING**
**June 27, 2019 – 12:00 o'clock p.m.**
**Classroom 7 - Eugene L. Geil Pavilion**
**Open Session – Assembly Rooms 1, 2 & 3**
**4002 Vista Way, Oceanside, CA 92056**

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 1 | Call to Order | 3 min. | Standard |
| 2 | Approval of agenda | | |
| 3 | Public Comments – Announcement<br>Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 19-018, 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<br>(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<br>(Authority: Government Code, Section 54956.9(d) 2 (1 Matter) | | |
| | b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees<br>(Authority: Health & Safety Code, Section 32155) | | |
| | c. Reports Involving Trade Secrets<br>(Authority: Health and Safety Code, Section 32106)<br>Discussion Will Concern: Proposed new service or program<br>Date of Disclosure: TBD | | |
| | d. Approval of prior Closed Session Minutes | | |
| 7 | Motion to go into Open Session | | |
| 8 | Open Session | | |
| | ***Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 1:00 p.m.*** | | |
| 9 | Report from Chairperson on any action taken in Closed Session<br>(Authority: Government Code, Section 54957.1) | | |

*Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.*

*Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.*

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 10 | Roll Call / Pledge of Allegiance | 3 min. | Standard |
| 11 | Public Comments – Announcement<br>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 19-018, members of the public may have three minutes, individually, to address the Board of Directors.<br>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 –<br>Victor Souza, M.D., Chief of Staff | 5 min. | Chair |
| 13 | Introductions –<br>a) Mark Yamanaka, M.D., Chief of Staff Elect<br>b) Gene Ma, M.D., Chief Medical Officer<br>c) Jeffrey Scott, Esq., Board Counsel | 5 min.<br>5 min.<br>5 min. | Board Chair<br>CEO<br>Board Chair |
| 14 | Report from TCHD Foundation – Jennifer Paroly, President | 10 min. | Standard |
| 15 | Appreciation of Mary Gleisberg, Auxiliary President | 5 min. | Board Chair |
| 16 | TCHD Auxiliary – Mary Gleisberg, Auxiliary President<br><br>a) Introduction of Jeff Marks, President Elect | 5 min.<br><br>5 min. | Standard<br><br>M. Gleisberg |
| 17 | May 2019 Financial Statement Results | 10 min. | CFO |
| 18 | New Business<br><br>a) Consideration to approve Resolution No. 796, A Resolution of the Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2019 and Ending June 30, 2020. | 5 min. | CFO |
| 19 | Old Business –<br><br>a) Approval of Board Policy 19-009 – Requests for Information or Assistance by Board Members | 5 min. | Ad Hoc Comm. |
| 20 | Chief of Staff<br><br>a) Consideration of June 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on June 24, 2019. | 10 min. | Chief of Staff |
| 21 | Consideration of Consent Calendar<br><br>**Administrative & Board Committees**<br><br>***(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.*** | 5 min. | Standard |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|

***(2) All items listed were recommended by the Committee.***

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

**(1) Administrative Committee**

**a) Patient Care Policies & Procedures**
1) Cancer Education Procedure
2) Disposal of Chemotherapy Waste Procedure
3) Electrocautery Machine Setup Procedure
4) End Tidal C)2 (EtCO2) Monitor Procedure (DELETE)
5) Family Presence During Resuscitation Policy
6) Growth Chart Documentation for Pediatrics, Adolescents and Neonates Policy
7) Hypoglycemia Management in the Adult Patient Standardized Procedure
8) Postural-Orthostatic Vital Signs, Obtaining Procedure (DELETE)
9) Vasc Band Hemostat: Radial Artery Compression Device Procedure

**b) Administrative**
1) Skilled Nursing Facility (SNF) Refusal to Readmit Policy

**c) Administrative Pay Practices**
1) Bereavement Leave for Benefited Employees Policy 435.01
2) Compensation for Mandatory Education Policy 474.01

**d) Medical Staff**
1) Credentialing Policy, Processing Medical Staff Reappointment 8710-548
2) Discharge Planning for Pediatric and Adolescent Patient Policy 8710-561 (DELETE)

**e) NICU**
1) Nasogastric (NG) and Orogastric (OG) Tube Insertion, Maintenance, and Removal Procedure

**f) Outpatient Behavioral Health**
1) Co-Treatment of Patients Policy

**g) Surgical Services**
1) Nursing Documentation for PANS Unit Policy (DELETE)
2) PACU Services in Alternate Area (ICU) After Hours Weekends Policy (DELETE)
3) Post Anesthesia Standards of Practice Policy

**h) Telemetry**
1) Management of Telemetry Patient Policy

**i) Women and Newborn Services**
1) Car Seat Challenge Test Procedure
2) Neonatal Resuscitation Team for Scheduled Cesarean Sections Procedure (DELETE)
3) Neonatal Team Attendance at a Delivery Policy

**j) Pre-Printed Orders**

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | 1) Outpatient Infusion Orders 8711-1910<br>2) Outpatient Transfusion Orders 8711-1910 | | |
| | **(2) Board Committees** | | |
| | **A. Community Healthcare Alliance Committee**<br>Director Chavez, Committee Chair<br>*(Committee minutes included in Board Agenda packets for informational purposes)* | | CHAC Comm. |
| | **B. Finance, Operations & Planning Committee**<br>Director Nygaard, Committee Chair<br>Open Community Seats – 1<br>*(Committee minutes included in Board Agenda packets for informational purposes)* | | FO&P Comm. |
| | 1) Approval of an agreement with Drs. Mohammad Jamshidi-Nezhad and David Spiegel as Cardiovascular Health Institute – Operations Committee members for a term of 12 months, beginning July 1, 2019 and end June 30, 2020, not to exceed four hours per month at an hourly rate of $210 for an annual and term cost of $10,080.<br>2) Approval of an agreement with Dr. Ponec as the coverage physician for a term of 12 months, beginning July 1, 2019 through June 30, 2020, not to exceed an average of 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160.<br>3) Approval of an agreement with Drs. Mohammad Jamshidi-Nezhad, Ashish Kabra, and David Spiegel as the coverage physicians for a term of 12 months, beginning July 1, 2019 through June 30, 2020, not to exceed 12 hours per month per physician for a total of 432 hours annually, at an hourly rate of $210 for an annual and term cost of $90,720.<br>4) Approval of an agreement with Drs. Donald Ponec, Andrew Deemer and Ashish Kabra as Cardiovascular Health Institute – Quality Committee members for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020, not to exceed six hours per month at an hourly rate of $210 for an annual and term cost of $15,120.<br>5) Approval of an agreement with Dr. Karim El-Sherief as the Medical Director of Cardiac Rehabilitation for a term of 24 months beginning July 1, 2019 through June 30, 2021, not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $185.50 for an annual cost of $97,944, and a total term cost not to exceed $195,888.<br>6) Approval of an agreement with Dr. Sharon Slowik, as the Supervising Physician, for a term of 24 months, beginning July 1, 2019 through June 30, 2021, not to exceed an average of 42.5 hours per month or 510 hours annually, at an hourly rate of $160 for an annual cost of $81,600 and a total cost for the term of $163,200.<br>7) Approval of an agreement with Dr. Mark Yamanaka, ICU Medical Director for a term of 12 months beginning July 1, 2019 through June 30, 2020, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175, for an annual and term cost of $42,000.<br>8) Approval of an agreement with Drs. Caroline Vilchis, Bradley | | |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | Frasier, Michael Guerena, Jason Philips and Aaron Boonjindasup, as the Urology ED-Call coverage physicians for a term of 24 months, beginning July 1, 2019 through June 30, 2021, at a daily rate of $650, for a term cost of $475,150.<br>9) Approval of an agreement with Anesthesia Services Medical Group (ASMG) for anesthesia coverage for a term of 24 months, beginning July 1, 2019 through June 30, 2021, not to exceed a total cost of $1,958,360 for the term.<br>10) Approval of an agreement with Drs. Ashish Kabra, Mohammad Pashmforough, Pargol Samani, David Spiegel, Kenneth Carr, Karim El-Sherief and Anitha Rajamanickam as the Cardiology-General coverage physicians for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $300, for an annual and term cost of $109,800.<br>11) Approval of an agreement with Drs. David Spiegel, Kenneth Carr, Karim El-Sherief and Anitha Rajamanickam, as the coverage physicians for Cardiology-STEMI, for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $1,000, for an annual term cost of $366,000.<br>12) Approval of an agreement with Drs. Christopher Devereaux, Thomas Krol, Javaid Shad, Michael Shim, Matthew Viernes, as the Gastroenterology General & ERP ED Call Coverage Physicians for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $775 for GI, for an annual cost of $283,650, and ERCP, at a daily rate of $500 for an annual cost of $183,000 and a total cost for the term of $466,650.<br>13) Approval of an agreement with Drs. Michael Burke, Brian Goelitz, Justin Gooding, Charles McGraw, Michael Noud, Donald Ponec and Richard Saxon as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $750, for an annual and term cost of $274,500.<br>14) Approval of an agreement with Drs. Robert Pendleton, Mark Smith, Maulik Zaveri, Henry Hudson, Peter Krall, Srinivas Iyengar, Logan Haak, James Davies, Bradley Greider, Atul Jain, Neeta Varshney, as the Ophthalmology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $300 for an annual and term cost of $109,800.<br>15) Approval of an agreement with Drs. Neville Alleyne, Payam Moazzaz, Tyrone Hardy, Mark Sterm, Kevin Yoo, Sunil Jeswani and Howard Tung as the Spine ED-Call coverage physicians for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $450, for a total annual and term cost of $164,700.<br>16) Approval of an agreement with Dr. Brian Mudd, as the Oral/Max Surgery ED-all coverage physician for a term of 12 months, beginning July 1, 2019 through June 30, 2020, at a daily rate of $350, for an annual and term cost of $128,100.<br>17) Approval of an agreement with Aya Healthcare for contract labor managed service agreement for a term of 36 months, beginning July 1, 2019 through June 30, 2022, for an | | |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | annual cost of $4.5M and a total cost for the term of $13.5M.<br>18) Approval of an agreement with Anesthesia Services Medical Group (ASMG) for anesthesia coverage for a term of 24 months, beginning July 1, 2019, through June 30, 2021, not to exceed a total cost of $1,958,360 for the term.<br>19) Approval of an agreement with Advance Sleep Medicine Services, Inc. for interpretation of sleep screening for a term of 12 months, beginning June 1, 2019 through May 31, 2020, for an annual and total term cost of $24,500.<br><br>**C. Professional Affairs Committee**<br>Director Reno, Committee Chair<br>*(No meeting held in June, 2019)*<br><br>**D. Audit, Compliance & Ethics Committee**<br>Director Schallock, Committee Chair<br>Open Community Seats – 2<br>*(No meeting held in June, 2019)*<br><br>**E. Ad Hoc Board Bylaw & Policies Committee *(Policy Number & Minor Changes Unless Noted as Revised)***<br><br>1) 19-006 Board of Directors Meeting Minutes<br>2) 19-007 Use of Board Committee Minutes at Meetings of Board of Directors<br>3) 19-021 Use of Board Counsel by Members of the Board of Directors<br>4) 19-023 – Responsibility for Decision-making on Legal Matters (Revised)<br>5) 19-027 – Prohibition of Political Activities, Solicitation, Distribution of Literature and Goods on District Properties<br>6) 19-030 - Government Claims Act Policy: Claims Presentation (Revised)<br>7) 19-031 – Recruitment of Community Members for Board Committees<br>8) 19-039 – Comprehensive Code of Conduct (Revised)<br>9) 19-041 – Board Policy on Public Information (Revised)<br><br>(3) Minutes – Approval of:<br><br>a) Regular Board of Directors Meeting – May 30, 2019 *(deferred to next Regular meeting)*<br><br>(4) Meetings and Conferences – None<br><br>(5) Dues and Memberships<br>1) MCOL – Payers & Providers Site License $219.00 | | PAC<br><br>Audit, Comp. & Ethics Comm.<br><br>Standard |
| 22 | Discussion of Items Pulled from Consent Agenda | 10 min. | Standard |
| 23 | Reports (Discussion by exception only)<br>(a) Dashboard – Included<br>(b) Construction Report – None<br>(c) Lease Report – (May, 2019)<br>(d) Reimbursement Disclosure Report – May, 2019)<br>(e) Seminar/Conference Reports - None | 0-5 min. | Standard |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 24 | Comments by Members of the Public<br>NOTE: Per Board Policy 19-018, 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 |
| 25 | Comments by Chief Executive Officer | 5 min. | Standard |
| 26 | Board Communications (three minutes per Board member) | 18 min. | Standard |
| 27 | Report from Chairperson | 3 min. | Standard |
| 28 | Total Time Budgeted for Open Session | 1.5 hours | |
| 29 | Adjournment | | |

**RESOLUTION NO. 796**

**A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2019 AND ENDING JUNE 30, 2020 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA**

WHEREAS, Section 1 of Article XIII B of the Constitution of the State of California provides that the total annual appropriations of each local government shall not exceed the appropriations limit of such entity of government for the prior year, adjusted for changes in the cost of living and population, subject to certain specified exceptions in said Article; and

WHEREAS, Section 8 of Article XIII B of the Constitution of the State of California defines "Appropriations subject to limitation" of an entity of local government as "any authorization to expand during a fiscal year the proceeds of taxes levied by or for that entity and the proceeds of state subventions to that entity" (other than subventions made pursuant to new programs or services mandates by the State Legislature) "exclusive of refunds to taxes"; and

WHEREAS, Section 7910 of the Government Code of the State of California provides that each year the governing body of each local jurisdiction shall, by resolution, establish its appropriations limit for the following fiscal year pursuant to Article XIII B of the Constitution of the State of California at a regularly scheduled meeting or noticed special meeting; and

WHEREAS, the documentation used in determining the appropriations limit adopted in this resolution has been available to the public for fifteen (15) days prior to the adoption of this resolution.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT DOES HEREBY RESOLVE AND ORDER AS FOLLOWS:

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2019 and ending June 30, 2020 is not to exceed $15,370,085.

2. In accordance with Section 2, Article XIII B of the Constitution of the State of California, any revenues received by TRI-CITY HEALTHCARE DISTRICT in excess of that amount, which is appropriated in compliance with Article XIII B of the Constitution of the State of California, during the fiscal year shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

ADOPTED, SIGNED AND APPROVED this 27th day of June, 2019.

Leigh Anne Grass, Chairperson of the
TRI-CITY HEALTHCARE DISTRICT and
of the Board of Directors thereof

ATTEST:

Julie Nygaard, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~17~~19-009**

**POLICY TITLE: Requests for Information or Assistance by Board Members**

1. Requests for information or assistance by individual Directors requiring more than 15 minutes of staff time shall be directed in writing to the Chairperson of the Board, with a copy to the President/CEO or his/her designee. All questions regarding confidentiality and privilege shall be directed to the Board Counsel, Compliance Officer or their designees. All requests shall be stated clearly and shall be specific. In making requests, Directors shall keep in mind that District staff time and resources are both limited and expensive, and that staff members have other duties.

2. All requests for information which concern another Director shall be directed in writing to the Chairperson of the Board, with a copy to the President/CEO or his/her designee. A copy of the written request shall be directed to all members of the Board including the member concerning whom information is requested, along with any information provided in response to the request.

3. All requests for information relating to Closed Session materials, including requested inspection, shall be directed to the Chairperson of the Board, with a copy to the President/CEO or his/her designee and shall be subject to the confidentiality provisions of Policy #19-022.

4. Requests for information and assistance shall receive a response as soon as reasonably possible, although not necessarily immediately. The President/CEO shall have the final authority to determine by what means and when District staff responds to the request. If, in the judgment of the Chairperson of the Board or the President/CEO, the request requires a material amount of employee time or the request includes information or documents which are confidential or privileged or the request is one which is deemed appropriate for Board consideration, the President/CEO or Chairperson may ask for a decision from the full Board of Directors before action is taken.

5. Should any Director's request for information or analysis require more than 30 minutes of staff time, the Chairperson or the CEO may require the Director to secure Board approval for the work.

6. This Policy shall not preclude the Chairperson from exercising authority granted under District Bylaws or Board Policy: Role and Powers of Chairperson. Nothing in this policy shall be construed to limit the rights of a Director under the Public Records Act.

**Reviewed by the Gov/Leg Committee: 8/10/05**
**Approved by the Board of Directors: 9/22/05**
**Reviewed by the Gov/Leg Committee: 11/8/06**
**Approved by the Board of Directors: 12/14/06**
**Reviewed by the Gov/Leg Committee: 10/10/07**

**Approved by the Board of Directors: 12/13/07**
**Received by the Gov/Leg Committee: 12/01/10**
**Approved by the Board of Directors: 12/16/10**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by the Gov/Leg Committee: 11/7/17**
**Reviewed by Ad Hoc Bylaw& Policy Committee: 05/2019**
**Approved by Board of Directors:**

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF INITIAL CREDENTIALS REPORT
# June 12, 2019

*Attachment A*

## INITIAL APPOINTMENTS (Effective Dates: 06/28/2019 – 05/31/2021)

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 06/28/2019 through 05/31/2021:

- **HENRY, Austin DO/Anesthesiology (ASMG)**
- **KIRKLAND, Jared MD/Teleradiology (StatRad)**
- **PATIL, Amol MD/Radiology (San Diego Imaging)**
- **SEIF, Joseph MD/Anesthesiology (ASMG)**
- **SHELLENBERGER, Jeffry MD/Emergency Medicine (TeamHealth)**
- **SILLDORFF, Morgan MD/Orthopedic Surgery (Orthopaedic Specialists of North County)**
- **WONG, Richard MD/Pathology (North Coast Pathology)**

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 4
# June 12, 2019

*Attachment B*

## BIENNIAL REAPPOINTMENTS: (Effective Dates 07/01/2019 -06/30/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 07/01/2019 through 06/30/2021, 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:

- ADHANOM, Teamrat, MD/Internal Medicine/Active
- ANTOUN, David, MD/Internal Medicine/Provisional
- COHEN, David, MD/Cardiology/Active
- CORONA, Frank, MD/Pulmonary Medicine/Active
- CURRAN, Perrin, MD/Internal Medicine/Refer and Follow
- DEMBITSKY, Zachary, MD/Emergency Medicine/Active
- DESADIER, Laura, DO/Neurology/Active
- FOLKERTH, Theodore, MD/Cardiothoracic Surgery/Active
- GUTIERREZ, Miguel, MD/Emergency Medicine/Active
- KAO, Jerry, MD/Pathology - Anatomic/Active
- KASED, Norbert, MD/Radiation Oncology/Active
- LEONARD, Lisa, MD/Obstetrics & Gynecology/Active
- LI, Xiangli, MD/Internal Medicine/Active
- MA, Gene, MD/Emergency Medicine/Active
- OH, Irene, MD/Neurology/Active
- PEREZ, Ronald, MD/Family Medicine/Refer and Follow
- PREGERSON, David, MD/Emergency Medicine/Active
- REISMAN, Bruce, MD/Otolaryngology/Active

*Attachment B*

- **SHIN, Heamin, DPM/Podiatric Surgery/Active**
- **STEWART, Ryan, MD/Internal Medicine/Refer and Follow**
- **STUPIN, Jeremy, MD/Diagnostic Radiology/Active**
- **VILCHIS, Caroline, MD/Urology/Active**
- **WACLAWSKI, Richard, MD/Anesthesiology/Active**

## UPDATE TO PREVIOUS REAPPOINTMENT:

- **MATTHEWS, Oscar, MD/Cardiology/Active**

## RESIGNATIONS: (Effective date 06/30/2019 unless otherwise noted)

**Automatic:**

- **MCWHIRTER, Robert, MD/Emergency Medicine**

**Voluntary:**

- **BUCKLEY, Michael, DO/Anesthesiology**
- **LEE, Yu-Po, MD/Orthopedic Surgery**

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
# June 12, 2019

## REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring, and given an additional six month period after that one. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by ***December 31, 2019*** would result in these privileges automatically relinquishing.

- **GERBER, Michele, MD** — **OB/GYN**
- **PRINCE, Jennifer, MD** — **Pediatrics**
- **SINGH, Himani, MD** — **Oncology**

## ADDITIONAL PRIVILEGE REQUEST (Effective 6/28/2019, unless otherwise specified)

The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s):

- **ALLEYNE, Neville, MD** — **Orthopedic Surgery**
- **FARHOOMAND, Kaveh, DO** — **Internal Medicine**
- **MOAZZAZ, Payam, MD** — **Orthopedic Surgery**

## CHANGE IN PRIVILEGE CARD (Effective 6/28/2019, unless otherwise specified)

The following practitioners are transitioning to the new version of the OB/GYN Privilege Card.

- **ARRIETA, Iris, MD** — **OB/GYN**
- **CAMPBELL, Leticia MD** — **OB/GYN**
- **COFFLER, Mickey MD** — **OB/GYN**
- **EBRAHIMI-ADIB, Tanna MD** — **OB/GYN**
- **GERBER, Michele MD** — **OB/GYN**
- **KARRANIKKIS, Christos DO** — **OB/GYN**
- **LOPEZ, Sandra MD** — **OB/GYN**
- **MAZAREI, Rahele DO** — **OB/GYN**
- **MOSTOFIAN, Eimaneh MD** — **OB/GYN**
- **POUNTNEY LEVESQUE, Marlene MD** — **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# CREDENTIALS COMMITTEE REPORT – Part 3 of 3
# June 12, 2019

## PROCTORING RECOMMENDATIONS (Effective 6/28/2019, unless otherwise specified)

| | |
|---|---|
| • ARRIETA, Iris MD | OB/GYN |
| • CAMPBELL, Leticia MD | OB/GYN |
| • GHOSH, Tanushree DO | Pediatric |
| • ROHER, Alexander MD | Anesthesiology |
| • WAKILY, Hussna MD | General/Vascular Surgery |

# ADMINISTRATION CONSENT AGENDA
## June 5th, 2019

**CONTACT: Barbara Vogelsang, CNE**

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Patient Care Services Policies & Procedures** | | |
| 1. Cancer Education Procedure | Practice Change | Forward to BOD for Approval |
| 2. Disposal of Chemotherapy Waste Procedure | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 3. Electrocautery Machine Setup Procedure | Practice Change | Forward to BOD for Approval |
| 4. End Tidal CO2 (EtCO2) Monitor Procedure | DELETE | Forward to BOD for Approval |
| 5. Family Presence During Resuscitation Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 6. Growth Chart Documentation for Pediatrics, Adolescents and Neonates Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 7. Hypoglycemia Management In the Adult Patient Standardized Procedure | Practice Change | Forward to BOD for Approval |
| 8. Postural-Orthostatic Vital Signs, Obtaining Procedure | DELETE | Forward to BOD for Approval |
| 9. Vasc Band Hemostat: Radial Artery Compression Device Procedure | Practice Change | Forward to BOD for Approval |
| **Administrative Policies & Procedures** | | |
| 1. Skilled Nursing Facility (SNF) Refusal to Readmit Policy | NEW | Forward to BOD for Approval |
| **Administrative Pay Practices** | | |
| 1. Bereavement Leave for Benefited Employees Policy 435.01 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 2. Compensation for Mandatory Education Policy 474.01 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| **Medical Staff** | | |
| 1. Credentialing Policy, Processing Medical Staff Reappointment 8710-548 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 2. Discharge Planning for Pediatric and Adolescent Patient Policy 8710-561 | DELETE | Forward to BOD for Approval |
| **NICU** | | |
| 1. Nasogastric (NG) and Orogastric (OG) tube Insertion, Maintenance, and Removal Procedure | 2 Year Review, Practice Change | Forward to BOD for Approval |
| **Outpatient Behavioral Health** | | |
| 1. Co-treatment of Patients Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| **Surgical Services** | | |
| 1. Nursing Documentation for PANS Unit Policy | DELETE | Forward to BOD for Approval |
| 2. PACU Services in Alternate Area (ICU) After Hours Weekends Policy | DELETE | Forward to BOD for Approval |
| 3. Post Anesthesia Standards of Practice Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |
| **Telemetry** | | |
| 1. Management of Telemetry Patient Policy | 3 Year Review, Practice Change | Forward to BOD for Approval |

# ADMINISTRATION CONSENT AGENDA
## June 5th, 2019

**CONTACT: Barbara Vogelsang, CNE**

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Women and Newborn Services** | | |
| 1. Car Seat Challenge Test Procedure | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 2. Neonatal Resuscitation Team for Scheduled Cesarean Sections Procedure | DELETE | Forward to BOD for Approval |
| 3. Neonatal Team Attendance at a Delivery Policy | Practice Change | Forward to BOD for Approval |
| **Pre-Printed Orders** | | |
| 1. Outpatient Infusion Orders 8711-1910 | 3 Year Review, Practice Change | Forward to BOD for Approval |
| 2. Outpatient Transfusion Orders 8711-1910 | 3 Year Review, Practice Change | Forward to BOD for Approval |

| Tri-City Medical Center | ~~Distribution:~~ Patient Care Services |
|---|---|
| **PROCEDURE:** | **CANCER EDUCATION** |
| Purpose: | To outline ~~for the registered nurse~~ the educational needs of ~~our~~ cancer patients at Tri-City **Healthcare District**~~Medical Center~~ (TCHD~~MC~~). |
| Equipment: | American Cancer Referral Form and ~~TCMC~~ **TCHD** Intranet |

A. **PROCEDURE:**

1. Patients admitted to ~~Tri-City Medical Center (~~TCHD~~MC)~~ with a diagnosis of cancer, and their families, will be offered the choice of a referral to the American Cancer Society for continuity of care, which offers ~~our~~ patients/families support in ~~the following~~ areas **including**, but ~~are~~ not limited to:
   a. Current Cancer Treatment and Research
   b. Financial Support (~~i.~~e.**g.**, medications, ~~rides~~ **transportation** to treatments, child care ~~etc.~~)
   c. Support Groups (~~i.~~e.**g.**, Look Good and Feel Good Program, Road to Recovery, Man to Man, Breast Cancer Support~~, etc.~~)
   d. Sponsor Program
   e. Clinical Trials
   f. Managing Your Cancer Experience
   g. Resources for a Healthy Life
2. Patients admitted to TCHD~~MC~~ with a diagnosis of cancer, and their families, will be given information on how to participate in and access information on clinical trials. This educational information for patients/families is located on the Tri-City~~MC~~ Intranet under "Patient Information" - Learn About and Find Clinical Trials. ~~or~~ Patients/families~~y~~ can **also** access this information by calling 1-800-303-5691 from the American Cancer Society.
3. If the patient/~~or~~ family would like to be referred to the American Cancer Society, **social worker, case manager the Registered Nurse (RN) shall:**
   **a.** Have patient/~~or~~ family complete the American Cancer Society Referral Form (**Tri-City**~~MC~~ Intranet under "Patient Information")~~ and~~ **. The registered nurse, social worker or case manager may assist patient in completing the form if patient is unable to complete the form independently but verbally agrees to the referral.**
   ~~3.~~**b.** Fax the form to the American Cancer Society (fax number is on the form). ~~The registered nurse, social worker or case manager may assist patient in completing the form if patient is unable to complete the form independently but verbally agrees to the referral.~~
4. **A representative**~~Someone~~ from the American Cancer Society will contact patient/~~or~~ family.
5. The following are other educational resources for cancer patients and their family. (Handout for patients is available on the Tri-City~~MC~~ intranet under **Departments > Clinical > References >** "Patient Information" **>** Cancer Resources.)
   a. National Comprehensive Cancer Network — www.nccn.com/
   b. Cancer Action Network — www.acscan.org
   c. Cancer Survivor's Network — csn.cancer.org/
   d. Cancer Research — www.cancer.org
   e. American Cancer Society — www.cancer.org/docroot/home/index.asp
   f. American Institute for Cancer Research — *www.aicr.org*
   g. American Society of Clinical Oncology — *www.asco.org*
   h. Cancer News on the Net — *www.cancernews.com*
   i. CancerNet (National Cancer Institute) — *cancernet.nci.nih.gov*
   j. Cansearch: A Guide to Cancer Resources on the Internet — *www.cansearch.org/canserch*

| Department ReviewPatient Care Services Content Expert | Clinical Policies & Procedures Committee | Nursing Nurse Executive Committee | Division of Oncology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration Approval | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 07/10, 07/13, 06/17 | 08/10, 07/13, 07/17 | 09/10, 07/13, 07/17 | 03/19 | n/a | 07/13, 05/19 | 06/19 | 09/10, 08/13, n/a | 09/10, 08/13 |

k. National Cancer Institute's bibliographic database *cnetdb.nci.nih.gov/cancerlit.shtml*
l. National Cancer Institute's - clinical trials information *cancertrials.nci.nih.gov*
m. Department of Health and Human Services *www.healthfinder.gov*

6. Additional educational materials **are** ~~is~~ available for cancer patients and their families in the following areas:
   a. Tri-City~~MC~~ Intranet:
      i. **Clinical Key** ~~Micromedex (Clinical Reference)~~
      ~~ii. MD consult (Clinical Reference)~~
      ~~iii.~~**ii. Elsevier Online** ~~Mosby's~~ Patient Education (**under** Policies and Procedures **link on Intranet**)
   **b. Cerner:**
      **i. ~~Krames~~ Patient Education Handouts (such as Krames)**
   ~~b.~~**c.** Education Pamphlets on 2 Pavilion
7. Document all referrals and cancer education in the Cerner AdHoc form under Education All Topics Form -- "Cancer/Chemo/Radiation."

**B. FORM(S):**

**1. American Cancer Society Referral Form PPROA**

**C. EXTERNAL LINK(S):**

**1. American Cancer Society- Learn About and Find Clinical Trials: https://www.cancer.org/treatment/treatments-and-side-effects/clinical-trials/clinical-trials-matching-service-find-trial.html**

# PATIENT REFERRAL FORM

American Cancer Society

## Notice to Patient

The American Cancer Society (ACS) offers services and information that could help you while you are dealing with your cancer. The information that you share on this form will be shared with the ACS so that they can contact you about the cancer information, services and resources that you request.

The ACS cares about your privacy and will protect and use your information only in accordance with its Privacy Policy, available at www.cancer.org. The ACS will use the information contained on this form to contact you about the services you have requested.

With your permission given below, the ACS may also use your information to contact you about other programs and services that may be of interest to you, to invite you to events in your community, and/or to tell you about volunteer or other support opportunities. If you would like to give the Society permission to contact you regarding these other opportunities, please initial here: _____ **(Patient Initials)**

If you have questions about your cancer, the ACS, its programs, services or privacy standards, or to change your contact preferences, please visit **www.cancer.org** or call **1-800-227-2345. The ACS is available 24 hours a day, 7 days a week.**

**Provider Information**

Healthcare Provider Name: Tri-City Medical Center | ACS ID: 1-RCWB7S

Referral Contact Name: | Phone: ( ) –

**Patient Information** *(Minimum of one method of contact required). Information shared here will assist us in efficiently coordinating services.*

**Patient Name: (required)**

*Primary Address:* ☐ Home ☐ Business ☐ Other

*City:* *State:* *Zip Code:*

*Primary Phone:* ( ) – ☐ Home ☐ Cell ☐ Business

*Alternate Phone:* ( ) – ☐ Home ☐ Cell ☐ Business

*Email:* ☐ Personal ☐ Business

Date of Birth: ex. MM/DD/YYYY | Primary Language: ☐ English ☐ Spanish ☐ Other: Please List

Race: ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Two or more races ☐ Declined to Share ☐ Other: Please List

Gender: ☐ Female ☐ Male

**Diagnosis**

Date of Diagnosis: ex. MM/DD/YYYY | Type of Cancer: ☐ Recurrence

Insurance: ☐ Medicaid ☐ Medicare ☐ Medicare + Medicaid ☐ Medicare + Private ☐ Military ☐ Private ☐ Uninsured ☐ Declined to Share

☐ Personal Health Manager Requested (Kit to organize your cancer and treatment information) ☐ English ☐ Spanish ☐ Other Language: Please List

**Requested Services**

Best Time to Call: ex. 00 00 ☐ AM ☐ PM | OK to leave a message: ☐ Y ☐ N

☐ Transportation to cancer treatment | First Date Needed: ex. MM/DD/YYYY | Time: ex. 00 00 ☐ AM ☐ PM

☐ Lodging during cancer treatment | First Date Needed: ex. MM/DD/YYYY

☐ One-on-one breast cancer support (Reach to Recovery) | Treatment Type: ☐ Early Support ☐ Lumpectomy ☐ Mastectomy ☐ Chemotherapy ☐ Radiation ☐ Advanced

☐ Classes to enhance appearance & self-esteem during treatment (Look Good Feel Better) | Skin Tone: ☐ Dark ☐ Extra Dark ☐ Light ☐ Medium

☐ Resources/Referrals for other needs: | ☐ Wig or head-coverings

Comments/Other information you would like us to know:

**Healthcare Provider Instructions:** The Notice above regarding American Cancer Society's use of information must be shared with the patient prior to submitting this form to the American Cancer Society. ACS will rely on Health Care Provider's submission of any Patient Referral Form as evidence that this Notice has been communicated to patient. Once completed, please fax form to **877-428-2862** or Email form to **SSBCREF@CANCER.ORG**

PPROA

| Tri-City Medical Center | ~~Distribution:~~ Patient Care Services |
|---|---|
| **PROCEDURE:** | **DISPOSAL OF CHEMOTHERAPY WASTE** |
| Purpose: | To outline the nursing responsibility and management of proper disposal of chemotherapy waste |
| Supportive Data: | Oncology Nursing Society's Chemotherapy and Biotherapy Guidelines and Recommendations for Practice 4th Edition 2014 |
| Equipment: | Chemotherapy Safe Personal Protective equipment<br>Puncture –proof container labeled "chemotherapy" container<br>Gloves specified for use with chemotherapy agents<br>Large yellow bag marked "Chemotherapy waste"<br>Gown specified for use with Chemotherapy Agents |

A. **PROCEDURE:**

1. Place puncture-proof chemotherapy container and large yellow chemotherapy waste plastic bags marked "Chemotherapy Waste" in patient's room upon initiating chemotherapy treatment.
2. Always use chemotherapy safe personal protective equipment when handling chemotherapy waste.
3. Place any disposable cytoxic contaminated materials into a yellow chemotherapy waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items, **and** items that are saturated **with chemotherapy or chemotherapy contaminated** body fluids.
4. Place contaminated Intravenous (IV) tubing, IV bags, and all non-sharp materials in the large yellow plastic bag marked "Chemotherapy Waste~~.~~" **after striking out any patient information on the label or tubing with a black permanent marker.**
5. Tie off large yellow chemotherapy waste bag carefully gathering top portion of bag with one hand and slowly pull downward on gathered portion until internal air in bag resists further pulling down. Place yellow chemotherapy waste bag in puncture proof container labeled "Chemotherapy Waste."
6. ~~Upon completion of treatment,~~ **P** ~~p~~lace puncture-proof chemotherapy container in **the** chemo waste room **when no longer in use or container is 2/3 full.** ~~If the container is less than 2/3 full, place lid gently on top.~~
   a. For **inpatient** areas without a chemo waste room, contact Environmental Services (EVS) for removal.
7. Completely close **the** lid **on the chemotherapy puncture proof waste containers** when ~~the container is~~ **they are** 2/3 full or if a potential risk is perceived. Document on top of the **puncture proof container "full" with the date** ~~container that the puncture proof container is full and date it~~**before placing it in the chemo waste room or contacting EVS for removal.**
8. Notify environmental services when chemotherapy puncture-proof waste containers are full. Chemotherapy containers must be removed from the chemo waste room within 24 hours.
   ~~1.~~**a. Outpatient Infusion Center staff shall notify currently contracted waste management provider to pick-up chemotherapy waste containers.**

| Department Review Patient Care Services Content Expert | Clinical Policies & Procedures Committee | Nurse Executive Committee | Division of Oncology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 6/03; 11/11, 05/16 | 12/11, 08/15, 6/16 | 09/15, 7/16 | 07/16, 03/17, 03/19 | 6/16 | 1/12, 10/15, 05/19 | 06/19 | 2/12, 11/15, n/a | 2/12, 12/15 |

| Tri-City Medical Center | Patient Care Services |
|---|---|
| **PROCEDURE:** | **ELECTROCAUTERY MACHINE SETUP, USE AND SAFETY** |
| Purpose: | To outline nursing responsibilities in the **set-up and safe** operation of the electrocautery machine. |
| Equipment: | Electrocautery machine<br>–Adult dispersive electrode (grounding pad)<br>~~-Pediatric dispersive electrode (grouding pad)~~<br>-Safety holster<br>Cautery pencil (hand ~~activities~~**activated**) and ~~blade~~**accessory tip(s)**<br>Foot pedal – Monopolar<br>Foot pedal – Bipolar<br>Scratch pad |

A. **PROCEDURE:**

1. The electro surgery unit (ESU), dispersive electrode, and active electrode selected for use shall meet the following performance and safety criteria:
   a. Use according to manufacturer's ~~written instructions~~**instructions for use (IFU)**.
   b. Design shall minimize unintentional activation.
   c. Cord shall be of adequate length and flexibility.
   d. The machine shall be inspected by the surgical/procedural team before each use.
   e. The ESU shall be appropriately grounded for each use.
   f. The ESU and all reusable parts shall be cleaned according to manufacturer's ~~written instructions~~**IFU**.
   g. Personnel shall check the entire circuit if higher than normal power settings are requested during the surgical procedure.
   h. Each ESU shall be assigned an identification number and shall have routine scheduled preventive maintenance performed, per **Engineering** ~~TCMC~~ ~~p~~Policy: **Preventive** ~~Maintanence~~**Maintenance**. Ensure the electrocautery machine has a current Bio-Medical **Engineering Preventative Maintenance (PM)** sticker.
   i. Position the machine near sterile field. The machine, ~~-and-~~cord, **and accessories** shall be kept away from fluids **and protected from spills.**
      **i. Containers of liquids should not be placed on energy-generating devices, as liquids may enter the device and cause unintentional activation, device failure, or an electrical hazard.**
      ~~i.~~**ii. Foot pedal accessories should be encased in a fluid-resistant cover when there is potential for fluid spills.**
2. Personnel shall demonstrate competency with the ESU prior to use:
   a. Personnel shall be instructed in the proper operation, care and handling of the ESU before use.
   b. The **device** manufacturer's ~~manual of operating instructions~~**IFU** shall be readily available to ~~the~~ users.
3. **Follow fire safety precautions while using an ESU, per Patient Care Services (PCS) procedure Fire Prevention and Management in Invasive Procedure Areas.**
~~3.~~**4.** The ~~ESE~~**ESU**, active electrode, and dispersive electrode shall be used in a manner that reduces the potential for injury, including the following safety measures:
   a. Do not use in the presence of flammable agents (alcohol**-based prep solutions** and ~~tincture-based~~**other flammable** agents must be allowed sufficient time to dry and fumes to dissipate before draping and/or use of an ESU).

| ~~Department Review~~Patient Care Services Content Expert | Clinical Policies & Procedures Committee | Nursing Executive ~~Council~~Committee | Operating Room Committee | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 6/08, 04/11, 01/13, 07/18 | 02/11, 01/13, 08/18, 02/19 | 03/11, 1/13, 09/18, 03/19 | 04/19 | n/a | 11/13, 05/19 | 06/19 | 03/11, 2/14, n/a | 04/11, 2/14 |

b. Use caution during head and neck surgery when using an active electrode in the presence of combustible anesthetic gases.
c. Test safety features (i.e., lights, activation sounds) before each use.
d. Check the cord, plug and footswitch for integrity before each use.
e. Verbally confirm the power settings with the operator before activation, and operate at the lowest power settings possible to achieve the desired surgical effect.
~~f. Protect the ESU from spills.~~
~~g.~~**f.** Plug the ESU into an isolated electrical circuit.
~~h.~~**g.** Do not place other electrical equipment on top of or immediately next to the ESU. Allow space between the ESU and other electrical equipment, to avoid interference and potential inadvertent activation of the machines.
~~i.~~**h.** Sponges used near the active electrode tip should be moist to prevent unintentional ignition.
~~j.~~**i.** Electrosurgery should not be used in the presence of gastrointestinal gases.
~~k.~~**j.** Electrosurgery should not be used in an oxygen-enriched environment.
   i. The lowest possible oxygen concentrations that provide adequate patient oxygenation should be used.
   ii. Surgical drapes should be arranged to minimize the build-up of oxidizers under the drape.
   iii. The active electrode should be used as far from the oxygen source as possible.

~~4.~~**5.** Select **and use a dispersive electrode (i.e.,** grounding pad~~) (dispersive electrode) appropriate to patient's size~~ **according to manufacturer's IFU**.
~~a. Use grounding pad according to manufacturer's written instructions.~~
~~b.~~**a.** Inspect the grounding pad for damage prior to use.
~~c. Use pediatric pad if the patient weighs less than 13.5 kg (30 pounds).~~
~~d.~~**b.** Never cut pad to fit **or alter grounding pad in any way**.
**c.** Never use grounding pad when only bipolar cautery is being used.
~~e.~~**d.** **Open grounding pad package as close to the time of use as possible and confirm the manufacturer's expiration date has not passed. The longer the pad package is open, the greater the potential for drying of the dispersive electrode's adhesive and conductive gel.**

~~5.~~**6.** Select grounding pad site.
a. Place the grounding pad after the patient is in the final position for surgery/procedure.
b. Ensure the grounding pad site is clean and dry, over a large, **well-perfused** muscle mass, intact skin, and as close to the operative site as possible.
c. Ensure grounding pad maintains uniform contact with the patient's body throughout the procedure.
d. Metal jewelry **(including body piercings, subdermal implants, and transdermal or microdermal implants)** that is between the active and dispersive electrode should be removed.
**e. Place the grounding pad away from a warming device whenever possible.**
~~e.~~**f.** AVOID the following areas when selecting a site for grounding pad placement:
   i. **Over E**~~e~~xcessively hairy areas.
   ii. **Over** ~~Scar~~ **scar tissues**
   iii. Over metal implants
   iv. **Over B**~~b~~ony prominences~~ such as hip or knee bone.~~ **and potential pressure points**
   ~~iv.~~**v. Over skin folds**
   ~~v.~~**vi.** Wet areas (pooled fluids)
   ~~vi.~~**vii.** Areas distal to tourniquets
   ~~vii.~~**viii.** Over tattoos, which may contain metallic dyes~~.~~

~~f.~~**7.** The following corrective measures shall be performed for poor contact of a single use electrode:
~~i.~~**a.** Apply a new grounding pad~~.~~
~~ii.~~**b.** Remove oil, lotion, moisture~~,~~ or prep solution~~.~~

~~iii.~~**c.** Remove excessive hair~~.~~
~~iv.~~**d.** Change sites
~~v.~~**e.** Never use tape to hold the single-use dispersive electrode in place.
~~vi.~~**f.** If the patient is repositioned intraoperatively, the nurse should verify that the dispersive electrode is in full contact with the patient's skin.

8. **If two ESU's will be used simultaneously during a procedure, a dispersive electrode should be used for each ESU.**
   a. **The dispersive electrodes should be placed as close as possible to the surgical site.**
   b. **The dispersive electrodes should not overlap.**
   c. **The dispersive electrodes should be placed equidistant from the surgical site when it is a single site.**

~~6.~~9. Plug grounding pad into cautery machine and turn on machine**, per manufacturer's IFU.**
   a. Adjust the volume to ensure audible alerts when the cautery is in use.
   b. Ensure connections are intact, clean, and make effective contact with the ~~electro-surgery machine~~**ESU**.

~~7.~~10. The active electrode shall:
   a. Fasten directly in the ESU in a stress-resistant receptacle (adapters shall be manufacturer approved and not compromise safety features)
   b. Be inspected on the field for damage prior to use.
   c. Be inspected in a clean, dry, well-insulated safety holster when not in use, and used according to manufacturer's ~~written instructions~~**IFU**.
   d. Be impervious to fluids.
   e. Be disconnected from the ESU if allowed to drop below the sterile field.
   f. Have a tip that is secure and easy to clean, and the tip shall never be altered, including cut, bent, or used with an insulating sheath made from inappropriate materials (i.e., rubber catheters).
   g. Be cleaned whenever there is visible eschar, which impedes the desired current flow, causing the entire unit to function less effectively and serving as a fuel source for fire.

~~8.~~11. The ESU shall be used with foot pedal or hand-control forceps according to manufacturer's ~~written instructions~~**IFU**.

~~9.~~12. If an active monopolar electrode is being used in a fluid-filled cavity, the fluid used should be an electrically inert, near isotonic solution (i.e., sorbitol), unless the equipment manufacturer's written directions for use instruct otherwise.

~~10.~~13. Set ESU with desired power settings.

~~11.~~14. Adjust settings per physician preference.
   a. Refer to manufacturer's ~~written instructions~~**IFU** for adjusting

~~12.~~15. **Energy-generating device cords should be secured to the sterile drapes with a plastic or other non-conductive, non-piercing device, in a manner which does not crush or damage the cord.** Do not secure ESU cords to drapes with a metal instrument.~~ Only use plastic clamps or loops provided on drapes to secure cords.~~

~~13. Patients with pacemakers shall have continuous electrocardiogram (ECG) monitoring when an ESU is being used.~~

16. **Be aware of potential patient safety hazards associated with implanted electronic device (IED) (i.e., pacemaker, implantable cardioverter defibrillator [ICD], implantable hearing devices, implantable infusion pumps, deep brain, vagal nerve, or spinal cord stimulator) and take precautions to protect the patient from injury:**
   a. **Patients with pacemakers shall have continuous electrocardiogram (ECG) monitoring when an ESU is being used.**
   ~~14.~~**b.** Additional precautions for patients with pacemakers include, but are not limited to:
      ~~a.~~**i.** Make the distance between the active and dispersive electrode as short as possible, and place both as far from the pacemaker as possible.
      ~~b.~~**ii.** Ensure that the current path from the surgical site to the dispersive electrode does not pass through the vicinity of the heart.

~~c.~~iii. Keep all ESU cords away from the pacemaker and the leads.
~~d.~~iv. Have a defibrillator available.
~~e.~~v. Check with the pacemaker's manufacturer regarding its function during the use of an ESU.

~~15.c. Patients with AICD's shall have the device deactivated before the procedure and have their ECG monitored continuously if the ESU will be used~~**Manage ICD's according to manufacturer's IFU and Surgical Services Policy: Patients with AICD Implant.**

~~16. Personnel should be aware of potential patient safety hazards associated with internal implanted electronic devices, and take the appropriate patient care interventions required to protect the patient from injury. These devices may include, but are not limited to, AICD's, neurostimulators, implantable hearing devices, implantable infusion pumps, and osteogenic stimulators.~~

17. After completion of the case, turn off the ESU, dispose of single use items appropriately, clean all reusable parts to the ESU, inspect accessories and parts for damage, function and cleanliness, and carefully remove the dispersive electerode pad from the patient by peeling it back slowly.
18. Documentation shall include:
    a. Type of ESU
    b. ESU identification number
    c. ESU settings (minimum and maximum ranges)
    d. Location of dispersive electrode
    e. Description of skin at dispersive electrode site pre- and post- procedure
    f. Lot number of dispersive electrode
19. If injury occurs related to the ESU, the event must be reported to the manufacturer and/or the Food and Drug Administration (FDA) to comply with the Safe Medical Devices Act (refer to Administrative Policy: ~~#8610-201, "~~Equipment/ Medical Device Reporting **Sequester - 201** ~~/Impounding/Tracking"~~).
    a. Immediately remove the ESU from service.
    b. Send the ESU, active and dispersive electrodes, and their packaging to Biomedical Engineering Department.
    c. Enter a work order.
    d. Complete an incident report, including the ESU identification number and event information.

## B. RELATED DOCUMENT(S):

1. **Administrative District Operations Policy: Equipment Medical Device Reporting Sequester 8610-201**
2. **Engineering Policy: Preventive Maintenance**

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

1. ~~AORN Perioperative Standards and Recommended Practices (2012).~~ **Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.**

| Tri-City Medical Center | Patient Care Services |
|---|---|

**DELETE: Staff will refer to manufacturer instructions.**

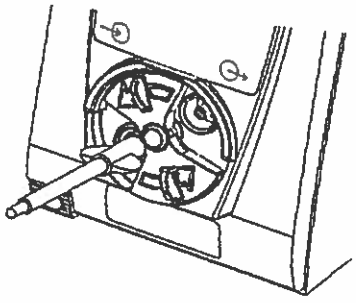
| PROCEDURE: | END TIDAL $CO_2$ ($ETCO_2$) MONITOR |
|---|---|
| Purpose: | To provide continued assessment of patient physiologic response to medications causing sedation and to alert RN healthcare provider for changes in EtCO2 and periods of apnea |
| Equipment: | Alaris® End Tidal $CO_2$ module<br>Disposable inline $EtCO_2$ cannula<br>Disposable inline $EtCO_2$ adapter |

A. **POLICY:**

1. $EtCO_2$ monitoring may be used:
   a. In conjunction with medications known to cause sedation
   b. To monitor for respiratory depression.
2. Contraindications are:
   a. Patients receiving Palliative Care for terminally ill conditions where medication is used for comfort and system management for end of life care.
   b. Patients in active labor.
   c. Patients receiving mechanical ventilation.
   d. Non-ventilated tracheotomy patients.
3. The purpose and function of the $EtCO_2$ monitor should be explained to the patient. Patient education information is to be given to patient/family during pre operative education and/or at initiation of medications known to cause sedation.
4. Patient/family instruction should be reinforced post operatively as needed.
5. If patient refuses to have the $EtCO_2$ monitor when ordered, document that the patient refuses in a clinical note in Cerner.
6. For patient receiving patient controlled analgesia (PCA) see Patient Care Services Patient Controlled Analgesia Procedure

B. **PROCEDURE: SET UP AND PROGRAMMING OF $ETCO_2$ MODULE**

1. Assemble equipment.
2. Explain $EtCO_2$ monitoring to patient and family. Assure that the patient has received $EtCO_2$ patient education guide.
3. Attaching the $EtCO_2$ cannula to the $EtCO_2$ module:
   a. Turn the gas inlet/exhaust door (protective cover) counterclockwise until you can clearly see the gas inlet on the lower left corner of the unit.
   b. While holding the door open, press the brightly colored end of the $EtCO_2$ cannula into the gas inlet and twist it gently but firmly clockwise until it is securely attached to the module.
   c. After securing the disposable to the module, release the door.



| Patient Care Services Content Expert | Clinical Policies & Procedures Committee | Nurse Executive Council | Division of Pulmonary | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| NEW05,18 | 06/14, 06/18, 11/18 | 06/14, 07/18, 11/18 | 09/14, 03/19 | n/a | 09/14, 05/19 | 06/19 | 10/14, n/a | 11/14 |

d. Place the $EtCO_2$ cannula on patient
   i. Non intubated patient:
      1) Apply as you would a nasal cannula.
      2) $EtCO_2$ cannula may be changed PRN.
   ii. Patients requiring oxygen ($O_2$):
      1) Replace $O_2$ cannula with $EtCO_2$ cannula and attach $O_2$ arm connector to $O_2$ flow meter.
      2) When $EtCO_2$ module is discontinued, patient may continue to require $O_2$, replace $EtCO_2$ cannula with standard $O_2$ cannula

4. Perform following steps for the Alaris® $ETCO_2$ set up
   a. Power on system
   b. Choose Yes or No to New Patient?
   c. Confirm current profile or select a new profile
   d. Press channel select key on the $ETCO_2$ module
      i. Sensor warming and then searching appear in Channel Message display until $EtCO_2$ and respiratory rate readings stabilize (up to 60 seconds).
5. Alarm limits:
   a. $EtCO_2$ Monitor Settings include the following:
      i. $EtCO_2$ value.
         1) Normal range (for a typical patient): 35-45 mmHg
      ii. Respiratory Rate (RR) in breaths per minute
      iii. No breath periods indicating potential apnea
      iv. $EtCO_2$ Waveform (capnogram)
      v. Fractional Inspired Carbon Dioxide ($FiCO_2$) value.
         1) Normal (for a typical patient): 0 mmHg
   b. EtCO2 preset monitor default values are.
      i. High $EtCO_2$ 60.
      ii. Low $EtCO_2$ 10.
      iii. High RR 48.
      iv. Low RR – < 6 monitor will alarm, 5 or < 5/4 will pause any continuous infusion of medications
      v. No breath detected alarms at 30 seconds
   c. To change the alarm limits:
      i. The following alarm limits on the Alaris® $EtCO_2$ module may be changed after completing patient assessment and collaborating with Respiratory Therapist or physician to determine a patient's normal parameters:
         1) $EtCO_2$ High
         2) $EtCO_2$ Low
         3) RR High
         4) RR Low
         5) No Breath limit
      ii. Press the Channel Select key on the Alaris® $EtCO_2$ module
      iii. On the $EtCO_2$ Main Display, press the limits soft key.
      iv. For each limit you want to modify, press the soft key on the Alaris® PC point-of-care unit and change the value by one of the following methods:
         1) Enter a new value using the numeric keys.
         2) Change the value using the up and down arrow keys.
      v. After making all of your changes, press the Confirm soft key to confirm the new limits.
      vi. Document changes outside the default settings in a clinical note
6. Monitoring:

a. To view $EtCO_2$ information while a patient is monitored, press the Channel Select key on the Alaris $EtCO_2$ module. From top to bottom on the Main $EtCO_2$ Display screen, the following information is visible:
   i. Current $EtCO_2$ value in mmHg with upper and lower alarm limits.
   ii. Current RR (respiratory rate) in breaths per minute.
   iii. Capnogram or $EtCO_2$ waveform

7. $EtCO_2$ Trend Data:
   a. The following information appears on the $EtCO_2$ Trend Data display.
      i. Time period for data collection.
      ii. Average $EtCO_2$ with maximum (MAX) and minimum (MIN) values.
      iii. Average RR with maximum (MAX) and minimum (MIN) values.
      iv. Alarm icon with "Fi" in the Time column to indicate high $FiCO_2$ alarm limit violations.
      v. Alarm icons indicating there were alarm violations with these values.
   b. To access the $EtCO_2$ trend data.
      i. Press the Channel Select key on the Alaris® $EtCO_2$ module.
      ii. Press the Trend soft key on the Alaris® PC point-of-care unit.
      iii. Six data collection periods are displayed on a single screen page. To move from page to page, press the Page Up and Page Down soft keys.
      iv. To move the cursor and scroll through the data one row at a time, press the up arrow and down arrow changing the Data Collection Time Period.
   c. To zoom in or out of a time period.
      i. Move the cursor to the desired time period for start of review.
      ii. Press the Zoom soft key.
      iii. Each press of the zoom soft key changes one time period. Available time periods are 120, 60, 30, 5, and 1 minute(s). Repeated pressing of the Zoom soft key cycles through the time period choices.
   d. Patient Controlled Analgesia (PCA) and $EtCO_2$ Trend Data.
      i. The following information appears on the combined Trend Data screen.
         1) Time period for data collection.
         2) Total dose of medication infused through the Alaris® PCA module*.
         3) Average $EtCO_2$.
         4) Average RR.
         5) Alarm icons indicating alarm violations.
      ii. The TOTAL DOSE column includes all infusions that have gone through the PCA module during that time period. This includes all PCA doses, Bolus doses, Loading doses, and Continuous infusions.
      iii. To access PCA and $EtCO_2$ Trend Data.
         1) Press the Channel Select key on the Alaris® $EtCO_2$ module.
         2) Press the Options key on the Alaris® PC point-of-care unit.
         3) On the Channel Options screen, press the PCA/ $EtCO_2$ Trend data soft key.

8. Alarms
   a. Pre-Silencing Alarms.
      i. The Pre-Silence feature allows you to silence alarms before they occur. For example, if you know you will be taking the disposable off your patient for a period of 2 minutes, you can first Pre-Silence the alarms and then take off the disposable. Monitoring audio alarms can be pre-silenced for 120 seconds. This does not apply to infusion alarms, which cannot be pre-silenced. While monitoring alarm tones are silenced, visual alarm indicators remain active.
      ii. To pre-silence monitoring audio alarms, press the Silence key on the Alaris® PC point-of-care unit. You will then see an alarm icon with an X over it next to the $EtCO_2$ channel on the Main Display
      iii. Canceling pre-Silence.

c. Check the patient for normal signs of ventilation – pause the PCA.
d. Increase ventilation by stimulation.
e. Assess vital signs for decompensation – $SpO_2$, BP, RR, HR and LOC.
f. If patients $EtCO_2$ does not trend with patients normal, defined limits within 5 minutes, collaborate with Respiratory Therapy via page.
g. If patient does not respond to stimulus and vital signs prove to be decompensating, call the Rapid Response Team (RRT) to bedside for support and use the pre-ordered reversal agent ordered on the PCA CPOE order set if appropriate.

3. Low $EtCO_2$ less than 10mmHg (Changes to $EtCO_2$ alarm settings will be made in collaboration with Respiratory Therapist, RN, and/or Physician based on patient's clinical history).
a. Assess patient for proper cannula placement.
b. Hyperventilation – patient is over breathing.
c. Check the patient for increased RR and work of breathing.
d. Verify the PCA is working correctly and delivering the appropriate amount of medication.
e. Decrease ventilation. Assess pain level using pain scale.
f. Monitor vital signs.
g. If patient's $EtCO_2$ does not trend within normal limits within 5 minutes, and pain is controlled, collaborate with Respiratory Therapy.
h. Based on bedside physician's order consider: adjusting pain medication and alternative care.

4. Respiratory Rate less than 6
a. Assess patient for proper cannula placement.
b. Verify hypoventilation via assessment of respiratory rate, quality and depth.
c. If patient receiving PCA, a respiratory rate < 4 will auto pause PCA.
d. Increase ventilation by stimulating patient.
e. Assess $SPO_2$, LOC, vital Signs.
f. If patient's RR does not return to normal defined limits within 5 minutes and/or vital signs prove to be decompensating call RRT and use the pre-ordered reversal agent ordered on the PCA CPOE order set if appropriate.
g. If patient is noted to be over sedated but does not cause an alarm call RRT and notify physician

## D. DISCONTINUATION:

1. $EtCO_2$ trend should be evaluated prior to discontinuation. Patient should meet the following criteria before $EtCO_2$ can be discontinued:
a. The patient is no longer receiving concomitant medications with sedation affect (examples: Opioids, anti-anxiety, anti-nausea, or anti-histamine being used at or around the same times).
b. Patient has gone 24 hours without periods of hypoventilation less than 12 breaths per minute
c. Patient has not received unplanned reversal agents.
d. Patient has not received moderate sedation or general anesthesia within the past 4 hours.
e. Patient does not have a diagnosis of Obstructive Sleep Apnea (OSA), or suspected OSA.

2. If patient has ongoing episodes of hypoventilation during the last 24 hours, do not discontinue the $EtCO_2$ monitor. Consult with physician to possibly decrease pain medication if appropriate and continue monitoring patient.

## E. DOCUMENTATION:

1. $EtCO_2$ monitoring will be documented with vital signs unless patient requires more frequent monitoring due to respirations or $CO_2$ levels that are outside of the normal ranges
a. For patients receiving PCA vital signs will be assessed per the PCS Patient Controlled Analgesia Procedure.

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

1. End-Tidal CO2 Patient Education
2. Patient Care Services Patient Controlled Analgesia Procedure

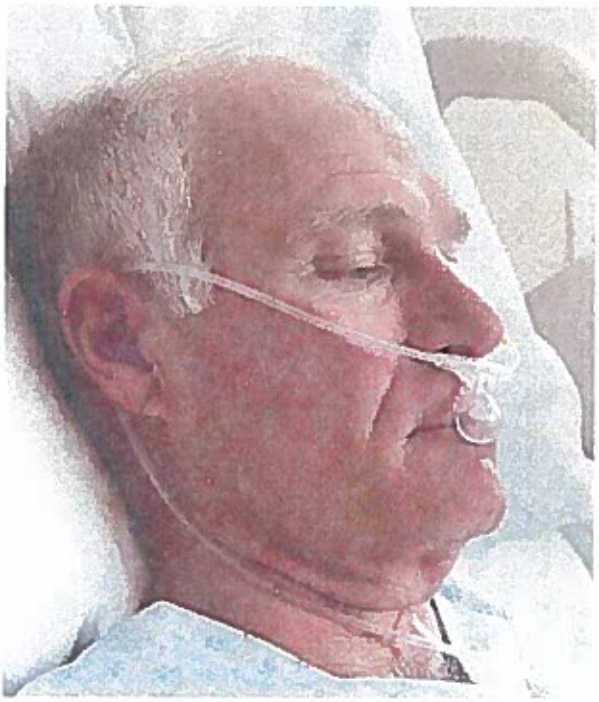
**G. REFERENCE(S):**

1. Joint Commission on Accreditation of Healthcare Organizations. Sentinel Event Alert – Patient Controlled Analgesia by Proxy. Issue 33, December 20, 2004.
2. Cardinal Health. (2006) Alaris System Directions for Use Manual

**DELETE**

# Patient information guide to end tidal carbon dioxide ($EtCO_2$) monitoring

Alaris® products



**What is this on my face and why do I need it?**

You are wearing this clear tube in your nose to monitor your breathing and to give you oxygen as needed. Your healthcare provider believes you need this because of your condition or because the medication you are getting can affect your ability to breathe.

The tube in your nose is attached to a device that will monitor your breathing. Be sure the tube is placed in both nostrils at all times. If you hear the device alarm, take a deep breath. It is not uncommon to hear more alarms while you are sleeping because your breathing is more relaxed. Think of the alarms as an alarm clock reminding you to take a deep breath.

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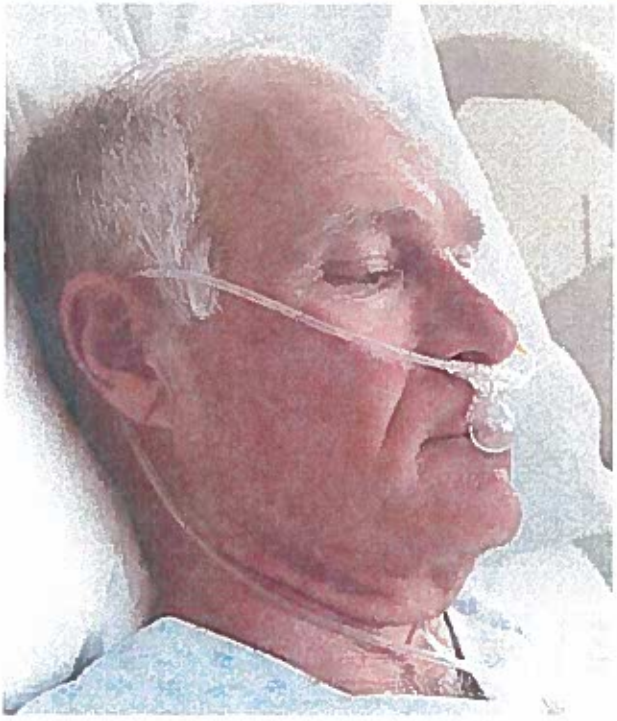
# Guia de infomación sobre el monitor de dióxido de carbono respiratorio final ($EtCO_2$)

Productos Alaris®



**¿Qué es lo que tengo en la cara y por qué lo necesito?**

Usted está usando este tubo transparente a fin de controlar su respiración y de proporcionarle el oxígeno que necesita. Su médico considera que lo necesita a causa de su afección, o bien debido a que la medicación que recibe puede afectar su capacidad respiratoria.

El tubo que tiene en la nariz está conectado a un dispositivo que controlará su respiración. Asegúrese de que el tubo esté colocado en las dos fosas nasales todo el tiempo. Si oye la alarma del dispositivo, respire profundo. Es normal oír más alarmas mientras está durmiendo, ya que su respiración es más relajada. Piense que las alarmas son como una alarma de reloj que le recuerda que debe respirar profundamente.

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Oceanside, California

**PATIENT CARE SERVICES**

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**ISSUE DATE:** 03/09

**SUBJECT:** Family Presence During Resuscitation

**REVISION DATE:** 01/12

~~**POLICY NUMBER: IV.PP**~~

~~**Department** Patient Care Services Content Expert Approval **Date(s)**: 04/16~~03/19
**Clinical Policies & Procedures Committee Approval:** ~~05/16~~04/19
**Nursing Executive Council Committee Approval:** ~~05/16~~04/19
**Medical Staff Department or Division Approval:** n/a
**Medical Executive Committee Approval:** ~~06/16~~05/19
**Administration Approval:** 06/19
**Professional Affairs Committee Approval:** ~~07/16~~ n/a
**Board of Directors Approval:** 07/16

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A. **DEFINITIONS:**

1. Family Presence: The presence of family in the patient care area in a location that affords visual or physical contact with the patient during resuscitation events.
2. Resuscitation: A sequence of events, which are initiated to sustain life or prevent further deterioration of the patient's condition.
3. Family: A relative of the patient or any significant other with whom the patient shares an established relationship.
4. Family Support Person: Tri-City Healthcare District (TCHD) employees including:
   a. Assistant Nurse Manager (ANM)
   b. Staff Registered Nurse (RN)
   c. Chaplain
   d. Social Worker
   e. Administrative Supervisor or other designee who is assigned to the family of a patient during a resuscitation event and assumes no direct care responsibilities for the patient. During day shift hours the ~~F~~family ~~S~~support ~~P~~person role will be fulfilled by a chaplain or social worker, or if unavailable, the ANM or his/her designee. During night shift hours the ~~Family Support Person~~**family support person** role will be fulfilled by the Administrative Supervisor, ANM, or his/her designee.

B. **PURPOSE:**

1. To assure patient and families are provided care consistent with the philosophy of patient/family-centered care and established emergency care standards.
   a. Supportive data:
      i. The family is a constant in the patient's life. Family participation and involvement in the patient's health care promotes collaborative relationships among the patient, family and health care professionals. The strengths and coping strategies of the family are supported and incorporated into the care of the patient.

C. **POLICY:**

1. Patient & Family Assessment
   a. Family members shall be assessed by the primary Registered Nurse (RN) or designee for the appropriate levels of coping, desires and needs.

i. In addition, family members should demonstrate the absence of combative or threatening behavior, extreme emotional volatility, and behaviors consistent with an altered mental status related to drugs or alcohol.
1) Family members demonstrating such behavior are not candidates for family presence.
ii. Children must have an adult caregiver present to be allowed at the bedside.

b. Cultural customs shall be considered and assessed. Healthcare providers shall maintain an awareness of cultural variations and be sensitive to these factors and family needs.

c. Decision to initiate family presence is dependent upon criteria consisting of three components:
i. Patient's desire to have family with them
ii. Family's desire to be present
iii. Agreement of the direct care providers

d. Family members who do not wish to participate shall be supported in their decision without judgment and the family support person shall remain with them.

e. When a resuscitation event is announced a ~~F~~family ~~S~~support ~~P~~person shall be determined based on available staff.

f. The family support person shall identify the primary RN and ask if the family can be present.

2. Preparation/Participation of Family Presence

a. The family support person shall explain the patient's appearance, treatments and equipment used in layman's language and shall prepare the family for entering the patient's room, including:
i. Communicating that the patient is the priority.
ii. Explaining how many family members may enter the room safely, where they may stand initially, when they shall be able to move to the bedside and what not to touch to prevent injury.
iii. Explaining and adhering to appropriate infection control measures if the patient is in isolation or contact precautions.
iv. Preparing family members for the sights and sounds of resuscitation.
v. Clearly informing the family of the status of their loved one at all times.
vi. Explaining why the family may be asked to step out of the room and when they can leave the room.
vii. Informing the health care providers of the presence of the family.
viii. Remaining with the family at all times during the resuscitation.
ix. Escorting the family from the bedside and/or out of the room if deemed necessary by the health care providers.

3. Post-Code Follow-Up

a. Immediately following the resuscitation event, the ~~F~~family ~~S~~support ~~P~~person shall meet with and debrief the family regarding circumstances of the resuscitation event and the outcome.

b. **If the ~~P~~**patient survives resuscitation efforts with good prognosis
i. **Provide** patient/family orientation to the Intensive Care Unit (ICU)
ii. **Explain ~~P~~**procedures/test fully ~~explained~~ and **update** all parties ~~updated~~ per primary care RN/Primary physician on an on-going basis.
iii. Transfer to ICU

c. **If the ~~P~~**patient survives with poor prognosis
i. Discussion **shall be** initiated with family regarding comfort measures, hospice, etc.
1) Hospitality cart ordered for family
2) Chaplain Services as appropriate
3) Open Visitation
ii. Life sharing referral initiated

d. **If the ~~P~~**patient Expires

i. **Explain** end of ~~Life~~ **life** process ~~explained~~ to family per primary care RN/ancillary staff (i.e., Chaplain, Social Worker, and Administrative Supervisor). **See Patient Care Services Policy: End of Life (Comfort Care)**
ii. **Notify** Life-Sharing ~~notified~~ of expiration.
iii. **Allow** ~~F~~family ~~allowed~~ private time in room.
~~iv.~~ **Complete** ~~R~~required documentation. ~~completed; patient representative phone number given when necessary.~~
v. ~~Grieving pamphlet offered~~ **Offer dealing with grief information** to family.
~~i. Sympathy card mailed to family within 24-48 hours of expiration.~~
~~ii. Follow-up phone call/survey completed regarding family who witnessed the resuscitation event.~~

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

**1. Patient Care Services Policy: End of Life (Comfort Care)**

~~D.~~**E. REFERENCE(S):**

1. American Association of Critical Care Nurses (AACN). (2016). Practice alert: Family Presence During Resuscitation and Invasive Procedures. Retrieved May 9,2016, from http://www.aacn.org/wd/practice/docs/practicealerts/family-presence-during-resusitation-and-invasive-procedures-pa-2015.pdf
2. Davidson, J. E., Powers, K. S., Hedayat, K. M., Tieszen, M., Kon, A. A., Shepard, E., et al. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit. American College of Critical Care Medicine Task Force 2004-2005. Critical Care Medicine, 35(2), 605-622.
3. Emergency Nurses Association (2007). Presenting the Option for Family Presence (3rd Edition).
4. Guzzetta, C. E., Clark, A. P., & Halm, M. A. (2008). Family presence facilitation. In E. Ackley, G. Ladwid, B. A. Swan, & S. Tucker (Eds.), Evidence-based nursing care guidelines. Philadelphia: Elsevier.
5. Mian, P., Warchal, S., Whitney, S., Fitzmaurice, J., & Tancredi, D. (2007). Impact of a multifaceted intervention on nurses' and physicians' behaviors toward family presence during resuscitation. Critical Care Nurse, 27(1), 52-61.
6. Oczkowski, S.J.W., Mazzetti, I., Cupido, C., Fox-Robichaud, A. E. (July/August 2015). Family Presence During Resuscitation: A Canadian Critical Care Society Position Paper. Canadian Respiratory Journal, 22(4), 201-205.
7. Porter, J. E., Cooper, S. J., Sellick, K. (2014). Family Presence During Resuscitation (FPDR): Perceived Benefits, Barriers and Enablers to Implementation and Practice. International Emergency Nursing, 22(2), 69-74.
8. Beesley, S.J., Hopkins, R. O., Francis, L., Chapman, D., Johnson, N., & Brown, S. M. (April 2016). Let Them In: Family Presence During Intensive Care Unit Procedures. American Thoracic Society.

Tri-City Medical Center
Oceanside, California

**PATIENT CARE SERVICES ~~POLICY MANUAL~~**

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**ISSUE DATE:** 10/07

**SUBJECT:** Growth Chart Documentation for Pediatrics, Adolescents, and Neonates

**REVISION DATE(S):** 10/10, 01/11

**~~POLICY NUMBER: III.K~~**

| | |
|---|---|
| **Patient Care Services Content Expert Approval:** | **08/17** |
| **Clinical Policies & Procedures Committee Approval:** | **~~08/14~~11/18~~01~~/19** |
| **Nurse Executive Committee Approval:** | **~~08/14~~01/19** |
| **Department of Pediatrics Approval:** | **~~11/14~~04/19** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~11/14~~05/19** |
| **Administration Approval:** | **06/19** |
| **Professional Affairs Committee Approval:** | **~~01/15~~ n/a** |
| **Board of Directors Approval:** | **01/15** |

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A. **PURPOSE:**

1. Monitoring of growth (weight~~,~~ **and** length/height-and head circumference **~~(KEEP))~~** of neonates, infants, pediatric, and adolescent patients (up to **twenty-one** [21] years of age) is necessary to evaluate nutrition status, growth, and appropriateness of nutrition intake.

B. **POLICY:**

1. Nursing shall document (plot) weight and height/length data on predetermined growth charts for all neonate, infant, pediatric, and adolescent patients.
   a. Weight and height/length data shall be plotted on admission and as indicated.
   b. Head circumference for infants, neonates, and children less than three years of age, shall be plotted on admission.
      i. Head circumference shall be monitored after admission per physician/**Allied Health Professional (AHP)** order.
2. Growth Charts used for specific age groups are as follows per Center for Disease (CDC) recommendations and shall be added to the medical record:
   a. **Term** Infant boys (birth to **twenty-four [24~~36~~]** months): **~~(Form #6290-1020)~~**
      i. Length–for–Age and Weight–for–Age, 3 – 97th Percentiles
      ii. Head circumference–for–Age and Weight–for–Length, 3 – 97th Percentiles
   b. **Term** Infant girls (birth to **twenty-four [24~~36~~]** months): **~~(Form #6290-1018)~~**
      i. Length–for–Age and Weight–for–Age, 3 – 97th Percentiles
      ii. Head circumference–for–age and Weight–for–length, 3 – 97th Percentiles
   c. Children and adolescent boys (**two** [2] to **twenty-one** [21] years): **~~(Form #6290-1021)~~**
      i. Stature–for–Age and Weight–for–Age, 3 – 97th Percentiles
      ii. Body Mass Index (BMI)–for–Age, 3 – 97th Percentiles
      iii. Cerner: Weight by age percentile for boys aged **two** (2) – **twenty** (20) years
      iv. Cerner: Stature by age percentile for boys aged **two** (2) – **twenty** (20) years
   d. Children and adolescent girls (**two** (2) to **twenty-one** [21] years): **~~(Form #6290-1019)~~**
      i. Stature–for–Age and Weight-for-Age, 3 – 97th Percentiles
      ii. BMI–for–Age, 3 – 97th Percentiles
      iii. Cerner: Weight by age percentile for girls aged **two** (2) – **twenty** (20) years
      iv. Cerner: Stature by age percentile for girls aged **two** (2) – **twenty** (20) years
   ~~v.~~ **e.** Fenton Fetal-Infant Growth Chart for Preterm Infants (**Fenton Growth Chart** Form #6070-1015)

i. Infant boys (Twenty two [22] weeks to fifty [50] weeks - Gestational age (weeks)
   1) Length–for–Age and Weight–for–Age, 10 – 97th Percentiles
   ~~vi.~~2) Head circumference–for–Age and Weight–for–Length, 3 – 97th Percentiles

ii. Infant girls (Twenty two [22] weeks to fifty [50] weeks - Gestational age (weeks)
   1) Length–for–Age and Weight–for–Age, 10 – 97th Percentiles
   ~~vii.~~2) Head circumference–for–age and Weight–for–length, 3 – 97th Percentiles

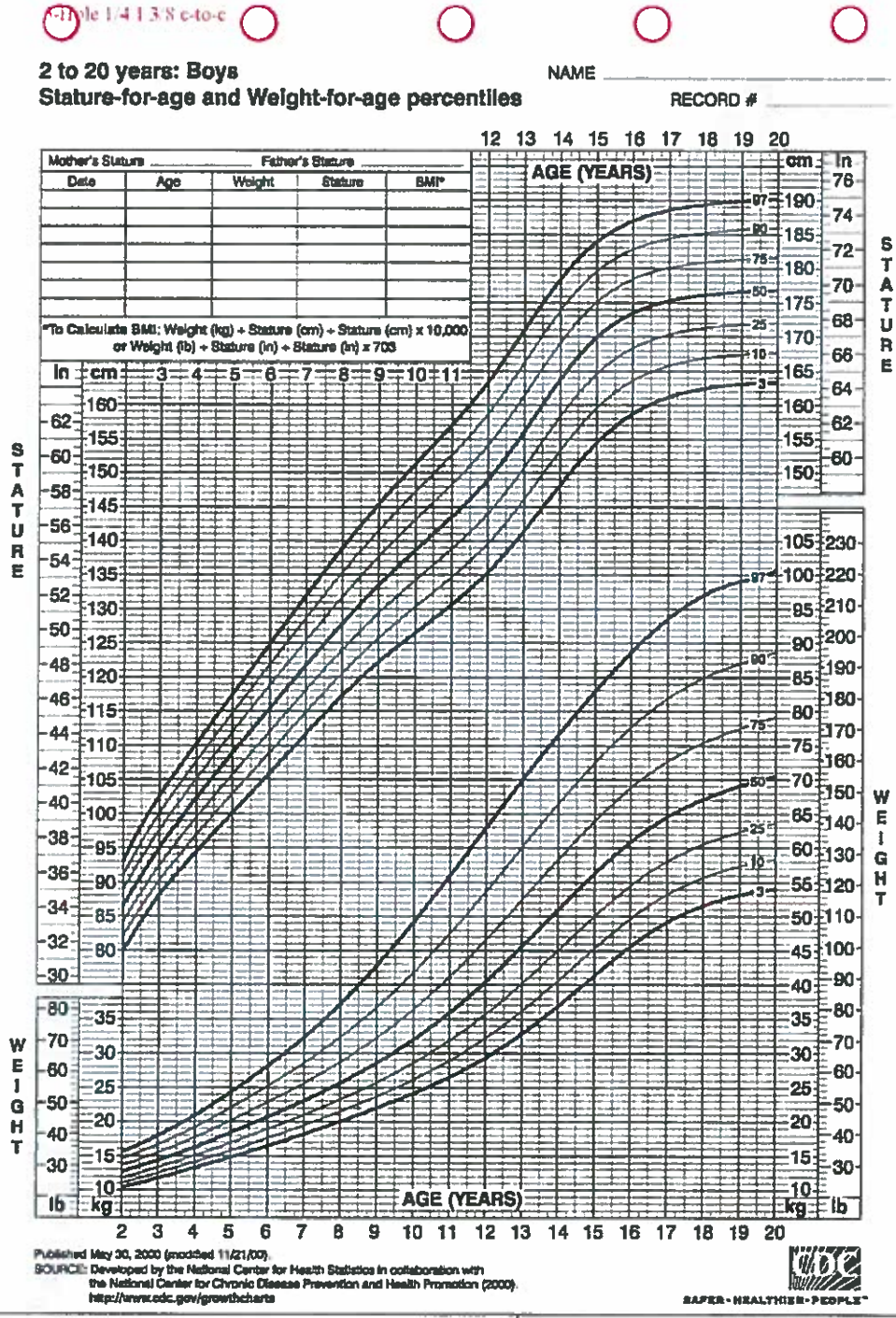
~~Infant boys (birth to thirty-six [37] Weeks)~~
~~i. Length–for–Age and Weight–for–Age, 10 – 97th Percentiles~~
~~ii. Head circumference–for–Age and Weight–for–Length, 3 – 97th Percentiles~~

~~b) Infant girls (birth to thirty-six [37] Weeks):~~
~~i. Length–for–Age and Weight–for–Age, 10 – 97th Percentiles~~
~~ii. Head circumference–for–age and Weight–for–length, 3 – 97th Percentiles~~

B. FORM(S):
1. 2 to 20 Years: Boys Stature-for-Age and Weight-for-Age Percentiles and Boys Body Mass Index-for-Age Percentiles 6290-1021 - Sample
2. 2 to 20 Years: Girls Stature-for-Age and Weight-for-Age Percentiles and Girls Body Mass Index-for-Age Percentiles 6290-1019 - Sample
3. Birth to 36 Months: Boys Length-for-Age and Weight-for-Age Percentiles and Boys Head Circumference-for-Age and Weight-for-Length Percentiles 6290-1020 - Sample
4. Birth to 36 Months: Girls Length-for-Age and Weight-for-Age Percentiles and Girls Head Circumference-for-Age and Weight-for-Length Percentiles 6290-1018 - Sample
5. Fenton Growth Chart 6070-1015 – Sample
6. Fenton Preterm Growth Chart – Boys – Sample
7. Fenton Preterm Growth Chart – Girls – Sample
~~e.~~8. Classification of Newborns – Based on Maturity and Intrauterine Growth - Sample

~~A.~~C. REFERENCE(S):
1. American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. (2012). *Guidelines for Perinatal Care* (7th ed.).
2. *Gestational Charts and Growth Charts.* (2015). Retrieved Jan 20, 2015, from Meadjohnson: http://www.meadjohnson.com/pediatrics/us-en/nurse-connections/helping-moms-and-babies/gestational-growth-charts
3. Simpson, K. R., & Creehan, P. A. (2014). *Perinatal Nursing* (4th ed.). N.p.: Lippincott Williams & Wilkins.

## 2 to 20 Years: Boys Stature-for-Age and Weight-for-Age Percentiles and Boys Body Mass Index-for-Age Percentiles #6290-1021 - Sample

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6290-1021
(Rev 12/07)

2 TO 20 YEARS: BOYS
STATURE-FOR-AGE AND
WEIGHT-FOR-AGE PERCENTILES

Affix Patient Label

Article 1413 Note-to-c

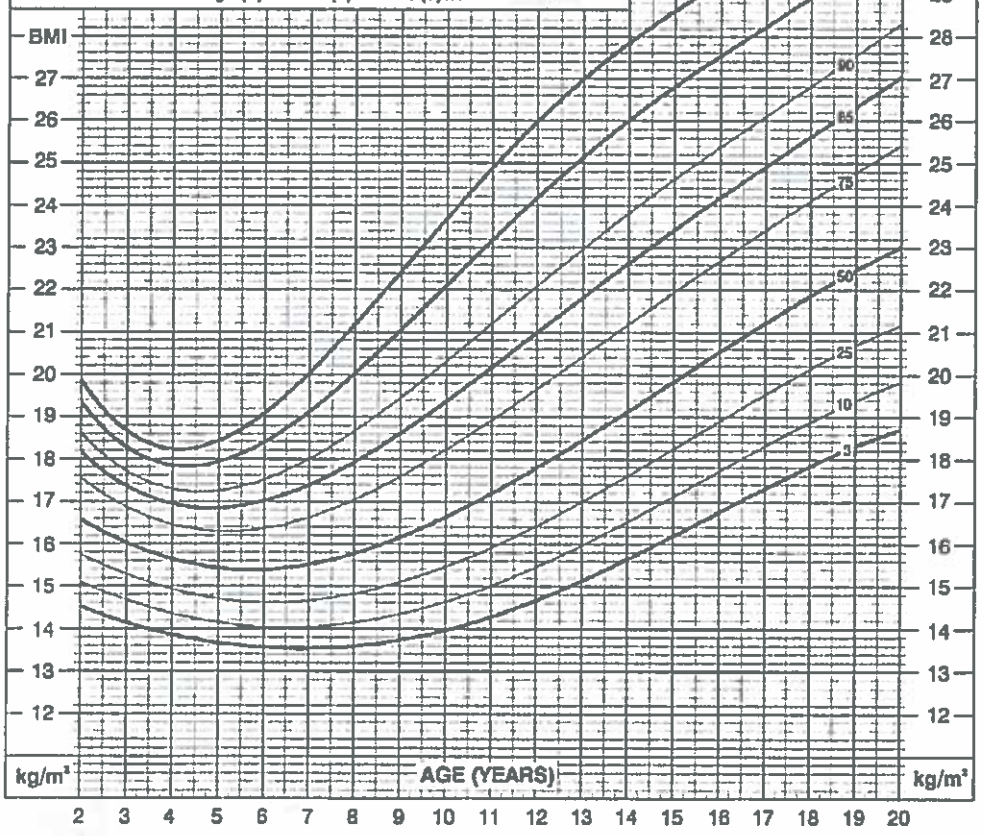
## 2 to 20 years: Boys
## Body mass index-for-age percentiles

NAME _____

RECORD # _____

| Date | Age | Weight | Stature | BMI* | Comments |
|---|---|---|---|---|---|
| | | | | | |

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703




Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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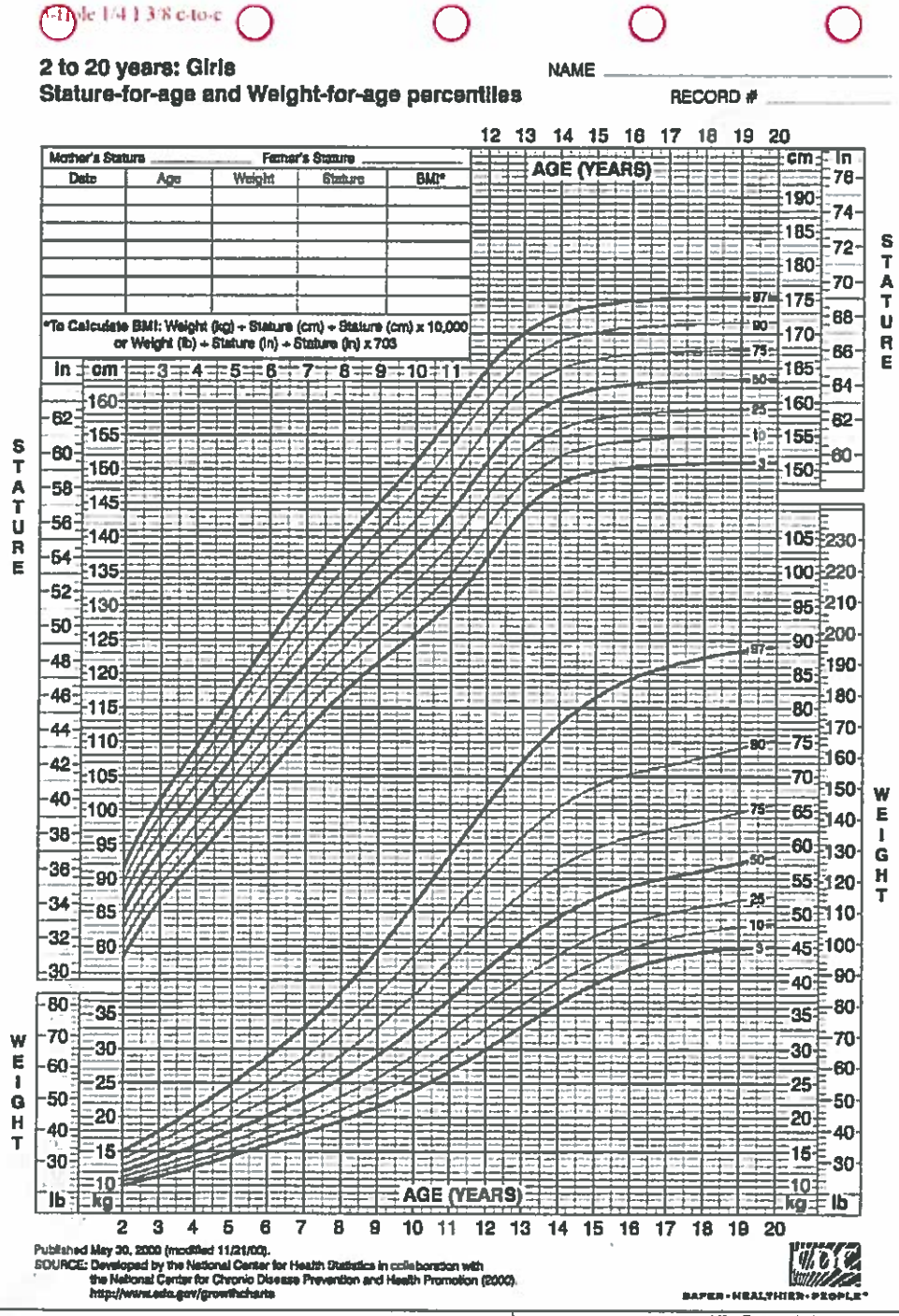
6290-1021
(Rev 1/07)

2-20 YEARS: BOYS
BODY MASS INDEX-FOR-AGE
PERCENTILES

## 2 to 20 Years: Girls Stature-for-Age and Weight-for-Age Percentiles and Girls Body Mass Index-for-Age Percentiles #6290-1019 - Sample

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6290-1019
(Rev. 12/07)

2 TO 20 YEARS: GIRLS
STATURE-FOR-AGE AND
WEIGHT-FOR-AGE PERCENTILES

## 2 to 20 years: Girls
## Body mass index-for-age percentiles

NAME _____

RECORD # _____

| Date | Age | Weight | Stature | BMI* | Comments |
|---|---|---|---|---|---|
| | | | | | |
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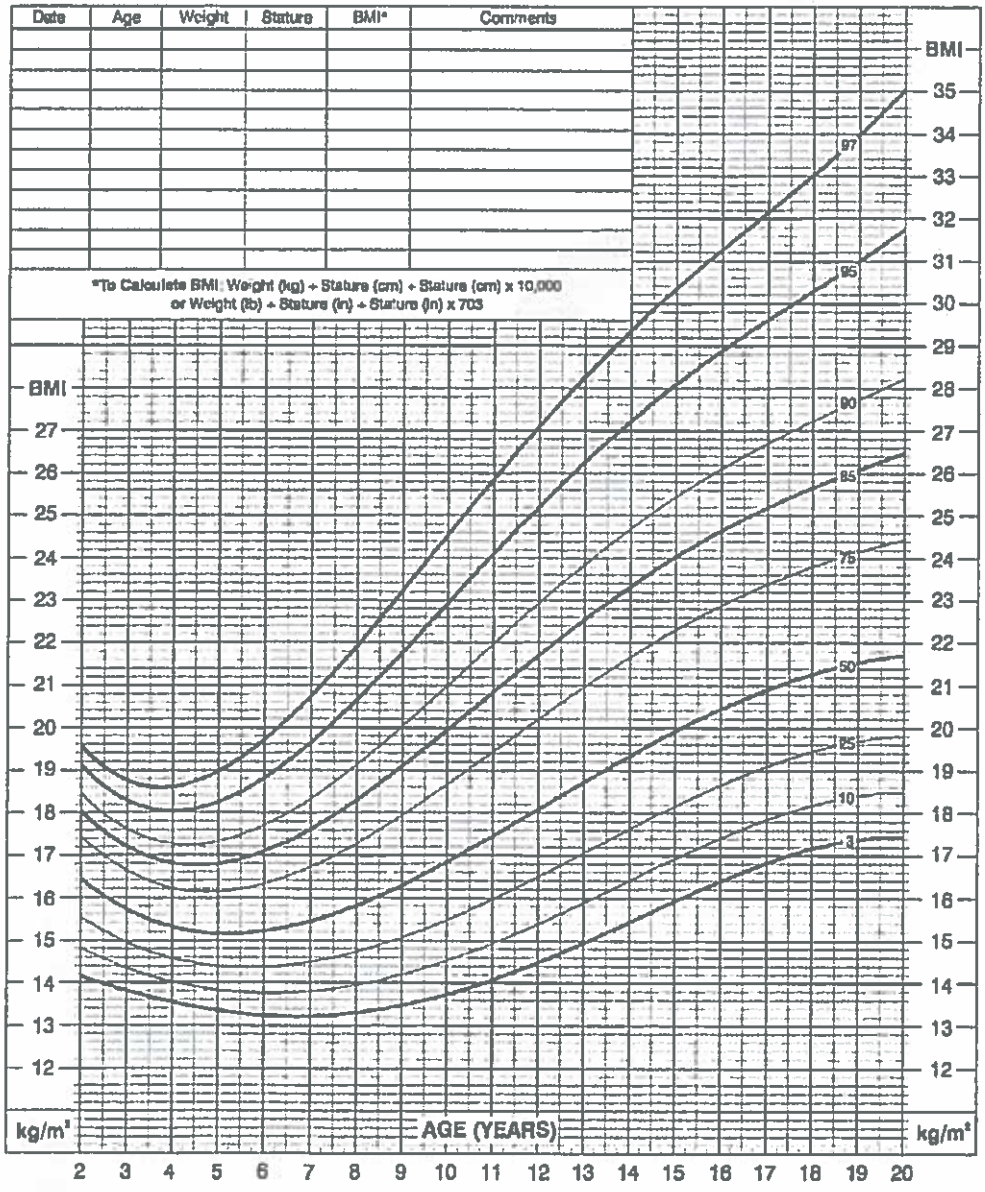
*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703




Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts

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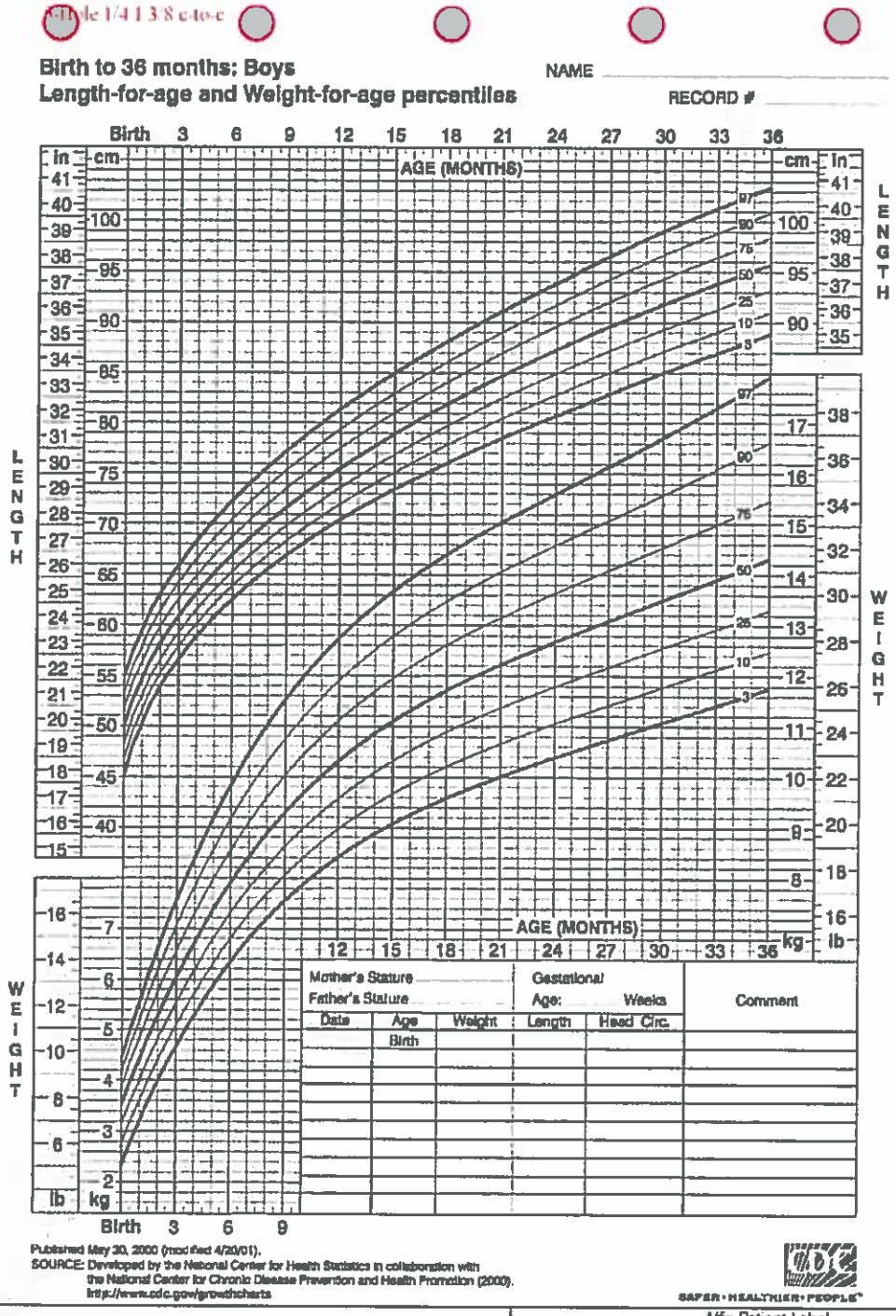
2 TO 20 YEARS: GIRLS
BODY MASS INDEX-FOR-AGE
PERCENTILES

Affix Patient Label

## Birth to 36 Months: Boys Length-for-Age and Weight-for-Age Percentiles and Boys Head Circumference-for-Age and Weight-for-Length Percentiles #6290-1020 - Sample

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6290-1020
(Rev 12/07)

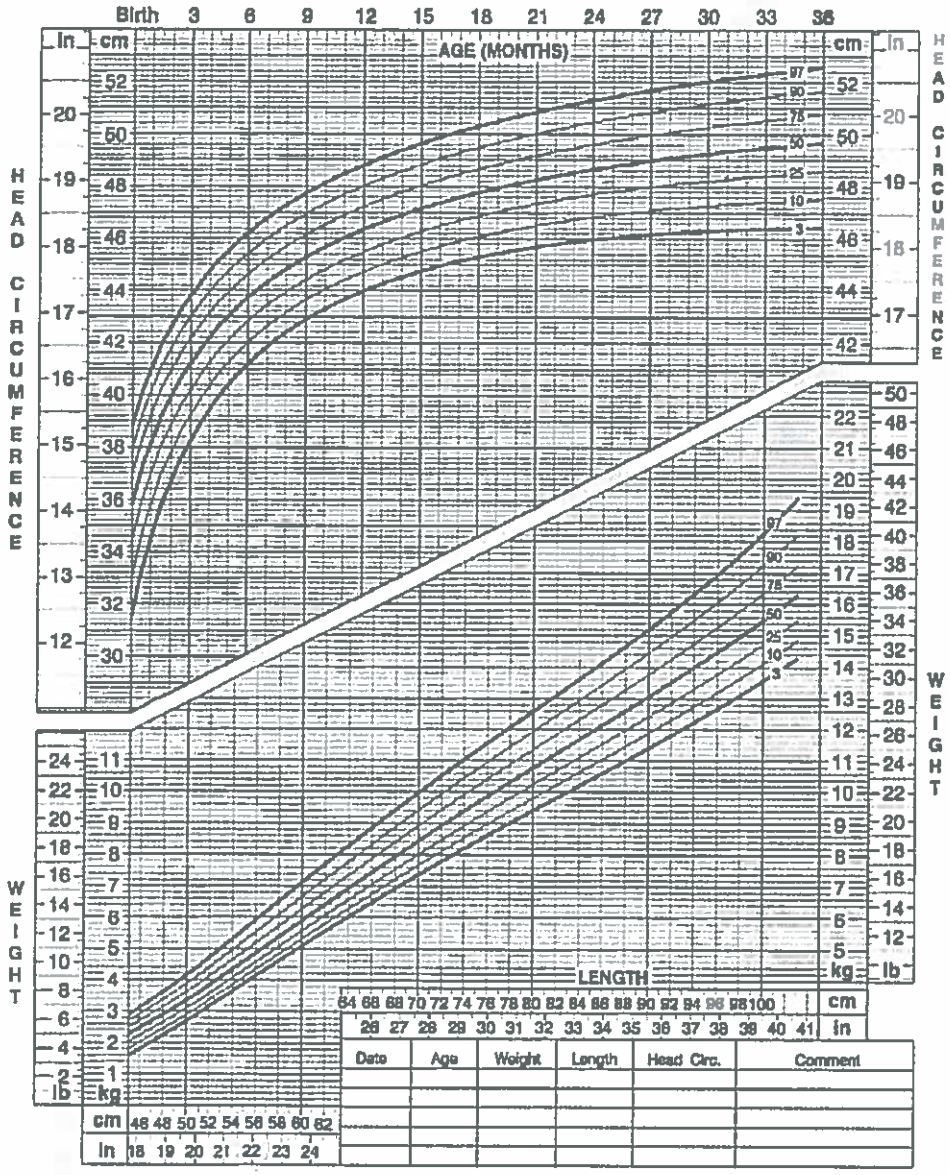
BIRTH TO 36 MONTHS: BOYS
LENGTH-FOR-AGE AND
WEIGHT-FOR-AGE PERCENTILES

Scale 1/4 1 3/8 c-to-c

**Birth to 36 months: Boys**
**Head circumference-for-age and**
**Weight-for-length percentiles**

NAME _____

RECORD # _____




| Date | Age | Weight | Length | Head Circ. | Comment |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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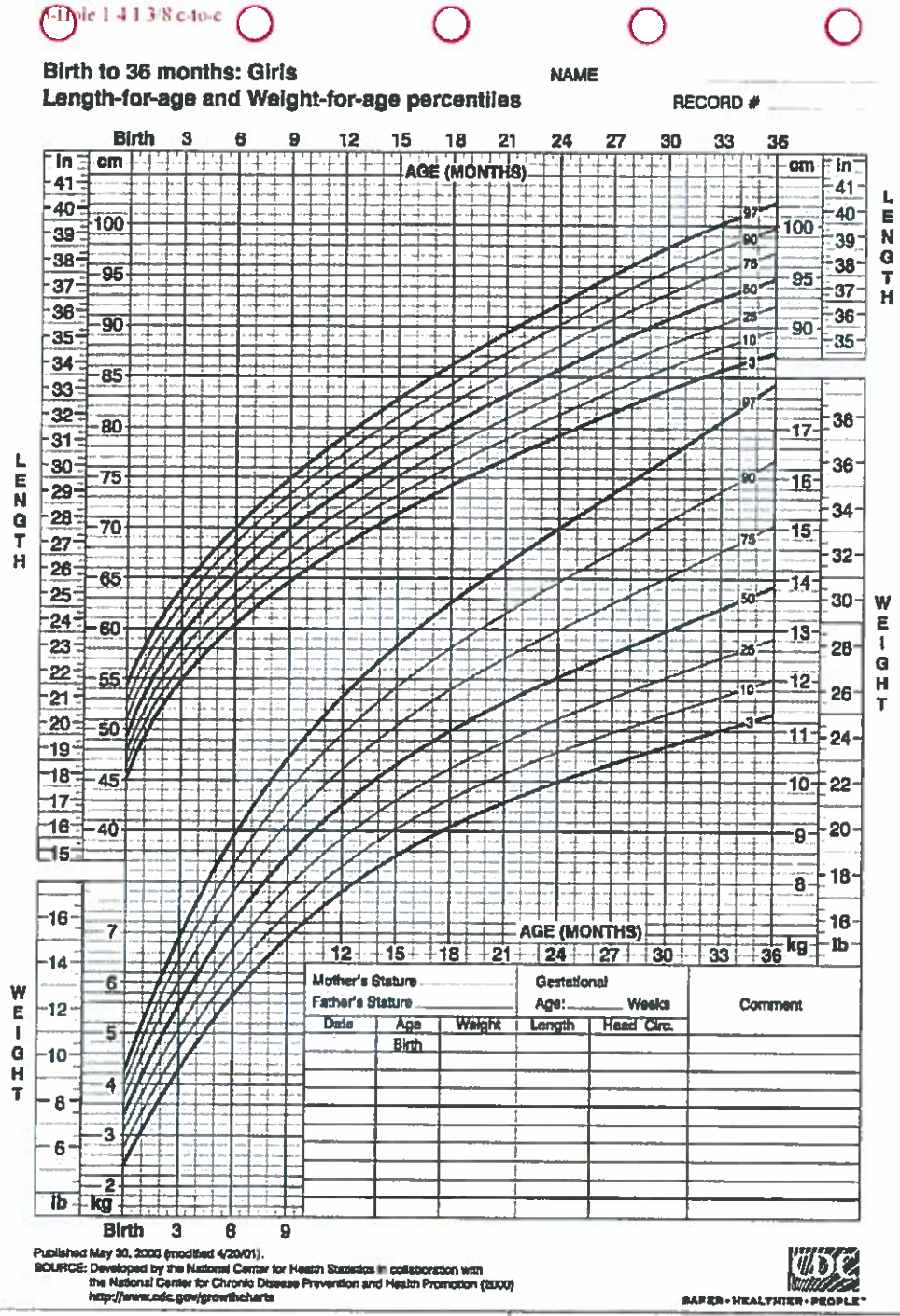
6290-1020

BIRTH TO 36 MONTHS: BOYS
HEAD CIRCUMFERENCE-FOR-AGE AND
WEIGHT-FOR-LENGTH PERCENTILES

Affix Patient Label

## Birth to 36 Months: Girls Length-for-Age and Weight-for-Age Percentiles and Girls Head Circumference-for-Age and Weight-for-Length Percentiles #6290-1018 - Sample

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6290-1018
(Rev 12/07)

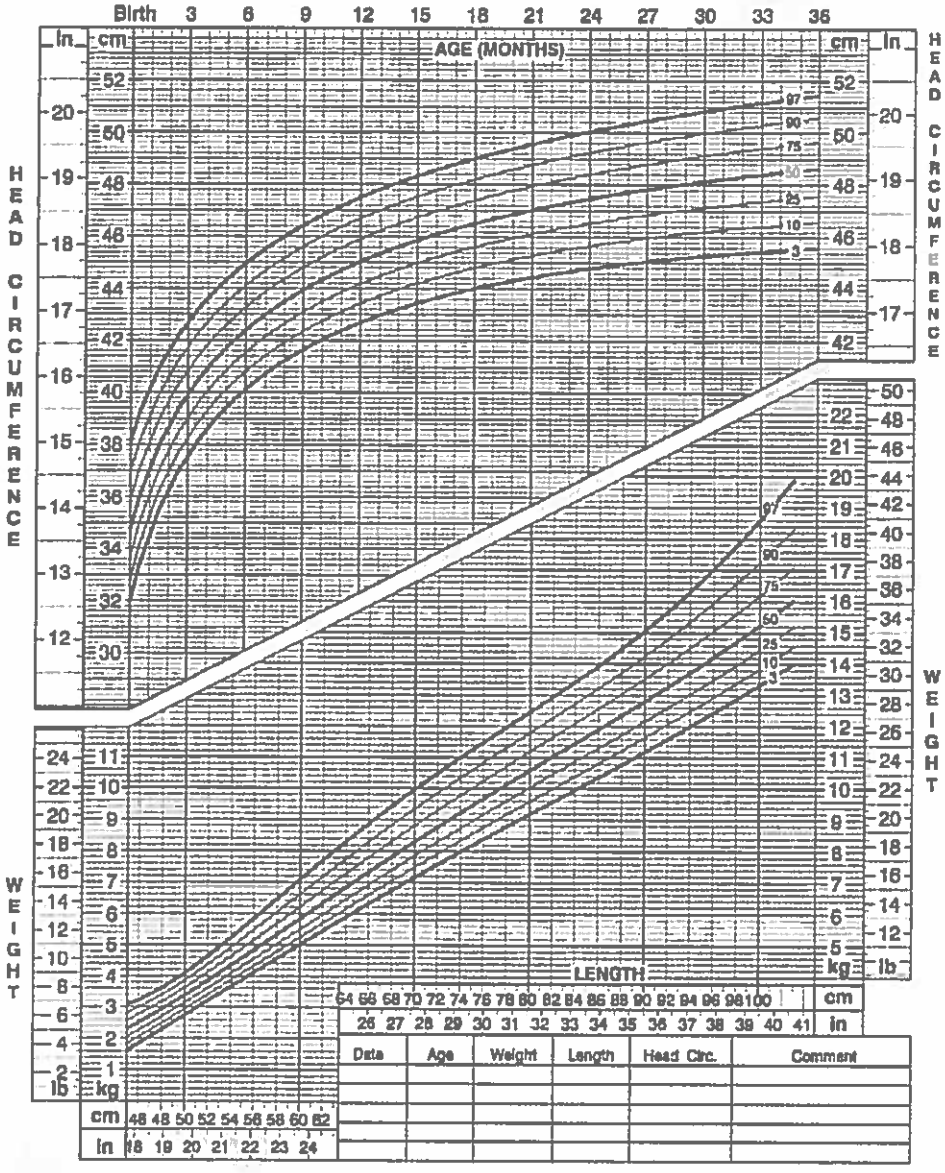
BIRTH TO 36 MONTHS: GIRLS
LENGTH-FOR-AGE AND
WEIGHT-FOR-AGE PERCENTILES

Table 1/4 1 3/8 c-to-c

**Birth to 36 months: Girls**
**Head circumference-for-age and**
**Weight-for-length percentiles**

NAME _____

RECORD # _____




Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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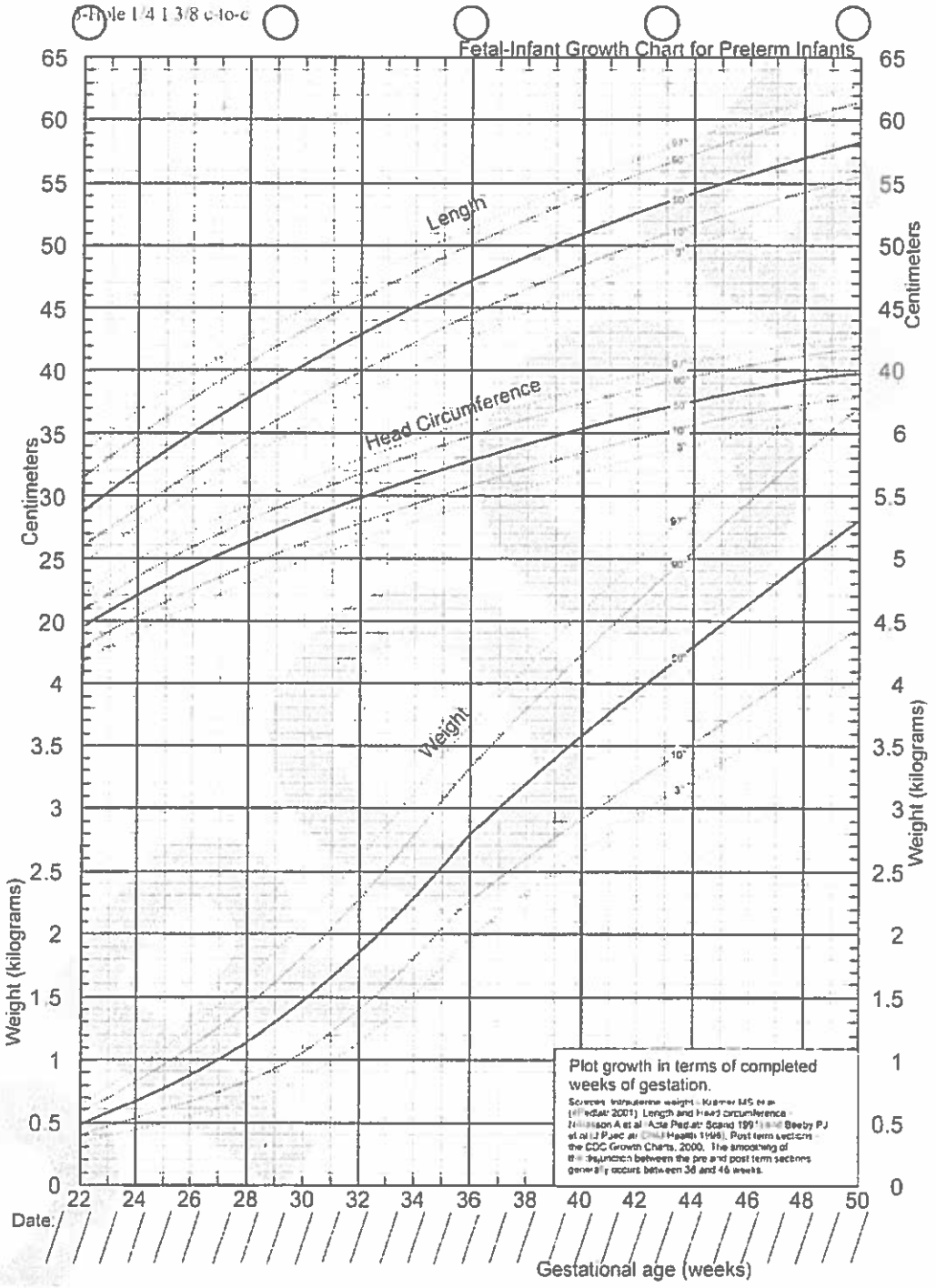
6290-1018
(Rev 12/07)

BIRTH TO 36 MONTHS: GIRLS
HEAD CIRCUMFERENCE-FOR
AGE AND WEIGHT-FOR-LENGTH
PERCENTILES

Affix Patient Label

## Fenton Growth Chart #6070-1015 - Sample

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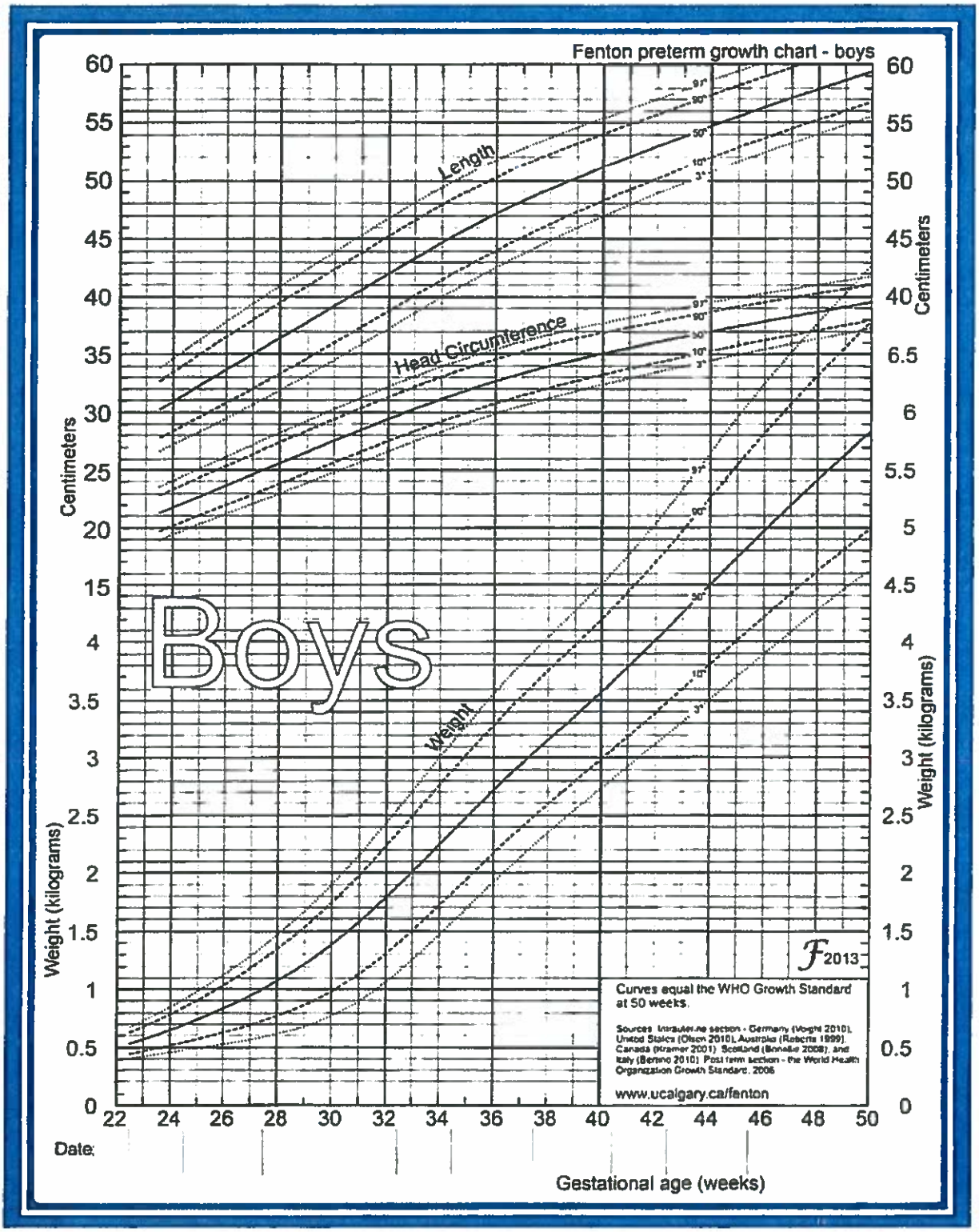
6070-1015
(Rev 11/07)

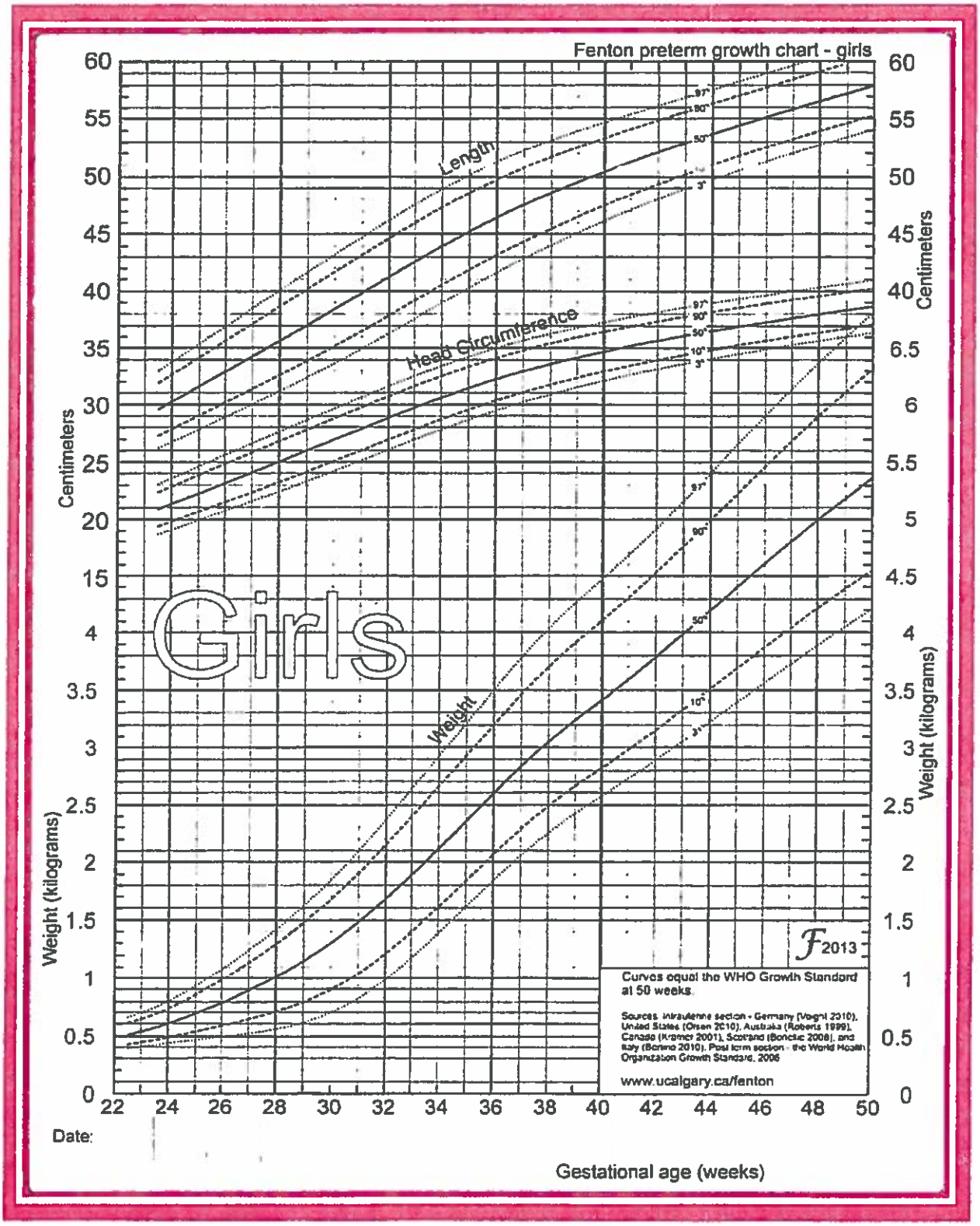
FENTON GROWTH CHART

Affix Patient Label

## Fenton Preterm Growth Chart – Boys – Sample



## Fenton Preterm Growth Chart – Girls – Sample

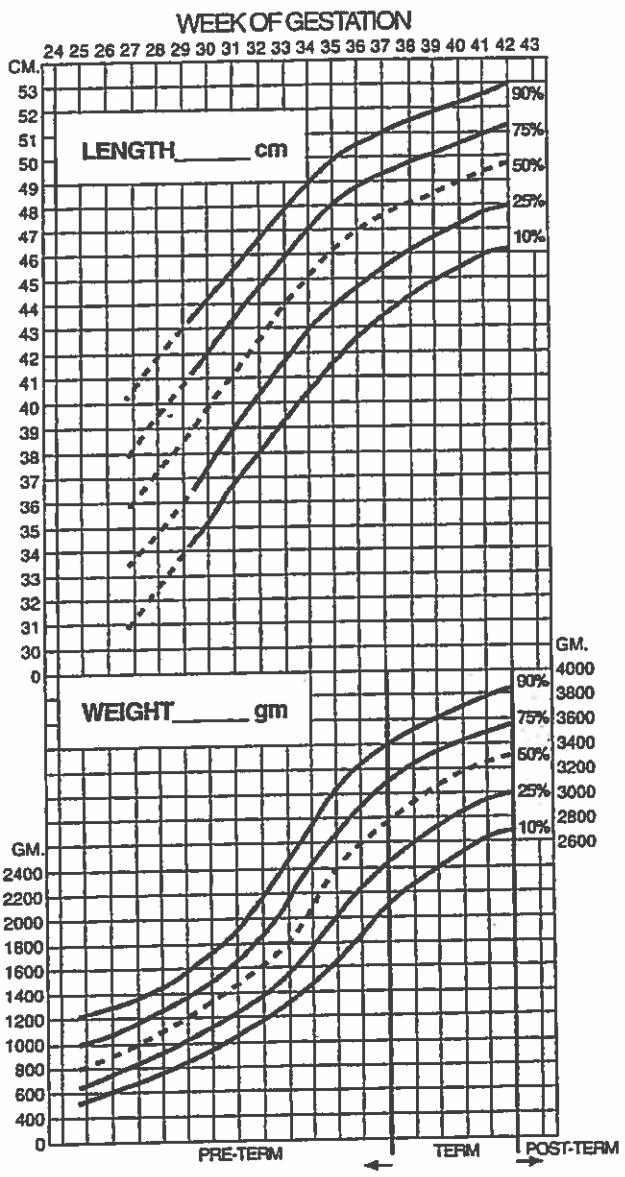


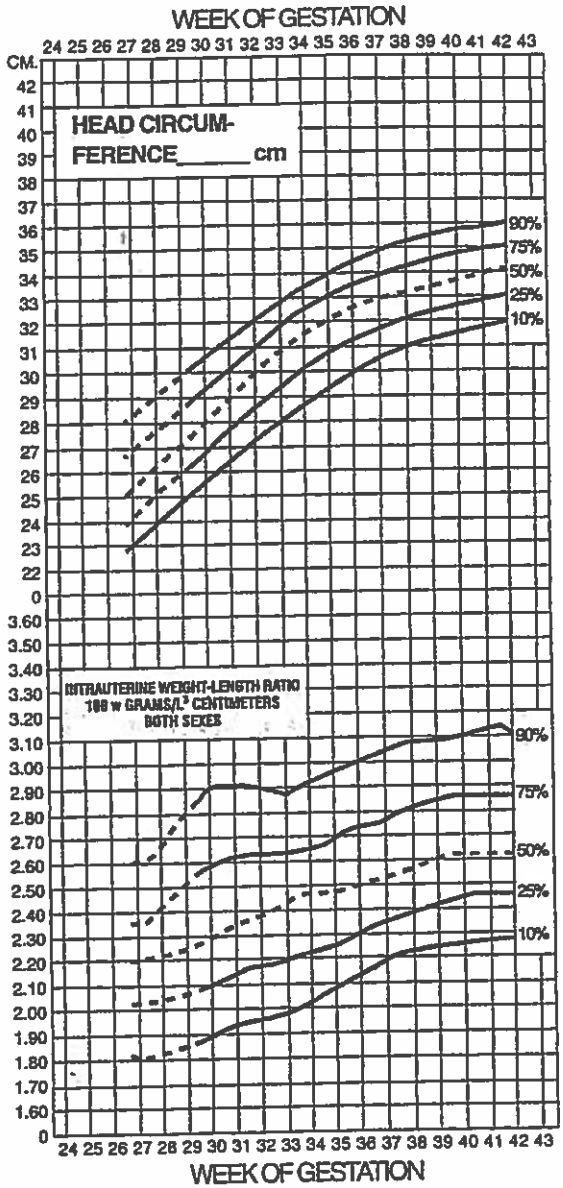
## Classification of Newborns – Based on Maturity and Intrauterine Growth – Sample

### CLASSIFICATION OF NEWBORNS - BASED ON MATURITY AND INTRAUTERINE GROWTH

Side 2

Symbols: X - 1st Exam O - 2nd Exam




| | 1st Exam (X) | 2nd Exam (O) |
|---|---|---|
| LARGE FOR GESTATIONAL AGE (LGA) | | |
| APPROPRIATE FOR GESTATIONAL AGE (AGA) | | |
| SMALL FOR GESTATIONAL AGE (SGA) | | |
| Age at Exam | hrs | hrs |
| Signature of Examiner | M.D./R.N. | M.D./R.N. |

Adapted from Lubchenco LO, Hansman C, and Boyd E: *Pediatr.* 1966;37:403; Battaglia FC, and Lubchenco LO: *J Pediatr.* 1967;71:159.

Tri-City Medical Center
Oceanside, California

## PATIENT CARE SERVICES

## STANDARDIZED PROCEDURE: HYPOGLYCEMIA MANAGEMENT IN THE ADULT PATIENT

I. **POLICY:**
- A. Function: Management of the adult patient with hypoglycemia.
- B. Circumstances:
  1. Setting: Tri-City Healthcare District using hospital approved point of care blood glucose meter
- C. Excludes: Patients on intravenous insulin infusion.

II. **ASSESSMENT:**
- A. Assess patient for hypoglycemia:
  1. Blood glucose less than 70 mg/dL with or without symptoms.
  2. Early adrenergic symptoms may include pallor, diaphoresis, tachycardia, shakiness, hunger, anxiety, irritability, headache, dizziness
  3. Later neuroglycopenic symptoms may include confusion, slurred speech, irrational or uncontrollable behavior, extreme fatigue, disorientation, loss of consciousness, seizures, pupillary sluggishness, decreased response to noxious stimuli.

III. **TREATMENT:**
- A. Treat if the point of care (POC) blood glucose is:
  1. Less than 70 mg/dL for the diabetic patient, non-diabetic patient and outpatient
  2. Less than 60 mg/dL for the pregnant patient during all phases of the pregnancy
- B. If patient is conscious and able to tolerate oral intake, give one 15 gram tube of glucose gel. May give 4 ounces orange or apple juice if patient refuses glucose gel.
  1. If the POC blood glucose was less than 50 mg/dL give an additional 15 gram tube of glucose gel (total of 30 grams of glucose gel). May give additional 4 ounces orange or apple juice if patient refuses glucose gel (total of 8 ounces orange or apple juice).
- C. If patient is NPO or unable to tolerate oral intake or has a decreased level of consciousness, administer:
  1. 30 mL of 50% Dextrose intravenously (IV) at a rate of 10mL per minute.
     a. If the POC blood glucose was less than 50 mg/dL give an additional 20 mL of 50% dextrose (total of 50 mL of 50% dextrose)
  2. If no IV access, Glucagon 1 mg subcutaneously (SQ) or intramuscularly (IM) times one (do not repeat).
- D. Recheck POC blood glucose in 15-30 minutes after treatment.
  1. If **equal to or** greater than 70 mg/dL, no additional treatment required.
  2. If still less than 70 mg/dL:
     a. Repeat above treatment
     b. Obtain serum blood glucose to verify blood glucose level
     c. If repeated POC blood glucose and initial POC blood glucose was less than 50 mg/dL notify physician and request a 10% dextrose infusion
- E. Notify the attending physician/AHP immediately only if treatment is ineffective, otherwise notify physician of hypoglycemic episode(s) prior to next dose of scheduled insulin or hypoglycemic agent.

| Patient Care Services Content Expert | Clinical Policies & Procedures | Nurse Executive Committee | Diabetic Task Force | Pharmacy & Therapeutics Committee | Inter-disciplinary Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|---|
| 08/12, 10/18 | 09/12, 4/15, 01/17, 11/18 | 09/12, 4/15, 02/17, 11/18 | 05/15,12/16, 02/17, 12/18 | 11/12, 05/15, 03/17, 01/19 | 01/13, 09/15, 04/17, 04/19 | 02/13, 09/15, 04/17, 05/19 | 06/19 | 10/15, 05/17, n/a | 02/13, 10/15, 05/17 |

F. Treatment of serum (lab draw) blood glucose if less than 70mg/dL:
   1. Because serum blood glucose is resulted at least 40 minutes (or more) after the blood is drawn, recheck with POC blood glucose prior to treatment. If less than 70 mg/dL, treat as outlined above.

## I. DOCUMENTATION:

A. Document the following:
   1. Document patient symptoms, glucose values, treatments, and patient's response to treatment and physician notification in the medical record.
   2. 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.
   3. Document administration of medications on the Medication Administration Record

## II. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current **unencumbered** California RN license.
B. Education and Training: Blood glucose analysis training using blood glucose monitoring device including hypoglycemia management.
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual blood glucose monitoring device review with return demonstration and hypoglycemia management.

## III. 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. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses (RNs) who have successfully completed requirements as outlined above are authorized to direct and perform Hypoglycemia Management Standardized Procedure.

## V. REFERENCE(S):

A. California Diabetes and Pregnancy Program Sweet Success: Guidelines for Care. **2015**~~2012~~. California Department of Public Health.
B. Clinical Diabetes, Volume 34, Number 4, Fall 2016, American Diabetes Association.
C. Diabetes Spectrum Volume 18, Number 1, 2005.
D. Hospital Practice, 2016, Volume 44, No. 1, 1-8.
E. Rule of 15 endorsed by the ADA and Mayo Clinic, Complete Nurses Guide to Diabetes Care, second edition, ADA, 2009.

| Tri-City Medical Center | ~~Distribution:~~ Patient Care Servi | **DELETE: Material is covered in Elsevier Skills** |
|---|---|---|
| **PROCEDURE:** | **POSTURAL (ORTHOSTATIC) VITAL SIGNS, OBTAINING** | |
| Purpose: | To outline the nursing responsibilities when obtaining postural (orthostatic) vital signs. | |
| Supportive Data: | Abnormal postural vital signs may indicate intravascular volume depletion, fluid loss, inadequate vasoconstriction, cardiac dysrhythmias or autonomic insufficiency secondary to the administration of pharmacological agents. | |
| Equipment: | Manual blood pressure cuff and stethoscope or automatic blood pressure machine | |

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

~~1. Postural (orthostatic) hypotension: occurs when the systolic blood pressure (S-BP) or blood pressure (BP) drops after a change in position from supine posture to upright posture. Orthostatic instability usually takes place within one (1) minute. Heart rate (HR) may increase with a fall in BP.~~

~~a. Normal postural changes include the following:~~

~~i. HR increases by 5 to 20 beats per minute transiently~~

~~ii. Systolic BP (SBP) drops 10 mm Hg~~

~~iii. Diastolic BP (DBP) drops 5 mm Hg~~

~~iv. Patient has no presenting symptoms~~

~~b. Positive postural (orthostasis) changes include the following:~~

~~i. Drop in SBP by more than 20 mm Hg~~

~~ii. Drop in DBP by more than 10 mm Hg within 3 minutes~~

~~iii. HR may increase by 15-30 beats per minute with a fall in BP~~

~~iv. Patient presents or complains of one or more of the following symptoms:~~

~~1) Dizziness~~

~~2) Lightheadedness~~

~~3) Cardiac rhythm changes~~

~~4) Syncope~~

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

~~Postural (orthostatic) vital signs shall be obtained with the patient **supine and standing.**~~

~~1. **Obtain vital signs in a sitting position only if ordered or if standing is contraindicated or patient is unable to stand.** in the following three positions; supine, sitting and standing unless contraindicated.~~

~~a. For pregnant patients, ensure lateral hip wedge is used.~~

~~2. Postural (orthostatic) vital signs shall consist of BP readings and heart rates taken in three positions i.e., supine, sitting, and standing.~~

~~3. It is important to obtain a complete set of postural vital signs before changing the patient's position.~~

~~4. The blood pressure cuff shall not be removed between position changes.~~

~~5. Obtaining accurate BP readings includes the following:~~

~~a. Compare right and left measurements.~~

~~b. Position the extremity at the level of the heart.~~

~~c. Document the position of the patient.~~

~~d. Ensure proper cuff size.~~

~~e. Measure readings at eye level at the top of the meniscus for manual readings.~~

~~C. **PROCEDURE:**~~

~~1. Select appropriate blood pressure cuff size.~~

~~a. A cuff that is too small may result in a false high result.~~

~~b. A cuff that is too large may result in a false low result.~~

| 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 |
|---|---|---|---|---|---|---|---|---|
| 12/94, 6/09, 6/12, 11/15, 03/19 | 7/12, 12/15, 04/19 | 8/12, 01/16, 04/19 | n/a | n/a | 8/12, 6/16, 05/19 | 06/19 | 9/12, 07/16, n/a | 9/12, 7/16 |

At any time during procedure, if patient exhibits positive orthostatic changes, return patient to supine position and notify physician/Allied Health Professional (AHP).
2. **Advanced Care Technician (ACT) notify primary Registered Nurse**
3. Perform hand hygiene and don gloves as needed.

4. Position patient in the supine position (flat) for approximately 10 minutes before taking initial vital signs.
   a. If the patient cannot tolerate a supine position, lower the head of bed per patient's tolerance.
   b. Obtain supine BP and HR measurements.
   c. This reading is considered the initial baseline measurement.
5. Position patient in the sitting position with legs hanging.
   a. Obtain BP and HR measurement immediately and after approximately 2 minutes.
6. Assist patient to standing position.
   a. Obtain BP and HR measurements immediately and after approximately 2 minutes.
   b. If BP and HR are stable but orthostasis is suspected, repeat BP and HR in approximately 2 minutes.
7. The physician should be notified if patient has one or more positive orthostatic changes.
   a. On cardiac monitoring units, notify physician/AHP of patient's cardiac rhythm

D. **DOCUMENTATION:**
1. Document the following on the medical record.
   a. Patient's position
   b. BP and HR in each position
      i. Cardiac rhythm on cardiac monitoring units
   c. Patient's associated signs and symptoms
2. Document physician/AHP notification of any positive orthostatic changes.

E. **REFERENCE(S):**
1. **Elsevier Performance Manager Clinical Skills. (2019). Assessment: Orthostatic vital signs. Retrieved from TCMC intranet**
Urden, L.D., Stacy, K. M., & Lough M, E. (2014). Critical care nursing: Diagnosis and management. (7th ed). Cardiovascular Clinical Assessment, Chapter 13 Elsevier. St. Louis, MO.

| Tri-City Medical Center | Patient Care Services |
|---|---|
| **PROCEDURE:** | **~~VASC BAND HEMOSTAT:~~ RADIAL ARTERY COMPRESSION BAND~~DEVICE~~** |
| Purpose: | To ensure continuity of care and patient safety **when** using **a radial compression band to maintain or regain hemostasis post cardiac catheterization or post radial artery procedure.** ~~the Vasc Banc Hemostat band following radial artery catheterization by defining device application and removal, nursing assessment requirement, device complications, and nursing interventions to resolve or minimize complications.~~ |
| Supportive Data: | Vasc Band Hemostat ~~(Models 3524, 3527, 3529, 3537)~~ Package insert – Instructions for Use, Vascular Solutions, Inc<br>Vascular Solutions Vasc Band Hemostat Tips for Optimal Performance<br>Vascular Solutions Vasc Band Hemostat Clinical Deployment Steps<br>**TR Band Instructions for Use** |
| Equipment: | ~~Vasc Band Hemostat:~~ Radial Artery Compression Device<br>Syringe – **syringe supplied by compression device manufacturer** ~~22 mL supplied~~ with ~~the Vasc Band~~<br>Pulse Oximeter with Probe<br>2 x 2 Gauze Dressing<br>Small ~~Tegaderm~~**Transparent Dressing (i.e., tegaderm)** ~~or Manufacturer's Adhesive Bandage~~<br>Wrist Positioning Splint<br>**Personal Protective Equipment (i.e., gloves, gown, mask, face shield, eye protection)** |

A. **DEFINITIONS:**

1. **Radial Compression Device**~~Vasc Band Hemostat~~: A radial artery compression device **is** used to control surface bleeding from **radial** arterial access sites after radial artery catheter removal. ~~For the purpose of this document, the Vasc Band Hemostat will be referred to as a radial compression device~~.
2. **Band Balloon** ~~Vasc Band~~: a clear plastic inflatable balloon **used to apply pressure to the radial artery.**
3. Arterial Occlusion: – A blockage of blood flow through an artery
4. Non-Occlusive Pressure Applied to an Artery: – manual pressure or pressure applied with the use of a mechanical device that does not block (prevent) the flow of blood through an artery.
5. Occlusive Pressure Applied to an Artery: – manual pressure or pressure applied with the use of a mechanical device that blocks the flow of blood through an artery

B. **POLICY:**

1. The radial artery sheath may be removed by the procedural staff or Interventional Cardiologist prior to applying the radial arterial compression **band**~~device~~.
2. The **Registered Nurse** (RN) on the receiving unit is responsible for monitoring, weaning, and removing the radial arterial compression **band**~~device~~ post procedure.
3. **A radial band** ~~The Vasc Band Hemostat~~ may not be used to apply occlusive pressure to the radial artery at any time.
4. Do not place a blood pressure (BP) cuff or obtain blood pressure measurements on the affected arm.

C. **PROCEDURE:**

1. Application of the Radial Arterial Compression **Band**~~Device~~

| ~~Department Review~~Patient Care Services Content Expert | Clinical Policies & Procedures | Nurse Executive Committee | Division of Cardiology | Pharmacy and& Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| ~~NEW~~ 01/17, 03/19 | 02/17, 03/19 | 02/17, 03/19 | 04/17, 05/19 | n/a | 06/17, 05/19 | 06/19 | 07/17, n/a | 07/17 |

**a.** Using sterile technique, open the pouch and transfer the **band**~~Vasc Band~~ and syringe onto the sterile field.
~~a.~~**i. Identify the type of syringe (locking or non-locking)**

b. At the end of the catheterization procedure, withdraw the introducer sheath 2-3 centimeter (cm) from the puncture site.

**c.** Align the center of the **band**~~Vasc Band~~ balloon 2-5 millimeter (mm) proximal to the puncture site and wrap the ~~Vasc B~~**b**and around the patient's extremity.
**i. Inflation line can point in either direction e.g. toward patient's hand or toward patient's head.**

~~c.~~**d.** ~~-~~Secure the device to the ~~patients~~**patient's** extremity using the hook and loop fastener. For optimal fit, secure the band around the extremity, allowing no room for slack, but do not overtighten.

~~d.~~**e.** Draw 18 milli~~liter~~~~meter~~ (mL) of air into the syringe and connect the syringe to the inflation valve on the ~~Vasc B~~**b**and

~~e.~~**f.** Slowly inject air into the ~~Vasc B~~**b**and balloon while simultaneously removing the sheath from the vessel. Once the sheath is completely removed, continue to inject air into the balloon until hemostasis is achieved. Note: the nominal air injection volume for the ~~Vasc~~ **b**~~B~~and is 15 mL and the maximum air injection volume is 18 mL

~~f.~~**g.** Slowly withdraw air from the ~~Vasc~~ **b**~~B~~and balloon until there is oozing from the puncture site. Once oozing is observed, re-inject 2 mL of air into the ~~Vasc B~~**b**and until complete hemostasis is achieved.

2. Post-Application of the ~~Vasc~~ **Radial** Band: ~~Nursing Care Areas~~
   a. Initial Assessment on Arrival to Nursing Care Areas
      i. Upon arrival to the nursing care area **assess the following**~~, assesses the following with the procedure Registered Nurse (RN) and~~ every 5 minutes times (x) 3: (Timing begins with the first assessment performed with the procedure RN).
         **1)** Blood pressure (BP)
         ~~1)~~**2)** **Heart Rate (HR)**
         ~~2)~~**3)** Cardiac rhythm
         ~~3)~~**4)** Oxygen Saturation ($SpO_2$)
         4~~)~~**5)** Assess temperature once on arrival and then as **ordered**~~outlined in this policy~~
         ~~5)~~**6)** Radial pulse by palpation proximally and distal**ly** to the ~~Vasc~~ **b**~~B~~and
         ~~6)~~**7)** **Neurovascular checks (P**~~p~~erfusion ~~(~~by means of pulse oximetry, color, sensation and temperature of the **affected** arm~~, and sensation)~~. ~~with the Vasc Band)~~
         ~~7)~~**8)** Presence of bleeding
      ii. Implement continuous pulse oximetry monitoring
         1) Place the pulse oximeter probe on the index finger or thumb on affected wrist ~~distal to the Vasc Band during compression and weaning the device.~~
         2) Check pulse oximetry waveform
            a) If pulse oximetry waveform is not visible (e.g., lost), decrease pressure slowly by removing 1 mL of air from the ~~Vasc~~ **b**~~B~~and until a waveform is visible
            b) If pulse oximetry waveform is lost and bleeding is present see ~~management~~ **Management** of ~~bleeding~~**Bleeding**
      iii. Document ~~the~~ vital sign results and assessment findings in the electronic health record (EHR)~~.~~
   b. Vital Signs **Assessment and Monitoring:**
      i. Assess the following every 15 minutes x 4 then, every 30 minutes after completing the initial assessment until the ~~Vasc B~~**b**and is removed and then per **the Standards of Care or** unit policy. **Document results in the EHR**~~**medical record**~~**.**

~~ii.~~**1)** Vital signs **(BP, HR, cardiac rhythm, respiratory rate, SpO2). Assess temperature as ordered**~~assessment includes the following:~~
~~1) BP~~
~~2) Heat rate~~
~~3) Cardiac rhythm~~
~~4) Respiratory rate~~
~~5) Oxygen saturation~~
~~6) Temperature as ordered~~

~~iii. Document the vital sign results in the Electronic Health Record (EHR)~~

c. Procedure Site Assessment:
   i. **Assess the procedure site** ~~Procedure site assessments shall be performed~~ every 15 minutes x 4 then, every 30 minutes after completing the initial assessment until the ~~Vasc B~~band is removed, then per the Standards of Care or unit policy.
   ii. Procedure site assessment, includes but is not limited to, the following:
      1) Assess the procedure site for the presence of bleeding e.g.,~~,~~ new or an increase presence of blood, blood oozing around balloon and/or the presence of a hematoma ~~as follows or as ordered~~
      2) Assess perfusion of procedure hand (by means of color, sensation and temperature of the arm with the ~~Vasc B~~band)
      3) Palpate the radial pulse
   iii. Document the assessment findings in the ~~Electronic Health Record (~~EHR~~)~~

3. Neurovascular Assessments:
   a. Perform a neurovascular assessment with vital signs and site assessments
   b. The ~~Vasc B~~band should be left on the patient's extremity for at least **120 minutes** (2 hours) following catheterization unless directed otherwise by physician's order or patient's condition.
      ~~i. Perform a neurovascular assessment with vital signs and procedure site assessments~~
4. Device Removal:
   **a.** Maintain the ~~Vasc B~~band ~~in~~ **on** for the recommended device removal time, withdraw 2 mL of air from the ~~Vasc B~~band and observe the puncture site for bleeding
      ~~a.~~**i. If using a locking syringe, place syringe in the locked position prior to attaching to the inflation valve.**
   b. If bleeding is present, re-inject 1-2 mL of~~r~~ air to restore hemostasis. Wait 30 minutes and repeat Device Removal process
   c. If no bleeding is present, continue to remove 2 mL of air every 15 minutes x 3 or until pressure is fully released (e.g. the ~~Vasc B~~band balloon is depressed).
   d. When the pressure is fully released and hemostasis is confirmed, carefully remove the ~~Vasc B~~band from the puncture site~~,~~. **Do not** ~~being careful not to~~ disrupt the clot.
   **e.** Apply a 2 x 2 gauze dressing and secure the dressing with a **transparent** ~~tegaderm~~ dressing. **Do not apply a non-adhering -wrap over the dressing.**
   **f. Remove wrist positioning splint 15 to 60 minutes after dressing applied.**
   ~~e.~~**g. Discard radial band, syringe and wrist positioning splint**
5. Management of Bleeding:
   a. Ensure device is in the proper position
   b. Slowly inject enough air in the ~~Vasc B~~band balloon to restore hemostasis. Do not inject more than 15 mL of air.
   c. Palpate for the presence of a radial pulse. A palpable radial pulse must be present at all times.
   d. Do ~~not over~~**not over**-inflate the compression device to occlude radial pulse.
   e. Notify the physician immediately if unable to regain hemostasis.
   f. Uncontrolled bleeding:

i. Remove radial arterial compression device, elevate arm while applying manual pressure to the radial artery proximal to the puncture site to stop the bleeding.
ii. Notify Physician immediately.

6. Removing the Dressing:
   a. Remove dressing within 24 hours of application or prior to discharge for inpatients. Do not disrupt the clot.
   b. Apply a Band-Aid to puncture site or leave open to air if ordered
7. Reportable Conditions:
   a. Notify the procedure ~~P~~physician immediately if any of the following occur:
      i. New onset of distal pain, numbness, tingling, duskiness, bleeding, unable to palpate the radial pulse, or circulation to the hand appears compromised
8. Documentation:
   a. Document the following in the ~~Electronic Health Record (~~EHR~~)~~
      i. All assessments
      ii. Vital signs with pulse oximetry results
      iii. Neurovascular assessments
      iv. Dressing applications and changes
      v. Physician Notification
      vi. Education provided – use Depart Custom Education: **Cardiac** leaflet Radial Artery Cardiac Catheterization/Angioplasty Discharge Instructions

Tri-City Medical Center
Oceanside, California

**ADMINISTRATIVE POLICY**
**PATIENT CARE**

---

**ISSUE DATE:** NEW

**SUBJECT:** Skilled Nursing Facility (SNF) Refusal to Readmit

**REVISION DATE(S):**

**POLICY NUMBER:** 8610-300

| | |
|---|---|
| **Administrative Patient Care Content Expert Approval:** | 04/19 |
| **Administrative Policies & Procedures Committee Approval:** | 04/19 |
| **Utilization Review Committee Approval:** | 05/19 |
| **Medical Executive Committee Approval:** | 05/19 |
| **Administration Approval:** | 06/19 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | |

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A. **POLICY:**

1. The following policy is used to address situations in which Skilled Nursing Facilities (SNF) refuse to readmit their patients (from either the Emergency Department or from an acute inpatient bed).

B. **BACKGROUND**

1. Nursing homes/SNF's have a tendency to not readmit certain long-term (non-skilled) Medi-Cal/private pay patients once they transfer them to an acute care hospital due to their perception that the patient is undesirable. Reasons for this can include (but not limited to):
   a. Patient/family behavioral issues (e.g. Dementia)
   b. Nursing home's perception that patient's care is cost prohibitive
   c. Patients not paying their bill
2. The nursing home's refusal to readmit patients is viewed as illegal based on the following:
   a. As per Title 22 **of the California Code of Regulations,** ~~Nursing~~ **nursing** home residents have the right to be readmitted after a hospital stay. Whenever a resident is transferred to a hospital, the nursing home must provide a written notice to the patient/family of their right to hold the nursing home bed for up to seven days.
      i. For private pay patients – patient/family must pay the per-diem rate to hold the bed.
      ii. For Medi-Cal patients, Medi-Cal will pay for the bed hold up to seven days.
         1) Note: any Medi-Cal patient has a right to be readmitted to a nursing home even if the patient's hospital stay exceeds seven days (the nursing home must readmit the patient to the first available bed).
      iii. Failure of the nursing home to provide the patient with written notification of their right to a bed-hold and/or failure to honor a bed hold is considered an "involuntary transfer" and is illegal.

C. **PROCEDURE:**

1. **Case Management/Social Worker** (CM/MSW) – Upon being notified by a SNF of their intention to NOT readmit their patient, the CM/MSW must inquire as to whether the patient (or surrogate decision maker) agrees to return back to the SNF.
   a. If the patient agrees to return, the CM/MSW contact the SNF and inquire as to the specific reason why they refusing readmission. Inquire should include contacting the

SNF's Director of Nursing (DON) or Administrator (Adm) as to why the SNF will not readmit. Specifically:

i. What is the specific reason as to why you (SNF) will not readmit?
ii. What was the payer source used at the time of transferring the patient to **Tri-City Medical Center** (TCMC)?
iii. The CM/MSW should remind the SNF of their legal obligation to readmit the patient back, citing that Medi-Cal allows for a bed hold to return back to the SNF.

b. If (after contacting the SNF and addressing the above questions) the SNF continues to refuse to readmit the patient, the CM/MSW must notify ~~CM Management~~**Director of Case Management**.
   i. ~~CM~~ **Director of Case** Management will then contact the SNF in an attempt to clarify the reason to not readmit and remind the SNF of their legal obligations.
   ii. If the SNF continues to refuse readmission, ~~CM~~ **Director of Case** Management will make it clear to the SNF that it will be the intent of ~~Tri-City Medical Center~~ ~~(~~TCMC~~)~~ to contact The California Department of Public Health (CDPH) to file a complaint on behalf of the patient regarding the SNF's decision to refuse readmission.

c. If the SNF continues to refuse, ~~CM Management~~**Director of Case Management** must contact the CDPH office (see Reference List for office contact numbers for CDPH offices near TCMC).
   i. ~~CM Management~~**Director of Case Management** will file a formal complaint on behalf of the patient regarding the SNF's refusal to readmit the patient. CDPH will need the following information to open the complaint process:
      1) Patient name, date of TCMC admission
      2) Name of SNF – name of SNF staff that was contacted
      3) Issue (SNF refusing to readmit patient)
   ii. CDPH will go out to the SNF and investigate the complaint with the goal of convincing the SNF to readmit the patient.

d. CDPH will contact ~~CM Management~~**Director of Case Management** to provide the results of the investigation.
   i. If the SNF continues to refuse readmission of the patient, the ~~CM Management~~**Director of Case Management**/CDPH will contact the Department of Healthcare Licensing Board to initiate a "Refusal to Readmit Hearing". (see Department of Healthcare Licensing Board below)

e. The Refusal to Readmit Hearing consists of the following process:
   i. CDPH will contact ~~CM Management~~**Director of Case Management** as to the date and time of the hearing.
   ii. Hearings are held at TCMC
   iii. Participants in the hearing include:
      1) Hearing Officer
      2) Patient (and/or surrogate decision maker)
      3) SNF staff (Adm, DON)
      4) TCMC staff (~~CM Management~~**Director of Case Management**, MSW, CM, interpreter(s))
   iv. The focus of the hearing is for the SNF to explain their reasons to deny readmission.
   v. Approximately 72 hours after the hearing, the hearing officer will fax to all parties, the hearing decision to readmit.

f. If the decision is in favor of patient to return back to the SNF, ~~CM Management~~**Director of Case Management** will contact the SNF and inform them of the results of the hearing and coordinate time to readmit.
   i. If the SNF continues to refuse readmission, ~~CM Management~~**Director of Case Management** will contact TCMC Legal Counsel as to their input to address this issue.

ii. ~~CM Management~~**Director of Case Management** will also re-connect with the CDPH office and inform them of the SNF's intent to not readmit despite the ruling from the hearing.

g. If the SNF continues to stall and not readmit the patient, ~~CM Management~~**Director of Case Management** will instruct the CM/MSW to go back to the patient with the goal of finding another SNF placement.

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

1. Reference List – Skilled Nursing Facility (SNF) Refusal to Readmit

E. **REFERENCE(S):**

1. California Department of Health Care Services: Transfer Discharge and Refusal to Readmit Unit (available via external link: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Transfer-Discharge-and-Refusal-to-Readmit-Unit.aspx)
2. CCR 22, sub-section 72520 (available via external link: https://govt.westlaw.com/calregs/Document/I7311F370D4BC11DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=%28sc.Default%29&bhcp=1)
3. CFR 42, subsection 483.12(b) (available via external link: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div8&node=42:5.0.1.1.2.2.7.4)

# Reference List – Skilled Nursing Facility (SNF) Refusal to Readmit

**Instructions:**

1. Call CDPH first to alert about SNF Refusal to readmit, or appropriate county
2. Once CDPH decides resident should return to SNF, both CDPH & TCMC should notify Department of Healthcare Licensing Board

**Department of Healthcare Licensing Board**
Phone: (916)322-5603
Fax: (916)323-3377

**San Diego North District Office**
**7575 Metropolitan Drive, Suite 104**
**San Diego, CA 92108-4402**
District Manager: Carol Littler
District Administrator: Candice Nagel
District Administrator: Jose Cano (A)
Phone: (619) 278-3700
Toll Free: (800) 824-0613
Fax: (619) 278-3725
Counties Served: (Parts of) Imperial, San Diego North County

**San Diego South District Office**
**7575 Metropolitan Drive, Suite 211**
**San Diego, CA 92108-4402**
District Manager: Donna Loza
District Administrator: Claire Allegretti
District Administrator: JoBeth Henry
Phone: (619) 688-6190
Toll Free: (866) 706-0759
Fax: (619) 688-6444
Counties Served: Imperial, San Diego (Cities south of Interstate 8)

**Riverside District Office**
**625 E. Carnegie Drive, Suite 280**
**San Bernardino, CA 92408**
District Manager: M. Connie Chester
District Administrator: Teresita Reyes
District Administrator: Deena McFarland
Phone: (909) 388-7170
Toll Free: (888) 354-9203
Fax: (909) 388-7174
County Served: Riverside

**Orange County District Office**
**681 S. Parker Street, Suite 200**
**Orange, CA 92868**
District Manager: Hang Nguyen
District Administrator: Kathleen Davidson
District Administrator: Josefina Sabino
County Served: Orange
Phone: (714) 567-2906
Toll Free: (800) 228-5234
Fax: (714) 567-2815

**Los Angeles District Offices**

**Administrative Headquarters**
**Health Facilities Inspection Division**
**Administration**
**12440 E. Imperial Highway, Room 522**
**Norwalk, CA 90650**
Acting Chief: Nwamaka Oranusi
Assistant Chief: Suzette Leverette Clark
Toll Free: 1-800-228-1019
Phone: (562) 345-6884 Gen. #
Fax: (562) 406-8801

**Los Angeles North District Office**
**15643 Sherman Way Street, Suite 200**
**Van Nuys, CA 91406**
Program Manager: Michael Stampfli
Phone: (818) 901-4375
Fax: (562) 409-5096

**Los Angeles West District Office**
**600 South Commonwealth Avenue, Suite 903**
**Los Angeles, CA 90005**
Program Manager: Michael Stampfli
Phone: (213) 351-1131
Fax: (213) 351-0768

**Los Angeles East District Office**
**3400 Aerojet Avenue #323**
**El Monte, CA 91731**
Program Manager: Monica Austin
Program Manager: Eric Stone
Phone: (626) 569-3724
Fax: (626) 927-9842

**Los Angeles San Gabriel District Office**
**5050 Commerce Drive, Suite 102**
**Baldwin Park, CA 91706**
Program Manager: Monica Austin
Phone: (626) 430-5600
Fax: (562) 409-5096
County Served: Los Angeles

Tri-City Medical Center
Oceanside, California

**ADMINISTRATIVE ~~POLICY MANUAL~~**
**HUMAN RESOURCES – PAY PRACTICE**

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**ISSUE DATE:** 10/04 **SUBJECT:** Bereavement Leave

**REVISION DATE(S):** **POLICY NUMBER:** 8610-435.01

| | |
|---|---|
| **Administrative Human Resources ~~Department~~Content Expert Approval:** | **03/19** |
| **Administrative Policy & ~~and~~ Procedures Committee Approval:** | **03/19** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **06/19** |
| **Professional Affairs Committee:** | **n/a** |
| **Board of Directors:** | |

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A. **PURPOSE:**

**1.** To provide guidelines for the payment of time away from work to benefited employees for bereavement. While every attempt will be made to accommodate an employee during his/her time of bereavement, the department Director may be unable to grant a specific request for time off due to the workload and staffing needs.

B. **DEFINITION(S):**

1. **Immediate Family Member: An immediate family member shall be defined as the employee's spouse, child (including adoption child, minor ward of employee guardian, foster-child, step-child or grandchild), mother, father, mother-in-law, father-in-law, individual who serves as the legal guardian for either the employee the spouse, or the domestic partner of the employee, brother, sister, step-mother, step-father, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandparents, and California State registered domestic partners and domestic partner who is a bona fide spousal equivalent either of the employee, the spouse or the domestic partner of the employee.**

~~B.~~C. **~~PROCEDURES~~POLICY:**

1. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**
2. ~~1.~~ Benefited employees are eligible for bereavement leave upon employment.
3. Employees shall receive up to three **(3)** days ~~(maximum of twenty-four (24) hours)~~ off with pay if time off is requested and taken within ~~two weeks~~**ninety (90) days** of the death of an immediate family member.
   ~~2. For represented employees see Collective Bargaining Agreement~~
4. ~~An immediate family member shall be defined as the employee's mother, father, spouse, mother-in-law, father-in-law, child, stepchild, brother or sister.~~
4. Paid time off **(PTO)** shall be based on the employee's regular scheduled hours.
5. Managers may require employees to provide appropriate documentation if deemed necessary.
6. Employees may use available PTO for time away from work due to the death of an immediate family member.
7. Time spent away from work for bereavement will not be included in the calculation of overtime.
8. Part-time employees shall receive bereavement pay on a pro-rated basis.

~~8.~~D. **PROCEDURE(S):**

~~8.~~**1.** Employee informs manager of the need to take bereavement leave.
~~10.~~**2.** Employee completes Request for Time Off form requesting time off and/or PTO.
~~11.~~**3.** Manager arranges for employee to be ~~deleted~~ **removed** from the schedule.
**4.** Time taken off for bereavement leave shall be coded on the employee's time card **accordingly**~~as 'BRV- Bereavement'.~~

**E. FORM(S):**

~~12.~~**1. Request for Time Off**

Tri-City Medical Center

DATE: _____

## REQUEST FOR TIME OFF FROM WORK

NAME: _____

DEPARTMENT: _____

SHIFT: _____

NUMBER OF DAYS REQUESTED: _____

NUMBER OF SCHEDULED WORK DAYS: _____

START DATE: _____

RETURN DATE: _____

REASON FOR ABSENCE

- ☐ VACATION
- ☐ LEAVE OF ABSENCE
- ☐ NON-MANDATORY EDUCATION (CNA)
- ☐ NON-RECOGNIZED HOLIDAY
- ☐ PERSONAL
- ☐ OTHER: _____

REMARKS: _____

## WEEKEND COVERAGE

ARE YOU SCHEDULED TO WORK A WEEKEND DURING THIS PERIOD? ☐ YES → ☐ NO

IF YES, ANSWER QUESTIONS 1, 2, AND 3.

1. WHO WILL ARRANGE COVERAGE FOR YOUR SCHEDULED WEEKEND?
   - ☐ SELF
   - ☐ SUPERVISOR
2. NAME OF EMPLOYEE WHO WILL WORK YOUR SCHEDULED WEEKEND: _____
3. WILL THIS WEEKEND FOR WHICH YOU ARE SCHEDULED TO WORK BE RE-SCHEDULED AT ANOTHER TIME?
   - ☐ YES → WHEN?: _____
   - ☐ NO

I UNDERSTAND THAT IF COVERAGE FOR MY SCHEDULED WEEKEND CANNOT BE ARRANGED BY MYSELF OR THE SHIFT SUPERVISOR, THIS REQUEST FOR TIME OFF FROM WORK WILL BE DENIED.

_____ _____

EMPLOYEE SIGNATURE DATE

## SIGNATURE APPROVALS

| | APPROVED | DISAPPROVED | DATE |
|---|---|---|---|
| DEPARTMENT MANAGER: _____ | ☐ | ☐ | _____ |
| IMMEDIATE SUPERVISOR: _____ | ☐ | ☐ | _____ |

8650-1001 (9/08) White - HR Canary - Employee

Tri-City Medical Center
Oceanside, California

~~Pay Practice Manual~~ADMINISTRATIVE
HUMAN RESOURCES – PAY PRACTICE

**ISSUE DATE:** 10/04 **SUBJECT:** Compensation for Mandatory Education

**REVISION DATE(S):** 12/14 **POLICY NUMBER:** 8610-474.01

| | |
|---|---|
| **Administrative Human Resources Content Expert Approval:** | **05/19** |
| **Administrative Policies & Procedures Committee Approval:** | **05/19** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **06/19** |
| **Professional Affairs Committee:** | **n/a** |
| **Board of Directors:** | |

A. **PURPOSE:**

1. To establish compensation practices for mandatory training and education.

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

1. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**
2. ~~1.~~ All fulltime, part time and per diem employees **of Tri-City Healthcare District (TCHD)** will be compensated for **their** attendance at approved ~~-~~mandatory~~,~~ meetings, training programs**, lectures** and**/or** similar activities ~~(e.g., renewal of required certifications)~~.
3. ~~2.~~ Employees will not be reimbursed for expenses related to the re-certification or renewal of expired certificates or professional licenses.
4. ~~3. Employees will not be reimbursed for expenses related to the re-certification or renewal of expired certificates or professional licenses.~~
5. ~~4. Registered Nurses under the CNA contact must code mandatory training using the appropriate Kronos workrule – MandCLass.~~

~~C. FORMS/TABLES/SCHEDULES:~~

4. **Eligible employees will be compensated for actual time spent at approved mandatory meetings, training programs, lectures and/or similar activities and TCHD will consider the time as hours worked.**
5. **Employees must schedule their approved mandatory meetings, training programs, lectures and/or similar activities without incurring overtime.**
6. ~~1.~~ Approved ~~hours for required education/certification~~**training and seminars are listed on the following table and are not to exceed the maximum hours.**

| ~~Class/Course Certification~~**Training and Seminars** | **Compensation** | ~~Payment Schedule~~**Maximum Hours** |
|---|---|---|
| **Advanced Cardiac Life Support (ACLS)** | **Actual Time in Attendance** | Initial Certification: 16 Hours<br>Renewal **Certification**: 8 Hours |

| **~~Class/Course Certification~~Training and Seminars** | **Compensation** | **~~Payment Schedule~~Maximum Hours** |
|---|---|---|
| **Basic Life Support (BLS)** | **Actual Time in Attendance** | Initial Certification: ~~Up To~~ 4 Hours<br>**In-Class** Renewal **Certification:** ~~Up To~~ 3 Hours<br>Online Renewal**/Skills Certification:**~~Up To 2~~**-3** Hours **total** |
| ~~ENPC~~ | ~~Certification- 16 hours~~ | |
| Fetal Monitoring | **Actual Time in Attendance** | Initial **Certification:**– ~~Up To~~ 16 Hours<br>Renewal **Certification:**– ~~Up To~~ 8 Hours |
| **Neonatal Resuscitation Program (NRP)** | **Actual Time in Attendance** | ~~Certification: 4~~ Hours |
| Nonviolent Crisis Intervention **(NVCI)** | **Actual Time in Attendance** | Initial Certification:– ~~Up To~~ 8 Hours<br>Renewal **Certification:**– ~~Up To~~ 4 Hours<br>**Flex Certification: 3 Hours total** |
| **Pediatric Advanced Life Support~~/~~ (PALS)** | **Actual Time in Attendance** | Initial Certification: 16 Hours<br>Renewal **Certification**: 8 Hours |
| Safety,~~/~~ Joint Commission,~~/~~ **and/or** Annual NetLearning Education | **Actual Time in Attendance** | ~~Paid For Actual Time Required~~**No Maximum** |
| ~~Skills Lab~~ | ~~**Actual Time in Attendance**~~ | ~~Up To 4 Hours Annually~~ |
| Other | ~~Vp~~**Human Resources** Approval Required | |

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

**ISSUE DATE:** 04/08 **SUBJECT:** Credentialing Policy, Processing Medical Staff Reappointments

**REVISION DATE(S):** 04/08~~;~~, 04/10~~;~~, 01/12~~;~~, 08/12~~;~~ ~~2/19~~ **POLICY NUMBER:** 8710–548

| | |
|---|---|
| **Medical Staff Department Approval:** | 02/19 |
| **Credentials Committee Approval:** | ~~04/16~~04/19 |
| **Pharmacy ~~and~~ & Therapeutics Committee Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~04/16~~05/19 |
| **Administration approval:** | 06/19 |
| **Professional Affairs Committee Approval:** | ~~07/16~~ n/a |
| **Board of Directors Approval:** | 07/16 |

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership renewal are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaws requirements.
2. The Medical Staff shall consider each application for reappointment using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and Rules and Regulations appropriate for each department. The Medical Staff shall perform this function also for reappointment of privileges for Allied Health Professionals. The Medical Staff shall investigate each application for reappointment and make an objective, evidence-based decision based upon assessment of the applicant's general competencies before recommending action to the Board of Directors. The Board of Directors shall ultimately be responsible for granting membership and privileges. By applying to the Medical Staff for reappointment, the applicant agrees that regardless of whether he/she is reappointed or granted the requested privileges, he/she will comply with the responsibilities of Medical Staff membership and the Medical Staff Bylaws and Rules as they exist and as they may be modified from time-to-time.

B. **REAPPOINTMENT PROCESS:**

1. **Schedule for Reappointment**
   a. As described in the Medical Staff Bylaws Article IV, §4.6, at least 90 days prior to the expiration date of each staff member's term of appointment, the Medical Staff office shall provide the member with a reappointment application form . Completed reappointment application forms shall be returned to the Medical Staff office at least sixty (60) days prior to the expiration date. Failure, without good cause, to return the form within the specified timeframe shall result in termination of privileges and prerogatives at the end of the current staff membership.
2. **Content of Reappointment Form**
   a. The reappointment application shall seek information concerning the changes in the member's qualifications since his or her last review. Specifically, the application shall request an update of all of the information and certifications requested in the appointment application form with the exception of that information which cannot change over time; such as information regarding the member's premedical and medical education, date of birth, and so forth. The application shall also require information as to whether the member requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for

additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application.

i. If the staff member's level of clinical activity at this hospital is not sufficient to permit evaluation of his or her competence to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at another institution in whatever form the Medical Staff may require.

b. In addition to completing the information requested on the reappointment form, the staff member shall submit his or her Medical Staff dues as described in the Medical Staff Bylaws Article XIII, §13.2. Application for reappointment will be considered incomplete if dues (or other fine or assessments) are not paid within the time frame as described in §4.6 of the Medical Staff Bylaws and the member is deemed to be voluntarily resigned without the rights to a hearing as described in Article VII §7.2 of the Bylaws.

3. **Verification and Collection of Information** (Medical Staff Bylaws §4.6)

a. The Medical Staff shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Department/Division Chair, Credentials Committee, Medical Executive Committee, or Board of Directors. The information shall address without limitation:

i. Reasonable evidence of current ability to perform privileges that may be requested including, but not limited to, consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

ii. Participation in relevant continuing education activities.

iii. Level/amount of clinical activity (patient care contacts) at the hospital. Patient care activities include:

1) Inpatients:
   a) Admitting
   b) Attending
   c) Assisting at Surgery
   d) Consulting
   e) Operative and other procedures

2) Outpatients:
   a) Assisting at Surgery
   b) Operative and other procedures
   c) Emergency Room visits

iv. Sanctions imposed or pending including, but not limited to, previously successful or currently pending challenges to any licensure or registration (State or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

v. Confirmation of the applicant's health status, both physical and mental, or substance abuse that could affect his or her ability to exercise the clinical privileges requested, or whether the applicant required any type of accommodation in order to exercise the requested privileges safely and competently.

vi. Attendance at Medical Staff Department/Division and committee meetings.

vii. Participation as a staff officer and committee member/chair.

viii. Timely and accurate completion and preparation of medical records as outlined in Medical Staff Policy: Medical Record Documentation Requirements 8710-518.

ix. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel, and patients as described in the Medical Staff Policy: Professional Behavior 8710-570.

x. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims in the past 5 years.

xi. Compliance with all applicable Medical Staff and hospital bylaws, rules, and policies.
xii. Two Professional references are required, at least one (1) from a practitioner who is familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases.
xiii. Any other pertinent information, which may include, the staff member's activities at other hospitals and his or her medical practice outside the hospital.
xiv. Teleradiologists - Hospital affiliations shall be selected for 5 institutions and verified.
xv. Information concerning the member from the State licensing board and the Federal National Practitioner Data Bank.
xvi. Information from other relevant sources.

4. **Department Action**
   a. The Department/Division Chair shall review the application and all other relevant available information. The Department/Division Chair will then forward his or her written recommendations to the Credentials Committee.
5. **Credentials Committee Action**
   a. The Credentials Committee shall review the application, all other relevant available information and the Department /Division Chair's recommendations. The committee shall transmit to the Medical Executive Committee its written recommendations.
6. **Medical Executive Committee Action**
   a. The Medical Executive Committee shall review the Department/Division Chair's and the Credentials Committee's recommendations and all other relevant information available and shall forward recommendations to the Board of Directors.
7. **Board Closure**
   a. To ensure the Medical Staff reappointment credentialing process is completed; upon Board of Directors approval of the reappointments, board closure process shall be initiated to include notifying the practitioner of the decision regarding privilege(s) and/or Medical Staff membership.
8. **Reappointment Recommendations**
   a. Reappointment recommendations shall be written and shall specify whether the member's appointment should be renewed; renewed with modified membership category and/or clinical privileges; or terminated. The reason for any adverse recommendation shall be described.
   b. The Medical Staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

C. **SPECIAL CONSIDERATIONS:**

1. ~~**Extension of Appointment:** As provided in Bylaws, Article 4, §4.6-4.~~
2. **Failure to File Reappointment Application:** As provided in Bylaws, Article 4, §4.~~5.10~~.6-4
   a. Members who automatically resign under this rule shall be processed as new applicants should they wish to reapply.
3. **Reapplication After Adverse Appointment:** As provided in Bylaws, Article 4, §4.5-.10
4. **Relinquishment of Privileges**
   a. A staff member who wishes to relinquish or limit particular privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall notify the Credentials Committee identifying the particular privileges to be relinquished or limited.
5. **Additional Privilege Requests**
   a. Whenever a member desires to increase his/her clinical privileges, he/she shall indicate additional requested privileges on a privilege request form and submit the completed form to the Credentials Committee. The member's request must include documentation of training and/or experience as required by the Rules and Regulations. The request shall be processed in the same manner as an application for initial clinical privileges.

b. Prior to the consideration or granting of any privilege not currently delineated on the Delineation of Privileges it shall be determined, by the Department/Division Chair whether the resources necessary to support the requested privilege are currently available or are available within a specified time frame as stated in the Medical Staff Policy: Requests for New Privileges/Technologies New to TCMC 8710-526.

6. **Leave of Absence**

a. During any period of leave of absence, the requirement for reappointment as specified in the Bylaws, Article 4.4, shall continue unless waived by the Medical Executive Committee (MEC).

D. **RELATED DOCUMENTS:**

1. Medical Staff Policy: Medical Record Documentation Requirements 8710-518
2. Medical Staff Policy: Professional Behavior Policy 8710-570
3. Medical Staff Policy: Requests for New Privileges/Technologies New to TCMC 8710-526

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY

**DELETE: Policy Being Deleted Due to because we do not have the personnel to support what is defined in the policy**

**ISSUE DATE:** 02/10

**SUBJECT:** Discharge Planning for Pediatric and Adolescent Patient

**REVISION DATE(S):** 02/10

**POLICY NUMBER:** 8710-561

| | |
|---|---|
| **Medical Staff Department Approval:** | ~~03/17~~03/19 |
| **Department of Pediatrics Approval:** | ~~05/17~~05/19 |
| **Medical Executive Committee Approval:** | ~~05/17~~05/19 |
| **Administration Approval:** | 06/19 |
| **Professional Affairs Committee Approval:** | ~~06/17~~ n/a |
| **Board of Directors Approval:** | 06/17 |

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

~~1. To facilitate an organized discharge planning program for the timely and efficient discharge of the adolescent and pediatric patient.~~
~~2. To ensure that every patient has a comprehensive Care Management plan that strives to meet each patient's present and future needs.~~
~~3. To provide a systematic, multidisciplinary, and coordinated process that begins upon admission to the facility and continues throughout the patient's stay.~~

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

~~1. Discharge planning is an integral part of the inpatient Care Management process and serves to identify those patients who require continued healthcare services after acute hospitalization.~~
~~2. Discharge planning provides a systematic, multidisciplinary, and coordinated process for patients that are treated in the Emergency Department and require out patient follow up.~~
~~3. The Interdisciplinary Team is composed of the Medical Staff, Care Manager, Social Workers, Nursing, Dietary, Physical, Occupational, and Speech Therapy, Pulmonary Therapists, wound care staff, and any other staff that contribute to the development of a comprehensive discharge plan.~~
~~4. The activities and assessments of the interdisciplinary team lead to the development of an individualized treatment plan for the patient.~~

~~C. **PROCEDURE:**~~

~~1. All new admissions are initially screened at the point of entry into the system this includes the patients treated in the Emergency Department for potential discharge needs using the Care Management Initial Discharge Planning Assessment form.~~
~~2. The initial discharge screening includes an assessment of at least but not limited to the following:~~
~~a. Reason for admit and social and financial issues affecting patient~~
~~b. Living arrangements prior to admission (e.g., home with family)~~
~~c. Family support system~~
~~d. Medical condition and limitations prior to admission~~
~~e. Services in place prior to admit (e.g., DME, Home Health, CCS)~~
~~f. Mental Status~~
~~g. Parents or others ability to participate in decision regarding care~~
~~h. Recent major life events~~
~~3. All discharge materials shall be provided in the primary language of the patient/family.~~
~~a. The Care Manager shall communicate the appropriate primary language to the post hospital health care providers/companies at the time of referrals.~~
~~4. The Care Manager and Social Worker shall:~~

a. Ensure all referrals are made to CCS providers.
b. Discuss the case with the attending/consulting physician(s) to determine if the condition is CCS eligible and design the plan of care based on this information.
c. Discuss with the physician any identified specific CCS Specialty Care Centers for post-discharge referral and identify all appropriate sources of follow-up care including referral to CCS-approved providers and the CCS Medical Therapy Program. These shall also include any care provided within the Emergency Department that requires out-patient follow-up.
d. Collaborate with the attending physician to make referrals to appropriate CCS special care centers. This includes working with the local CCS program to choose the most appropriate center. CCS policy 08-0900 defines the conditions that require referral to a special care center.
e. Identify interdisciplinary services that must be provided while inpatient to ensure a timely discharge.
    i. Interdisciplinary Services shall include teaching services, dietitian consult, wound care, and any further follow-up care that is required.
f. Make referrals to the local CCS program(s).
    i. If the appointment can be made before discharge, this shall be on the discharge instruction sheet.
    ii. If the appointment cannot be made before discharge, the special care center contact number and information shall be provided to the patient/family to make their own appointment.
g. Collaborate with the PT/OT/ST for:
    i. Referrals to the local medical therapy units (MTU).
    ii. DME related to PT/OT/ST needs
h. Identify all post acute alternative levels of services (e.g., rehabilitation, LTAC). The Care Manager must develop a "best" plan as well as a back up plan.
    i. These plans shall include identification of an established CCS paneled Primary Care Physician (PCP) for follow-up care prior to discharge or if there isn't a PCP of record, work with the patient in identifying a PCP for follow-up care.
    ii. All identification and coordination shall be made for all appropriate programs/providers including CCS paneled providers that are appropriate for patient referral to include:
        1) Social Work referral to the CCS Care Manager
        2) Mental health or Regional center,
i. Collaborate with the nutritionist for special dietary needs.
j. Collaborate with the respiratory therapist for any respiratory issues, education and need for any respiratory equipment upon discharge.
k. Document the discharge plan and any additional patient/family communication in the Cerner Clinical Note system with anticipated discharge dates as soon as possible.
    i. If a delay in documentation is anticipated, communication with Care Management team must take place and/or a note placed in the progress note section of the medical record.
    ii. Documentation MUST be completed no later than the end of the shift. Additionally, this documentation shall include all CCS referrals for adolescents needing Special Care Center referrals
l. Submit a copy of the discharge summary to the local CCS program office for CCS-eligible clients who have been referred to CCS or have authorizations for care from a CCS program.
    i. Documentation that this was provided shall be placed in the medical record.
m. Re-evaluate the plan of care and the anticipated discharge plan at least every 2 days to modify as needed and at least 24 hours before the anticipated discharge to ensure all equipment or items needed in the home are provided PRIOR to discharge.
n. Verify if an uninsured patient's condition (whether the patient is in the Emergency Department or Inpatient) is a CCS eligible condition prior to discharge and ensure

alternative arrangements for transportation, medication, or destinations have been discussed with the patient and family.
- i. If transportation is an issue, provide bus pass to community placement or a private option.
- ii. If oral medications are an issue, provide a one-week supply of medication. This service is provided to prevent further hospitalization or possible exacerbation of illness

e. Communicate to the Unit Coordinator the appropriate Discharge Disposition category for entry into the medical record.

5. Nursing shall ensure:
   a. Discharge orders are written
   b. Discharge instructions include any medication instructions on the discharge form, instructions addressing diet ,activity, equipment, other therapies, and follow up information
   c. Medications are obtained and instructions for use provided to patient/family.
      i. Instructions shall be written without medical/nursing abbreviations
   d. A written summary is available at the time of discharge, provided to the patient, and documented in the medical record.
6. The clinical dietitian shall
   a. Participate in patient care rounds
   b. Assess and reassess nutrition status
   c. Identify and address any food related issues
   d. Educate the patient and family regarding nutrition related issues.
   e. Ensure the patient/family are provided with education and literature prior to discharge and shall document in the medical record.
      i. Any ongoing outpatient nutritional referrals shall be made with collaboration between the Care Manager and the nutritionist.
         1) If the appointment can be made before discharge, this shall be on the discharge instruction sheet.
         2) If the appointment cannot be made before discharge, then the outpatient nutritionist phone number would be provided so they can make their own appointment.
7. Physical Therapy (PT) shall design a plan that addresses the patient's functional status and mobilization, including need for DME and assistive devices.
   a. If ongoing therapy shall be provided by the local MTU, the therapy staff shall call the MTU to discuss current progress with therapy in the unit as well as fax or mail a copy of the discharge therapy note.
8. Occupational Therapy (OT) shall:
   a. Evaluate activities of daily living and the patient's ability to accomplish self-care based upon assessment and medical condition
   b. Collaborate with the interdisciplinary team in identifying the patient's plan of care and post discharge needs
   c. Identify the third party payors or other CCS providers regarding durable medical equipment, home health and other referrals
      i. If ongoing therapy shall be provided by the local MTU, the therapy staff shall call the MTU to discuss current progress with therapy in the unit as well as fax or mail a copy of the discharge therapy note.

| Tri-City Medical Center | Women's and Children's Newborn Services Manual —Neonatal Intensive Care Unit (NICU) |
|---|---|
| **PROCEDURE:** | **NASOGASTRIC (NG) AND OROGASTRIC (OG) TUBE INSERTION, MAINTENANCE, AND REMOVAL** |
| Purpose: | To outline the nursing responsibilities in the placement, maintenance, and removal of enteral tubes. |
| Supportive Data: | Nasogastric and orogastric tube placement is used for diagnostic and therapeutic purposes. Enteral tubes are placed to decompress the stomach and proximal small intestine, evacuate gastric contents, administer lavage, and instill medications, fluids and feedings. Enteral tube placement requires a physician's order. Once per shift and before use for diagnostic or therapeutic reasons, the enteral tube is observed to ensure that the system is intact, without leaks, kinks or clots. |
| Equipment: | Enteral tube (type and size appropriate for intended purpose)<br>Non-sterile gloves<br>Hydrocolloid dressing or appropriate skin protective barrier<br>Transparent dressing<br>5-10 mL syringe<br>Stethoscope<br>Water-soluble lubricant or sterile water<br>Syringe feeding pump and extension tubing as needed |

A. **PROCEDURE:**

1. Insertion:
   a. RN collaborates with attending physician regarding placement of NG/OG tube for purpose of gastric decompression or gavage feedings.
   b. Perform hand hygiene and apply non-sterile gloves.
   c. Assemble appropriate equipment.
   d. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" policy.
   e. Position the patient:
      i. **Place infant on back.** ~~Patients~~ **Infant** may be swaddled.
      ii. A second person may assist with patient containment.
   f. Determine length of enteral tube to be inserted by measuring the tube from the tip of the nose to the earlobe, and from the earlobe to a space halfway between the umbilicus and the termination of the xiphoid process **(NEMU method)**.
   g. Mark the measured distance on the tube with a small piece of tape or make note of the preprinted centimeter measurement on the tubing.
   h. Place an appropriate sized piece of hydrocolloid dressing on skin where tube is to be secured
   i. Lubricate the distal end of the tube with sterile water or water-soluble lubricant. **then slowly iInsert the tube gently through the mouth or nares, aiming down and back.**
   ~~i.~~ **If there appears to be resistance, do not force. Try rolling the enteral tube gently. If still unable to pass the enteral tube, remove it and try the other nostril.**
   ~~j.a. Insert the tube gently through the mouth or nares, aiming down and back.~~
   ~~k.j. If there appears to be resistance, do not force. Try rolling the enteral tube gently. If still unable to pass the enteral tube, remove it and try the other nostril.~~
   ~~l.~~k. Do not pass the enteral tube beyond the original mark until further assessment is made.

| Women and Newborn Services Department Review | Department of OB/GYN | ~~Department of OB/GYN~~Perinatal Collaborative Practice | Department of Pediatrics | Pharmacy ~~&and~~ Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 08/13, 01/19 | n/a | 12/13, ~~04/19~~04/19 | n/a | n/a | 04/14, 05/19 | 06/19 | 10/14, n/a | 19/07; 06/09; 06/11; 08/12; 11/14 |

~~m.~~l. Remove enteral tube at once if there are signs of distress, coughing, gasping, apnea, bradycardia or cyanosis.
~~n.~~m. Allow the patient to stabilize and resume insertion procedure.
~~o.~~n. Continue to pass enteral tube until marked position is at the tip of the nostril or at the lip.
~~p.~~o. Verify placement of the tube in stomach by
   i. Aspirating gastric contents
   ii. Listening with a stethoscope over the epigastric area while injecting small amount (1-~~2~~3 mL) of air
~~q.~~p. Secure the enteral tube in place on top of hydrocolloid dressing with transparent dressing, **making sure not to distort or obstruct the nares**.
~~r.~~q. Place a small label (tape or patient label) with insertion date on enteral tubing just below the hub.
~~s.~~r. Discard used supplies and gloves in appropriate receptacle.
~~t.~~s. Perform hand hygiene.
~~u.~~t. Document the following in the patient's medical record:
   i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.
   ii. Tolerance of procedure.

2. Maintenance:
   a. Ongoing proper placement is verified by:
      i. Measuring the distance from nares to the distal end of the ng/og tube every shift.
      ii. Verifying proper placement prior to use through auscultation and/or aspiration.
      iii. Whenever an x-ray is obtained.
   b. Evaluate color and amount of aspirate and notify physician for residuals containing blood, brown or dark green bilious fluid.
   c. Short term (PVC) feeding tubes inserted for gastric decompression are changed every 72 hours. Long-term enteral only feeding tubes (polyurethane) are replaced every 30 days.
3. Gavage feedings:
   a. Gavage feeds are given via gravity or by use of a feeding pump utilizing enteral only syringes and tubing.
   b. Verify proper tube placement prior to every feed.
   c. Check residual on preterm infants prior to feed making note of amount, color and consistency. Residuals greater than ~~20~~30% of previous feed amount are reported to the physician unless a specific order regarding residual management has already been obtained. Do not check residuals of infants on continuous feeds unless ordered by the physician.
   d. For gravity gavage feeds attach barrel of syringe to feeding tube and pour prepared feed into barrel. Insert plunger into barrel to start fluid flow. Adjust the height of the barrel to control flow speed. Do not force feed in with plunger instead allow it to flow by gravity.
   e. For pump feeds, attach syringe to extension tubing and prime tubing then attach **the extension tubing** to feeding tube. Place syringe into feeding pump and set pump infusion rate to infuse feed over the ordered time frame and volume. Extension tubing should be changed with each feed.
   f. If infant is on continuous feeds, prepare a syringe with up to 4 hours of breastmilk or formula and attach to infant as described above. A new extension tube is used with each new syringe. Program pump to deliver the feed at the ordered rate.
   g. Offer a pacifier with gavage feeds to allow infant to associate sucking with a full stomach.
   h. At the end of the feed, either remove the barrel or extension tubing and clamp feeding tube or leave a barrel attached for venting if necessary.
   ~~i. Keep head of bed elevated during gavage feeds~~
4. Removal:
   a. Perform hand hygiene and apply non-sterile gloves.

b. Remove semi-permeable transparent dressing using warm water or saline prep pad.
c. Pull tube out of mouth or nose in a steady motion. If resistance is encountered, rotate the tube and again attempt removal. The tube should not be forced out. If resistance continues to be met, location of the tube may need to be verified using x-ray.
d. Discard used supplies and gloves in appropriate receptacle.
e. Document the procedure in the patient's electronic medical record.

B. **RERERENCE(S):**

1. **Cirgin Ellett, M.L., M.D. Cohen, S.M. Perkins, C.E. Smith, K.A. Lane and J.K. Austin. 2011. Predicting the insertion length for gastric tube placement in neonates. Journal of Obstetrics, Gynaecologic and Neonatal Nursing 40(4): 412-421.**
2. **Dias, F.S.B., S.C.D. Emidio, M.H.B.M. Lopes, A.K.K. Shimo, A.R.M. Beck and E.V. Carmona. 2017. Procedures for measuring and verifying gastric tube placement in newborns: an integrative review. Latino-Am. Enfermagem 25: e2908. Available at: http://dx.doi.org/10.1590/1518-8345.1841.2908**
~~1.~~3. Merenstein, G.G. & Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th Ed. St. Louis, MO. Mosby.
4. **Nguyen, S., A. Fang, V. Saxton and J. Holberton. 2016. Accuracy of a weight-based formula for neonatal gastric tube insertion length. Advances in Neonatal Care 16(2): 158-161.**
~~2.~~5. Bowden, V.R. & Greenberg, C.S. (2011). Pediatric nursing procedures, 3rd Ed. Philadelphia. PA. Lippincott Williams and Wilkins.
~~3.~~6. Ikuta, Linda M., and Sandra S. Beauman, eds. (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care. .

Tri-City Medical Center
Oceanside, California

# OUTPATIENT BEHAVIORAL HEALTH ~~UNIT~~ SERVICES

**ISSUE DATE:** 08/96 **SUBJECT:** Co-treatment of Patients

**REVISION DATE(S):** 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16

| | |
|---|---|
| **Outpatient Behavioral Health Services Department Approval ~~Date(s)~~:** | ~~11/15~~ 02/18 |
| **Division of Psychiatry Approval ~~Date(s)~~:** | ~~02/16~~03/19 |
| **Pharmacy ~~and~~ & Therapeutics Committee Approval ~~Date(s)~~:** | n/a |
| **Medical Executive Committee Approval ~~Date(s)~~:** | ~~02/16~~05/19 |
| **Administration Approval:** | 06/19 |
| **Professional Affairs Committee Approval ~~Date(s)~~:** | ~~03/16~~ n/a |
| **Board of Directors Approval ~~Date(s)~~:** | 03/16 |

A. **PURPOSE:**

1. To provide guidelines on provision of physician Co-Treatment of patients by attending psychiatrists.

B. **POLICY:**

1. Co-treatment by attending psychiatrists will be facilitated if a patient has a primary psychiatrist in the community who will continue to manage medications while patient is attending the program. The Program physician will oversee treatment of the patient in Behavioral Health Outpatient program and will collaborate with the community physician with regard to medications, and post Program follow up. Co-treatment will be directed and certified as medically necessary by the attending program psychiatrist.

C. **PROCEDURES:**

1. Who May Perform/Responsible: Psychiatrists
   a. Patients will be admitted and followed by an attending Program psychiatrist. The Program psychiatrist will complete the admission order, and psychiatric evaluation. Monthly progress notes will be completed by the psychiatrist and/or Allied Health Professional (AHP) and will indicate medical necessity and patient's progress toward treatment goals.
   b. The Program psychiatrist and AHP will be encouraged to communicate regularly with the community psychiatrist to update him/her on the patient's progress and any medication issues.
   c. The Program psychiatrist will direct all treatment planning. The co-treating physicians are informed regarding any patient concerns and treatment progress.

Tri-City Medical Center
Oceanside, California

PERI-ANESTHESIA NURSING SERVICES POL

**DELETE — incorporated into Surgical Services Peri-Anesthesia Nurses Services Policy: Post Anesthesia Standards of Practice and Documentation**

**SUBJECT:** NURSING DOCUMENTATION FOR PANS UNIT

**ISSUE DATE:** 04/12
**REVISION DATE(S):**

| | |
|---|---|
| Department Approval Date(s): | 05/18 |
| Department of Anesthesiology Approval Date(s): | n/a |
| Operating Room Committee Approval Date(s): | n/a |
| Pharmacy and Therapeutics Approval Date(s): | n/a |
| Medical Executive Committee Approval Date(s): | n/a |
| Administration Approval: | 06/19 |
| Professional Affairs Committee Approval Date(s): | n/a |
| Board of Directors Approval Date(s): | |

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

~~1. To outline the documentation responsibilities & methods for staff in the Post anesthesia care unit (PACU) and Special procedures recovery area (SPRA). Documentation facilitates communication among health care team members, promotes continuity of care, serves as a tool for data collection, billing, inventory control, and as a legal record of care provided. Protecting the confidentiality of the information documented is the responsibility of all staff members.~~

~~B. **METHODS/FORMS:**~~

~~1. Compass PowerChart Electronic Record~~
~~2. Outpatient Surgery Patient Record and Care Plan paper form 7725-1001~~
~~3. Inpatient Pre-Post Anesthesia Care Short Record paper form7427-1001~~
~~4. Infusion/Transfusion Flowsheet paper form 7420-1054~~
~~5. Sedation Flowsheet paper form 8720-1030~~
~~6. Anesthesia Discharge Evaluation paper form~~
~~7. Patient Charges document- all patients~~
~~8. PACU logbook all patients admitted to PACU~~

~~C. **PROCEDURE:**~~

~~1. REQUIRED DOCUMENTATION ELEMENTS FOR SURGICAL, CARDIAC CATHETERIZATION LAB & INTERVENTIONAL RADIOLOGY OUTPATIENTS:~~

~~a. PACU initial assessment~~

~~i. Airway/respiratory targeted assessment~~
~~ii. Vital signs to include Sp02%, RR, Temp, BP, HR & rhythm (print strip)~~
~~iii. Anesthesia type & any complications~~
~~iv. Allergies~~
~~v. Person(s) providing post procedure report~~
~~vi. Head to toe systems assessment~~
~~vii. Pain level, location, character~~
~~viii. Dressings/drains/incisions~~
~~ix. Invasive lines/drips/fluids~~
~~x. Modified Aldrete score~~
~~xi. Fluid balance~~
~~xii. Additional elements as indicated by procedure & anesthesia/sedation type~~
~~xiii. Time of admission to PACU~~

xiv. Mode of arrival & Location admitted from

b. Ongoing Assessments
   i. Airway
   ii. Pain status
   iii. Respiratory status
   iv. Modified Aldrete every 15 minutes 1st hour of phase I or until meets baseline
   v. Surgical site
   vi. Vital Signs per ASPAN guidelines
   vii. Fluid balance
   viii. Any additional elements as indicated by procedure & changes in condition

c. PACU Nursing Care Plan(s)
   i. To include applicable nursing diagnoses, goals, plans, & outcomes

d. Medications given, time, dose, route, effects

e. Discharge Documentation
   i. Discharge score
   ii. Discharge Criteria
   iii. Patient Teaching/discharge instructions
   iv. Pain status
   v. Nausea/vomiting
   vi. Vital signs HR, RR, BP, Temp, sp02
   vii. Surgical site assessment
   viii. Fluid balance to include PO intake & urine output
   ix. Method of discharge & responsible adult
   x. Prescriptions/medications/supplies given to patient
   xi. Contact information for post procedure follow up call
   xii. Post Anesthesia Evaluation paper form or print from Cerner (if anesthesia services used)
   xiii. Time of discharge from PACU
   xiv. Post procedure follow up call document results of call on form 7725-1001

2. REQUIRED DOCUMENTATION FOR TRANSFUSION/INFUSION PATIENTS
   a. Admission assessment (short version on paper form 7420-1054)
   b. Vital signs
   c. Current medications & last dose
   d. IV access/start
   e. Vital Signs per PCS transfusion procedure
   f. Medications as administered
   g. Fluid balance
   h. Expected outcomes
   i. Discharge criteria
   j. Discharge vital signs
   k. Transport mode & destination
   l. Discharge instructions to responsible adult

3. REQUIRED DOCUMENTATION ELEMENTS FOR AM ADMITS & INPATIENTS
   a. PACU Initial assessments as listed in 1. a
   b. Ongoing assessments as listed in 1. b
   c. PACU nursing care plan(s) as listed in 1. c
   d. Medications given as listed in 1. d
   e. Discharge Documentation
      i. Aldrete score on discharge

ii. Discharge Criteria
iii. Patient teaching
iv. Pain status
v. Vital signs at discharge HR, RR, BP, Temp, sp02
vi. Nausea/vomiting
vii. Surgical site assessment
viii. Fluid balance
ix. Other assessments as indicated by procedure & changes in patient condition
x. Name of RN report given to
xi. Name of transporter & method of transport
xii. Print Post Anesthesia Evaluation form from Cerner
xiii. Time of discharge from PACU
xiv. Discharge destination (inpatient unit)

D. **REFERENCES:**

1. TriCity Patient Care Services Procedure: *Blood Product Administration, 2/2011*
2. TriCity Patient Care Services: *Standards of Patient Care 7/2011*
3. American Society of PeriAnesthesia Nursing: *Perianesthesia Nursing Standards and Practice Recommendations 2010-2012.* Cherry Hill, NJ: ASPAN; 2010.

Tri-City Medical Center
Oceanside, California

DELETE: There are no alternate areas for PACU after hours or weekends.

PERI-ANESTHESIA NURSING SERVICES POLICY MANUAL

**ISSUE DATE:** 04/~~2011~~

**SUBJECT:** PACU SERVICES IN ALTERNATE AREA (ICU) AFTER HOURS/WEEKENDS

**REVISION DATE(S):**

**POLICY NUMBER:**

| | |
|---|---|
| Surgical Services Department Approval: | 05/18 |
| Department of Anesthesiology Approval: | ~~03/19~~05/19 |
| Operating Room Committee Approval: | n/a |
| Pharmacy & Therapeutics Committee Approval: | n/a |
| Medical Executive Committee Approval: | 05/19 |
| Administrative Approval: | 06/19 |
| Professional Affairs Committee Approval: | n/a |
| Board of Directors Approval: | |

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

~~To define use of an ICU room for PACU care of surgical patients after hours (i.e., 12:00 am to 7:00 am Monday – Friday) and 7:00 pm – 7:00 am weekends and holidays.~~

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

~~1. **Staffing:** The staffing ratio for Stage I PACU care is 1:2 or 1:1. A minimum of 2 RNs, one of whom is an experienced Stage I PACU RN must be in the unit or area where Stage I recovery is taking place.~~

~~2. **Time Frame:** The time frame will not exceed 72 hours. If the use of the ICU PACU room continues past the 72 hours CDPH will be notified pursuant to AFL 06-33.~~

~~C. **ROLES AND RESPONSIBILITIES:**~~

~~1. During designated hours, when post-surgery recovery of one patient is needed, If patient post-op destination is home or an inpatient bed NOT in ICU, the OR desk will inquire with admin supervisor if ICU room is available for use as alternate recovery location. If so, one PACU RN will be called in to recover in ICU.~~

~~a. Administrative supervisor will coordinate with ICU and notify surgery staff of the outcome.~~

~~b. For intubated patients who will be admitted to ICU care post operatively, the procedure is for the ICU to accept the patient direct and PACU is not called in. If ICU RN or bed is not available, the first and second PACU RNs on call will be called by the OR desk.~~

~~c. If no physical room is available in ICU both PACU nurses will be called in to open the PACU.~~

~~2. Anesthesiologist will provide telephone report to PACU RN with the following:~~

~~a. Patient name & MRN/FIN~~

~~b. Allergies~~

~~c. Which narcotic medication(s) will be ordered for the patient post operatively~~

~~d. Other medications not on the standard orders that will or may be ordered~~

~~e. Any other special needs anticipated~~

~~3. The anesthesiologist and OR RN will assist with transfer of the patient from the OR to the ICU PACU room, providing handoff report to the PACU RN. The Circulating RN will fax the post-op orders to pharmacy before leaving the ICU.~~

~~4. The PACU RN will provide and document post anesthesia care according to policies, guidelines and accepted PACU nursing care practice in the same fashion as is provided in the main PACU.~~

~~5. Only one patient may be recovered at a time in the ICU recovery location.~~

~~6. Upon discharge of the patient from the ICU recovery location, the PACU RN is responsible to~~

notify the ICU ANM/Charge RN of the discharge and is responsible to reset the room. PACU RN will replenish the medication kit from the Pyxis by charging medications used to the patient, withdrawing them and restocking the kit.

7. Recovery care for more than one patient during the after hours time frame will necessitate opening and staffing the Main PACU.

D. **TRANSFER/ DISCHARGE GUIDELINES:**

1. Patients are discharged from the ICU PACU room according to the same guidelines as discharged from the main PACU.

E. **REFERENCES:**

1. AFL 06-33 ASPAN Standards of Perianesthesia Nursing Practice

Tri-City Medical Center
Oceanside, California

**SURGICAL SERVICES**
**PERI-ANESTHESIA NURSING SERVICES ~~POLICY MANUAL~~**

**ISSUE DATE:** 08/03

**SUBJECT:** Post Anesthesia Standards of Practice and Documentation

**REVISION DATE(S):** 10/09~~, 07/14~~

| | |
|---|---|
| Surgical Services Department Approval: | 03/18 |
| Department of Anesthesiology Approval: | 09/18 |
| Operating Room Committee Approval: | ~~10/18~~04/19 |
| Pharmacy & Therapeutics Committee Approval: | n/a |
| Medical Executive Committee Approval: | 05/19 |
| Administration Approval: | 06/19 |
| Professional Affairs Committee Approval: | n/a |
| Board of Directors Approval: | 01/13 |

A. **PURPOSE:**

1. To outline ~~admission/discharge assessment~~**standards of practice and documentation** for patients in the Post Anesthesia Care Unit (PACU). **Assessment and data collection provide the clinical basis for an individualized plan of care during the post-operative period. A comprehensive plan of care shall be developed and implemented for each patient to achieve optimal outcomes.**

B. **POLICY:**

1. **Ongoing patient assessment and management in PACU shall include phase-specific components and assessment frequency.**
2. **Documentation shall appropriately reflect assessment and care provided. Documentation shall include interventions based on the plan of care, response to interventions, consultation and collaboration with the patient/family and other healthcare providers.**
3. **Patients who have met discharge criteria and are being held in PACU due to bed capacity restraints shall have assessment, vital signs and documentation per the admitting unit's Standards of Care and surgeon's orders.**
   ~~1.~~**a) The PACU RN shall initiate time sensitive orders (such as medications, labs, X-rays) during the holding interval in PACU.**

~~B.~~**C. ADMISSION PROCEDURE:**

1. Confirm patient ~~ID on admission~~**identification upon arrival to PACU**. Review medical record **and obtain hand-off report from the anesthesiologist ~~(if applicable)~~ and/~~or~~ surgical/procedural registered nurse (RN)**.
2. **Place monitors on patient~~,~~ and begin continuous monitoring, including:**
   **a) Blood pressure cuff (initially set for every 5 minutes)**
   **b) Pulse Oximeter**
   **c) EKG**

~~1.~~**3.** Evaluate~~ion of~~ airway/**respiratory** status:

a) Auscultate breath sounds and count respiratory rate~~.~~
**b) Observe ~~R~~**respiratory depth and effort~~.~~
   **i. Hypoventilation, Obstruction or Hypoxia (implement in descending order if previous intervention unsuccessful):**
      **1) Reposition the patient as tolerated (head of bed elevated, side lying or high fowlers)**
      **2) Stimulate the patient**

3) **Institute jaw thrust/support, chin lift**
4) **Insert oral airway. Notify anesthesia before inserting nasal airway.**
5) **Manually ventilate patient with bag-valve-mask, notify anesthesiologist and prepare for medication intervention and/or intubation.**

ii. **Laryngeal Edema/Spasm:**
1) **Place in high fowlers position**
2) **Institute jaw thrust**
3) **Encourage coughing to clear secretions or gently suction to remove secretions or foreign material from cords, avoiding vigorous suctions as it can increase the spasm and result in complete closure of airway.**
~~b)~~4) **Notify anesthesiologist, Mmanually ventilate patient with bag-valve-mask, ~~notify anesthesiologist~~ and prepare to administer racemic epinephrine mini-nebulizer treatment, steroids, or other interventions to decrease edema.**

c) **Monitor** $O_2$ saturation via pulse oximetry ~~which will be monitored continuously in PACU.~~
i. Pulse oximetry sensor ~~wish~~**all** be placed on a finger **of the hand** opposite **the** blood pressure cuff, **when possible.**
ii. Administer $O_2$ to maintain $SpO_2$ at ~~94~~**95% or greater,** or as ordered by anesthesiologist.

~~2.~~**4.** ~~Evaluation of~~ **Measure** vital signs **and verbally report vital signs to anesthesiologist**:
**a)** ~~Vital signs to include b~~**B**lood pressure~~,~~
**b)** ~~h~~**H**eart rate~~,~~
**c)** $SpO_2$~~,~~
**d)** ~~t~~Temperature ~~and~~
~~a)~~**e)** ~~r~~**R**espiratory rate~~.~~
~~b) Monitor temperature on admission, at transfer, and as indicated.~~

~~3.~~**5.** Evaluate~~ion of~~ fluid status:
**a) Assess intravenous (IV) line(s)**
**i.** Maintain IV access at all times
**ii. Assess IV catheter site(s)**
**iii. Verify IV fluids, medication dosages and flow rates as indicated**
**b)** ~~and a~~**A**dminister fluids per **anesthesia** orders. Surgeon's IV orders may be initiated before **transfer to the floor, as needed.** ~~discharge when fluids from OR are completed.~~
~~a) Mark IV infusion bags, transfer, check flow rates and IV site.~~
~~i. Check medication dosages as indicated.~~
~~b) Maintain infusion pump for all pediatric patients (0-14) years.~~

~~4.~~**6.** Assess **all lines, drains and tubes:** ~~and document placement, patency, amount and type of drainage and amount of suction as indicated.~~
**a) Assess type, placement, patency, amount and type of drainage and amount of suction (as applicable)**
~~a)~~**b)** Do not move **nasogastric** (NG) tubes placed for gastric surgery without a physician order ~~and label tube: "Do not move NG".~~
~~b)~~**c)** Maintain any continuous irrigations initiated in OR.

~~5.~~**7.** Assess condition and location of dressings and type and amount of drainage.
~~a) Reinforce dressing if drainage extends to linens.~~
~~b) Change dressing if saturated or soiled using aseptic technique.~~
**a) Reinforce or change dressing per surgeon's order.**

~~6. Report initial vital signs to anesthesiologist and receive their verbal report.~~
~~a) Relevant pre-operative status, anesthetic agents used (local, sedatives, anxiolytics, opioids) and dosage and time, surgical procedure, estimated blood loss and type and amount of fluid replacement, and any complications or problems that occurred during the procedure.~~
~~7. Obtain additional information from circulating RN including:~~

~~a) Pre-operative concerns, emotional status, coping ability, preferred name, and location of family.~~

8. Neurologic system:
   a) Assess level of consciousness
   b) Assess movement of extremities
   c) Determine dermatome level of block for patients who have received spinal/epidural anesthesia by assessing level of sensation.
      i. For patients who have received interscalene, supraclavicular, infraclavicular, or cervical plexus ~~or stellate ganglion~~ blocks:
         1) Observe for Horner's Syndrome, as evidenced by facial flushing, constricted pupil, ptosis and congestion on side of block.
         ~~Note that Horner's Syndrome for a stellate ganglion block is evidence of a successful block.~~
      ii. Notify anesthesiologist of a block T4 or higher.
      iii. Notify anesthesiologist of an ascending block.
   d) Assess pupils as indicated by surgical intervention.
9. Cardiovascular system:
   a) Obtain baseline cardiac rhythm strip
   b) All Phase I patients shall have continuous cardiac monitoring in lead II.
      i. For patients receiving local anesthesia, cardiac monitoring is not required unless otherwise ordered.
   c) Assess heart sounds, peripheral circulation, capillary refill, and skin temperature and color as indicated by surgical intervention or patient's past medical history.
   d) Invasive lines: pulmonary artery catheters/cardiac output, central venous pressure, or arterial catheters, refer to Standards of Patient care.
10. Temperature regulation:
   a) Obtain temperature (temporal artery)
      i. Temp <36°C initiate warming with Bair Paws forced air warming unit
      ii. Temp <35°C initiate warming with Bair Paws ~~Hugger~~ forced air warming ~~blanket~~ unit
      iii. Temp <34°C initiate warming with Bair Paws forced air warming unit ~~forced air warming blanket~~, warmed IV solutions via fluid warmers, heated aerosol for $O_2$ delivery and place warm blankets around head, neck, and shoulders. Notify anesthesia.
      iv. Temp >37.2°C (99°F) remove extra linens using only one light cover.
   b) Monitor temperature every 15 minutes while active rewarming.
   c) Notify anesthesiologist for shivering not readily controlled with warming interventions and anticipate order for Meperidine.
      i. Continue supplemental $O_2$ when temperature elevated or decreased and shivering present.
11. Pain management:
   a) See PCS Policy Pain Management
12. Gastrointestinal system:
   a) Assess for bowel sounds in all four quadrants
   b) Assess for nausea/vomiting
      i. Encourage deep breathing, monitor BP and treat hypotension.
      ii. Turn patient to side if vomiting, suction if necessary and provide oral care.
13. Integumentary system:
   a) Complete a head to toe skin assessment
   b) Position for comfort, straighten linens and change if soiled/wet, and activate air mattress pumps (as needed).
   c) Maintain proper body alignment, place effected extremity in proper position
   d) Check for properly fitted appliances, casts, splints, CPM, pneumatic compression stockings as indicated.
14. Complete additional surgery/procedure specific assessments as indicated.

**D. DOCUMENTATION OF ADMISSION ASSESSMENT:**

**1. Complete the following sections of Cerner iView, as applicable:**

- **a) PACU Arrival information**
- **b) Vital signs (including temperature)**
- **c) Safety Checks**
- **d) OR Intake and Output**
- **e) IV Drips**
- **f) Pain Assessment and Interventions**
  - **i. Document acceptable pain number, pain tool used, pain level, location, laterality, quality, time pattern and aggravating factors**
- **g) Peripheral IV**
- **h) Aldrete I Assessment**
- **i) Artificial airway**
- **j) Head-to-Toe Assessment, as relevant to surgery/procedure and patient condition**
- **k) Dermatome Assessment**
- **l) Surgical/Procedural Site**
- **m) All invasive lines, tubes and drains**
- **n) Post-Operative Hydration (including nausea, vomiting and hydration status)**
- **o) Antiembolism Devices**
- **p) Warming/cooling measures**
- **q) Nerve blocks**
- **r) PCA/PCEA**
- **s) Intake and Output**
- **t) Additional elements of assessment as indicated by procedure and anesthesia/sedation type**

**2. Document all medications given on the eMAR**

~~8.~~**E. ONGOING ASSESSMENT:**~~Reassessment/ongoing assessment:~~

1. Vital signs:
   - a) ~~will be documented~~**Take vital signs (blood pressure, heart rate, respiratory rate, and $SpO_2$)** ~~every five minutes X3 then, if stable, every 15 minutes until (blood pressure, heart rate, respiratory rate, and $SpO_2$) discharge criteria met.~~ **while in Phase I.**
   - **b) Continuously monitor** $SpO_2$ ~~will be continuously monitored~~ in Phase I.
   - ~~b)~~**c) Take vital signs every 1 hour, while in Phase II and PRN.**
   - **d)** Report abnormal vital signs or $SpO_2$ not corrected by interventions, abnormal diagnostic tests, pain not relieved by prescribed analgesia or failure to attain discharge score ordered for transfer.
   - ~~c)~~**e) For inpatients, o~~~~O~~**nce patient meets PACU discharge criteria, follow surgeon's floor orders for vital signs.**
2. **Pain management:**
   - ~~i.~~**a) Assess, treat and reassess pain per PCS Policy: Pain Management**
     - **i. Provide pillow and instruct patient to splint abdomen when coughing if abdominal incision present.**
     - **ii. Implement Patient Controlled Analgesia (PCA) if ordered ~~by surgeon when pain level ≤~~ 4 and teaching has been completed and documented in EHR.~~**
3. ~~9.~~ Monitor ~~and document~~ intake and output hourly~~:~~.
   - ~~a) Total intake and output prior to transferring patient.~~
4. ~~10.~~ Neurologic system:
   - ~~a) Consciousness level will be documented on admission.~~
   - **a) Complete Aldrete assessment every 15 minutes x4 (or until meets baseline), then hourly.**
   - **b) Assess dermatome level of block hourly for patients receiving spinal/epidural anesthesia.**

~~b) Movement of extremities will be documented on admission and every hour using Aldrete Scale.~~

~~c) Determine dermatome level of block for patients who have received regional anesthesia by assessing level of sensation on admission and hourly.~~

~~d) Observe for facial flushing, constricted pupils, ptosis and stuffiness of nose on side of block in patients who have received brachial plexus block.~~

~~e) Pupils will be assessed as indicated by surgical intervention.~~

~~11.~~**5.** Cardiovascular system:

a) All patients will have continuous cardiac monitoring in lead II with a baseline rhythm strip obtained and posted in Phase I.

~~i. Cardiac monitoring is not required unless otherwise ordered for patients receiving local anesthesia.~~

~~ii.~~**b)** Heart sounds, peripheral circulation, capillary refill, and skin temperature and color will be assessed as indicated by surgical intervention or patients past medical history.

~~iii. Invasive lines: pulmonary artery catheters/cardiac output, central venous pressure, or arterial catheters, refer to Standards of Patient care.~~

~~12.~~**6.** Respiratory system:

a) Monitor airway patency and respiratory rate and effort until patient fully reactive and responsive.

b) Monitor $SpO_2$ ~~until discharge to Phase II~~.

i. Titrate oxygen to maintain $SpO_2$ at 9~~5~~4% unless otherwise ordered.

ii. Discontinue $O_2$ when $SpO_2$ is above ordered level, breathing pattern and vital signs stable, and patient is easily arouseable.

iii. Monitor for at least 15 minutes after $O_2$ discontinued before transferring patient.

iv. Position patient in semifowlers position unless contraindicated.

c) Retain artificial airways (oral, nasal, or endotracheal tube) until gag and/or cough reflex returns or extubation criteria met.

d) Encourage deep breathing with "stir up" routine (initially every five minutes, then every fifteen minutes with vital signs). ~~Change $O_2$ cannula when patient is awake and $O_2$ sats ≥95%.~~

e) Encourage patient to cough or suction as needed to clear secretions, improve $SpO_2$ or increase depth of respirations.

f) Extubation:

i. Monitor for thirty minutes following extubation before patient transferred unless patient transferred to ~~ACCU.~~ **Critical Care unit.**

~~g) Hypoventilation: (implement in descending order if previous intervention unsuccessful)~~

~~i. Institute jaw thrust/support.~~

~~ii. Insert oral/nasal airway.~~

~~iii. Place in high fowlers position.~~

~~iv. Manually ventilate patient with bag valve mask and notify anesthesiologist and prepare to administer reversal agent or intubation of patient.~~

~~h) Laryngeal Edema/Spasm:~~

~~i. Place in high fowlers position.~~

~~ii. Institute jaw thrust.~~

~~iii. Encourage coughing to clear secretions or gently suction to remove secretions or foreign material from cords avoiding vigorous suctions as it can increase the spasm and result in complete closure of airway.~~

~~iv. Manually ventilate patient with bag valve mask and notify anesthesiologist and prepare to administer racemic epinephrine mini nebulizer treatment, steroids, or other interventions to decrease edema.~~

~~13.~~**7.** Temperature regulation:

**a)** ~~Obtain~~**Monitor** temperature (temporal artery~~, oral, axillary or tympanic~~) ~~on admission,~~ hourly ~~and on discharge.~~ **if temp was 36.~~2~~°C or greater on admission.**

b) **If patient temperature was less than 36.2°C on admission, actively warm and recheck temperature every 30 15 minutes until temp reaches 36.4°C or greater, then monitor temperature hourly.**

~~i.~~

~~1) A 36°C temperature is required for discharge (confirm with oral thermometer prior to transfer to floor).~~

~~2) Temp <36°C initiate warming with Bair Paws warming unit. Obtain/record temperature in ten minutes in Cerner and on PACU flow sheet. Adjust Bair Paws temperature control as needed to warm patient. Obtain/record temperature hourly.~~

~~3) Temp <35°C initiate warming with forced air warming blanket and monitor temperature every thirty minutes.~~

~~4) Temp <34°C initiate warming with forced air warming blanket, warmed IV solutions via fluid warmers, heated aerosol for $O_2$ delivery and place warm blankets around head, neck, and shoulders. Notify anesthesia.~~

~~5) Notify anesthesiologist for shivering not readily controlled with warming interventions and anticipate order for Demerol.~~

~~6) Temp >99° remove extra linens using only one light cover.~~

~~7) Continue supplemental $O_2$ when temperature elevated or decreased and shivering present.~~

~~14.~~8. Gastrointestinal:~~ and genitourinary:~~

a) **Assess for bowel sounds prior to feeding patient**

~~i. Nausea: encourage deep breathing with each wave of nausea, monitor BP and treat hypotension.~~

~~1) Turn patient to side if vomiting, suction if necessary and provide mouth care.~~

~~15.~~9. Integumentary system:

~~a) Position for comfort, straighten linens and change if soiled/wet, and activate air mattress pumps.~~

~~b)~~a) Maintain proper body alignment, effected extremity in proper position and reposition at least every two hours for patient who is immobile (post-regional anesthesia).

~~c) Check for proper fitted appliances, casts, splints, CPM, pneumatic compression stockings as indicated.~~

10. **Assess surgical site and any additional elements as indicated by procedure and by changes in condition.**

a) **A focused assessment should occur every 15 minutes while in Phase I and every 1 hour while in Phase II and PRN**

~~16. Pain management:~~

~~a) Pain level is determined by using the Pain Rating Score or Faces Scale for awake/oriented patient and observation of patient behaviors i.e., grimacing, moaning, crying rigidity, restlessness, increased heart rate, and increased blood pressure for the cognitively impaired patient.~~

~~i. Treat pain with medication as ordered to keep pain score ≤4, if RR>8, sedation score ≤3, and $SpO_2$ >95%.~~

~~ii. Provide pillow and instruct patient to splint abdomen when coughing if abdominal incision present.~~

~~iii. Implement Patient Controlled Analgesia (PCA) if ordered by surgeon when pain level ≤4.~~

F. **DOCUMENTATION OF ONGOING ASSESSMENT AND CARE:**

1. **Document ongoing assessment in iView in Cerner ~~iView PACU InPt Post Procedure band:~~**
   a) **Vital signs (including temperature)**
   b) **Pain assessment**
   c) **Aldrete assessment**
   d) **Dermatome level**

e) Intake and output
f) Additional elements of assessment as indicated by procedure and anesthesia/sedation type

2. Document medications given, time, dose, route and effects on the MAR

G. DISCHARGE/TRANSFER PROCEDURE AND DOCUMENTATION:~~iscbarge/transfer:~~

1. For transfer to an inpatient unit, see PANS Policy: Discharge of Post Anesthesia & Post Sedation Patients to Inpatient Units.
~~17.~~2. For outpatient discharge, see PCS Policy: Standardized Procedure: Discharge from Outpatient Post-Anesthesia Service

~~Discharge or transfer when patient meets or exceeds discharge score ordered, surgical/procedure site stable with dressing dry and intact, sedation level <3, and comfort acceptable or <4 onr pain scale and RR >10.~~

~~Review and verify orders applicable to PACU are implemented and reported.~~

~~i. Communicate report to receiving licensed nurse to include pertinent medical history, procedure, type of anesthesia, complications, current vital signs and intake and output.~~

~~ii. Review post op orders, medication times, tests, and treatments that are due.~~

~~iii. Transport to receiving unit with side rails in upright position.~~

~~C.~~H. RELATED DOCUMENT(S):

1. ASPAN Standards Phase I & II Recovery

~~D.~~I. REFERENCES:

1. American Society of Perianesthesia Nurses. (2014). *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements 2015- 2017.* Cherry Hill, NJ: American Society of Perianesthesia Nurses.
2. American Society of Perianesthesia Nurses. (2014). *A Competency Based Orientation and Credentialing Program for the Registered Nurse in the Perianesthesia Setting.* Cherry Hill, NJ: American Society of Perianesthesia Nurses.
~~2.~~3. Schick, L., & Windle, P. E. (Eds.). (2016). *PeriAnesthesia Nursing Core Curriculum: Preprocedure, Phase I and Phase II PACU Nursing* (3rd ed.). St. Louis, MO: Elsevier.

# ASPAN Standards
# Phase I & Phase II Recovery

## PHASE I

- Patients are considered Phase I from initial admission from the OR until the following criteria are met:
  - Patient can maintain airway
  - Patient can cough and deep breathe
  - Patient's skin is appropriate for ethnicity
  - $SpO_2 \geq 90\%$ with or without $O_2$
  - Blood pressure is stable and within +/- 20 from baseline, unless discharged to critical care unit
  - Temperature $\geq$ 36 degrees, with no signs/symptoms of hypothermia
  - Patient is oriented, responds to simple questions, and able to call for assistance/voice concerns.
  - Patient has protective reflexes (i.e., gag reflex)
  - Moderate to severe pain is controlled
  - No ongoing emesis, minimal level of nausea
  - Spinal anesthesia beginning to resolve or moving down
  - Able to move extremities on command
  - Mild/moderate drainage on dressing, that is not increasing

## PHASE II

- Patients are considered Phase II until the following criteria are met:
  - Able to cough and deep breathe
  - Patient's skin is appropriate for ethnicity
  - $SpO_2 \geq 94\%$ on room air, unless on home $O_2$
  - Vital signs stable or baseline
  - Temperature at least 36 degrees
  - Awake, alert and oriented. Able to voice concerns/call for assistance.
  - Understands basic instructions
  - Acceptable pain level
  - Acceptable level of nausea
  - Voiding and fluid/oral intake as needed
  - Dressing/surgical site is clean, dry and intact
  - Ambulation back to baseline or consistent with post procedure. Demonstrates understanding of assistive devices as appropriate
  - Patient and home-care provider understand discharge instructions
  - Written instructions and Rx given
  - Post-Op orders complete
  - Discharge criteria per institution
    - Must be discharged in the company of a responsible adult.
    - Aldrete 10 or baseline for outpatients and Aldrete $\geq$8 for inpatients. Or per anesthesia order.

Tri-City Medical Center
Oceanside, California

**TELEMETRY~~UNIT~~**
**~~UNIT SPECIFIC POLICY~~**

| | |
|---|---|
| **ISSUE DATE:** 06/06 | **SUBJECT: Management of Telemetry Patients** |
| **REVISION DATE(S):** 03/07, 09/10, 12/10, 01/11, ~~9/12, 11/14~~ | **~~POLICY NUMBER: 6150-108~~** |
| **Cardiology Department Approval:** | ~~12/14~~03/19 |
| **Division of Cardiology Approval:** | ~~04/17~~05/19 |
| **Pharmacy ~~and~~ & Therapeutics Committee Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~07/17~~05/19 |
| **Administration Approval:** | 06/19 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | 02/11 |

A. **PURPOSE:**

1. Telemetry monitored patients will be assured of early detection of arrhythmias by continuous cardiac monitoring as ordered **by a physician.**
2. Appropriate nursing care will be implemented in a timely manner as outlined in this policy.
   ~~1.~~**a. A timely manner is defined in the Standards of Care for Adults**
~~2.~~**3.** A Registered Nurse (RN) with Advance Cardiac Life Support (ACLS) certification and successful completion of the Telemetry Unit Specific Skills lab or the Intensive Care Unit (ICU) Specific Skills lab shall be present on the unit at all times.
~~3.~~**4. All Telemetry patients requiring cardiac monitoring shall have a patent intravenous (IV) access at all times unless otherwise ordered.**
**5. Admissions, transfers, and patients returning to Telemetry from test/procedures will be placed on a cardiac monitor immediately upon arrival.**
   **a. Exceptions to placing a patient on a cardiac monitor immediately upon arrival to the unit:**
      **i. Physician order to discontinue cardiac monitoring.**
      **ii. Primary RN or relief RN present in patient's room and assessing patient's stability.**
      **iii. Prior to leaving the patient's room, the primary RN or relief RN will ensure the patient's cardiac rhythm is visible on the cardiac monitoring screen.**
   **b. A six second electrocardiographic (ECG) tracing i.e., strip shall be printed, interpreted, and posted in the patient's medical record per the Standards of Care for Adults – Assessment Cardiovascular System Review.**
   **c. Ongoing assessments and documentation of the patient's cardiac rhythm shall occur per the Standards of Care for Adults.**
~~4.~~**6. Telemetry monitoring may be interrupted for transport to tests/procedures with a physician order. See the ~~Please review~~Telemetry's Admission Discharge Criteria policy.**
   **a. The primary RN or designee will notify the Monitor Technician (MT) of interruptions in cardiac monitoring as soon as possible as outlined in this policy.**
   **b. The MT will notify a RN or ACT immediately when a patient's cardiac rhythm is not visible.**
**7. Patients that have their telemetry monitoring interrupted or disconnected from the view of the central monitoring station for any reason (except for physician order) shall be placed back on the cardiac monitor i.e., telemetry box immediately once identified by nursing staff or nursing staff are notified by the MT. Exceptions are as follows:**
   **a. RN or Advanced Care Technician (ACT) is providing direct care for the patient.**
   **b. RN present in patient's room and identifies patient's condition as stable.**

c. **Patient refuses to allow nursing staff to attach/apply the cardiac monitor.**
   i. **ACTs shall notify the primary RN and MT as soon as possible.**
   ii. **RNs shall provide education to the patient on the rationale for telemetry monitoring, the importance of reapplying the cardiac monitor~~,~~. ~~o~~Once the cardiac monitor is applied, document events and education provided in the Electronic Health Record (EHR).**
      1) **If the patient continues to refuse to allow staff to apply the cardiac monitor after receiving education, the primary RN shall notify the appropriate physician, ANM/Relief Charge RN, and MT.**
      ~~A.~~2) **If a physician order is obtained to discontinue telemetry monitoring, the Primary RN shall notify the MT and ANM/Relief Charge RN.**
      3) **If a physician order is not obtained to discontinue telemetry monitoring and the patient ~~is still~~continues to refuse~~ing~~ the monitor, the primary RN shall notify the ANM/Relief Charge RN, nursing staff on their assigned unit, and MT. Document interventions in EHR and increase surveillance of the patient as ordered.**

8. **Documentation**
   a. **Document the following in the EHR in a timely manner:**
      i. **Delays in placement of the cardiac monitor not related to direct patient care being provided.**
      ii. **Patient's status during delay in cardiac monitoring or visualization of the cardiac rhythm.**

~~B. POLICY:~~

~~1. Telemetry patients shall have cardiac monitoring per physician order.~~
~~2. Telemetry monitoring may be interrupted for transport to tests/procedures with a physician order. Please review Telemetry's Admission Discharge Criteria.~~
~~3. All Telemetry patients requiring cardiac monitor shall have a patent IV access at all times unless otherwise ordered.~~
~~4. Admissions and transfers placed on a cardiac monitor within 5 minutes of arriving to the unit~~
~~a. The primary RN must verify the patient's cardiac rhythm is visible on the cardiac monitor by printing a cardiac rhythm strip.~~
~~5. Patients returning from procedures shall be placed on a cardiac monitor within 15 minutes of arriving to the unit.~~
~~a. The primary RN must verify the patient's cardiac rhythm is visible on the cardiac monitor by printing a cardiac rhythm strip.~~
~~b. The Monitor Technician (MT) shall place a reminder call if the cardiac monitor is not placed on the patient within 5 minutes of notification the patient has arrived to the unit.~~
~~c. A second reminder call shall be placed if the cardiac monitor is not applied after 10 minutes.~~
~~d. A third reminder call shall be placed to the unit and the Assistant Nurse Manager (ANM) or relief charge nurse if the cardiac monitor is not applied after 15 minutes.~~
~~6. Patients who have their cardiac monitor interrupted for any reason shall be placed back on the cardiac monitoring within five minutes after a telemetry staff member is notified.~~
~~1.~~9. ~~7. Telemetry box batteries shall be maintained in working order at all times and changed as indicated~~.

B. **TELEMETRY MONITORING AND LEAD PLACEMENT PROCESS:**

~~2.~~1. The patient shall be prepared for monitoring as follows:
   a. **Skin preparation**
      ~~a.~~i. Clean skin with soap and water and pat dry.
      ii. Use a surgical clipper to prep patients as necessary. Do not use a razor to remove excessive body hair.
      iii. **Gently rub surface of the skin to increase capillary blood flow.**

iv. **Obtain clean lead wires, attach the lead wires to the electrodes, and place the electrodes on the patient's skin as directed by the diagram on the telemetry box.**

~~i.~~v. Electrodes shall be removed ~~and skin care provided daily as needed.~~ **daily during AM or PM hygiene care. Apply new electrodes after completing hygiene care.**

vi. The telemetry box corresponding with the patient's room number **or assigned to the patient** shall be used **unless DASH monitoring is required.**

~~ii.~~vii. ~~b. Electrodes shall be placed as directed by the picture on the telemetry box unless the patient requires monitoring using a DASH~~

~~c. Obtain clean lead wires~~

~~f. Attach leads to electrodes as outlined in #C1c~~

~~g. Attach lead wires to Telemetry Box~~

~~h. Place Telemetry box in plastic protective pouch. Pouches are single use only,~~

~~discard if torn, damaged, and at discharge~~

~~i. Open pouch and insert Telemetry box with lead wires connected~~

~~j. Seal Velcro closure on pouch~~

~~k. Place pouch with (velcro side facing patient) in pocket on patient gown or use clip on pouch to secure to patient gown~~

~~3.~~2. Standard monitoring leads shall be Lead II and VI. Secondary lead selection shall be based on the patient's pathology. ECG monitoring shall be continuously with minimum interruptions. ~~See image;~~

~~4.~~3. For Dysrhythmia Monitoring: Monitor per **the** American **Association of** Critical Care Nurses Dysrhythmia Practice Alert:

a. Select the best monitoring leads for dysrhythmia identification
b. Display two leads when possible
c. Lead V1 to diagnose wide QRS complex
**d.** Lead II to diagnose atrial activity and measure heart rate
~~a.~~**e. For patients without definitive Acute Coronary Syndrome (ACS) but are suspected of having or are being assessed for ACS, leads III and V1 should be considered for monitoring**

4. Default alarm settings may be altered at the discretion of the primary RN.

~~2.~~**a.** The MT shall **not** ~~discuss all~~ changes ~~in~~ default **cardiac settings or make parameter adjustments.** ~~setting with the primary Telemetry RN or ANM prior to adjusting~~ ~~the alarms.~~

5. The RN or primary Telemetry RN shall record a six (6) second **ECG tracing/**strip **at the beginning of the shift.** ~~measure, interpret and post the strip for their assigned patients at the beginning of their 12 hour shift and PRN.~~

**a. The ECG tracing/strip shall be measured, interpreted and posted in the EHR within in a timely manner and PRN as outlined in the Standards of Patient Care for Adults.**

~~a.~~**b. The following shall be documented in the EHR, if present:** ~~The heart rate, the lead interpreted and measurements of following wave forms, if present, will be documented in the medical record:~~

**i. Ventricular heart rate**
**ii. Lead interpreted**
**iii. Wave form measurements of the following:**
**1) PR Interval**
**2) QRS Interval**
**3) QT Interval**

~~PR Interval~~
~~QRS Interval~~

**iv.** ~~QT Interval~~**Presence of ectopic beats**

~~i.~~v. **Documentation of the following is recommended but not required:**
~~i.~~1) **ST segment elevation or depression**
~~1)~~2) **Morphology of P waves and T waves**

6. **The primary RN** ~~Each RN nurse~~ shall document their assigned patient's rhythm every four hours and PRN with any significant rhythm or rate changes **or the presence of new ectopic beats in** ~~in~~the **EHR**~~medical record~~.
   a. **The ECG tracings/strips may be posted in the medical record per the primary RN's discretion.**
   ~~3. The task of posting ECG tracings/strips in the medical record may be delegated to support staff per the RN's discretion. Support staff includes ACTs, Lift Team Technicians (LTT) and Unit Secretaries (US).~~

~~6.~~7. The MT shall report ~~all~~ changes in cardiac rhythms to the RN **or relief RN** ~~and document the name of the RN notified on the cardiac rhythm strip~~.

~~7.~~8. Life threatening dysrhythmias shall be reported to a RN by telephone or by using the emergency red telephone **immediately**. The MT shall:
   a. Print a continuous rhythm strip.
   b. Post the continuous rhythm strips as directed by an RN.
   c. Perform task as outlined by the primary RN or designee.

9. All significant changes in patient's status, rhythm, or heart rate (HR) ~~require~~**require** a review of rhythm, vital signs and **assessment of the patient for** associated symptoms.
   ~~4.~~a. **ECG tracings/strips associated with changes in a patient's status shall be posted in the medical record.**

10. The primary Telemetry RN shall notify the MT when bedside therapies or procedures are initiated if times permits. i.e., cardioversion, bronchoscopy, temporary pacing, initial administration of ~~antidysrhythmics~~**Aantidysrhythmics**.
   ~~5.~~a. **The primary RN will provide instructions to the MT if additional monitoring is required.**

## ~~B.~~C. PROCESS FOR CLEANING TELEMETRY BOXES AND LEAD WIRES:

1. On discharge or transfer:
   a. Remove **the** ~~Telemetry~~ lead wires from electrodes.
   b. Remove electrodes from patient's skin.
   c. Disconnect lead wires from **the** ~~T~~telemetry box.
   ~~Remove Telemetry box from plastic pouch~~
   ~~Place used/dirty electrodes in Telemetry lead wire container~~
   d. Remove batteries from ~~Telemetry~~**telemetry** box and ~~store~~ **store in the proper location identified on the unit.** ~~or discard~~
   e. **Clean the telemetry box and lead wires using the appropriate disinfectant per manufacturer's recommendation. Allow lead wires and telemetry box to dry and then place both the lead wires and telemetry box in the proper storage location.**
   f. **Discard damage lead wires.**
   g. **Notify an ANM/Relief Charge Nurse if debris cannot be removed from a telemetry box.**
      i. **When debris cannot be removed using a disinfectant wipe, send the telemetry box to biomed for cleaning.**

   ~~Place used/dirty lead wires in the container marked LEAD WIRES~~
   ~~Dirty Lead wires will be taken to SPD by the MT for cleaning between 2200-2400~~
   ~~Clean Lead wires will be obtained from SPD the MT between 0500 and 0600~~
   ~~a.ii. h. Discard damaged lead wires and informs an Assistant Nurse Manager~~

## ~~C.~~D. TRANSPORTING TELEMETRY PATIENTS REQUIRING CARDIAC MONITORING:

1. A physician's order is required to interrupt cardiac monitoring for transport to test/procedures.
   a. RNs shall not contact physicians by telephone for transport orders.

b. When the RN determines a patient would be safe to transport to test/procedures without an RN and a cardiac monitor capable of defibrillating, the RN will consult with the physician during daily rounds to **obtain**~~seek~~ an order to interrupt Telemetry monitoring for transport to tests/procedures without a nurse.

2. **Patients without a physician order to interrupt cardiac monitoring for transport shall be transported with an RN and a cardiac monitor capable of defibrillating. The transporting RN shall:**
   a. **Meet the requirements outlined in the purpose statement #3 of this policy.**
   ~~1.~~**b. Remain in the procedure area with the patient. Exceptions: the procedure RN has ACLS certification and accepts hand-off.**

   **A Respiratory Care Practitioner (RCP) shall be asked to assist with transports as needed. Exceptions: Patients requiring intermittent BiPap may transport without a RCP with a physician's order or with the recommendations of the RCP providing care for the patient.**

~~2.~~3. If the **RN has concerns relating to a** patient's current stability, recent changes in **a patient's** ~~condition,~~**condition** or the probable impact of test/treatment/transfer are contraindications to transport~~,~~: the **RN**~~nurse~~ will consult the patient's physician and other interdisciplinary team members regarding recommendations for rescheduling **the test/procedure**, beside testing ~~or procedures,~~ or alternative interventions.

~~3. Patients without a physician order shall be transported with an RN and a cardiac monitor capable of defibrillating. The transporting RN shall;~~
~~a. Meet the requirements outlined in the purpose statement #2 of this policy/ or an RN assigned by the Telemetry ANM/relief charge nurse.~~
~~b. Remain in the procedure area with the patient. Exceptions: the procedure RN has ACLS certification and accepts hand-off..~~
~~4.a. A Respiratory Care Practitioner (RCP) shall be asked to assist with transports as needed. Unless the physician writes orders to the contrary, patients who meet the criteria in number one (1) listed below will be transported off the unit with a Telemetry or ICU ACLS provider RN and cardiac monitor.~~

~~3.~~4. The following patients shall be transported off the unit with nurse and monitor via bed or gurney, **no physician order is required:**
   a. Unstable vital signs or cardiac rhythm
   b. Unstable respiratory status
   c. Change in mental status
   d. Patients with continuous intravenous (IV) infusions of antidysrhythmic or vasoactive medications
   e. Endotracheal or tracheostomy intubated patients on mechanical ventilation
      i. Patients requiring mechanical ventilation will be accompanied by RCP, an ACLS provider RN, and a portable cardiac monitor to all off unit procedures.
   f. Temporary pacemaker
   g. Conscious sedation
   h. Transfer to ICU

~~4.~~5. **The primary or relief RN will document all patient transports off of the unit and patient's returns from test/procedures in the EHR per the**

~~D.~~E. **MONITOR TECHNICIAN SHIFT TASK PROCESS:**

1. **Communicating to nursing staff. The MT shall:**
   a. **Communicate changes in the patient's baseline cardiac rhythm, rate, and ectopic findings to the primary RN or relief RN immediately.**
   b. **Communicate interruptions in cardiac monitoring not related to transport to the primary RN or relief RN.**
   c. **Interruptions in monitoring not related to transport:**
      i. **Notify the primary RN, if monitoring is not resumed or unable to contact any RN or ACT on the patient's assigned unit, THEN**

ii. Notify the ANM/relief Charge RN, if unable to notify the ANM/Relief Charge RN, then notify the Clinical Manager

~~1.~~2. Hand-off Worksheet

a. A Shift Hand-off Worksheet will be used to communicate hand-off between MTs prior to the beginning of each shift and anytime the task of observing cardiac tracings is handed-off to a MT or RN for break relief.

b. Each shift a new worksheet will be updated with the following by the off-going MT

i. Patient's Name

1) Summation of cardiac tracings 2 Shifts Ago and Previous Shift Summation of cardiac tracings 2 Shifts Ago and Previous Review the Telemetry MR Shift-Hand-off worksheet.

~~b.~~c. Use the following key to document Communications, Reasons for Calling Floor, and Abbreviations.

| Communications | Reasons for Calling Floor | Abbreviations |
|---|---|---|
| CC = Conventional Care<br>D/C = Discharged<br>IVP = Medication given<br>CP = Chest Pain | LO = Leads Off<br>B = Battery Change Needed<br>NT = No Telemetry<br>▭ = Patient off Monitor | ~~RINF =~~<br>~~Rare~~Infrequent<br>FRQ = Frequent<br>Occ = Occasional<br>Int = Intermittent |

d. The day shift MT will discard the Telemetry MT Shift Hand-off Worksheet in the Shred-it bin 48 hours after the date written on the worksheet

i. The worksheets may not be stored in notebooks or lockers

~~2.~~3. Interruptions in monitoring not related to transports

a. Notify primary RN, if monitoring is not resumed or unable to contact any RN or Advanced Care Technician (ACT) on the unit, then

b. Notify the ANM/Relief Charge RN, if unable to notify the ANM, then

c. Notify the Clinical Manager

~~3.~~4. Each shift a new worksheet will be updated with the following by the off-going MT

a. The day shift MT will discard the Telemetry MT Shift Hand-off Worksheet in the Shred-it bin 48 hours after the date written on the worksheet

b. Worksheets may not be stored in notebooks or lockers

~~4.~~5. The on-coming MT will perform the following tasks and document the following on the Telemetry MT Shift Hand-off Worksheet:

a. Take sample of the patient's current rhythm.

b. Check defaults on DASH units that are in use

c. Verify spelling of patient's name, if not completed on previous shift.

d. Print strips for 2 East as directed by the RNs.

e. Document rate and rhythm every hour on the Telemetry MT Shift Hand-off Worksheet.

f. Document ectopic events PRN on the Telemetry MT Shift-hand-off Worksheet.

g. Maintain/Filter Alarm Banks every 4 hours.

~~1.~~h. Document interruptions in monitoring not related to transports on the Telemetry MT Shift Hand-off Worksheet

i. Document patient transports off of the unit on the MT Shift Hand-off Worksheet

6. Copying or storage of the Telemetry MT Shift Hand-off Worksheet forbidden without the permission of the Clinical Manager, ANMs, or Clinical Educator

7. The Telemetry MT Shift Hand-off Worksheet may not be removed from the unit without the Clinical Manager's permission.

8. Notify a Unit Secretary to place work orders for all broken equipment

a. Check for updates on repairs PRN via TAMBIS

F. REFERENCE(S) ~~LIST~~:

1. Fedar, S. & Funk, M. (2013). Over-monitoring and alarm fatigue: For whom do the bells toll? Heart & Lung (42)395e396. doi.org/10.1016/j.hrtlng.2013.09.001
2. Funk, M., Winkler, G., May, J., Stephens, K., Fennie, K. Drew, B. (2010). Unnecessary arrhythmia monitoring and underutilization of ischemia and QT interval monitoring in current clinical practice: baseline results of the practical use of the latest standards for electrocardiography trial (PULSE). Journal of Electrocardiology 43:542–547. doi:10.1016/j.jelectrocard.2010.07.018
3. Lazzara, P., Redheedran Santos, A., Hellstedt, L. & Walter, R. (2010). The evolution of a centralized telemetry program. Nursing Management. ():51-54. doi: 10.1097/01.NUMA.0000388670.02663.b6
4. Northwestern Memorial Hospital - Telemetry: Care of the patient on centralized telemetry monitoring (2008). Hospital Specific Patient Care Policy
5. Telemetry and cardiac monitoring policy. (2002). 7N Telemetry Unit.
6. Whelan, D., Covelle, P., Piepenbrink, J., Villanova, L. & Cuneo, C. (2014). Novel approach to cardiac alarm management on telemetry units. Journal of Cardiovascular Nursing, 29(5): E13YE22. doi: 10.1097/JCN.0000000000000114
~~5.~~7. Whelen, L. & Stanton, M. (2013). Updating telemetry practices to improve the culture of safety. Nursing Management Risk Management doi:10.1097/01.NUMA.0000427192.74586.45

| PROCEDURE: | CAR SEAT CHALLENGE TEST |
|---|---|
| Purpose: | To assess premature, low birth weight and compromised infants positioning in a car seat without evidence of respiratory compromise prior to discharge. |
| Supportive Data: | The infant's head is proportionally large relative to the rest of the body; the straight back of the car seat may flex the neck excessively, increasing the risk of hypoxia. |
| Equipment: | ~~1.~~ ~~Patient's~~ **Infant's** car seat<br>~~2. Car seat base~~<br>~~3.~~ Cardio-respiratory monitor **and leads**<br>Pulse oximeter **and pulse oximeter probe**<br>~~4.~~ **Blanket rolls**<br>~~5. Pulse oximeter patient probe~~<br>~~6.~~ ~~Blanket rolls~~ |

A. **POLICY:**

1. In accordance with the American Academy of Pediatrics (AAP) recommendations, all ~~patients~~ **infants** meeting one of the following criteria at the time of discharge should receive a ~~positional~~ car seat challenge test:
   a. Gestational age is less than 37 weeks at the time of birth.
   b. Low birth weight ~~patients~~ **infants** weighing less than 2,500 gm.
   c. ~~Patients~~ **Infants** with a medical condition that places them at risk for apnea or oxygen desaturation**, per physician order**.
   d. Other ~~patients~~ **infants** at discretion of physician/Allied Health Professional, (i.e., supplemental oxygen at discharge or oxygen within one week of discharge).
2. According to AAP/National Association of Neonatal Nurses (NANN) guidelines, car seat challenge tests are to be completed ~~2 to 4 days prior to discharge/7 days maximum~~**within 7 days of discharge**.
~~2.~~3. **Car Seat safety education should be provided to parents prior to discharge of infant.**

B. **PROCEDURE:**

1. Verify physician/Allied Health Professional's order for car seat challenge test.
   ~~a. A car seat challenge test on a patient with an NG tube is applicable only if the patient is being discharged home with NG tube.~~
   ~~b. Recommendation is to wait until the NG tube is discontinued prior to proceeding with testing.~~
2. **Follow standard precautions while performing all steps of the procedure.**
3. Confirm ~~patient~~ **infant** identity using two-identifier system. Refer to ~~Patient~~ **Infant** Care Services Identification, Patient policy.
4. **Tests shall be conducted in the car safety seat intended for regular use by the infant.**
~~2.~~5. **Test should be done in between feedings.**
~~3.~~6. Place the car seat ~~in the car seat base~~ on ~~a stable surface~~**the floor (base not necessary)**.
   ~~a. Shall be conducted in the car safety seat intended for regular use by that particular patient.~~
7. Place the ~~patient~~ **infant** in the car seat with buttocks and back flat against the back of the car seat.
   a. **Nothing should be placed under or behind the infant.**
   ~~4.~~i. **Positioning devices (only if necessary):**
      ~~a.~~1) Blanket rolls may be placed on both sides of the ~~patient~~ **infant** for lateral support of the head and neck

| ~~Department~~ ViewWomen and Newborn Services | Department of OB/GYN | Perinatal Collaborative Practice~~Division of Neonatology~~ | Department of Pediatrics | Pharmacy and & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 01/15, 04/19 | n/a | 01/15, 04/19 | 04/15, 05/19 | n/a | 05/15, 05/19 | 06/19 | 07/15, n/a | 09/07, 12/09, 06/11, 08/12, 07/15 |

~~b.~~2) To keep the patient from slouching, pad the sides of the seat and between the legs with rolled diapers or receiving blankets, provided by parents.

~~c. Nothing should be placed under or behind the patient~~

~~5.~~8. Position the car seat retainer clip on the ~~patient's~~ **infant's** chest **at armpit level**.

~~6.~~9. Ensure that the ~~patient~~ **infant** is **positioned at correct recline** ~~reclined to a 45°~~ angle **per manufacturer's guidelines** ~~when positioned in the car seat to prevent the patient's head from dropping forward~~.

~~7.~~10. Place the ~~patient~~ **infant** on a cardio respiratory monitor **with**~~,~~ pulse oximeter ~~monitor,~~ and observe for 90 minutes **while positioned in the car seat** (or longer if the predicted car ride home is longer)~~., while positioned in the car seat.~~

a. Do not leave the ~~patient~~ **infant** unattended at any time

~~b. Test should be done in between feedings~~

~~8. Record the patient's baseline heart rate, respiratory rate, oxygen saturation, and assessment parameters when first positioned in the car seat and every 15 minutes thereafter for the duration of the test.~~

~~a. The values recorded should be taken from the monitor readings.~~

~~9. Visually assess the patient's skin color, respiratory effort and activity level.~~

~~a. Record observations when patient is first positioned in the car seat and every 15 minutes thereafter~~

~~9. Record the patient's diagnoses, age, weight, medication regime and time of last feeding. Indicate whether oxygen is in use.~~

~~a. Encourage the parents to take the car seat home at the conclusion of the study, or the following day~~

~~10.~~11. ~~The t~~Testing should be discontinued immediately and considered failed if the ~~patient~~ **infant** experiences:

a. Bradycardia below 80 bpm or a heart rate drop of 30 beats below baseline for 20 seconds or longer

b. Apnea (lack of respirations for 20 seconds or longer)

~~c. Persistent labored respirations~~

~~d.~~c. ~~Dusky colored skin accompanied by p~~**P**ulse oximetry readings of less than 90% for 10 seconds or longer

~~11. In the event of apnea, bradycardia or oxygen desaturation, clinically stimulate the patient, reposition, administer oxygen and perform other appropriate interventions.~~

~~a. Document actions in the patient's medical record.~~

**d. If infant experiences desaturations likely related to positioning, consider the following interventions or corrections:**

**i. Remove the existing head support (if applicable) that is original to the car seat.**

**ii. Consider blankets for positioning, being careful not to place blankets behind infant.**

**iii. If positioning adjustments are made, restart test.**

**e. Document actions in the infant's medical record.**

12. Terminate the test if symptoms persist.

~~a. Document whether the patient has passed or failed the test in the patient's medical record.~~

~~b.~~a. Notify the physician/Allied Health Professional if the ~~patient~~ **infant** fails the test, including ~~the assessment values~~**event details**.

13. Remove the ~~patient~~ **infant** from the car seat at the end of testing ~~and resume routine care~~**in modeling of safe sleep practices**.

14. **Documentation:**

**a. Record the time of last feeding.**

**b. Indicate whether oxygen is in use (NICU).**

c. **From the monitor readings, record the following when first positioned in the car seat and then every 30 minutes for the duration of the test.**
   i. **Heart rate**
   ii. **Respiratory rate**
   iii. **Oxygen saturation**

d. **Document events observed and any corrective actions taken.**

e. **Document whether the infant has passed or failed the test in the infant's medical record.**

~~13.~~**f.** **Document Physician notification, as needed, for failed test or event.**

~~14.~~**15.** Unless there is a definitive change in the ~~patient's~~ **infant's** condition or stability, a successful test does not need to be repeated, **unless the**~~even if the~~ discharge date is extended **more than 7 days from the date of test**.

~~15.~~**16.** If **infant** fail~~sed~~ first test ~~repeat~~ **the** test **may be repeated** in 12-24 hours **or sooner per physician order**.

~~16.~~**17.** If the ~~patient~~ **infant** fails the test a second time, ~~the patient can be discharged in a car bed following a discussion with the attending physician/Allied Health Professional~~**notify the Neonatologist / AHP for further instructions based on infant's medical diagnosis**.

~~17. Inform the parents that the patient should be transported in a car bed until he reaches 20 lb.~~

~~18. The physician/Allied Health Professional should educate parents about restrictions on related activities (e.g., swings in which upright sitting positions are required).~~

~~19. Place the completed flow sheet in the patient's medical record at the bedside.~~

C. **MOTHER-BABY/NURSERY SPECIAL CONSIDERATIONS:**

1. Recommendations for Failed car seat challenge tests (CSCT) performed on late preterm ~~patients~~ **infants** admitted to the Mother-Baby unit:

   ~~a. Notify pediatrician of failed car seat challenge test.~~

   ~~b.~~**a.** Notify Neonatologist/Allied Health Professional if pediatrician is unavailable or not able to see ~~patient~~ **infant** within 30 minutes

   ~~c. Transfer patient to boarder status in the newborn nursery.~~

   ~~d.~~**b.** Place cardio-respiratory (CR) monitor on ~~patient~~ **infant** for continuous monitoring of SpO2, respiratory rate, and heart rate.

   ~~e.~~**c.** Notify pediatrician for any concerns or issues while ~~patient~~ **infant** on (CR) monitoring requiring further and timely examination.

D. **REFERENCE(S):**

1. American Academy of Pediatrics (AAP), Bull, M.J., Engle, W.A. (2009). *Safe Transportation of Preterm and Low Birth Weight Infants at Hospital Discharge*. Pediatrics: 123, 5.
2. Besuner, P. (2007). AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Association of Women's Health, Obstetric and Neonatal Nurses: *Positional Apnea Car Seat Assessment*. Washington, D.C.
3. ~~Ikuta, L.M. & Beauman, S.S. (2011). *Policies and procedures, and competencies for neonatal nursing care*. Glenview, IL: National Association of Neonatal Nurses~~

| Tri-City Medical Center | Distribution: Women's and Newborn's Services |
|---|---|
| **PROCEDURE:** | **NEONATAL RESUSCITATION TEAM FOR SCHEDULED CESAREAN SECTIONS** |
| Purpose: | To provide guidelines and role responsibilities ... like up attending scheduled, lower risk Cesarean ... al Resuscitation for any delivery is guided by the ... 2) developed by the American Academy of Pedi... Association. |

**DELETE – Integrated into Women and Newborn Services Policy: Neonatal Team Attendance at Deliveries.**

A. **POLICY:**

1. The goals of neonatal resuscitation include rapid assessment and stabilization of the newborn's airway, breathing and circulations as well as the stabilization of the thermal environment.
2. To the degree that all resuscitations can be anticipated, the guidelines for neonatal resuscitation as directed by the Neonatal Resuscitation Program (NRP) developed by the American Academy of Pediatrics (AAP) and the American Heart Association (AHA) will apply to all impending deliveries.
3. According to NRP guidelines, every birth should be attended by someone who has been trained in initiating a neonatal resuscitation.
   a. For this institution, the staff member in attendance must be trained in and hold an active NRP certification.
   b. It is important to note that additional trained personnel may be necessary when a full resuscitation is required and this can be coordinated by using the "white phone" line to request Neonatal Team attendance and/or dialing #66 for a Code Caleb see Standardized Procedure Code Caleb.
4. The Resuscitation Team for scheduled and "lower risk" Cesarean Sections (C-Sections) that occur Monday through Friday from 0730-1630 will consist of a Registered Nurse (RN) AND Respiratory Care Practitioner (RCP) who are NRP certified.
   a. Scheduled C-Sections that occur after these hours or on weekends shall be attended by a Neonatologist.
5. The scheduled C-Section criteria that is considered lower risk at this institution include an estimated gestational age **greater than 35 6/7 weeks AND one of these indications**:
   a. C-Sections without Maternal Medical or Fetal indications
   b. Breech Presentation
   c. Placenta Previa with no reported bleeding episodes
   d. Active Herpes Lesions
6. A Neonatologist will be expected to attend:
   a. Any NON-SCHEDULED C-Section, which can include:
      i. Failed Induction, Failed Labor, Failed Descent
      ii. A repeat C-Section outpatient, who is "in labor"
      iii. An emergency C-Section
   b. Any scheduled C-Section NOT MEETING lower risk criteria identified in 5 (a-d). This can include but is not limited to:
      i. Prematurity, less than 35 6/7 completed weeks gestation
      ii. More than 42 completed weeks gestation
      iii. Multiple Gestations
      iv. Unstable Placenta Previa
      v. Known or suspected congenital defects or chromosomal anomalies
      vi. Macrosomic Fetus
   c. Any C-Section at the request of the Labor and Delivery Assistant Nurse Manager (ANM), or designee, in collaboration with the Obstetrician.

| 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 |
|---|---|---|---|---|---|---|---|---|
| 5/14, 02/18 | 5/14, 06/18 | 08/18 | n/a | n/a | 8/14, 05/19 | 06/19 | 10/14, n/a | 11/14 |

**B. PROCEDURE:**

1. The primary nurse and/or charge nurse will review the scheduled C-Section patient type and surgical indication prior to the scheduled surgery to determine whether the Neonatologist is required to attend the delivery.
   a. If the surgery is deemed "lower-risk",the Neonatologist will be notified that s/he is not required to attend, but is made aware of the pending surgery. All other members on the card will be notified of the C-Section prior to the patient's move back to the Operating Room (OR) by the unit clerk or designated person.
   b. For NONSCHEDULED and/or cases not meeting the "lower risk criteria", the Neonatologist will be notified when the C-Section notification pager card is implemented by the unit clerk or designated person.
2. Prior to the infant's delivery the Resuscitation Team is responsible for preparing these items back in the OR:
   a. **RN:** will be responsible for turning on the warmer and having the resuscitation supplies available in the OR.
   b. **RCP:** will be responsible for airway management anticipation, which includes ensuring suction is on and working, positive pressure airway device/s are available and pulse oximeter is available and operational.
3. It is required that the RN and RCP both be present for the Surgical Time Out process to ensure immediate availability for the delivery.
   a. It is the RN's responsibility to ensure the RCP is present.
4. The resuscitation team shall identify themselves to the patient/family and to the OR Team.
5. The RN will receive the infant from the Obstetrician. Serving in "the baby catcher role" requires the nurse don a sterile gown, sterile gloves, and use a sterile drape to receive the infant from the surgical field.
   a. Once infant is received, the nurse will bring it to the infant warmer/ high care bed for initial evaluation and resuscitation.
6. The initial resuscitation, assessment, care and evaluation of the infant will be provided by the RN following the NRP guidelines with RCP providing support and airway management as needed.
7. The RN will assign the infant's APGAR scores and be responsible for the documentation of these scores on the Newborn History and Physical Form and in the Electronic Medical Record (EMR).
8. The RN will ensure there is communication with the parents and OR team about the infant's condition after delivery.
   a. Routine transition care, monitoring, and infant identification practices are the responsibility of the RN.
   b. Once the infant is stable, not evidencing a need for airway support, the RCP shall be released by the RN.
9. At no time will an infant be left without the presence of a nurse designated to provide care for him/her.

**C. REASONS TO INVOLVE THE NEONATAL TEAM/ NEONATOLOGIST:**

1. Please see Women and Children's Policy: Neonatal Team Attendance at Deliveries
2. Reasons to involve the Neonatologist during an infant resuscitation include but are not limited to these considerations:
   a. Anytime the need for intubation is anticipated or required, as the anesthesiologist's primary responsibility is caring for the mother.
   b. Unexpected meconium stained fluid with a non-vigorous infant
      i. The RN shall bulb suction any visible meconium from the infant's mouth and nose and begin resuscitation per NRP guidelines until the Neonatologist arrives.

c. Infant receiving PPV for 30-60 seconds without clinical improvement ( Continued Apnea, Heart Rate less than 100)
d. Infant with an APGAR score less than 7
e. Infants with pulse oximetry saturation values (in 5 minutes of life) lower than NRP guidelines
f. Any time chest compressions are initiated
g. Anytime the resuscitation team feels further evaluation of the infant is needed

3. The primary, direct method for contacting the Neonatologist will be the responsibility of the Circulating Nurse by using the WHITE PHONE in the OR.
   a. A back up measure can included paging the Neonatologist.
4. If the Neonatal Crash Cart is needed the OR Circulating Nurse shall bring it to the room
5. A "Code Caleb" can also be initiated as indicated, please see the Standardized Procedure: Code Caleb.

## D. REFERENCES

1. American Academy of Pediatrics (AAP) & American Heart Association, 2011. Neonatal Resuscitation Program 6th Ed., Library of Congress.
2. AAP and American College of Obstetricians and Gynecologists (ACOG), 2012. Guidelines for Perinatal Care, 7th Ed., Library of Congress.

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

| | | | |
|---|---|---|---|
| **ISSUE DATE:** | **10/94** | **SUBJECT:** | **Neonatal ~~TEAM ATTENDANCE AT DELIVERIES~~Delivery Room Attendance** |
| **REVISION DATE(S):** | **01/00, 06/03, 03/06, 09/09, 04/10, 06/13** | | |

| | |
|---|---|
| **Women and Newborn Services Department Approval:** | **~~01/16~~06/18** |
| **Department of OB/GYN Approval:** | **~~12/16~~08/18~~02~~/19** |
| **Perinatal Collaborative Practice~~Division of Neonatology~~ Approval:** | **~~08/16~~08/18~~04~~/19** |
| **~~Department of Pediatrics Approval:~~** | **~~11/16~~** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~01/17~~05/19** |
| **Administration Approval:** | **06/19** |
| **Professional Affairs Committee Approval:** | **~~02/17~~ n/a** |
| **Board of Directors Approval:** | **02/17** |

A. **DEFINITIONS:**
   1. **The Neonatal Intensive Care Unit (NICU) resuscitation team consists of:**
      a. **The Neonatologist or Allied Health Professional (AHP)**
      b. **NICU Registered Nurse (RN)**
      c. **Respiratory Care Practitioner (RCP)**
      ~~1.~~d. **Additional personnel, including other RNs may be included depending on the maternal/neonatal condition.**

B. **PURPOSE:**
   ~~B.~~1. **To provide guidelines for neonatal delivery attendance for both vaginal and cesarean section deliveries.**

C. **POLICY:**
   1. **At every delivery there will be at least one RN whose primary responsibility is the newborn and who is skilled to initiate resuscitation per the Neonatal Resuscitation Program (NRP) guidelines. The RN will initiate the steps of the NRP algorithm, as appropriate until the NICU resuscitation team arrives. In cases of multiple births, one RN is present for each newborn.**
   ~~D.~~2. **A multidisciplinary NICU resuscitation team is immediately available at all times to perform a complete resuscitation, including endotracheal intubation, use of medications and intravenous line placement.**
   3. **Verbal Situation, Background, Assessment, Recommendation (SBAR) communication of maternal history and risk factors will be provided by the delivery RN to the attending neonatal team.**
   4. **In unforeseen emergencies, the designated NICU team will be notified to respond immediately. This emergency response is triggered by dialing 66 and activating a Code Caleb. Please refer to the Code Caleb Standardized Procedure.**
   ~~1. The goals of neonatal resuscitation include rapid assessment and stabilization of the newborn's airway, breathing and circulation (ABC's) as well as the stabilization of the thermal environment.~~
   ~~2. To the degree that all resuscitations can be anticipated, the guidelines for neonatal resuscitation as put forth by the Neonatal Resuscitation Program (NRP) developed by the American Academy of Pediatrics and the American Heart Association will apply to all impending deliveries in the Women and Newborn Services (WNS) of Tri-City Medical Center.~~

~~3. Compliance with this policy is the responsibility of all health care providers in WNS and the Neonatal Intensive Care Unit (NICU).~~

~~E. EQUIPMENT:~~
~~1. Infant warmer~~
~~2. Resuscitation equipment~~
~~3. Warmed Blankets and towels~~
~~4. Warming Mattress if 35 weeks gestation and less~~
~~5. Neowrap (if 32 weeks gestation and less)~~
~~6. Stethoscope~~
~~7. Thermometer~~
~~8. Neonatal Crash Cart~~
~~9. Neonatal Transport Warmer~~

**D. TRANSITION RN ATTENDANCE AT DELIVERIES**

**1. Spontaneous Vaginal Delivery**

**a. The transition registered nurse (RN) will attend all low-risk, spontaneous vaginal deliveries.**

**b. Vaginal deliveries with identified risk factors (as listed below) will require the NICU resuscitation team.**

**2. Cesarean Section**

**a. The transition RN and the RCP will attend the scheduled low-risk cesarean section deliveries.**

**b. The transition RN~~, RCP, and Neonatologist/AHP~~ and RCP will attend the unscheduled low risk cesarean section deliveries. Neonatologist will be available as needed.**

**c. ~~Nonscheduled C~~csarean sections~~,~~ with risk factors will be attended by the NICU resuscitation team~~.~~**

**~~F.~~E. NICU RESUSCITATION TEAM ATTENDANCE AT DELIVERIES:**

1. ~~The NICU resuscitation team will be present at the delivery of newborns with the following risk factors~~**The team will be alerted before delivery for the following risk factors: :**
   - a. Anticipated delivery of ~~35 completed weeks (35 weeks 6 days) or less~~**less than 36 weeks gestation** or ≥ 42 weeks gestation
   - **b. Fetal heart rate patterns suggesting hypoxia (Category III and some Category II patterns)**
   - **c. Placental abnormalities (e.g. placenta previa, vasa previa, abruption)**
   - ~~b.~~**d. ~~Known or suspected congenital defects or chromosomal anomalies~~Fetal anomalies, if it is suspected that resuscitative measures may be needed (e.g. pulmonary hypoplasia, diaphragmatic hernia)**
   - ~~c.~~**e.** Multiple gestations
   - **f. Emergency c~~C~~esarean delivery~~sections~~ or general anesthesia**
   - **g. Operative vaginal delivery (e.g. vacuum assist, forceps)**
   - **h. Prolapse of the umbilical cord**
   - ~~d. Suspected hydrops or isoimmunization – Emergent, and/or with high risk indications not limited to:~~
   - ~~i. Fetal Heart Rate Category III strip tracing~~
   - ~~ii. Prolapsed Cord suspicion~~
   - ~~iii. Placental Abruption~~
   - ~~iv.~~**i.** ~~Uterine Rupture~~
   - ~~e. Signs of fetal distress at the discretion of the Obstetrical (OB) provider~~
   - ~~f.~~ Macrosomic fetus and/-or potential for shoulder dystocia
   - **j.**
     - ~~g. Any situation at the discretion of the maternal primary care provider OR RN.~~

2. The maternal primary care provider/~~o~~Obstetrician/Anesthesiologist ~~or~~OR delivery RN may request the presence of the NICU resuscitation team at any delivery.
   ~~h. At the request of the labor and delivery (L&D) Assistant Nurse Manger (ANM)/or designee in collaboration with the OB provider.~~

~~2. The NICU resuscitation team shall consist of:~~
   ~~a. Neonatal Attending Physician (MD) or Neonatal Nurse Practitioner/ Allied Healthcare Provider (AHP)~~
   ~~b. NICU nurse~~
   ~~c. Respiratory Care Practitioner~~

~~3. The composition of the NICU resuscitation team may vary according to special circumstances.~~

~~4. One member of the team must be skilled in neonatal intubation.~~

~~5. All team members must be currently trained in NRP~~

~~G.~~F. **DELIVERY ATTENDANCE RESPONSIBILITIES: ~~OF L&D AND NICU TEAM MEMBERS~~**

1. An infant warmer with all supplies for a neonatal resuscitation should be available in the delivery room.
2. The labor and delivery (L&D) RN has the primary responsibility for having the neonatal resuscitation supplies available and checked for function in the delivery room. Transition RN additionally verifies supply availability and function if time allows prior to delivery. ~~An infant warmer with all supplies for a neonatal resuscitation should be available in the delivery room.~~
3. When the request for neonatal attendance at delivery is made, the following information shall be communicated to the transition and/or NICU RN, as available:
   a. Whether the infant(s) already delivered
   b. Expected gestational age
   c. Color of the amniotic fluid
   d. How many babies are expected
   e. Any risk factors
   f. Location of the delivery
4. The appropriate neonatal team is then assembled based on the perinatal risk factors.
5. The L&D RN shall provide sufficient time for the transition RN or NICU RN to arrive and check equipment as possible.
6. Upon arrival for the delivery, the transition RN or NICU resuscitation team shall identify themselves to the L&D team and patient/family, as the situation allows. ~~and to the L&D team~~.
7. The RN or MD/AHP is responsible for assigning and documenting the newborn's APGAR scores.
8. The transition RN or NICU RN shall receive the newborn identification bands from the L&D RN and place them on the baby.
9. The transition RN or NICU RN will report off to the L&D RN prior to leaving the birthing area.
10. At no time will a newborn be left without an RN designated to provide care for him/her.
11. NICU Resuscitation Team:
    a. The NICU resuscitation team shall be identified at the start of each shift.
    b. The L&D charge RN will communicate with the NICU charge RN throughout the shift to ensure the team is alerted to patients that may require the presence of the NICU resuscitation team at delivery.

~~1. The NICU resuscitation team shall be identified at the start of each shift.~~

~~2. The L&D ANM or designee shall provide the NICU ANM or designee with updated information regarding the status of high risk patients that will require the presence of the NICU resuscitation team at a delivery as indicated.~~

~~3. The OB provider or the L&D nurse (in collaboration with the OB provider) may request the presence of the NICU resuscitation team at birth.~~

~~4. When the request for the NICU resuscitation team is made the following information shall be communicated, as available:~~

~~a. Whether the infant is yet delivered~~
~~b. The type of problem and estimated gestational age (if known)~~
~~c. The location~~
~~5. The L&D or Nursery nurse shall be responsible for having the resuscitation supplies available in the room.~~
~~6. The L&D or Nursery nurse shall provide sufficient time for the NICU team to arrive and check equipment as possible.~~
~~7. Management of the NICU resuscitation team shall belong to the neonatologist/AHP, and includes coordination, performance, and delegation of activities.~~

**c. Management of the NICU resuscitation team shall belong to the neonatologist/AHP, and includes coordination, performance, and delegation of activities.**

**d. In the event of multiple births (i.e. twins, triplets), the neonatologist/AHP should verify that adequate resources are available to provide adequate and complete resuscitation of each infant.**

~~8. For delivery of multiple gestations, the neonatologist shall determine the staffing and supplies needed to ensure adequate neonatal care.~~
~~9. Upon arrival for the delivery the NICU resuscitation team shall identify themselves to the patient/family and to the L&D team.~~

e. The N~~n~~eonatologist/AHP will ensure that there is communication with the parents ~~and the L&D team~~ about the infant's condition ~~after delivery~~.

**12. Cesarean section considerations:**

**a. It is required that the neonatal team (the transition RN or NICU RN and RCP) be present for the surgical time out process to ensure immediate availability for the delivery.**

**b. The RN/Neonatologist/AHP will receive the infant from the Oobstetrician. This will require the RN/Neonatologist/AHP to don a sterile gown, sterile gloves, and the use of a sterile drape to receive the infant from the surgical field. Once the infant is received, the RN/Neonatologist/AHP will bring the newborn to the infant warmer/high care bed for initial evaluation and stabilization.**

~~10.~~**c. Maternal newborn skin-to-skin in the operating room may be initiated, providing the neonate and mother ~~y~~ are stable.**

~~11. The assessment, care and evaluation of the infant shall be provided by the NICU resuscitation team following the guidelines put forth in the NRP program.~~
~~12. The NICU nurse shall receive the ID bands from the L&D or Nursery nurse and place them on the baby.~~
~~13. The NICU nurse will report off to the L&D or Nursery nurse prior to leaving the birthing area.~~
~~14. At no time will a newborn be left without the presence of a nurse designated to provide care for him/her.~~

## ~~H.~~G. DOCUMENTATION:

1. Documentation of all assessments and interventions shall be completed **in the Electronic Health Record** by the ~~NICU nurse~~**RN** and/or licensed professional performing the interventions/assessments. ~~prior to leaving the birthing area on the newborn admission record and in the patient's **newborn's** electronic medical **health** record, as appropriate.~~
2. The documentation shall include:
   - a. The time the **transition RN and/or** NICU team arrived. ~~and~~
   - ~~a.~~**b.** ~~who on the team performed the~~ **What** interventions **were performed.**
   - ~~b.~~**c.** The condition of the infant and response to interventions.
   - ~~c.~~**d.** Use of the Neonatal Resuscitation Record, if indicated.

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

1. American Heart Association and American Academy of Pediatrics (2016). Neonatal Resuscitation **Textbook:** 7th Ed. Washington, D.C., Library of Congress.

2. American Academy of Pediatrics (2010). Special Report- Neonatal resuscitation: 2010 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. Pediatrics, 126 (5), 1400-1411.
3. **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.~~

ADMIT TO: ☐ SPRA Date: Time:

- ☐ OUTPATIENT INFUSION CENTER, OCEANSIDE | 3617 Vista Way PH: (760) 758-5770 x 129 F: (760) 721-8597
- ☐ OUTPATIENT INFUSION SUITE @ TCMC | 4002 Vista Way PH: (760) 940-7572 F: (760) 940-7560
- ☐ PROGRESSIVE CARE UNIT
- ☐ OTHER: _____

PATIENT NAME: _____ Date of Birth: _____

MRN: _____ FIN: _____ (Completed by TCMC)

DIAGNOSIS: _____

CONSENT: _____

ALLERGIES: ☐ NKDA ☐ _____

CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*
*Requires notation in Progress Notes.

LAB:

Labs needed prior to infusion:

_____

- ☐ Results to be sent to infusion center by ordering MD
- ☐ Labs to be drawn at infusion center

Transfused within the last 3 months ☐ Yes ☐ No
Pregnant within the last 3 months ☐ Yes ☐ No
Pre-Transfusion H&H: _____
Pre-Transfusion Platelet Count: _____
☐ Irradiated Products Required
☐ Type and cross match for _____ Units of Packed Red Blood Cells on _____
☐ Platelet Pheresis _____ unit(s) on _____
☐ Other _____ unit(s) on _____

IV:

- ☐ TKO Start IV with 500 mL of 0.9% sodium chloride IV at 20 mL per hour.
- ☐ Prehydration: _____ to run at _____mL/hr.
- ☐ Posthydration: _____ to run at _____mL/hr.
- ☐ IV Fluid: _____ to run at _____mL/hr.

IV Fluid Diagnosis:

- ☐ Dehydration due to _____
- ☐ Per drug package insert
- ☐ Other: _____

TRANSFUSION ORDERS:

☐ Transfuse _____ Unit(s) Packed Red Blood Cells each unit over _____ hours on _____
☐ Transfuse _____ Unit(s) Platelet Pheresis over _____ hours on _____
☐ Transfuse _____ Unit(s) Other _____ on _____

INFUSION ORDERS:

☐ Infusion Orders Medication: _____ Dosage: _____
Length of time to infuse: _____

PRE-MEDS:

- ☐ Acetaminophen (Tylenol) 650 mg PO X times 1 dose prior to each infusion
- ☐ Diphenhydramine (Benadryl) 25 mg X times 1 dose prior to each infusion ☐ PO ☐ IV
- ☐ Furosemide (Lasix) _____ mg ☐ PO ☐ IV ☐ Between units ☐ After each unit

| ☐ Read Back all T.O./V.O.orders | |
|---|---|
| Nurse's – Signature Date Time | Physician's – Signature Date Time |

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

Affix Patient Label

8711-4010

# INFUSION / TRANSFUSION OUTPATIENT INFUSION ORDERS

☐ Dexamethasone ☐ 10mg ☐ 20mg ☐ PO ☐ IV times 1 dose prior to each infusion
☐ _____
☐ _____

**INFUSION ORDERS:**

☐ **Medication:** _____ **Dosage:** _____ **Route:** _____
**Frequency:** _____ **Number of Doses:** _____
☐ **Medication:** _____ **Dosage:** _____ **Route:** _____
**Frequency:** _____ **Number of Doses:** _____
☐ **Medication:** _____ **Dosage:** _____ **Route:** _____
**Frequency:** _____ **Number of Doses:** _____

~~**DIET:**~~ _____
~~**STATUS:**~~
~~☐ Alert ☐ Confused~~

**ACTIVITY:**

☐ ~~Ambulatory / Chair~~**Independent** ☐ ~~Non-ambulatory / gurney~~ **Needs assistance**

**TREATMENTS:**

☐ Peripheral IV
☐ Use long-term venous access / per TCMC procedure
☐ Vital-Port ☐ Hickman ☐ Groshong
☐ PICC ☐ VAS Caths ☐ **Mediport**

**MISCELLANEOUS:**

☑ **Discharge when infusion(s) are complete and post procedure instructions given.**
~~☐ Patient coming from home~~
~~☐ Patient coming from SNF~~ _____
_____ ~~(Name of Facility)~~ ~~(Phone Number)~~
~~☐ Discharge when completed with Instruction Sheet~~
~~☐ Resume home medications on discharge.~~
~~☐ I have reviewed the risks, benefits, and alternatives with the patient~~ _____
_____ ~~(Print Physician's Name)~~

## Information Needed for Scheduling Infusions~~Transfusions~~

Patient Name: _____

Date of Birth: _____

Sex: _____

Medical Record Number (MRN), if known: _____

Social Security Number (SSN): _____

Insurance: _____

Policy #: _____

ADMIT TO: ~~☐ SPRA~~ Date: _____ Time: _____

☐ OUTPATIENT INFUSION SUITE @ TCMC | 4002 Vista Way PH: (760) 940-7572 F: (760) 940-7560

☐ PROGRESSIVE CARE UNIT

☐ OTHER: _____

PATIENT NAME: _____ Date of Birth: _____

~~MRN: _____ FIN: _____ (Completed by TCMC)~~

DIAGNOSIS: _____

~~CONSENT:~~ _____

ALLERGIES: ☐ NKDA ☐ _____

~~CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*~~

~~*Requires notation in Progress Notes.~~

LAB:

**Labs needed prior to transfusion:**

_____

☐ **Results to be sent to infusion center by ordering MD**

☐ **Labs to be drawn at infusion center**

**Transfused within the last 3 months** ☐ Yes ☐ No

**Pregnant within the last 3 months** ☐ Yes ☐ No

Pre-Transfusion H&H: _____

**Pre-Transfusion Platelet Count:** _____

☐ Irradiated Products Required

☐ Type and cross match for _____ Units of Packed Red Blood Cells on _____

☐ Platelet Pheresis _____ unit(s) on _____

☐ Other _____ unit(s) on _____

IV:

☐ **TKA** Start ~~IV with 500 mL of~~ 0.9% sodium chloride IV at 20 mL per hour.

☐ **IV Fluid:** _____

**IV Fluid Diagnosis:**

☐ **Dehydration due to** _____

☐ **Other** _____

**TRANSFUSION ORDERS:**

☐ Transfuse _____ Unit(s) Packed Red Blood Cells each unit over _____ hours on _____

☐ Transfuse _____ Unit(s) Platelet Pheresis over _____ hours on _____

☐ Transfuse _____ Unit(s) Other _____ on _____

~~INFUSION ORDERS:~~

~~☐ Infusion Orders Medication: _____ Dosage: _____~~

~~Length of time to infuse: _____~~

**PRE-MEDS:**

☐ Acetaminophen (Tylenol) 650 mg PO X **times** 1 dose **prior to each transfusion**

☐ Diphenhydramine (Benadryl) 25 mg X **times** 1 dose **prior to each transfusion** ☐ PO ☐ IV

☐ Furosemide (Lasix) _____ mg ☐ PO ☐ IV ☐ Between units ☐ After each unit

**MEDICATIONS:**

☐ _____

| ☐ Read Back all T.O./V.O orders | |
|---|---|
| Nurse's – Signature Date Time | Physician's – Signature Date Time |

Tri-City Medical Center

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8711-4010

~~INFUSION / TRANSFUSION~~

**OUTPATIENT TRANSFUSION ORDERS**

Affix Patient Label

☐ _____

**DIET:** _____

~~**STATUS:**~~

~~☐ Alert ☐ Confused~~

**ACTIVITY:**

☐ ~~Ambulatory / Chair~~ **Independent** ☐ ~~Non-ambulatory / gurney~~ **Needs Assistance**

**TREATMENTS:**

☐ Peripheral IV

☐ Use long-term venous access / per TCMC procedure

☐ Vital-Port ☐ Hickman ☐ Groshong

☐ PICC ☐ VAS Caths ☐ **Mediport**

**MISCELLANEOUS:**

☑ **Discharge patient when transfusion(s) are complete and post procedure instructions given.**

~~☐ Patient coming from home~~

~~☐ Patient coming from SNF~~ _____

_____ ~~(Name of Facility)~~ _____ ~~(Phone Number)~~

~~☐ Discharge when completed with Instruction Sheet~~

~~☐ Resume home medications on discharge.~~

~~☐ I have reviewed the risks, benefits, and alternatives with the patient~~ _____

_____ ~~(Print Physician's Name)~~

## Information Needed for Scheduling Transfusions

Patient Name: _____

Date of Birth: _____

Sex: _____

Medical Record Number (MRN), if known: _____

Social Security Number (SSN): _____

Insurance: _____

Policy #: _____

# Tri-City Healthcare District
# Community Healthcare Alliance Committee (CHAC)
## MEETING MINUTES
### June 20, 2019

**MEMBERS PRESENT:** Chair Rocky Chavez, Director Julie Nygaard, Director RoseMarie Reno, Dr. Victor Souza, Bret Schanzenbach, Carol Herrera, Dung Ngo, Gigi Gleason, Linda Ledesma, Jan O'Reilly, Marilou de la Rosa Hruby, Mary Lou Clift, Sandy Tucker, Scott Ashton.

**MEMBERS ABSENT:** Barbara Perez, Danielle Pearson, Darren Brent, Guy Roney, Jack Nelson, Kathie Chan, Mary Donovan, Mary Murphy, Rick Robinson, Roma Ferriter, Rosemary Eshelman

**NON-VOTING MEMBERS PRESENT:** Steve Dietlin, CEO; Aaron Byzak, Chief Government & External Affairs Officer; Susan Bond, General Counsel

**NON-VOTING MEMBERS ABSENT:** Audrey Lopez, Fernando Sanudo (Betsy Heightman filled-in to represent the VCC)

**OTHERS PRESENT:** Gwen Sanders, one visitor

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Call To Order** | The June 20, 2019 Community Healthcare Alliance Committee meeting was called to order at 12:33pm by Chair Rocky Chavez. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

June 20, 2019

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Approval Of Meeting Agenda** | Director Julie Nygaard motioned to approve the June 20, 2019 meeting agenda. The motion was seconded by Gigi Gleason. Director Reno abstained. | | |
| **Public Comments & Announcements** | No public comments or announcements were made. | | |
| **Ratification Of Minutes** | Director Julie Nygaard motioned to approve the May 17, 2018 meeting minutes. The motion was seconded by Carol Herrera. Director Reno and Scott Ashton abstained as they were not present at the May 2018 meeting | | |
| **Presentation: Aaron Byzak** | Chief External Affairs Officer Aaron Byzak presented on the changes to the CHAC Committee, noting the following:<br>1. During the past year, TCMC has had many accomplishments, including how programs are sponsored within the District.<br>2. The changes to the CHAC Committee will help ensure a better return on investment of District funds while producing greater and better access to care.<br>3. The changes to the committee and grant funding are based on key areas identified in the triennial Community Health Needs Assessment conducted by the Hospital Association of San Diego and Imperial Counties (HASDIC) and include the priority areas of Behavioral Health, Cardiovascular Health and Social Determinants of Health. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| | 4. The CHAC Charter revisions were based on new requirements found in AB 1728 governing the spending of Public District Funds and grants. The revised CHAC Charter was approved in January 2019.<br>5. Grant funds must now be aligned with the Community Health Needs Assessment. A new version of the Assessment is anticipated within the next few months.<br>6. Successful grant applicants will be potentially funded for a three-year period so that results and goals can be better measured.<br>7. Submissions for grants will be reviewed by the External Affairs staff, applicant information will be given to the CHAC Committee for review, and the CHAC Committee will then forward their recommendations to the Board of Directors for approval.<br>8. The allotted grant funds will be revised to $100,000 annually. | | |
| **CEO Update Steve Dietlin** | CEO Steve Dietlin addressed the committee as follows:<br><br>1. Steve thanked Dr. Victor Souza for his accomplished service as Chief of Staff for the past two years, and noted that former Chief of Staff, Dr. Gene Ma, has accepted a position as Chief Medical Director.<br>2. Steve thanked the committee members for their good service to the community and hospital, noting that their continued communication is always welcomed.<br>3. Steve noted that TCMC as a whole is concerned about the many community needs of our district, such as childhood food insecurity, and is working alongside the CHAC Committee to meet these needs with programs such as the Child Backpack Program for hunger. | | |

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **COO Update Scott Livingstone** | Scott Livingstone was not available. | | |
| **Chief Of Staff Update Dr. Victor Souza MD** | Dr. Victor Souza addressed the committee as follows:<br>• Dr. Souza also thanked the members of the committee for their service.<br>• It was noted that several events took place this year to show TCMC's appreciation for the medical staff, including the Nurses Appreciation Tea Party.<br>• 2019 is the year selected to focus on the patient's experience. Dr. Souza reflected that significant improvements have been made in this area and are reflected in our satisfaction scores.<br>• Dr Souza noted that TCMC continues to receive awards and accolades for their excellent clinical care in the fields of heart and stroke. | | |

Tri-City Healthcare District

# Community Healthcare Alliance Committee (CHAC)

## MEETING MINUTES

June 20, 2019

| TOPIC | DISCUSSION | ACTION FOLLOW UP | PERSON(S) RESPONSIBLE |
|---|---|---|---|
| **Public Communications** | No public communications. | | |
| **Board Communications** | Director Nygaard expressed her appreciation to the committee for their service.<br><br>Director Reno noted that she is pleased to see the CHAC committee meeting again.<br><br>Chairman Rocky Chavez explained the Brown Act regulations concerning discussions as they relate to the meeting agenda. | | |
| **Committee Communications** | Various members of the Committee addressed the leadership with questions to clarify certain areas regarding the changes to the CHAC Committee. All questions were addressed. | | |
| **Next Meeting** | The next CHAC meeting is scheduled for Thursday, October 17, 2019 at 12:30 pm. | | |
| **Adjournment** | The June 20, 2019 CHAC meeting was adjourned at 1:38pm. | | |

**Tri-City M[illegible]ical Center**
**Finance, Operations and F[illegible]nning Committee Minutes**
**June 20, 2019**

| | |
|---|---|
| **Members Present** | Director Julie Nygaard, Director Rocky Chavez, Director Leigh Anne Grass, Dr. Marcus Contardo, Dr. Mark Yamanaka, Dr. Jeffrey Ferber, Mr. Jack Cumming |
| **Non-Voting Members Present:** | Steve Dietlin, CEO, Ray Rivas, CFO, Dr. Gene Ma, CMO, Susan Bond, General Counsel |
| **Others:** | Jane Dunmeyer, Mark Albright, Diane Sikora, Eva England, Kristy Larkin, Merebeth Richins, Maria Carapia, E. Sue Shrader, Jeremy Raimo, Anna Aguilar, Sherry Miller, Barbara Hainsworth |
| **Members Absent**: | Scott Livingstone, COO, Barbara Vogelsang, CNE |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to order | Director Nygaard called the meeting to order at 8:36 a.m. | | Chair |
| 2. Approval of Agenda | | **MOTION**<br>**It was moved by Director Grass, Dr. Ferber seconded, and it was unanimously approved to accept the agenda of June 20, 2019.**<br>**Members:**<br>**AYES: Nygaard, Grass, Chavez, Contardo, Yamanaka, Ferber, Cumming**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: None** | Chair |
| 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 May 23, 2019 | | Minutes were ratified.<br>**MOTION**<br>**It was moved by Dr. Contardo, Dr. Ferber seconded, and the minutes of May 23, 2019 were unanimously approved, with Director Grass** | Chair |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | | **abstaining from the vote.** | |
| 5. Old Business | None | | |
| 6. New Business | Director Nygaard welcomed Dr. Gene Ma to the Finance, Operations and Planning committee, in his new role as the Chief Medical Officer for Tri-City Medical Center. | | |
| 7. Consideration of Consent Calendar: | It was requested that the following item be pulled for discussion:<br><br><u>Dr. Contardo requested:</u><br>7.q. Registry Contract for Nursing & Allied Health Proposal<br>• Aya Healthcare | **<u>MOTION</u>**<br>**It was moved by Dr. Ferber, Director Grass seconded, and it was unanimously approved to accept the Consent Calendar of June 20, 2019.**<br>**<u>Members:</u>**<br>**AYES: Nygaard, Grass, Chavez, Contardo, Yamanaka, Ferber, Cumming**<br>**NOES: None**<br>**ABSTAIN: Dr. Yamanaka**<br>**ABSENT: None** | Chair |
| a. Physician Agreement for Cardiovascular Health Institute – Operations Committee<br>• Drs. Mohammad Jamshidi-Nezhad & David Spiegel | | **Approved via Consent Calendar** | Eva England |
| b. Cardiovascular Health Institute – Medical Director Proposal<br>• Dr. Donald Ponec | | **Approved via Consent Calendar** | Eva England |
| c. Cardiovascular Health Institute – Specialty Medical Directorship Proposal<br>• Drs. Mohammad Jamshidi-Nezhad, Ashish Kabra & David Spiegel | | **Approved via Consent Calendar** | Eva England |
| d. Physician Agreement for Cardiovascular Health Institute | | **Approved via Consent Calendar** | Eva England |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| – Quality Committee | | | |
| e. Physician Agreement for Cardiac Rehabilitation Medical Director<br>• Dr. Karim El Sherief | | **Approved via Consent Calendar** | Eva England |
| f. Physician Agreement for Cardiac Rehabilitation Physician Supervision<br>• Sharon Slowik, M.D. | | **Approved via Consent Calendar** | Eva England |
| g. Physician Agreement for ICU Medical Director<br>• Mark Yamanaka, M.D. | | **Approved via Consent Calendar** | Merebeth Richins |
| h. Physician Agreement for ED On-Call Coverage<br>• Urology | | **Approved via Consent Calendar** | Sherry Miller |
| i. Physician Agreement for Anesthesia Services<br>• Anesthesia Services Medical Group (ASMG) | | **Approved via Consent Calendar** | Scott Livingstone |
| j. Physician Agreement for ED On-Call Coverage<br>• Cardiology – General | | **Approved via Consent Calendar** | Sherry Miller |
| k. Physician Agreement for ED On-Call Coverage<br>• Cardiology – STEMI | | **Approved via Consent Calendar** | Sherry Miller |
| l. Physician Agreement for ED On-Call Coverage<br>• Gastroenterology – General & ERCP | | **Approved via Consent Calendar** | Sherry Miller |
| m. Physician Agreement for ED On-Call Coverage<br>• Interventional Radiology | | **Approved via Consent Calendar** | Sherry Miller |

| Topic | Discussions, Conclusions & Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| n. Physician Agreement for ED On-Call Coverage<br>• Ophthalmology | | **Approved via Consent Calendar** | Sherry Miller |
| o. Physician Agreement for ED On-Call Coverage<br>• Spine | | **Approved via Consent Calendar** | Sherry Miller |
| p. Physician Agreement for ED On-Call Coverage – Oral/Max Surgery<br>• Brian Mudd, D.D.S. | | **Approved via Consent Calendar** | Sherry Miller |
| q. Registry Contract for Nursing & Allied Health Proposal<br>• Aya Healthcare | | **MOTION**<br>**It was moved by Dr. Contardo, Director Grass seconded, to authorize the agreement with Aya Healthcare for the contract labor managed service agreement, for a term of 36 months, beginning, July 1, 2019 and ending, June 30, 2022 for an annual cost of $4.5M and a total cost for the term of $13.5M.**<br>**Members:**<br>**AYES: Nygaard, Grass, Chavez, Contardo, Yamanaka, Ferber, Cumming**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: None** | |
| r. Home Sleep Study Interpretation Proposal<br>• Advanced Sleep Medicine, Inc. | | **Approved via Consent Calendar** | Merebeth Richins |
| 8. Financials: | Ray Rivas presented the financials ending May 31, 2019 (dollars in thousands)<br>**TCHD – Financial Summary** | | Ray Rivas |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | **Fiscal Year to Date**<br>Operating Revenue $ 328,463<br>Operating Expense $ 332,902<br>EBITDA $ 16,386<br>EROE $ 1,919<br>**TCMC – Key Indicators Fiscal Year to Date**<br>Avg. Daily Census 153<br>Adjusted Patient Days 91,296<br>Surgery Cases 5,925<br>ED Visits 51,810<br>**TCHD – Financial Summary Current Month**<br>Operating Revenue $ 31,430<br>Operating Expense $ 31,197<br>EBITDA $ 2,221<br>EROE $ 904<br>**TCMC – Key Indicators Current Month**<br>Avg. Daily Census 143<br>Adjusted Patient Days 8,004<br>Surgery Cases 557<br>ED Visits 4,700<br>**TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year**<br>Net Patient A/R Avg. (in millions) $ 44.2<br>Days in Net A/R Avg. 52.7<br>**Graphs:**<br>• TCMC-Net Days in Patient Accounts Receivable<br>• TCMC-Average Daily Census, Total Hospital-Excluding Newborns<br>• TCMC-Acute Average Length of Stay | | |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 9. Work Plan: | | | |
| a. Physician Recruitment Tracking *(annual)* | Jeremy Raimo gave a brief overview of PowerPoint handout, which was included in the agenda packet. | | Jeremy Raimo |
| b. Dashboard | No discussion | | Ray Rivas |
| 10. Comments by committee members | None | | |
| 11. Date of next meeting | Thursday, July 18, 2019 | | Chair |
| 12. Community Openings (1) | | | Chair |
| 13. Adjournment | Meeting adjourned 8:56 a.m. | | Chair |

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**Physician Agreement for Cardiovascular Health Institute – Operations Committee**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Operations Committee |
| **Status of Agreement** | | New Agreement | | Renewal – New Rates | X | Renewal – Same Rates |

**Vendor's Name:** Drs. Mohammad Jamshidi-Nezhad & David Spiegel

**Area of Service:** Cardiovascular Health Institute – Operations Committee

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

**Maximum Totals:**

| Rate/Hour | Hours Per Month | Hours per Year | Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|---|---|---|
| $210 | 4 | 48 | $840 | $10,080 | $10,080 |

**Description of Services/Supplies:**

- Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Eva England, Cardiovascular Service Line Director / Scott Livingstone Chief Operating Officer

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Drs. Mohammad Jamshidi-Nezhad and David Spiegel as Cardiovascular Health Institute – Operations Committee members for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020. Not to exceed 4 hours per month at an hourly rate of $210 for an annual and term cost of $10,080.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**CVHI Medical Director Proposal**

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

**Vendor's Name:** Dr. Donald Ponec, Cardiovascular Health Institute Medical Director

**Area of Service:** Cardiovascular Health Institute

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

**Maximum Totals:**

| Rate/Hour | Hours Per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $210 | 8 | 96 | $1,680 | $20,160 | $20,160 |

**Description of Services/Supplies:**

Physicians shall service as the Institute Medical Director and shall be responsible for the medical direction of the Institute and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Eva England, Cardiovascular Service Line Director / Scott Livingstone Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Ponec as the coverage physician for a term of 12 months, beginning July 1, 2019 – Ending June 30 2020. Not to exceed an average 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**Cardiovascular Health Institute – Specialty Medical Directorship Proposal**

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

**Vendor's Name:** Mohammad Jamshidi-Nezhad, M.D. - Vascular Surgery, Medical Director
Ashish Kabra, M.D. - Non-Invasive Cardiology, Medical Director
David Spiegel, M.D. - Invasive Cardiology, Medical Director

**Area of Service:** Cardiovascular Health Institute

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

**Maximum Totals:**

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $210 | 36 | 432 | $7,560 | $90,720 | $90,720 |

**Description of Services/Supplies:**

Physicians shall service as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Eva England, Cardiovascular Service Line Director / Scott Livingstone Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Drs. Mohammad Jamshidi-Nezhad, Ashish Kabra, and David Spiegel as the coverage physicians for a term of 12 months, beginning July 1, 2019 – Ending June 30 2020. Not to exceed 12 hours per month per physician for a total of 432 hours annually, at an hourly rate of $210 for an annual and term cost of $90,720.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**Physician Agreement for Cardiovascular Health Institute – Quality Committee**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Quality Committee |
| **Status of Agreement** | | New Agreement | | Renewal – New Rates | X | Renewal – Same Rates |

**Vendor's Name:** Drs. Donald Ponec, Andrew Deemer & Ashish Kabra

**Area of Service:** Cardiovascular Health Institute – Quality Committee

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

**Maximum Totals:**

| Rate / Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|---|---|---|
| $210 | 6 | 72 | $1,260 | $15,120 | $15,120 |

**Description of Services/Supplies:**

- Physicians shall serve as Quality Committee Members and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

| | | | | |
|---|---|---|---|---|
| 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: | X | *Yes | | No |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Eva England, Cardiovascular Service Line Director / Scott Livingstone Chief Operating Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Drs. Donald Ponec, Andrew Deemer and Ashish Kabra as Cardiovascular Health Institute – Quality Committee members for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020. Not to exceed 6 hours per month at an hourly rate of $210 for an annual and term cost of $15,120.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for Cardiac Rehabilitation Medical Director**

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

**Physician's Name:** Dr. Karim El-Sherief

**Area of Service:** Cardiac Rehabilitation Services

**Term of Agreement:** 24 months, Beginning, July 1, 2019 – Ending, June 30, 2021

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 24 month (Term) Cost |
|---|---|---|---|---|---|
| $185.50 | 44 | 528 | $8,162 | $97,944 | $195,888 |

**Position Responsibilities:**

- Cardiac rehabilitation program Medical Director
- Maintain TCMC's main-campus cardiac rehabilitation program as the physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Eva England, Service Line Director, Cardio-Vascular Service Line / Scott Livingstone, Chief Operating Officer

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Karim El-Sherief as the Medical Director of Cardiac Rehabilitation for a term of 24 months beginning July 1, 2019 and ending June 30, 2021. Not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $185.50 for an annual cost of $97,944 and a total term cost not to exceed $195,888.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for Cardiac Rehabilitation Physician Supervision**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Physician Supervision |
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Physician's Name:** Dr. Sharon Slowik

**Area of Service:** Cardiac Rehabilitation Services

**Term of Agreement:** 24 months, Beginning, July 1, 2019 – Ending, June 30, 2021

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 24 month (Term) Cost |
|---|---|---|---|---|---|
| $160 | 42.5 | 510 | $6,800 | $81,600 | $163,200 |

**Position Responsibilities:**

- Cardiac rehabilitation program Medical Director
- Maintain TCMC's main-campus cardiac rehabilitation program as the physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with hospital's mission and vision.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Eva England, Service Line Director, Cardio-Vascular Service Line / Scott Livingstone, Chief Operating Officer

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sharon Slowik as the Supervising Physician for a term of 24 months beginning July 1, 2019 and ending June 30, 2021. Not to exceed an average of 42.5 hours per month or 510 hours annually, at an hourly rate of $160 for an annual cost of $81,600, and a total cost for the term of $163,200.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ICU Medical Director**

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

**Physician's Name:** Mark Yamanaka, M.D.

**Area of Service:** ICU

**Term of Agreement:** 12 months, Beginning, July, 1, 2019 – Ending, June, 30, 2020

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

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 12 month (Term) Cost |
|---|---|---|---|---|---|
| $175 | 20 | 240 | $3,500 | $42,000 | $42,000 |

**Position Responsibilities:**

- Provides Clinical Documentation
- Utilization review of program
- Evaluates and establishes policies/procedures/protocols for ICU
- Recommends, develops and implements new services
- Facilitates effective communications
- Assists with interviewing new staff
- Assists with public education
- Attend hospital meetings, as requested

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Merebeth Richins, Director, ICU, Telemetry & Pulmonary Services / Barbara Vogelsang, Chief Nurse Executive

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Mark Yamanaka as the ICU Medical Director for a term of 12 months beginning July 1, 2019 and ending June 30, 2020. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual and term cost of $42,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Urology**

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

**Physician's Name:** Caroline J. Vilchis, M.D, Bradley Frasier M.D., Michael Guerena, M.D., Jason Phillips, M.D, and Aaron Boonjindasup, M.D.

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

**Term of Agreement:** 24 months, Beginning, July 1, 2019 – Ending, June 30, 2021

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $650 | FY2020: 366 | $237,900 |
| $650 | FY2021: 365 | $237,250 |
| | **Total:** | **$475,150** |

**Position Responsibilities:**

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

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

**To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize urology physicians Caroline J. Vilchis, M.D., Bradley Frasier, M.D., Michael Guerena, M.D., Jason Phillips, M.D, and Aaron Boonjindasup, M.D. as the Urology ED-Call coverage physicians for a term of 24 months, beginning July 1, 2019 and ending June 30, 2021 at a daily rate of $650, for term cost of $475,150.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for Anesthesia Services**

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

**Physician's Name:** Anesthesia Services Medical Group (ASMG)
**Area of Service:** Surgery / OB
**Term of Agreement:** 24 months, Beginning: July 1, 2019 – Ending: June 30, 2021
**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES

| Coverage | Hourly / Daily Rate | Monthly Cost | FY2020 Cost | FY2021 Cost | Total Term Cost |
|---|---|---|---|---|---|
| Unassigned patients ED & OB | 0 | $51,840.58 | $622,087 | $622,087 | $1,244,174 |
| Extra Room Coverage | Varies ($1,050) per day Monday-Thursday | | *Not to Exceed* $210,000 | *Not to Exceed* $210,000 | $420,000 |
| Pre-Anesthesia Review (8 hours/week) | $198/hour | $6,864 | $82,368 | $82,368 | $164,736 |
| EHR Development, one-time cost (not to exceed 100 hours) | $198/hour | 0 | $19,800 | 0 | $19,800 |
| Stroke Code / Code Thrombectomy (FY2020 = 366 days; FY2021=365 days) | $150/day | *Not to Exceed* $4,650 | $54,900 | $54,750 | $109,650 |
| | | | **Total Term Cost:** | | **$1,958,360** |

**Position Responsibilities:**

- Physician Anesthesia services including on-call and designated on-site coverage
- Anesthesia Services for Unassigned Emergency Room patients
- Anesthesia Services for Unassigned Obstetrical patients
- Continued development of Electronic Health Record (EHR) modules
- Provide Anesthesia response for Stroke Code / Code Thrombectomy

| | | | | |
|---|---|---|---|---|
| Documents 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Scott Livingstone, Chief Operating Officer

**Motion:** I move that the Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Anesthesia Services Medical Group (ASMG) for anesthesia coverage for a term of 24 months, beginning July 1, 2019 and ending June 30, 2021. Not to exceed a total cost of $1,958,360 for the term.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, General**

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

**Physician's Name:** Ashish Kabra, M.D.; Mohammad Pashmforoush, M.D.; Pargol Samani, M.D.; David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El Sherief, M.D.; Anitha Rajamanickam, M.D.

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

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $300 | FY2020: 366 | $109,800 |

**Position Responsibilities:**

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

| | | | | |
|---|---|---|---|---|
| Document Submitted to Legal 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 |

**To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Ashish Kabra, M.D.; Mohammad Pashmforoush, M.D.; Pargol Samani, M.D.; David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El Sherief, M.D.; Anitha Rajamanickam, M.D. as the Cardiology-General coverage physicians for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020, at a daily rate of $300, for an annual and term cost of $109,800.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology-STEMI**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | X | Panel | | Other |
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Physician's Name:** David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El Sherief, M.D.; Anitha Rajamanickam, M.D.

**Area of Service:** Emergency Department On-Call: Cardiology-STEMI

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June30, 2020

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $1,000 - STEMI | FY20: 366 | $366,000 |

**Position Responsibilities:**

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

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

**To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize David Spiegel, M.D.; Kenneth Carr, M.D.; Karim El Sherief, M.D.; Anitha Rajamanickam, M.D. as the coverage physicians for Cardiology-STEMI for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020, at a daily rate of $1,000, for an annual and term cost of $366,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Gastroenterology – General & ERCP**

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

**Physician's Name:** Christopher Devereaux, M.D., Thomas Krol, M.D., Javaid Shad, M.D., Michael Shim, M.D., Matthew Viernes, M.D.

**Area of Service:** Emergency Department On-Call: Gastroenterology – General & ERCP

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

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

| Rate/Day | Panel Days per Year | Annual Panel Cost |
|---|---|---|
| GI -$775<br>ERCP-$500 | 366 | $283,650<br>$183,000 |
| | **Total Term Cost:** | **$466,650** |

**Position Responsibilities:**

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

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

**To be included in the proposed FY Budget*

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

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physicians Christopher Devereaux, M.D.; Thomas Krol, M.D.; Javaid Shad, M.D.; Michael Shim, M.D.; Matthew Viernes, M.D. as the Gastroenterology General & ERCP ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020 at a daily rate of $775 for GI, for an annual cost of $283,650, and ERCP at a daily rate of $500 for an annual cost of $183,000, and a total cost for the term of $466,650.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Interventional Radiology (IR)**

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

**Physician's Name:** Michael Burke, M.D.; Brian Goelitz, M.D.; Justin Gooding, M.D.; Charles McGraw, M.D.; Michael Noud, M.D.; Donald Ponec, M.D.; Richard Saxon, M.D.

**Area of Service:** Emergency Department On-Call: Interventional Radiology (IR)

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $750 | 366 | $274,500 |

**Position Responsibilities:**

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

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

**To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Drs. Michael Burke, Brian Goelitz, Justin Gooding, Charles McGraw, Michael Noud, Donald Ponec, and Richard Saxon as the Interventional Radiology (IR) ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020 at a daily rate of $750 for an annual and term cost of $274,500

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology**

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

**Physician's Name:** Robert Pendleton, M.D.; Mark Smith, M.D.; Maulik Zaveri, M.D.; Henry Hudson, M.D.; Peter Krall, M.D.; Srinivas Iyengar, M.D.; Logan Haak, M.D.; James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Neeta Varshney, M.D.

**Area of Service:** Emergency Department On-Call: Ophthalmology

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Ophthalmology
No increase in Expense

| Rate / Day | Panel Days per Year | Annual Panel Cost |
|---|---|---|
| $300 | FY2020: 366 | $109,800 |

**Position Responsibilities:**

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

| | | | | |
|---|---|---|---|---|
| Document Submitted to Legal 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 |

**To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with ophthalmology physicians Robert Pendleton, M.D.; Mark Smith, M.D.; Maulik Zaveri, M.D.; Henry Hudson, M.D.; Peter Krall, M.D.; Srinivas Iyengar, M.D.; Logan Haak, M.D.; James Davies, M.D.; Bradley Greider, M.D.; Atul Jain, M.D.; Neeta Varshney, M.D. as the Ophthalmology ED-Call Coverage Physicians for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020 at a daily rate of $300, for an annual and term cost of $109,800.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Spine**

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

**Physician's Name:** Alleyne Neville, M.D.; Payam Moazzaz, M.D.; Tyrone Hardy, M.D.; Mark Stern, M.D.; Kevin Yoo, M.D.; Sunil Jeswani, M.D.; Howard Tung, M.D.

**Area of Service:** Emergency Department On-Call: Spine

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

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

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $450 | 366 | $164,700 |

**Position Responsibilities:**

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

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

**To be included in the proposed FY Budget*

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

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize spine physicians Alleyne Neville, M.D., Payam Moazzaz, M.D., Tyrone Hardy, M.D., Mark Stern, M.D., Kevin Yoo, M.D., Sunil Jeswani, M.D. and Howard Tung, M.D. as the Spine ED-Call coverage physicians for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020, at a daily rate of $450, for a total annual and term cost of $164,700.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Oral/Max Surgery**

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

**Physician's Name:** Brian Mudd, D.D.S.

**Area of Service:** Emergency Department On-Call: Oral/Max Surgery

**Term of Agreement:** 12 months, Beginning, July 1, 2019 – Ending, June 30, 2020

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Oral/Max Surgery

| Rate/Day | Panel Days per Year | Panel Annual Cost |
|---|---|---|
| $350 | FY20: 366 | $128,100 |

**Position Responsibilities:**

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

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

**To be included in the proposed FY Budget*

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

**Motion:** I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize physician Brian Mudd, D.D.S. as the Oral /Max Surgery ED -Call coverage physician for a term of 12 months, beginning July 1, 2019 and ending June 30, 2020 at a daily rate of $350, for an annual and term cost of $128,100.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**Registry Contract for Nursing & Allied Health Proposal**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Contract Labor |
| **Status of Agreement** | X | New Agreement | | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Aya Healthcare

**Area of Service:** Staffing/Resource

**Term of Agreement:** 36 months, Beginning, July 1, 2019 – Ending, June 30, 2022

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $375,000 | $4.5M | $13.5M |

**Description of Services/Supplies:**

- Managed Service Provider single source for contract labor
- Aya Partner Network with one point of contact, one account manager, one Joint Commission certified Aya compliance process, one bill
- Rates are a savings of 4% over current standard rates with support in reducing internal overtime and premium pay costs

| | | | | |
|---|---|---|---|---|
| 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: | X | *Yes | | No |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Diane Sikora, Director - Staffing Resource / Barbara Vogelsang, Chief Nurse Executive

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Aya Healthcare for contract labor managed service agreement for a term of 36 months, beginning, July 1, 2019 and ending, June 30, 2022 for an annual cost of $4.5M and a total cost for the term of $13.5M.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**Home Sleep Study Interpretation Proposal**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Sleep Study / Interpretations |
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Advanced Sleep Medicine Services, Inc.

**Area of Service:** Pulmonary

**Term of Agreement:** 12 months, Beginning, June 1, 2019 through May 31, 2020

**Maximum Totals:**

| Cost per Test | Cost per Test with interpretation | Total Term Cost |
|---|---|---|
| $300 | $350 | $24,500 |

**Description of Services/Supplies:**

- Home Sleep Apnea Study (HSAT) Interpretation by a board Sleep Specialist within 24 hours

| | | | | |
|---|---|---|---|---|
| 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Merebeth Richins, Director – ICU-Pulmonary Services - Telemetry, ICU / Barbara Vogelsang, Chief Nurse Executive

**Motion:**
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Advance Sleep Medicine Services, Inc. for interpretation of sleep screening for a term of 12 months, beginning June 1, 2019 and ending May 31, 2020 for an annual and total term cost of $24,500.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: June 20, 2019**
**PHYSICIAN AGREEMENT for Anesthesia Services**

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

**Physician's Name:** Anesthesia Services Medical Group (ASMG)
**Area of Service:** Surgery / OB
**Term of Agreement:** 24 months, Beginning: July 1, 2019 – Ending: June 30, 2021
**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES

| Coverage | Hourly / Daily Rate | Monthly Cost | FY2020 Cost | FY2021 Cost | Total Term Cost |
|---|---|---|---|---|---|
| Unassigned patients ED & OB | 0 | $51,840.58 | $622,087 | $622,087 | $1,244,174 |
| Extra Room Coverage | Varies ($1,050) per day Monday-Thursday | | *Not to Exceed* $210,000 | *Not to Exceed* $210,000 | $420,000 |
| Pre-Anesthesia Review (8 hours/week) | $198/hour | $6,864 | $82,368 | $82,368 | $164,736 |
| EHR Development, one-time cost (not to exceed 100 hours) | $198/hour | 0 | $19,800 | 0 | $19,800 |
| Stroke Code / Code Thrombectomy (FY2020 = 366 days; FY2021=365 days) | $150/day | *Not to Exceed* $4,650 | $54,900 | $54,750 | $109,650 |
| | | | **Total Term Cost:** | | **$1,958,360** |

**Position Responsibilities:**

- Physician Anesthesia services including on-call and designated on-site coverage
- Anesthesia Services for Unassigned Emergency Room patients
- Anesthesia Services for Unassigned Obstetrical patients
- Continued development of Electronic Health Record (EHR) modules
- Provide Anesthesia response for Stroke Code / Code Thrombectomy

| | | | | |
|---|---|---|---|---|
| Documents 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 |

**To be included in the proposed FY Budget*

**Person responsible for oversight of agreement:** Scott Livingstone, Chief Operating Officer

**Motion:** I move that the Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Anesthesia Services Medical Group (ASMG) for anesthesia coverage for a term of 24 months, beginning July 1, 2019 and ending June 30, 2021. Not to exceed a total cost of $1,958,360 for the term.

# Professional Affairs Committee
# (No meeting held in June, 2019)

# Audit, Compliance & Ethics Committee
# (No meeting held in June, 2019)

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~18~~19-006**

**POLICY TITLE: Board of Directors Meeting Minutes**

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

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

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

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

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

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

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

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

8. Minutes of closed sessions shall not be produced except as may be reasonably necessary to document consideration of matters for accreditation, compliance, licensing and similar purposes or as required by court order. Minutes of closed sessions shall be taken by Board Counsel and/or the Board Executive Secretary, watermarked with Board member's name and presented for approval by the Board in closed session and returned to the Executive Assistant at the conclusion of the Closed Session. A minute book of closed sessions shall be maintained by Board Counsel with a copy to be kept and secured by the Board Executive Secretary. Closed session minutes shall be kept confidential and may not be reproduced or released for purposes other than previously described and only after advice of Board Counsel.

9. All documents distributed in the Closed Session including minutes are considered confidential and must not be removed from the Closed Session.

**Reviewed by Gov/Leg Committee: 04/13/05**
**Approved by the Board of Directors: 4/28/05**
**Reviewed by the Gov/Leg Committee: 8/10/05**
**Approved by the Board of Directors: 9/22/05**
**Reviewed by the Gov/Leg Committee: 11/8/06**
**Approved by the Board of Directors: 12/14/06**
**Reviewed by the Gov/Leg Committee: 10/10/07**
**Approved by the Board of Directors: 12/13/07**
**Reviewed by the Gov/Leg Committee: 10/12/10**
**Approved by the Board of Directors: 11/04/10**
**Reviewed by the Gov/Leg Committee: 2/09/11**
**Approved by the Board of Directors: 2/24/11**
**Reviewed by the Gov/Leg Committee: 10/10/12, 11/14/12**
**Approved by the Board of Directors: 12/13/12**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Approved by the Board of Directors: 9/25/18**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 6/2019**
**Approved by the Board of Directors:**

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~14~~19-007**

**POLICY TITLE: Use of Board Committee Minutes at Meetings of Board of Directors**

1. Whenever a Committee of the Board has met since the most recent regular Board meeting, the Agenda packet for the next regular Board meeting shall contain the minutes of the Committee meeting. Summary minutes shall include, in addition to actions taken, a brief description of the discussion, rationale for the Committee's determinations, and the person or persons responsible for any action or follow-up. Minutes shall be generally formatted per Attachment A. If the Committee has not yet reviewed the minutes for the Committee meeting, then the draft minutes of the Committee meeting will be included in the Board packet.

2. To facilitate review of Committee work by the Board, Committee agendas shall also clearly identify each item of business as "Information Only" or "Discussion/Action" and shall generally follow the format of **Attachment B**. The Committee minutes and recommendations in the Board packet are to be used by the Board for informational purposes only. Nothing in the minutes, including Committee's recommendations, limits the authority or discretion of the Board or the validity of any action taken by the Board, and are simply background and recommendations of the Committee.

3. Inclusion of Committee minutes in the Board packet does not limit the Committee from subsequently correcting and approving them. Such correction and approval shall not affect any Board action taken prior to the ratification. However, if the Committee corrects its recommendations to the Board, the Board shall be made aware of the modified recommendations(s) at its next Board meeting.

4. The Board relies on the Committee to review, analyze and make recommendations to the Board within the scope of the Committee's purview. The Committee will maintain a record of their activities and recommendations and will submit to the Board via the minutes of their meetings. However, nothing in the Committee minutes will limit the authority or discretion of the Board or the validity of any action taken by the Board.

5. It is not a function of the Board of Directors to approve Committee minutes.

6. Minutes of ~~ad hoc committee~~ Ad Hoc Committee meetings are not taken unless required by law. Generally, such minutes are not required by law.

**Reviewed by the Gov/Leg Committee: 8/10/05**
**Approved by the Board of Directors: 9/22/05**
**Reviewed by the Gov/Leg Committee: 11/8/06**
**Approved by the Board of Directors: 12/14/06**
**Reviewed by the Gov/Leg Committee: 10/10/07**
**Approved by the Board of Directors: 12/13/07**

**Reviewed by the Gov/Leg Committee: 8/12/09 and 9/9/09**
**Approved by the Board of Directors: 9/24/09**
**Received by the Gov/Leg Committee: 12/01/10**
**Approved by the Board of Directors: 12/16/10**
**Reviewed by the Gov/Leg Committee: 10/10/12**
**Approved by the Board of Directors: 11/08/12**
**Reviewed by the Gov/Leg Committee: 8/6/13**
**Approved by the Board of Directors: 8/29/13**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 6/2019**
**Approved by the Board of Directors:**

**(Attachment "A")**
**Tri-City Medical Center**

**Name of Committee**
**Date_____**
**Time_____**
**DRAFT**

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

**Non-Voting Members:**

**Others Present:** )
**Absent:**

| Topic | Discussions/ Recommendations | Action or Recommendation to Board | Person(s) Responsible |
|---|---|---|---|
| 5. Call to Order. | Chair _____ called the meeting to order at _____. | | |
| 6. Comments by members of the public on any item of interest to the public before Committee's consideration of the item. | Chairman _____ read the paragraph regarding comments from members of the public. | *There were no public comments.* | |
| 7. Ratification of minutes- | It was moved by _____ and seconded by _____ to approve the minutes of the _____ meeting. The motion carried unanimously. | *Minutes ratified* | |

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

(Attachment "B")

**TRI-CITY HEALTHCARE DISTRICT**
**I. AGENDA FOR A REGULAR MEETING**
**II. OF THE Name of Committee**
**Date _____**
**Time _____**
**Location _____**
**Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056**

**The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"**

| | Agenda Item | Action/ Information | Est. Time Allotted | Requestor/ Presenter |
|---|---|---|---|---|
| 1. | Call to order – Introductions | | 1 min. | Chair |
| 2. | Public Comments – Announcement<br>Comments may be made at this time by members of the public on any item on the Agenda before the Committee's consideration of the item or on any matter within the jurisdiction of the Committee.<br>NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item. | | 1 min. | Standard |
| 3. | Ratification of minutes-~~June 25, 2012.~~(Date) | **Approval** | 3 min. | |
| 4. | New Business | | | |
| | a. Topic | **Action/ Discussion** | | |
| | b. Topic | **Action/ Discussion** | | |
| 5. | Motion to go into closed session. | | | |
| | a. Conference with legal counsel: Anticipated Litigation (Authority: Government Code section 54956.9(b) (1 matter) | | 30 min. | |
| 6. | Motion to go into open session. | | | |
| 7. | Open Session. | | | |
| 8. | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1). | | | |
| 9. | Comments by committee members. | | 5 min. | Chair |
| 10. | Next Meeting: [Date] | **Information** | | |
| 11. | Adjournment. | | | Chair |
| | Total Time Budgeted for Meeting | | | |

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~17~~19-021**

**POLICY TITLE: Use of Board Counsel by Members of the Board of Directors**

In order to control legal costs, the Board policy is to permit use of Board Counsel by individual Directors only as follows:

**I.** An individual Director may initiate consultation with Board Counsel regarding the following:

A. A legal matter relating directly to District or Board business, but not for matters personal to the Director or matters adverse to the interests of the District or the Board as a whole. Consultation must be limited to relatively simple questions which relate directly to the statutory authority of the Board or to procedures applicable to the Board and which do not require a written opinion or significant amounts of legal or factual analysis.

B. Any other legal matter relating directly to District or Board business, with prior approval of the Chairperson of the Board.

**II.** An individual Director may initiate consultation with outside special legal counsel at the expense of the District only: (1) when approved by the Chairperson of the Board; and (2) when Board Counsel has a conflict of interest, potential conflict of interest, or there would be an appearance of impropriety, or Board Counsel lacks sufficient expertise regarding a legal matter relating directly to District or Board business; and (3) the matter is not personal to the Director or adverse to the interests of the District or the Board as a whole; (4) or when authorized by the Board.

**III.** Nothing in this Policy shall prohibit an individual Director from seeking the advice of Board Counsel on issues related to the Director's individual FPPC Form 700, or other relatively simple conflict of interest questions related to the individual Director.

**IV.** The Chairperson may initiate consultation with Board Counsel or outside special legal counsel in accordance with paragraphs I or II, above.

**Reviewed by the Gov/Leg Committee: 8/10/05**
**Approved by the Board of Directors: 9/22/05**
**Reviewed by the Gov/Leg Committee: 11/8/06**
**Approved by the Board of Directors: 12/14/06**
**Reviewed by the Gov/Leg Committee: 10/10/07**
**Approved by the Board of Directors: 12/13/07**
**Reviewed by Gov/Leg Committee: 10/12/10**
**Approved by the Board of Directors: 11/04/10**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**

**Reviewed by Gov/Leg Committee: 11/7/17**
**Approved by Board of Directors: 12/14/18**
**Reviewed by Ad Hoc Policy & Bylaw Committee: 6/2019**
**Approved by Board of Directors:**

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~17~~19-023**

**POLICY TITLE: Responsibility for Decision-making on Legal Matters**

## 1. ROLE OF THE BOARD OF DIRECTORS

While the Board of Directors retains ultimate responsibility for the conduct of the business of the Tri-City Healthcare District, the Board has delegated implementation of its policies and day-to-day operations to the Chief Executive Officer (CEO) and management of the compliance program to the Chief Compliance Officer. Notwithstanding these general delegations or other Board policies, the Board of Directors retains responsibility for making the following decisions:

a. **Board Counsel**. Hiring of Board Counsel to advise the Board on any legal matter as requested by the Board or as established by policy. The Board shall approve the retainer agreement, provided that the CEO may negotiate rates. Invoices shall be approved by the Chair of the Board.

b. **Chief Compliance Officer**. General oversight of the implementation of compliance programs.

c. ~~Outside~~ General **Counsel**. The Board shall be provided with information on at least a quarterly basis regarding all matters projected to exceed a total of $50,000 in legal fees, costs, and damages (if applicable).

~~C~~d. **Claims and Settlements**. With the exception of appeals of the denial of payment for clinical services, the Board shall approve or authorize the settlement of any legal matter exceeding $50,000 in value, whether in favor of or against the District. The Board shall authorize or approve the compromise of any claim made by the District in any litigation or other adversarial proceeding exceeding $50,000, and shall approve settlements exceeding $50,000.

e. **Initiation of litigation**. With the exception of appeals of the denial of payment for clinical services, authorizing initiation of formal arbitration or litigation shall require approval of the Board. However, in the event legal action must be taken to protect life, health or safety within or about the facilities operated by the District, the CEO, with the concurrence of ~~the Board~~ General Counsel or with the concurrence of the Chief Compliance Officer may approve the commencement of litigation seeking equitable relief. In such event, the Board shall be notified within 24 hours, and ratification of the action shall be placed on the next agenda for consideration by the Board.

## B. ROLE OF BOARD COUNSEL

See Appendix A.

**Approved by the Board of Directors: 1/30/14**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by the Gov/Leg Committee: 5/06/14**
**Approved by the Board of Directors: 5/29/14**
**Reviewed by the Gov/Leg Committee: 6/07/16**
**Approved by the Board of Directors: 6/30/16**
**Reviewed by the Gov/Leg Committee: 11/7/17**
**Approved by the Board of Directors: 12/14/17**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 6/2019**
**Approved by Board of Directors:**

*Appendix A*

**Position Description**
**Board Counsel**
**Tri-City Healthcare District**

**Summary**: Board Counsel is retained by and reports to the Board of Directors. Board Counsel carries out legal duties as assigned by the Board, General Counsel, and the Chief Executive Officer acting within his or her delegated authority. Board Counsel advises the District on compliance with state transparency laws, including but not limited to open meetings, public records and conflict of interest laws, as well as compliance with the Local Healthcare District Law.

**Essential Functions**:

(a) Advises the Board of Directors and District officers in all matters of law pertaining to their offices, upon request and consistent with District policies.

(b) Advises the District on the following subjects: (1) compliance with the Brown Act and related open meeting laws; (2) compliance with Public Records Requests (including risk management program materials) and other records requests referred by District staff; (3) compliance with conflict of interest laws under California law, such as the Political Reform Act; (4) compliance with the Local Health Care District law in operations and financial transactions (to be identified and requested of by General Counsel or Board Chair); (5) compliance with public works contracting rules, including competitive bidding statutes and prevailing wage laws; (6) compliance with Government Claims Act presentation requirements as respects claims against the District, as needed by General Counsel; (7) compliance with the California Voting Right Act; (8) completion of the Local Agency Formation Commission reorganization process.

(c) Attends regular and special meetings of the Board of Directors, and such meetings of Board committees, or other meetings as requested by the chairperson of the committee or the Chief Executive Officer.

(d) Prepares or reviews any and all proposed ordinances or resolutions for the District and amendments thereto.

(e) Prosecutes or defends claims or actions on behalf of the District as authorized by General Counsel pursuant to District policy.

(f) Devotes such time to the duties of office as may be specified by any ordinance, resolution or policy of the District.

(g) Advises the Board on proposed and existing legislation affecting the District.

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~15~~19-027**

**POLICY TITLE: Prohibition on Political Activities, Solicitation, Distribution of Literature and Goods on District Properties**

## A. PURPOSE

1. To avoid disruption of healthcare operations or disturbance of patients, and to maintain appropriate order and discipline, any solicitations or distribution of literature or goods on Tri-City Healthcare District (TCHD) managed properties shall be subject to this policy. In addition, this policy prohibits political activities on premises owned or controlled by TCHD.

## B. DEFINITIONS

1. Working areas are all areas on TCHD property except cafeteria(s), employee lounges, physicians' lounge, medical staff office and other areas reserved for the exclusive use of the medical staff. Working areas include TCHD lobbies and parking areas.

2. Working time includes the shift of both the employee doing the soliciting or distributing and the employee to whom the soliciting or distributing is directed. This does not include rest periods or meal times.

## C. POLICY

1. Any solicitation or distribution of literature or goods within TCHD-managed properties shall be limited to non-working areas, except scheduled uses of assembly rooms, classrooms and conference rooms per Board Policy #~~14~~19-043, and activities approved by the Chief Nurse Executive which are likewise limited to those public agencies, nonprofit organizations, associations and other groups which further the health care needs of the public within the District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District.

2. No person, including any officer or employee of TCHD shall engage in political activity during working hours on TCHD managed properties, including the solicitation of contributions regarding candidates or ballot measures, per Government Code sections 3205, 3507 and 3209.

3. Any and all solicitations and/or distribution of literature or goods among TCHD staff, patients, Medical Staff or the public on TCHD Property and facilities are subject to the following rules:

a. Solicitation or Distribution by non-employees: Persons and organizations not employed by TCHD may not solicit or distribute literature or offer goods on TCHD property, at any time, without prior written approval of the Human Resources Department for purposes consistent with this policy, provided that members of the Medical Staff may distribute literature in non-working areas reserved for their exclusive use.

b. Solicitation by TCHD Employees or Medical Staff or Allied Health Professionals: TCHD employees and members of the Medical Staff and Allied Health Professionals may not solicit at any time, for any purpose, in any working areas that may affect patient care (e.g. patient rooms, operating rooms, treatment rooms, corridors in patient treatment areas, family meeting rooms, and consultation rooms).

c. No Solicitations: Solicitation or distribution in any way connected with the sale of any goods (other than directly related to medical care to be provided) is strictly prohibited at any time among TCHD staff, patients, or visitors, in any working areas.

d. TCHD Employees may not distribute literature during working time for any purpose. Employees, members of the Medical Staff and Allied Health Professionals may not distribute literature, at any time, for any purpose in TCHD working areas.

e. Notice of Intent to Solicit or Distribute Literature: TCHD requires that prior to soliciting or distributing literature for any purpose an employee who intends to engage in solicitation and or distribution of literature must identify him or herself and notify the Human Resources Department of his or her intent before engaging in such activity.

f. Educational flyers and class materials will be reviewed and approved for posting by the Director of Education and Clinical Informatics.

g. Posting on TCHD Bulletin Boards: TCHD maintains bulletin boards located throughout its facilities for communicating with its employees.

    i. Postings on these boards are limited to TCHD-related material including statutory and legal notices, safety and disciplinary rules and procedures, and other TCHD items. No postings shall be permitted for any other purpose.

    ii. All postings require the approval of the Human Resources Department.

4. Except as authorized by Government Code section 3507, nothing in this policy shall be construed to limit the provisions of any TCHD collective bargaining agreement or labor relations policy, including provisions regulating access of employee organization officers and representatives to

work locations or the use of designated bulletin boards for communications related to the scope of representation.

D. **Approval of Exceptions**.

The Chief Nursing Executive may approve written requests submitted by employees and groups supported, sponsored by or affiliated with the District for permission to conduct activities within the scope of paragraph C.1, above, such as bake sales, handicraft fairs and similar charitable or non-commercial scale activities, limited in time and location which are otherwise consistent with this policy and the terms and conditions applicable to the use of Assembly Rooms, Classrooms and Conference Rooms per Board Policy ~~#14~~19-043.

**Reviewed by the Gov/Leg Committee: 9/1/15**
**Approved by the Board of Directors: 9/24/15**
**Reviewed by the Gov/Leg Committee: 12/1/15**
**Approved by the Board of Directors: 12/10/15**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 6/2019**
**Approved by Board of Directors:**

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~14~~19-030**

**POLICY TITLE: Government Claims Act Policy; Claims Presentation**

All claims against the Tri-City Healthcare District (the "District") including claims for money and damages which are excepted by Section 905 from Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the Government Code and which are not governed by any other statutes or regulations expressly relating thereto, shall be governed by the Claims Presentation Procedures set forth below, and which shall be deemed to include the provisions of the Government Claims Act (commencing with Section 900 of the Government Code), which are incorporated herein by reference. The inclusion of claims for money and damages which are otherwise excepted by Section 905 from Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the Government Code are hereby governed by the Claims Presentation Procedure ("Procedure") set forth below, in accordance with the provisions of Government Code section 935, so that all claims against the District shall be subject to the same claims presentation requirements to the extent permitted by law.

## I. CLAIMS PRESENTATION REQUIREMENTS

A. Notice of Claims (Gov. Code §§ 905, 945.4).

1. No suit for money or damages may be maintained against the District on a cause of action for which this Procedure requires a claim to be presented until a written claim has first been timely presented to the District in conformity with this Procedure.

B. Claims Subject to Claims Presentation Requirements.

1. All claims against the District for money or damages including claims which are otherwise exempted by Section 905 of the Government Code from the claims procedure provided in Part 3 of Division 3.6, Title 1 of the Government Code and which are not expressly governed by any other statute or regulation shall be governed by this Procedure. Claims set forth in Section 905 of the Government Code include the following:

a. Claims under the Revenue and Taxation Code or other statute prescribing procedures for the refund, rebate, exemption, cancellation, amendment, modification or adjustment of any tax, assessment, fee or charge or any portion thereof, or of any penalties, costs or charges related thereto.

b. Claims in connection with which the filing of a notice of lien, statement of claim, or stop notice is required under any provision of law relating to mechanics', laborers' or materialmen's liens.

c. Claims by public employees for fees, salaries, wages, mileage or other expenses and allowances.

d. Claims for which the workers' compensation authorized by Division 4(commencing with Section 3200) of the Labor Code is the exclusive remedy.

e. Applications or claims for any form of public assistance under the Welfare and Institutions Code or other provisions of law relating to public assistance programs, and claims for goods, services, provisions or other assistance rendered for or on behalf of any recipient of any form of public assistance.

f. Applications or claims for money or benefits under any public retirement or pension system.

g. Claims for principal or interest upon any bonds, notes, warrants, or other evidences of indebtedness.

h. Claims which relate to a special assessment constituting a specific lien against the property assessed and which are payable from the proceeds of such an assessment, by offset of a claim for damages against it or by delivery of any warrant or bonds representing it.

i. Claims by the State or by a state department or agency or by another local public entity or by a judicial branch entity.

j. Claims arising under any provision of the Unemployment Insurance Code, including but not limited to claims for money or benefits, or for refunds or credits of employer or worker contributions, penalties, or interest, or for refunds to workers of deductions from wages in excess of the amount prescribed.

k. Claims for the recovery of penalties or forfeitures made pursuant to Article 1 (commencing with Section 1720) of Chapter 1 of Part 7 of Division 2 of the Labor Code.

l. Claims governed by the Pedestrian Mall Law of 1960, part 1 (commencing with Section 11000) of Division 13 of the Streets and Highways Code.

m. In some circumstances, claims that include damages for childhood sexual abuse.

C. Delegation of Authority to Allow or Reject Claims.

1. The Board of Directors delegates to the President/CEO (designee) the authority to allow or reject claims, or return a claim as legally insufficient.

2. The President/CEO shall examine and allow, return or reject claims required to be filed by this Procedure.

3. The President/CEO's allowance, return or rejection of claims shall have the same effect as allowance, return or rejection by the Board of Directors.

## II. DISTRICT CLAIM FORM (Gov. Code 910.4)

A. The District shall provide a form that the claimant may use. **(See Attachment A)**

B. The District may return a claim to the claimant if the claim is not presented using the District's claim form, or if the claim is insufficient. Any claim returned to the claimant may be resubmitted using the appropriate District claim form. (Gov. Code § 910.4.)

C. The President/CEO may not take action on the claim for a period of 15 days after the written notice of insufficiency is given. (Gov. Code § 910.8.)

**Reviewed by the Gov/Leg Committee: 8/10/05**
**Approved by the Board of Directors: 9/22/05**
**Reviewed by the Gov/Leg Committee: 11/8/06**
**Approved by the Board of Directors: 12/14/06**
**Reviewed by the Gov/Leg Committee: 10/10/07**
**Approved by the Board of Directors: 12/13/07**
**Received by the Gov/Leg Committee: 12/01/10**
**Approved by the Board of Directors: 12/16/10**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 5/2019**
**Approved by Board of Directors:**

## Attachment "A"

**Claim Form**

(A claim shall be presented by the claimant or by a person acting on his behalf.)

NAME OF DISTRICT:

| | |
|---|---|
| 1 | Name, address, mailing address if different, and phone number. |
| | Name: |
| | Address(es): |
| | |
| | Phone Number: |
| 2 | List name, address and phone number of any witnesses |
| | Name: |
| | Address: |
| | Phone Number: |
| 3 | List the date, time, place and other circumstances of the occurrence or transaction which gave rise to the claim asserted. |
| | Date: Time: Place: |
| | Tell What Happened (give complete information): |
| | |
| | |
| | |
| | |
| | ***Note: Attach any photographs you may have regarding this claim.*** |
| 4 | Give a general description of the indebtedness, obligation, injury damage or loss incurred so far as it may be known at the time of presentation of claim. |
| | |
| | |
| | |
| 5 | Give the name or names of the public employee or employees causing the injury, damage, or loss, if known. |
| | |
| 6 | If the actual amount of your claim is less than $10,000 indicate the exact amount of your claim, and if possible show specific itemization and/or include copies of any documents in support thereof. If the amount of the claim exceeds $10,000, no dollar amount should |

| | |
|---|---|
| | be included in this claim form. However, it is necessary to indicate whether the claim would be a limited civil case. (Any claim under $25,000 would be a limited civil claim, and any claim over $25,000 would be an unlimited civil claim.) |
| | |
| | |
| | |

| | | |
|---|---|---|
| Date: | Time: | Signature |
| ANSWER ALL QUESTIONS. OMITTING INFORMATION COULD MAKE YOUR CLAIM LEGALLY INSUFFICIENT. | | |

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~15~~19-031**

**POLICY TITLE: Members on Board Committees; Conflicts of Interest**

## I. RECRUITMENT OF COMMUNITY MEMBERS FOR BOARD COMMITTEES

The following are the procedures for recruitment of community members for vacancies on Board Committees.

A. When a community member vacancy is scheduled to occur on a Board Committee, the District's administration shall:

1. Solicit applications from community members for positions on Board Committees by formally announcing openings at:

   a. Board meetings; and

   b. Board Committee meetings.

2. Solicit applications from community members for positions on Board Committees by advertising openings in a newspaper of general circulation within the boundaries of the Tri-City Healthcare District, not less than once a week for two successive weeks.

3. Solicit applications from community members for positions on Board Committees by posting openings on:

   a. The TCHD website (when availability permits); and

   b. Other public locations where the Tri-City Healthcare District regularly posts agendas for its Board and Board Committee meetings.

B. Solicitations shall include the following:

1. A request that the following information be submitted to the office of the Board Executive Secretary in support of the community members' application for a position on a Board Committee:

   a. A cover letter stating the community member's intention to serve as a Board Committee community member;

   b. A resume or biography delineating the community member's experience relevant to the applicable Board Committee.

c. A declaration of any possible conflicts of interest in a format approved by the Board.

2. A brief description of the scope of topics addressed at the applicable Board Committee, the meeting schedule for the applicable Board Committee, and the term of membership.

3. The following statement:

The Board of the Tri-City Healthcare District desires to ensure that its Board Committee community members are knowledgeable as to the issues that face the District. Therefore, the Tri-City Healthcare District shall only consider applications submitted by persons residing within the boundaries of the Tri-City Healthcare District, or as to the Community Healthcare Alliance Committee only, persons employed by a local agency or business within the boundaries of the District who appoint the individual to serve on the Community Healthcare Alliance Committee on behalf of the local agency or business.

C. The Board Executive Secretary shall forward applications for the position of Board Committee community member to the applicable Board Committee Chair. Applications shall be placed on the next Board Committee Agenda upon the Board Committee Chair's approval.

1. Community member applicants shall be invited to attend the Board Committee meeting at which their membership is considered so that the Board Committee may conduct a brief interview before making its recommendation to the Board.

2. Notwithstanding the above, an application shall not be placed on a Board Committee Agenda until the expiration of 30 days from the first solicitation action taken under Section I above.

D. Upon the recommendation of the applicable Board Committee, the item will be placed on the next Board agenda for final disposition.

E. If the Chair of a Board Committee finds, after completion of the process outlined in Sections A through D above is completed, that the Board Committee still needs one or two subject matter experts on the Board Committee to assist the Board Committee in complying with its charter, the Chair may provisionally appoint, through the date of the next regular Board meeting, not more than two subject matter experts to the Board Committee, subject to Board approval. Subject matter expert(s) for these purposes are individuals that possess special experience based on their experience, training or degree in those matters discussed by the Board Committee, e.g., a financial advisor or certified public accountant for the Audit Committee.

## II. TERM OF COMMUNITY MEMBERS ON BOARD COMMITTEES

Unless otherwise expressly provided in the Board Committee's charter, members of Board Committees shall serve a term of two years, with an option to renew the appointment for one additional two-year term, and shall continue to serve until a successor is appointed by the Board. After the end of his/her term, the community member shall not be eligible to serve on the same Board Committee for at least two years. In addition, it is preferable that a community member shall be a member of no more than one Board Committee at a time. However, it is recognized that circumstances may arise when positions are difficult to fill. Therefore, if a member's term has expired and no replacement has been appointed within 60 days of the expiration of the member's term, and if a community member who sits on a Board Committee wishes to be reappointed the Board Committee may make this recommendation to the Board.

## III. EXPIRATION OF TERM DUE TO ABSENCES

The term of any community member of a Board Committee shall automatically expire if the member is absent from three (3) consecutive regular meetings of the Committee of which he or she is a member, or from three (3) of any five (5) consecutive meetings of the Committee, except when absences are excused by action of the Committee for matters such as illness or military deployment.

## IV. CONFLICTS OF INTEREST

A. Committee members may be designated in the District's Conflict of Interest Code upon a determination that the committee on which they serve is not purely advisory to the Board.

B. Violations of the Conflicts of Interest Code.

In addition to any other remedy provided by law, if the Board of Directors determines that there has been a violation of conflict of interest laws by a Committee Member, the Board may take the appropriate disciplinary and corrective action which may include removal of the Committee Member from the Committee.

C. Inasmuch as Board Committees provide oversight and input into governance matters, employees of the District shall generally be ineligible to serve on any Board Committee as community members. Holding such an office shall be considered to be inconsistent, incompatible, in conflict with or inimical to an employee's duties. Where management employees are appointed to a Board Committee to represent the administration, they shall be counted towards achieving a quorum, but shall not be entitled to vote. However, nothing in this policy shall be construed as prohibiting or discouraging any District employee from speaking at any Board Committee meeting in a personal capacity.

**Reviewed by the Gov/Leg Committee: 8/10/05**
**Approved by the Board of Directors: 9/22/05**

**Reviewed by the Gov/Leg Committee: 5/10/06**
**Approved by the Board of Directors: 5/25/06**
**Reviewed by the Gov/Leg Committee: 11/8/06**
**Approved by the Board of Directors: 12/14/06**
**Reviewed by the Gov/Leg Committee: 10/10/07 & 11/07/07**
**Approved by the Board of Directors: 12/13/07**
**Reviewed by the Gov/Leg Committee: 12/01/10**
**Approved by the Board of Directors: 12/16/10**
**Reviewed by Gov/Leg Committee: 7/13/11**
**Approved by the Board of Directors: 7/28/11**
**Reviewed by the Gov/Leg Committee: 3/05/13**
**Approved by the Board of Directors: 3/28/13**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by the Gov /Leg Committee: 7/7/15**
**Approved by the Board of Directors: 7/30/15**
**Reviewed by Ad Hoc Bylaws & Policy Committee: 6/2019**
**Approved by Board of Directors:**

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY ~~#17-~~19039**

**POLICY TITLE: Comprehensive Code of Conduct**

The following is the Board-approved Code of Conduct for District Board Meetings:

## I. PURPOSES AND GOALS OF CODE OF CONDUCT

Effective leadership requires the Board to foster effective communication throughout the organization. Effective communication is necessary to encourage the delivery of safe, high quality care, as well as compliance with ethical and legal imperatives. Effective communication occurs best in an atmosphere of mutual respect, in which patients, physicians, hospital staff and members of the public, as well as members of the Board, feel valued and free to express themselves. Effective communication requires thorough preparation for meetings, adherence to approved procedures for the conduct of meetings, including compliance with time limits and ~~courteous conduct~~ civility during debate and discussion. Effective communication requires an atmosphere free from threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct.

The Board believes that at a minimum, its members must behave as if they are fiduciaries who are expected to honor the same duties of loyalty and care expected of their peers who serve on the boards of non-profit hospitals. Board members should act professionally at all times.

This Code of Conduct is intended to describe: (1) minimum expectations ~~for~~ of fiduciary conduct; ~~at, and surrounding Board meetings; (2) how Board members are provided the~~ (2) the resources needed for effective, informed governance; (3) rules for ensuring the fairness of proceedings; and to (4) ~~prescribe~~the consequences for misconduct which does not contribute to effective leadership of TCMC, including ~~making Board members ineligible for receipt~~ loss of discretionary perquisites ~~of office~~ within the jurisdiction of the Board.

## II. MINIMUM EXPECTATIONS FOR CONDUCT OF BOARD MEETINGS

1. Once the Board has a quorum, the meeting should immediately commence. Time periods announced by the Chair for recesses shall be strictly observed.

2. For each agenda item on which there is anticipated action, at the discretion of the Chair or upon request by any Board member, consideration may commence with a staff presentation or other report or public comments, or with a motion and a second. Board discussion shall be permitted following any presentation or public comments, except that:

a. Any Board member who must abstain from participation in a matter because of a legal conflict of interest shall ask the Chair for permission to announce the conflict prior to consideration of the item; and

b. Any Board member who has had any discussions or received information prior to the meeting with respect to an agenda item which will affect substantial legal rights of a party appearing before the Board such as regarding credentialing of a health care provider, proposed imposition of sanctions on a Board member, or another quasi-judicial matter, shall, prior to consideration of the item, ask the Chair for permission to describe the nature of those contacts. Disclosing such information helps ensure fairness of Board decisions by ensuring that, to the extent possible, all involved have the same information regarding the matter. In case of doubt, a Board member shall err on the side of disclosing relevant information obtained outside of the meeting, including who provided the information and in what circumstances.

c. If the requestor for an item is listed as "Standard," any member may make the first motion. If the anticipated action is based on a recommendation from a Board committee, the first motion should normally be made by the Chair of that committee. If a particular member is listed as the requestor for the item, the first motion on the item should normally be made by that member.

3. If there is no motion on an action item, or if a motion is made and there is no second, the Chair should move to the next agenda item without further comment from the Board members.

4. For each agenda item that has received a motion and a second, the Chair should ask each member in turn as to whether that member wishes to address the motion, starting with the maker of the motion.

5. Each member will be recognized by the Chair and shall be allotted up to 3 minutes to speak to the motion, once recognized. Time for questions and answers addressed by a member to staff or to other Board members is included in the three minutes, unless the Chair grants an exception. Members who anticipate that this time will be insufficient shall, whenever feasible: (1) submit written statements at any time; (2) submit written questions to the Chair and CEO at least 48 hours in advance of a regular meeting when feasible (see II, B, above); or (3) request additional time. Only the member who has been recognized may speak on the motion during that time. Once a member is recognized, a timekeeper selected by the Chair will start the three-minute clock upon the direction of the Chair. A person other than the Chair shall operate the time clock under the direction of the Chair. Upon expiration of the allotted time, the

timekeeper shall notify the Chair by word or sign. Time limits are to be consistently and strictly enforced.

6. When the member's three-minute time allotment has concluded, the Chair should immediately recognize the next member in turn to determine if he/she wishes to speak. When recognized, the member should start speaking and the prior speaker shall promptly yield the floor.

7. Once the Chair has offered each member the opportunity to be heard, the Chair may offer a second round of comments. The Chair should again offer each member a three-minute opportunity to speak.

8. Unless recognized by the Chair, Board members shall not address members of the public who come forward to speak, and should not enter into a dialogue or debate. Members of the public shall be recognized to speak in accordance with Board Policy No. ~~10~~19-018.

9. Agenda materials are intended to provide answers to as many questions as possible regarding agenda items, prior to the Board meetings. Board members are expected to review the agenda materials thoroughly, prior to the Board meetings, and to timely request additional information or clarification in advance whenever feasible—generally prior to any regular meeting. Questions from Board members at the meetings should be for the purposes of seeking clarification and/or additional information regarding particular agenda items and/or agenda materials.

10. Board members should be courteous and respectful of all meeting participants, including the Chair. Board members shall comply with the legitimate orders of the Chair regarding the orderly conduct of the business before the Board.

11. Conduct while attending Board meetings and other meetings and events related to the Board and Board committees, and while engaged in other Board-related business, which is unsafe, disruptive or which constitutes threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct, willful disturbance of the meeting or which otherwise violates Penal Code section 403 is prohibited. Board members shall comply with, and are subject to the District Harassment policy, which is set forth in **Exhibit "A"** to this Policy.

12. Board members and other persons shall comply with all applicable Board Policies pertaining to the conduct of board meetings, including but not limited to Board Policy ~~#07~~19-010 (Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings) ~~#07~~19-22 (Maintenance of Confidentiality) and Board Policy ~~10~~19-018 (Public Comments at the Tri-City Healthcare District Board of Directors Meetings/Committee Meetings).

13. Board Members should attend every Board Meeting and remain for the entirety of each meeting, including returning to the meeting after exclusion from closed session or any portion thereof. The Board Chair shall make an oral announcement of any departure from the meeting, ~~and the reason, if available.~~

## III. BREACHES OF ORDER AT MEETINGS; SANCTIONS

The Board has a right to make and enforce rules to ensure the conduct of the public's business in an efficient and orderly manner, and without disruption by members of the public or members of the Board. At the same time, the public and Board members shall be free to criticize the policies, procedures, programs and services of the organization, and the acts and omissions of the Board.

Notwithstanding any other policy of the Board, violations of this policy during a Board meeting may be enforced, as follows:

1. The Chair shall call to order, by name, any person who is in violation of any of the rules of conduct established under this policy, and Board Policy ~~No. 1019~~-018, which is committed in the immediate view and presence of the Board. The Chair shall request that person refrain from any further violation, warn that a repetition may violate Penal Code section 403 and result in removal from the meeting, and may specifically state that any further violation may constitute contempt of the Board.

2. If the person repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board (such as by refusing to yield the floor or otherwise disrupting proceedings), the Chair may call a recess of the meeting, stating that the reason for the delay is due to the misconduct of the Board member or other person. If following such recess, the Board member or other person persists in willfully interrupting the meeting such that order cannot be restored, the Chair, with the concurrence of the Board, shall order the disruptive Board member or other person removed from the meeting room by District security personnel, or, ~~as to~~ by Board members, via ~~may request~~ a motion ~~under~~ as described in paragraph 3. If removal of a Board member is ordered, the Board member shall be entitled to adjourn to attend the balance of the meeting by telephone at the meeting location or other location consistent with the Brown Act, notwithstanding the provisions of any other Board policy.

3. In the alternative, if a Board member repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board, or, following a return from recess of the meeting if called, the Chair may call for a motion holding the Board member in contempt. Such a motion shall take precedence over any other motion, and shall describe the action or actions constituting the violation of this policy. If such a motion is made and seconded, each board member shall have an opportunity to discuss

the motion in accordance with this policy. If the motion is passed, the Board member shall be advised by the Chair that he or she has been held in contempt. A second motion may then be made to prescribe the sanction or sanctions to be imposed, which may include, but shall not be limited to, one or more of the following:

a. A statement of censure, identifying the misconduct;

b. Removal of the offending Board member from membership on one or more Board committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board officers;

c. Removal of the offending Board member from holding any Board office currently held;

d. Removal of the offending Board member from the meeting room and offering the member the right to adjourn to attend the balance of the meeting by telephone at the meeting location or another location consistent with the Brown Act (notwithstanding the provisions of any other Board policy) ; provided that the offending Board member may also be required to attend one or more future meetings by teleconference;

e. A determination that no compensation shall be earned by the offending Board member for attendance at the meeting at which the contempt occurred;

f. A determination that the offending Board member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct or the agenda items whose consideration was willfully disrupted or prejudicially delayed by the misconduct, based upon the Board member's actual malice;

g. Rendering the offending Board member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings otherwise permitted under Board Policy ~~#07~~19-020 (except those previously-approved for which expenses have been incurred prior to the time of the finding of contempt), for a period of time or subject to conditions specified in the motion;

h. Referral of the matter to the County Criminal Grand Jury pursuant to Government Code section 3060.

i. Referral of the matter to the Fair Political Practices Commission or other prosecuting authority with jurisdiction over the matter.

4. Following the outcome of a motion for sanctions, the Chair shall direct that the order of the Board be carried out by security, the Chief Executive Officer, and/or Board Counsel, as appropriate.

5. In the event violations of this Policy occur in a closed session, the Chair may suspend the closed session and return to open session for the purpose of commencing the enforcement process contemplated by this section. All proceedings under this section III shall occur in open session.

## IV. VIOLATIONS OF BOARD POLICIES OUTSIDE OF BOARD MEETINGS

1. Board members shall not act on behalf of, nor represent themselves as speaking on behalf of, the Board without the Board's express authorization.

2. When a violation of a Board policy by a member of the Board is alleged to have occurred outside of a Board meeting, the Chair or any member of the Board may request that an item be placed on the agenda to consider what sanctions may be appropriate, if any. In such instances, evidence of the misconduct shall be presented by the requesting member. The Board member accused of misconduct shall have an opportunity to present evidence and respond to the allegations made. Formal rules of evidence shall not apply.

3. After consideration of the evidence presented, the Board may take such actions as it may deem appropriate, including but not limited to those described in section III of this policy, other than paragraph III(e).

## V. AUTHORITY OF ADMINISTRATION TO PROVIDE FOR SECURITY

1. The District Administration is authorized and directed to develop and implement policies and procedures designed, engage employees or contractors to provide security, consistent with applicable law, to promote a secure and orderly environment for Directors, employees, staff, and members of the public. These policies and procedures will include a process for notifying the District Administration in the event that any person feels that he or she has been subjected to conduct which violates this Policy.

2. The District Administration is authorized and directed to take lawful and appropriate action and to pursue lawful and appropriate remedies against any person found to have violated this Policy.

## VI. BOARD ORIENTATION AND TRAINING

1. Every Board member shall participate in an orientation and training to be offered by Tri-City Healthcare District within 60 days of election, re-election to office, or assuming office, as a condition to receiving compensation or allowance of expenses.

2. The required orientation and training shall be offered at times and places convenient to the Board member.

3. The orientation and training shall include:

   a. A tour of the facilities owned or operated by Tri-City Healthcare District

   b. An explanation of Board policies, procedures, committee structure and bylaws, and delivery of a copy of the current Board policies, procedures and bylaws

   c. Briefings delivered by members of the management team regarding:

      i. Health care finance

      ii. District financial management and budgeting practices

      iii. Compliance laws and regulations, including conflict of interest rules under State and Federal law and the accreditation process

      iv. Areas of health care and specialties offered

      v. Medical staff organizations and relationship with the hospital

      vi. ~~Nursing~~ Overview of policies, staffing, ~~and~~ practices, and administrative policies

      vii. The roles and responsibilities of ~~each~~ departments within the organization

      viii. Legal responsibilities of Board members

4. This orientation and training shall supplement the training required by law under AB 1234.

5. This orientation and training shall also supplement the Sexual Harrassment training required by law for public officials.

**Reviewed by the Gov/Leg Committee: 1/13/10**
**Approved by the Board of Directors: 1/28/10**
**Reviewed by Gov/Leg Committee: 4/13/11**
**Approved by the Board of Directors: 4/28/11**
**Reviewed by Gov/Leg Committee: 9/14/11**
**Approved by the Board of Directors: 9/29/11**
**Reviewed by Gov/Leg Committee: 4/11/12**
**Approved by the Board of Directors: 4/26/12**
**Approved by the Board of Directors: 5/31/12**

**Reviewed by the Gov/Leg Committee: 6/04/13**
**Approved by the Board of Directors: 6/27/13**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by the Gov/Leg Committee: 10/6/15**
**Approved by the Board of Directors: 10/29/15**
**Approved by the Board of Directors: 12/14/2019**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 6/2019**
**Approved by Board of Directors:**

Tri-City Medical Center
Oceanside, California

EXHIBIT "A"

**Administrative Policy**
**Human Resources**

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**ISSUE DATE:** 05/83

**SUBJECT:** DISCRIMINATION, HARASSMENT AND RETALIATION PREVENTION POLICY

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

**POLICY NUMBER:** 8610-403

| | |
|---|---|
| **Department Review:** | 11/17 |
| **Administrative Policies and Procedures Approval:** | 11/17 |
| **Human Resources Committee Approval:** | 04/18 |
| **Board of Directors Approval:** | 04/18 |

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A. **POLICY:**

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

childbirth, lactation and related medical conditions), gender identity and gender expression (including transgender individuals who are transitioning, have transitioned, or are perceived to be transitioning to the gender with which they identify), age (40 or over), sexual orientation, Civil Air Patrol status, military and veteran status, immigration status or any other consideration protected by federal, state or local law. For purposes of this policy, discrimination on the basis of "national origin" also includes harassment against an individual because that person holds or presents the California driver's license issued to those who cannot document their lawful presence in the United States. All such harassment is prohibited.

b. This policy applies to all persons involved in our operations, including coworkers, supervisors, managers, temporary or seasonal workers, agents, clients, vendors, customers, or any other third party interacting with TCHD ("third parties") and prohibits proscribed harassing conduct by any employee or third party of TCHD, including nonsupervisory employees, supervisors and managers. If such harassment occurs on TCHD's premises or is directed toward an employee or a third party interacting with TCHD, the procedures in this policy should be followed.

i. Sexual Harassment Defined

1) Sexual harassment includes unwanted sexual advances, requests for sexual favors or visual, verbal or physical conduct of a sexual nature when:
   a) Submission to such conduct is made a term or condition of employment; or
   b) Submission to, or rejection of, such conduct is used as a basis for employment decisions affecting the individual; or
   c) Such conduct has the purpose or effect of unreasonably interfering with an employee's work performance or creating an intimidating, hostile or offensive working environment.

2) Sexual harassment also includes various forms of offensive behavior based on sex and includes gender-based harassment of a person of the same sex as the harasser. The following is a partial list:
   a) Unwanted sexual advances.
   b) Offering employment benefits in exchange for sexual favors.
   c) Making or threatening reprisals after a negative response to sexual advances.
   d) Visual conduct: leering; making sexual gestures; displaying sexually suggestive objects or pictures, cartoons, posters, websites, emails or text messages.
   e) Verbal conduct: making or using derogatory comments, epithets, slurs, sexually explicit jokes, or comments about an employee's body or dress.
   f) Verbal sexual advances or propositions.
   g) Verbal abuse of a sexual nature; graphic verbal commentary about an individual's body; sexually degrading words to describe an individual; suggestive or obscene letters, notes or invitations.
   h) Physical conduct: touching, assault, impeding or blocking movements.
   i) Retaliation for reporting harassment or threatening to report sexual harassment.

3) An employee may be liable for harassment based on sex even if the alleged harassing conduct was not motivated by sexual desire. An employee who engages in unlawful harassment will be personally liable for harassment even if TCHD had no knowledge of such conduct. TCHD cannot be liable for harassment complaints if it has not been brought to the attention of the employee's supervisor, Human Resources Department (HR) and/or the Compliance Department. Any harassing

conduct must be reported through the appropriate channels. TCHD discourages romantic or sexual relationships between co-workers because such relationships tend to create compromising conflicts of interest or the appearance of such conflicts. In addition, such a relationship may give rise to the perception by others that there is favoritism or bias in employment decisions affecting the staff employee which is prohibited. If a relationship exist that creates harassment or a conflict of interest, it must be reported to the supervisor, HR or the Compliance Department.

ii. Other Types of Harassment

1) Harassment on the basis of any legally protected characteristic, as identified above, is prohibited. Prohibited harassment may include behavior similar to the illustrations above pertaining to sexual harassment. This includes conduct such as:

a) Verbal conduct including threats, epithets, derogatory comments or slurs based on an individual's protected characteristic;

b) Visual conduct, including derogatory posters, photographs, cartoons, drawings or gestures based on protected characteristic; and

c) Physical conduct, including assault, unwanted touching or blocking normal movement because of an individual's protected characteristic.

3. Abusive Conduct Prevention

a. It is expected that TCHD and persons in the workplace perform their jobs productively as assigned, and in a manner that meets all of managements' expectations, during working times, and that they and refrain from any malicious, patently offensive or abusive conduct including but not limited to conduct that a reasonable person would find offensive based on any of the protected characteristics described above. Examples of abusive conduct include repeated infliction of verbal abuse, such as the use of malicious, derogatory remarks, insults, and epithets, verbal or physical conduct that a reasonable person would find threatening, intimidating, or humiliating, or the intentional sabotage or undermining of a person's work performance.

4. Protection against Retaliation

a. Retaliation is prohibited against any person by another employee or by TCHD for using TCHD's complaint procedure, reporting proscribed discrimination or harassment or filing, testifying, assisting or participating in any manner in any investigation, proceeding or hearing conducted by a governmental enforcement agency. Prohibited retaliation includes, but is not limited to, termination, demotion, suspension, failure to hire or consider for hire, failure to give equal consideration in making employment decisions, failure to make employment recommendations impartially, adversely affecting working conditions or otherwise denying any employment benefit.

5. Discrimination, Harassment, Retaliation and Abusive Conduct Complaint Procedure

a. Any employee who believes that he or she has been harassed, discriminated against, or subjected to retaliation or abusive conduct by a co-worker, supervisor, agent, client, vendor, customer, or any other third party interacting with TCHD in violation of the foregoing policies, or who is aware of such behavior against others, should immediately provide a written or verbal report to his or her supervisor, any other member of management, HR or the Compliance Department either directly, or through the Compliance Hotline. Employees are not required to make a complaint directly to their immediate supervisor, but they must report any conduct to the HR or Compliance Department. Supervisors and managers who receive complaints of misconduct must immediately report such complaints to the HR and/or the Compliance Department, who will attempt to resolve issues internally. When a report is received, TCHD will conduct a fair, timely, thorough and objective investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected. TCHD

expects all employees to fully cooperate with any investigation conducted by TCHD into a complaint of proscribed harassment, discrimination or retaliation, or regarding the alleged violation of any other TCHD policies. TCHD will maintain confidentiality surrounding the investigation to the extent possible and to the extent permitted under applicable federal and state law.

b. Upon completion of the investigation, TCHD will communicate its conclusion as soon as practical. If TCHD determines that this policy has been violated, remedial action will be taken, commensurate with the severity of the offense, up to and including termination of employment. Appropriate action will also be taken to deter any such conduct in the future.

c. All employees, regardless of their positions, are covered by and are expected to comply with this policy and to take appropriate measures to ensure that prohibited conduct does not occur. Appropriate disciplinary action will be taken against any employee who violates this policy. Based on the seriousness of the offense, disciplinary action may include verbal or written reprimand, suspension or termination of employment.

d. TCHD mandates that if any employee feels they are being harassed in any way, the employee must make a formal written complaint with HR and/or the Compliance Department. If an alleged victim does not report timely, TCHD cannot be held responsible for any alleged bad conduct. TCHD will courteously treat any person who invokes the complaint procedure, and will handle all complaints swiftly and confidentially to the extent possible in light of the need to take appropriate corrective action. Lodging a complaint will in no way be used against the employee or have an adverse impact on the individual's employment status. Because of the damaging nature of harassment to the victims and the alleged violator, and to the entire workforce, aggrieved employees are strongly urged to report immediately so that an immediate investigation can take place. However, filing groundless or malicious complaints is an abuse of this policy and will be treated as a violation. No formal action will be taken against any person under this policy unless HR and or the Compliance Department has received a written and signed complaint containing sufficient details to determine if the policy may have been violated.

B. **EXTERNAL LINK(S):**

1. Equal Employment Opportunity Commission https://www.eeoc.gov/
2. California Department of Fair Employment and Housing https://www.dfeh.ca.gov/

C. **REFERENCE(S):**

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

**TRI-CITY HEALTHCARE DISTRICT**
**BOARD OF DIRECTORS POLICY**

**BOARD POLICY #~~14~~19-041**

**POLICY TITLE: Board Policy On Public Information**

A. General Operations: The release of public information, except records requested under the Public Records Act, in situations relating to the general operations of the hospital are the responsibility of the Chief Executive Officer/President of TriCity Health Care District. Board members and staff shall forward all media and other public requests for information regarding operations of the District, except records requested under the Public Records Act, to the CEO or to the ~~Public Affairs and Marketing Department~~Chief Governmental & External Affairs Officer..

Notwithstanding the foregoing, Board members may respond independently to any request for public information, providing they make clear that they are speaking only as individuals and not on behalf of the organization.

Whenever feasible, the CEO shall ensure that press releases to be issued to the public are disseminated to the members of the Board prior to their public release, together with the expected date and time of the release (including any embargo conditions).

Contact information for the ~~Vice President of Public Affairs and Marketing~~Chief Governmental & External Affairs Officer, other members of the Marketing Department, and members of the Executive Management team (including but not limited to the Chief Operating Officer, Chief Compliance Officer, Chief Nursing Officer and Chief Financial Officer), and a brief description of their areas of responsibility and availability for public comment, will be distributed at least annually to Board members.

B. Emergencies: The Board recognizes that emergencies may arise from time to time making advanced release of press releases to the Board impracticable. In such instances, every effort shall be made to release statements to the Board concurrently with their release to the public.

In addition, at least annually the CEO, Public Safety Officer, or other designee will provide the Board with a briefing on the Hospital Incident Control System, including the protocols for emergency communications regarding District operations.

C. Confidentiality and Privacy: Every attempt will be made to assist the public in obtaining requested information in a timely and efficient manner, however, under HIPAA, the District is required to protect patient privacy, and may be required to obtain patient or family member consent before allowing public access to patients or any portion of the District's licensed facilities, or to provide information regarding current or former patients. Areas within the hospital facility which are located outside of the Board or Board committee meeting rooms, while such rooms are in active use for publicly-noticed meetings, are not open to the public or considered to be public forums for any purpose.

**Reviewed by the Gov/Leg Committee: 9/08/10**
**Approved by the Board of Directors: /30/10**
**Reviewed by the Gov/Leg Committee: 4/01/14**
**Approved by the Board of Directors: 4/24/14**
**Reviewed by Bylaw & Policy Ad Hoc Committee: 6/2019**
**Approved by Board of Directors:**

mcol
1101 Standiford Ave #C-3
Modesto, CA 95350
Tax ID: 77-0400000
209.577.4888

# Invoice

| Date | Invoice # |
|---|---|
| 5/9/2019 | 016111 |

Bill To

Tri-City Medical Center
Teri Donnellan
4002 Vista Way
Oceanside, CA 92056

| P.O. No. | Terms | Due Date | Account # |
|---|---|---|---|
| | Due on receipt | 5/9/2019 | |

| Description | Qty | Rate | Amount |
|---|---|---|---|
| Payers and Providers site license for up to 10 subscribers | | 219.00 | 219.00 |
| CA Sales Tax | | 7.625% | 0.00 |

Annual Subscription Fees - Aug2019-July2020

| | |
|---|---|
| **Total** | $219.00 |
| **Payments/Credits** | $0.00 |
| **Balance Due** | $219.00 |

mcol

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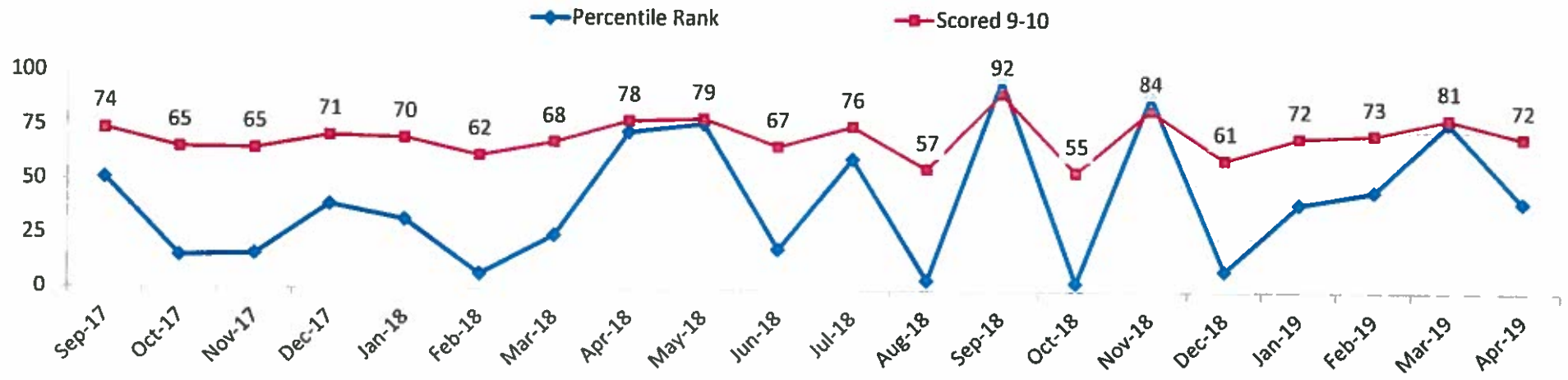
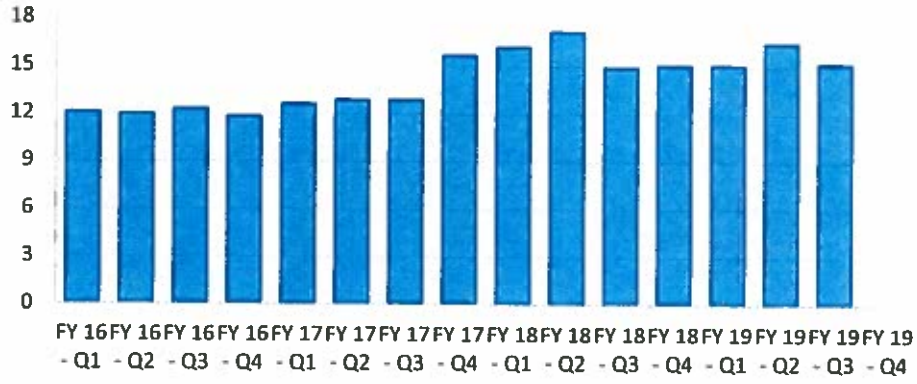
Payers & Providers / MCOL
1101 Standiford Ave., Suite C-3
Modesto, CA 95350
209.577.4888

## Stakeholder Experiences

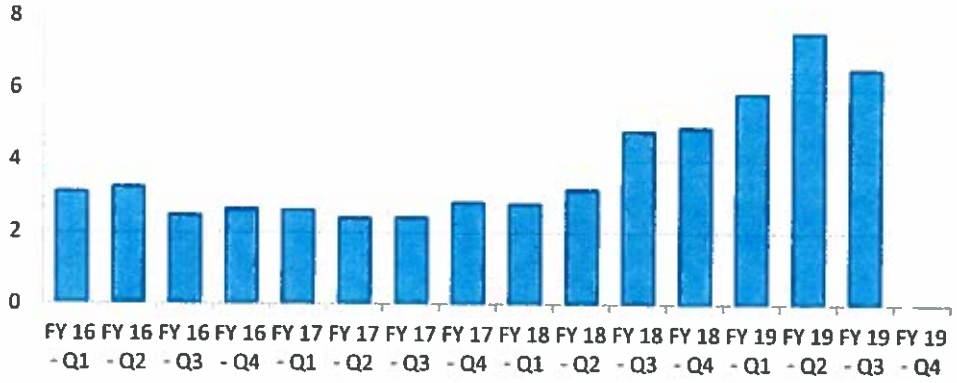
### Overall Rating of Hospital (0-10)




### Voluntary Employee Turnover Rate




### Involuntary Employee Turnover Rate



# 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 | 22 | 16 | 23 | 30 | 25 | | 251 |
| FY18 | 26 | 23 | 23 | 20 | 27 | 27 | 22 | 23 | 24 | 20 | 20 | 28 | 255 |

## 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 | 11 | 4 | 17 | 15 | 11 | | 108 |
| FY17 | 14 | 6 | 7 | 13 | 7 | 15 | 14 | 8 | 12 | 7 | 10 | 6 | 113 |

## 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 | 17 | 13 | 18 | 16 | 10 | | 165 |
| FY18 | 11 | 12 | 12 | 14 | 16 | 18 | 23 | 12 | 15 | 15 | 16 | 20 | 164 |

## 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 | 19 | 16 | 18 | 12 | 20 | | 206 |
| FY18 | 15 | 20 | 20 | 16 | 23 | 15 | 15 | 19 | 23 | 11 | 20 | 17 | 197 |

## 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 | 23 | 40 | 36 | 24 | 29 | | 345 |
| FY18 | 48 | 37 | 33 | 32 | 26 | 38 | 29 | 24 | 30 | 38 | 33 | 38 | 368 |

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 | - | - | - | - | - | - | - | - | | 2.9 |
| 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 | 14.3 |

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 | 6.8 | 8.4 | 7.2 | 5.8 | 4.4 | | 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 | 7.6 |

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 | 10.1 | 8.9 | 11.3 | 10.0 | 9.5 | | 10.2 |
| 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 | 12.7 |

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 | 164.8 | 166.3 | 157.7 | 142.4 | 143.3 | | 153.0 |
| 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 | 175.5 |

Deliveries

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY19 | 186 | 202 | 170 | 187 | 185 | 166 | 170 | 150 | 177 | 131 | 146 | | 1,870 |
| FY18 | 210 | 222 | 194 | 206 | 184 | 166 | 209 | 169 | 186 | 156 | 163 | 188 | 2,065 |

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 | 6 | 9 | 11 | 10 | 20 | | 106 |
| FY18 | 12 | 11 | 11 | 11 | 11 | 18 | 16 | 5 | 7 | 16 | 15 | 20 | 133 |

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 | 11 | 17 | 6 | 10 | 8 | | 94 |
| FY18 | 4 | 7 | 7 | 3 | 4 | 3 | 2 | 4 | 8 | 2 | 7 | 8 | 51 |

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 | 8 | 10 | 16 | 6 | 7 | | 95 |
| FY18 | 8 | 7 | 7 | 11 | 3 | 14 | 11 | 10 | 4 | 10 | 8 | 5 | 93 |

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 | 1.72 | 1.73 | 1.75 | 1.82 | 1.8 | | 1.78 |
| FY18 | 1.75 | 1.80 | 1.81 | 1.80 | 1.83 | 1.72 | 1.64 | 1.77 | 1.78 | 1.83 | 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 | 58.9 | 56.7 | 57.0 | 50.5 | 48.9 | | 52.7 | 48-52 |
| FY18 | 47.7 | 47.8 | 48.9 | 50.8 | 49.6 | 49.5 | 49.8 | 47.2 | 46.8 | 47.0 | 46.6 | 45.8 | 48.3 | |

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 | 93.1 | 92.2 | 83.6 | 84.1 | 91.4 | | 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 | 82.9 | |

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 | ($527) | $99 | $206 | $885 | $904 | | $1,919 | $4,253 |
| FY18 | ($394) | ($429) | ($224) | ($171) | ($2,571) | ($383) | ($1,242) | ($542) | ($337) | ($679) | ($408) | $3,118 | ($7,380) | |

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% | -1.76% | 0.34% | 0.67% | 2.89% | 2.88% | | 0.58% | 1.32% |
| 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% | -2.23% | |


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 | $826 | $1,468 | $1,548 | $2,219 | $2,221 | | $16,386 | $19,181 |
| FY18 | $898 | $864 | $1,091 | $1,146 | ($1,288) | $908 | $81 | $751 | $963 | $571 | $900 | $4,407 | $6,885 | |

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% | 2.76% | 5.07% | 5.00% | 7.25% | 7.07% | | 4.99% | 5.96% |
| 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% | 2.08% | |

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 | 6.68 | 6.52 | 6.71 | 7.27 | 7.29 | | 6.90 | 6.66 |
| 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 | 6.26 | |

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 | $36.3 | $32.9 | $20.6 | $40.7 | $57.1 | | |
| 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 May 31, 2019

| Lessor | Sq. Ft. | Base Rate per Sq. Ft. | | Total Rent per current month | LeaseTerm Beginning | Ending | Services & Location | Cost Center |
|---|---|---|---|---|---|---|---|---|
| **6121 Paseo Del Norte, LLC**<br>6128 Paseo Del Norte, Suite 180<br>Carlsbad, CA 92011<br>V#83024 | Approx 9,552 | $3.59 | (a) | 45,637.80 | 07/01/17 | 06/30/27 | **OSNC - Carlsbad**<br>6121 Paseo Del Norte, Suite 200<br>Carlsbad, CA 92011 | 7095 |
| **American Health & Retirement**<br>DBA: Vista Medical Plaza<br>140 Lomas Santa Fe Dr., Ste 103<br>Solona Beach, CA 92075<br>V#82904 | Approx 1,558 | $2.47 | (a) | 5,318.65 | 01/27/17 | 05/31/20 | **PCP Clinic - Venus**<br>2067 W. Vista Way, Ste 160<br>Vista, CA 92083 | 7093 |
| **Camelot Investments, LLC**<br>5800 Armada Dr., #200<br>Carlsbad, CA 92008<br>V#15608 | Approx 3,563 | $1.97 | (a) | 11,028.33 | 04/01/16 | 01/31/20 | **PCP Clinic - Radiance**<br>3998 Vista Way, Ste. C<br>Oceanside, CA 92056 | 7092 |
| **Cardiff Investments LLC**<br>2729 Ocean St<br>Carlsbad, CA 92008<br>**V#83204** | 10,218 | $2.58 | (a) | 31,550.62 | 07/01/17 | 06/30/22 | **OSNC - Oceanside**<br>3905 Waring Road<br>Oceanside, CA 92056 | 7095 |
| **Creek View Medical Assoc**<br>1926 Via Centre Dr. Suite A<br>Vista, CA 92081<br>V#81981 | Approx 6,200 | $2.76 | (a) | 21,112.00 | 02/01/15 | 01/31/20 | **PCP Clinic Vista**<br>1926 Via Centre Drive, Ste A<br>Vista, CA 92081 | 7090 |
| **CreekView Orthopaedic Bldg, LLC**<br>1958 Via Centre Drive<br>Vista, Ca 92081<br>**V#83025** | Approx 4,995 | $2.58 | (a) | 15,640.35 | 07/01/17 | 06/30/22 | **OSNC - Vista**<br>1958 Via Centre Drive<br>Vista, Ca 92081 | 7095 |
| **Elfin Investments, LLC**<br>Clancy Medical Group<br>20136 Elfin Creek Trail<br>Escondido, CA 92029<br>V#82575 | 3,140 | $2.62 | (a) | 9,867.81 | 12/01/15 | 12/31/20 | **PCP Clinic - Clancy**<br>2375 Melrose Dr. Vista<br>Vista, CA 92081 | 7091 |
| **Investors Property Mgmt. Group**<br>c/o Levitt Family Trust<br>2181 El Camino Real, Ste. 206<br>Oceanside, Ca 92054<br>V#81028 | 5,214 | $1.86 | (a) | 10,807.45 | 09/01/17 | 08/31/19 | **OP Physical Therapy**<br>**OP OT & OP Speech Therapy**<br>2124 E. El Camino Real, Ste.100<br>Oceanside, Ca 92054 | 7772 - 76%<br>7782 - 12%<br>7792 - 12% |
| **Melrose Plaza Complex, LP**<br>c/o Five K Management, Inc.<br>P O Box 2522<br>La Jolla, CA 92038<br>V#43849 | 7,347 | $1.35 | (a) | 10,101.01 | 07/01/16 | 06/30/21 | **Outpatient Behavioral Health**<br>510 West Vista Way<br>Vista, Ca 92083 | 7320 |
| **OPS Enterprises, LLC**<br>3617 Vista Way, Bldg. 5<br>Oceanside, Ca 92056<br>#V81250 | 4,760 | $4.24 | (a) | 26,713.00 | 10/01/12 | 10/01/22 | **Chemotherapy/Infusion Oncology Center**<br>3617 Vista Way, Bldg 5<br>Oceanside, Ca 92056 | 7086 |
| Total | | | | **$ 187,777.02** | | | | |

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

**Education & Travel Expense**
**Month Ending May 2019**

| Cost Center | Description | Invoice # | Amount | Vendor # | Attendees |
|---|---|---|---|---|---|
| 7320 | DIALECTICAL BEHAVIOR TRAINING | 50719 | 199.00 | 83477 | JOSIE SIDHU |
| 8390 | NPPA PHARMACY PURCHASING NETWORK CONFRENCE | 41619 | 300.00 | 83470 | LAURA BALL |
| 8390 | 340B ROUNDTABLE EDUCATION | 41719 | 172.06 | 79349 | TORI HONG |
| 8420 | CPI INSTRUCTOR RENEWAL | 184700 | 989.00 | 80934 | JONATHAN INGRAM |
| 8614 | AAOS 2019 ANNUAL MEETING | 32919 | 3,043.57 | 77376 | JEREMY RAIMO |
| 8650 | CBT EXAM | 4587639 | 1,283.00 | 74956 | ANNETTE MORRIS |
| 8710 | PHYSICIAN LEADERSHIP CONFRENCE/SEMINAR | 51719EXP | 3,588.74 | 77773 | VICTOR L. SOUZA, M.D. |
| 8710 | CPHQ CONFRENCE | 51519 EXP | 1,717.69 | 82501 | JAMES L JOHNSON |
| 8710 | ASER CONFERENCE | 51719 EXP | 714.55 | 82501 | JAMES L JOHNSON |
| 8740 | MASTER OF BUSINESS ADMINISTRATION | 51619 | 5,000.00 | 82133 | CELIA E GARCIA |
| 8740 | RN TO BSN TUITION REIMBUSEMENT | 50319EDU | 2,500.00 | 83269 | ANAYELI SOTO MAYA |
| 8740 | RN TO BSN TUITION REIMBUSEMENT | 52319EDU | 2,500.00 | 83487 | SARAH GEORGE |
| 8740 | BSN TUITION REIMBURSEMENT | 42619EDU | 2,000.00 | 83476 | CHERRY ANTOINE |
| 8740 | SOCIETY OF OTORHIN GOSQ. COM CLASS | 51019EDU | 200.00 | 38530 | BONNIE KLOTZLY |
| 8740 | PULMONARY REHABILITATION CERTIFICATE | 50319EDU | 200.00 | 65658 | MARGARET STRIMPLE |
| 8740 | INPATIENT OBSTETRIC NURSE | 51019EDU | 200.00 | 77472 | KRISTEN D'ELISEO |
| 8740 | NRP INSTRUCTOR RENEWAL | 51619 | 200.00 | 78876 | RONALD CLARKE |
| 8740 | ACLS RECERTIFICATION | 52319 EDU | 200.00 | 80176 | VICTOR MAGNO |
| 8740 | CRT/RRT REVIEW | 50319EDU | 200.00 | 83373 | JULIE DANIELS |
| 8740 | SKIN AND WOUND MANAGEMENT COURSE | 52319EDU | 200.00 | 83488 | CHRISTINE PALER |
| 8740 | ADVANCE CARDIAC LIFE SUPPORT | 51019EDU | 145.00 | 77849 | ERIN ENGLE |
| 8754 | ANNUAL SOUTHERN CA RISK MANAGEMENT CONFERENCE | 51019 | 1,159.59 | 83312 | MICHAEL D LEVINE |
| 8756 | PSH LEARNING COLLABORATIVE 2020-2019 | 50519EXP | 399.03 | 83102 | JACLYN HUNTER |
| 8758 | JOINT COMMISSION HOSPITAL ACCREDITATION ESSENTIALS | 50619 | 619.73 | 83225 | KELLY WELLS |

**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.