TRI-CITY HEALTHCARE DISTRICT AGENDA FOR A REGULAR MEETING December 12, 2019 – 2:30 o'clock p.m. Assembly Room 1 - Eugene L. Geil Pavilion Open Session – Assembly Rooms 2 & 3 4002 Vista Way, Oceanside, CA 92056

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|------------------|-----------|
| 1 | Call to Order | 3 min. | Standard |
| 2 | Approval of agenda | | |
| 3 | Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 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 (Authority: Government Code, Section 54957.7) | | |
| 5 | Motion to go into Closed Session | | |
| 6 | Closed Session | 1 Hour | |
| | a. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 1) Medical Acquisition Company vs. Tri-City Healthcare District Case No: 2014-00009108 2) Tri-City Healthcare District vs. Medical Acquisition Company Case No: 2014-00022523 | | |
| | b. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (1 Matter) | | (ii |
| | c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155) | | |
| | d. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: TBD | | |
| | e. Approval of prior Closed Session Minutes | | |

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

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

| | Agenda Item | Time Allotted | Requestor |
|----|--|------------------|----------------|
| 7 | Motion to go into Open Session | | |
| 8 | Open Session | | |
| | Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m. | | |
| 9 | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) | | |
| 10 | Roll Call / Pledge of Allegiance | 3 min. | Standard |
| 11 | Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications. | 2 min. | Standard |
| 12 | TCHD Foundation, Jennifer Paroly, President | 10 min. | Standard |
| 13 | October 2019 Financial Statement Results | 10 min. | CFO |
| 14 | New Business | | |
| | a) Consideration and possible action to elect Board of Director Officers for calendar year 2020 | 10 min. | Chair |
| i | b) Consideration of proposed 2020 Board Meeting Schedule | 5 min. | Chair |
| | c) Consideration to authorize the Chairperson to cast the ballot to fill eight open seats on the 16-member LAFCO Special Districts Advisory Committee. | 5 min. | Chair |
| 15 | Old Business – None | | |
| 16 | Chief of Staff | 10 min. | Chief of Staff |
| | a) Consideration of November 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on November 25, 2019. | | |
| 17 | Consideration of Consent Calendar | 5 min. | Standard |
| | Administrative & Board Committees | | |
| | (1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar. | | |
| | (2) All items listed were recommended by the Committee. | | |
| | (3) Requested items to be pulled <u>require a second</u> . | | |
| | (1) Administrative Committee | | |
| | a) Patient Care Policies & Procedures | | |

| Agenda Item | Time Allotted | Requesto |
|--|------------------|----------|
| Consent for Minors Policy Glucose Point of Care Testing using the Nova StatStrip Blood Glucose Meter Procedure Haloperidol IV Administration Standardized Procedure Needle Thoracentesis of Chest for Pneumothorax in Neonates Standardized Procedure (DELETE) Nursing Students Advanced Practice Policy Ordering Non-District Provided Services for Patients Policy | | |
| 7) Rapid Response Standardized Procedure b) Administrative Policies & Procedures 1) Photo Identification – 436 | | |
| c) Cardiology 1) Quality Improvement Policy Echocardiogram | | |
| d) Engineering Access to Secured Doors – 5009 Documentation of Site Facility Utility Systems – 2014 Engineering Disaster Response Plan – 4035 Fire Smoke Management System – 2015 Handling and Use of Compressed Gas Cylinders – 5007 Kitchen Hood Fire Extinguishing System 2012.1 Lockout Tagout Procedures 5003.1 Management of Portable Fire Extinguishers – 2012 Quality Assurance Plan – 7000 The Operation of the Hospital Electrical Distribution System – 5013 Use of Extension Cords – 5002 | | |
| e) Food and Nutrition 1) Food Service Restrictions for Infectious Disease 2) Protocols for Nutrition Care | | |
| f) Infection Control 1) Bed Bugs, Identification and Control 2) Bloodborne Pathogen Exposure Control Plan Policy 3) Construction 4) Waterborne Illness | | |
| g) Intensive Care Unit 1) Epicardial Pacing Wires Procedure | | |
| h) NICU1) Pulse Oximetry, NICU2) Transfer of Neonates and Infants | | |
| Rehabilitation Services Audiology Services Inpatient Rehabilitation Services – 801 Discharge Criteria – 501 Patient & Caregiver Education – 507 (DELETE) Pre-Op Teaching Speech Pathology Services Department Policy – 802 Supervision Requirements of Minors During Outpatient Rehabilitation | | |

(DELETE)

7) Use of Encrypted E-mail for Outpatient Rehab Services

| | Agenda Item | Time Allotted | Requestor |
|---|---|------------------|--------------------------------|
| | j) Rehabilitation Center (Acute Rehabilitation Unit) 1) Ethical Code of Conduct 2) Inpatient Rehabilitation Center Admission, Continued Stay and Discharge Criteria 3) Interdisciplinary Plan of Care 4) Interdisciplinary Team Conference 5) Mission Statement, Goals and Objectives 6) Patient/Family Conferences 7) Policies and Procedures 8) Pre-Admission Screening 9) Utilization Review Plan | | |
| | k) Women & Newborn Services1) Breast Milk Misadministration2) Discharge Process | | |
| | (2) Board Committees | | |
| | A. Community Healthcare Alliance Committee Director Chavez, Committee Chair (No meeting in November/December, 2019) | | CHAC Comm. |
| | B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 (No meeting in December, 2019) | | FO&P Comm. |
| | C. Professional Affairs Committee Director Reno, Committee Chair (No meeting held in November/December, 2019) | | PAC |
| | D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 1 (No meeting held in November/December, 2019) | | Audit, Comp. 8 Ethics Comm. |
| | (3) Minutes – Approval of: | | Standard |
| | a) October 31, 2019 - Regular Meeting b) October 31, 2019 - Special Meeting c) October 24, 2019 - Special Meeting d) November 12, 2019 - Special Meeting | | |
| | (4) Meetings and Conferences – None | | |
| | (5) Dues and Memberships - None | | |
| 1 | (6) Reports (a) Dashboard - None (b) Construction Report - None (c) Lease Report - (October, 2019) (d) Reimbursement Disclosure Report - (October, 2019) (e) Seminar/Conference Reports - 1) HASDIC Annual Meeting - Director Schallock | | |

| la | Agenda Item | Time Allotted | Requestor |
|----|---|--------------------|-----------|
| 18 | Discussion of Items Pulled from Consent Agenda | 10 min. | Standard |
| 19 | Comments by Members of the Public 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 |
| 20 | Comments by Chief Executive Officer | 5 min. | Standard |
| 21 | Board Communications (three minutes per Board member) | 18 min. | Standard |
| 22 | Report from Chairperson | 3 min. | Standard |
| 23 | Total Time Budgeted for Open Session | 1 hour/ 45 min. | |

Adjournment

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TCHD BOARD OF DIRECTORS MEETING SCHEDULE CALENDAR YEAR 2020

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m. Closed Session to begin at approximately 1:30 p.m. (depending on agenda items) and again immediately following Open Session, if needed

- January 30, 2020 (Last Thursday)
- > February 27, 2020 (Last Thursday)
- March 26, 2020 (Last Thursday)
- ➤ April 30, 2020 (Last Thursday)
- May 28, 2020 (Last Thursday)
- June 25, 2020 (Last Thursday)
- July 30, 2020 (Last Thursday)
- August 27, 2020 (Last Thursday)
- > September 24, 2020 (Last Thursday)
- No meeting in October due to November General Election
- November 12, 2020 (Thursday) −
- > December 10, 2020 (Second Thursday in December)

<u>Special Board of Directors Meeting – June 11, 2020</u> Budget Meeting

2020 Dates to Note:

- ➤ AHA Annual Meeting April 19-22, 2020
- ➤ General Election November 3, 2020
- Board Swearing In Ceremony Friday, December 4, 2020

| Proposed | Schedule: | December | 12, | 2019 | |
|----------|-----------|----------|-----|------|--|
| Approved | by BOD: | | | | |



BALLOT FORM

November 4, 2019

TO:

Independent Special Districts in San Diego County

FROM:

Tamaron Luckett, Executive Assistant

SUBJECT:

Ballot Form | Election to Special Districts Advisory Committee

On August 12, 2019, the San Diego Local Agency Formation Commission (LAFCO) solicited nominations pursuant to Government Code Section 56332(1) to fill eight open seats on the 16-member Special Districts Advisory Committee. A total of eleven nominations were received following a 60day filing period. All terms on the Advisory Committee are four-years.

San Diego LAFCO is now issuing ballots to all 58 independent special districts in San Diego County and inviting each district to cast a ballot selecting up to eight eligible nominees. Write-in candidates are permitted, and spaces have been provided for that purpose. Only cast one vote for each nominee on the ballot and vote certification form; a ballot that is cast for more than indicated number of positions the vote will be disregarded. The ballot and vote certification form along with nominee resumes provided by the candidates are attached.

State Law specifies a district's vote is to be cast by its presiding officer, or an alternate member designated by the board and a valid signature is required on the ballot. A ballot received without a signature will be voided. A minimum of 30 ballots must be received to certify that a legal election was conducted. A candidate for a special districts advisory committee member must receive at least a majority of the votes cast to be elected. The ballots will be kept on file in this office and will be made available upon request.

Ballots may be submitted by mail, courier, hand delivered, FAX or via email to tamaron.luckett@sdcounty.ca.gov. The deadline for receipts of the ballots by LAFCO is Monday, January 6, 2020, any ballots received after the deadline will be voided. All election materials are available on the website: www.sdlafco.org.

Should you have any questions, please contact me at (858) 614-7755.

Attachments:

- a) Ballot and Vote Certification Form
- b) Nominees resumes

Administration Keene Simonds, Executive Officer Collect of San Diego County Operations Center 9335 Hazard Way, Suite 200 San Diego, California 92123 T 858 614 7755 F 858.614 7766 www.sdlafco.org

ATTACHMENT A SPECIAL DISTRICTS ADVISORY COMMITTEE MEMBER ELECTION BALLOT and VOTE CERTIFICATION

| VOTE | FOR C | DNLY EIGHT NOMINEES | | | |
|-----------|----------|--|--------------------|---|---------------|
| Richar | rd S. V | Villiamson (Yuima Municipal Water Distri | ct) | Ţ | Г |
| Micha | iel (Mi | ke) Sims (Bonita-Sunnyside Fire Protecti | on District) | | <u>-</u> Г |
| | | (Fallbrook Public Utility District) | · | | - [|
| James | E. Go | rdon (Deer Springs Fire Protection Distri | ct) | | - [|
| | | mas (Pomerado Cemetery District) | • | 1 | - |
| Albert | C. La | a (Santa Fe Irrigation District) | | | - |
| Thoma | as (To | m) Kennedy (Rainbow Municipal Water | District) | | |
| Courtn | ney G. | Provo (Mission Resources Conservation | District) | ı | |
| Kimbe | erly A. | Thorner (Olivenhain Municipal Water Di | strict) | | |
| Brian B | Bogge | In (Alpine Fire Protection District) | | [| |
| Mark F | Robak | (Otay Water District) | | [| |
| l hereby | certify | that I cast the votes of the | (Name of District) | | |
| for the S | pecial I | Districts Advisory Committee Election as: | (Name of District) | | |
| [|] | the presiding officer, or | | | |
| [|] | the duly-appointed alternate board member. | | | |
| (Signatur | re) | | | | |
| (Print na | me) | | | | |
| (Title) | | | | | |
| | | | | | |
| (Date) | | | | | |

proceed with voting as they see fit. Additionally, a candidate's forum is tentatively scheduled for November 21, 2019 as part of the quarterly meeting of the San Diego Chapter of the California Association of Special Districts.

Return Ballot and Vote Certification Form to:

San Diego LAFCO
Tamaron Luckett
9335 Hazard Way, Suite 200
San Diego, CA 92123
(858) 614-7755 (office) · (858) 614-7766 (FAX)
Email: tamaron.luckett@sdcounty.ca.gov

^{*} Incumbent member

RICHARD S. WILLIAMSON

· 951-297-0373

richwmson@gmail.com

EXPERIENCE

1979 - 1982

DRINKING WATER PROGRAM MANAGER, STATE OF ARIZONA, DHS

- Developed program Regulations and Compliance Strategies for the State's compliance with the Safe Drinking Water Act.
- Managed State's implementation of Electronic Data Processing of program data.
- Coordinated with the Governor's office on the implementation of the Groundwater Management Act and contracts for the use of Central Arizona Project water.

1982 - 1985

GENERAL MANAGER/DISTRICT ENGINEER, NORTHERN GILA COUNTY SANITARY DISTRICT

- Managed construction of new innovative nutrient removal plant.
- Obtained grant funds for project, and negotiated a waiver from more restrictive standards.
- Developed Strategic Plan, budgets, policies, built reclaimed water line which eliminated any stream discharge from the facility.

1985 - 2002

PRESIDENT/CHIEF EXECUTIVE OFFICER, UTILITY SYSTEMS GROUP, INC.

- Formed first Contract Operations firm in Arizona for water and wastewater systems, which managed municipal and private water and wastewater facilities.
- Purchased twenty-seven water and wastewater utility companies and became largest
 Arizona-owned private provider of water and wastewater services in the State.
- This Holding Company owned the utilities cited above, as well as providing for contract operations services, engineering consulting and licensed contracting for treatment, pipeline and excavation projects.

2002 - 2006

PLANNING AND ENGINEERING MANAGER, TUCSON WATER DEPARTMENT

- Oversaw development of the City of Tucson 50-year Water Plan.
- Coordinator between the Water Department and the Mayor's office, as well as the liaison with the Pima County Wastewater Management Department.
- Negotiated over \$200 million in system improvements with area developers to allow for extension and improvements in service.

2006 - 2008

GENERAL MANAGER, RED ROCK UTILITIES, INC.

- Developed all the administrative and field protocols for this start-up utility.
- Served new communities developed by the parent company.
- The housing collapse in 2007 and 2008 slowed growth in this company, and left for more active challenges and opportunities with a new position.

2008 - 2010

GENERAL MANAGER/DISTRICT ENGINEER, BORREGO WATER DISTRICT

- Initiated a series of studies to determine the water supply sustainability of the Borrego groundwater basin which determined community only had a 35-year supply.
- Developed new Strategic Plan and partnerships with federal and local water agencies to address the water supply sustainability issues.
- Directed the consolidation of the District with a smaller Community Services District and took over wastewater, recreation, and solid waste services in the community.

2010 - 2015

ASSISTANT GENERAL MANAGER, RANCHO CALIFORNIA WATER DISTRICT

- Responsible for filling in for the General Manager in his absence for this utility located in Temecula, CA.
- Primary responsibilities included development and implementation of the District's Strategic Plan, oversight of the Integrated Water Resource Management Planning efforts in Southern Riverside County, manage the Water Conservation program, coordinate activities with other local agencies including federal, state and local governments.
- Direct oversight of the District's Groundwater Management efforts, and author of the Groundwater Protection Plan for the area.

2015 - 2017

WATER UTILITY MANAGER, CITY OF CARLSBAD, CA

- Overall responsibility for the operation and maintenance of the City's water and reclaimed water activities.
- Coordinated with Mayor's office on regional issues.
- Developed and managed water conservation program during the severe drought that California experienced during this period.

2017 - PRESENT

GENERAL MANAGER/DISTRICT ENGINEER, YUIMA MUNI, WATER DISTRICT

- Total administrative and operations responsibility to the Board of Directors.
- Assisted with development of the Groundwater Sustainability Agency (GSA). Serve as Administrator of the GSA
- Oversee Capital Improvements program; setting policies and insuring consistency with the District Strategic Plan.

EDUCATION

JUNE, 1975

WATER RESOURCES ENGINEERING, UNIVERSITY OF CALIFORNIA, LOS ANGELES

APRIL, 1979

MASTER BUSINESS ADMINISTRATION, GOLDEN GATE UNIVERSITY

20 units of credits toward degree, when transferred to Arizona. Specialized in organizational behavior, accounting and marketing.

SKILLS

- Strategic Planning for Organizations in the Infrastructure Sector.
- Excellent Communication Skills, with experience in Expert Witness Testimony and Seminars.
- Results driven with integrity and experience
- Strong Governmental and Private Sector experience
- Team organizer to address all facets of an issue in the Industry.
- Utilization of Networking from experience in the geographic area and subject matter.

REGISTRATIONS AND LICENSES

- Registered Civil Engineer (California and Arizona)
- Registered Land Surveyor (California and Arizona)
- Certified Water System Operator (Arizona) non-active status
- Certified Wastewater System Operator (Arizona) non-active status
- Licensed Commercial Contractor, Pipelines, Treatment Plants, Excavation (Arizona) non-active

Michael Sims

(619) 479-2346

msims@bonitafd.org 4900 Bonita Road, Bonita CA 91902 Bonitafd.org

Objectives

Serve on the LAFCO Special District Advisory Committee

Education

Bachelor Degree in Public Administration

Experience

Fire Chief

Bonita Sunnyside Fire Protection District

Hired in 1995 as a firefighter and worked through the ranks of Captain, Deputy Chief and was selected as Fire Chief in 2018

Special Assignments

San Diego County Fire Chiefs Liaison to the County Training Officers Section

San Diego County Fire Chiefs - Executive Board - Member at Large

As the past Chair of County Training Officers Section I helped to revitalize countywide participation and collaboration on all manor of training topics in our local fire service by investing in and utilizing the vast talents of the fire training officers in our region.

FAIRA Board Member

PASIS Board Member

SUMMARY:

Over twenty years experience in the management of operations, design and planning of water and wastewater infrastructure, including water treatment, distribution and wastewater collections and reclamation facilities. Oversee entire District operation with a staff of 68 FTE's with 11 direct reports in my current position as both General Manager for the Fallbrook Public Utilities District.

EXPERIENCE:

Fallbrook Public Utilities District

9/2017-Present

General Manager

Oversee all District functions including Finance, Customer Service, Public Relations, Human Resources, Operations, and Engineering. Responsible for establishing a productive and positive work environment. Facilitates development and implementation of the Board of Directors overall vision for the District. Communicates and Coordinates District operational needs with the Board of Directors.

EXPERIENCE:

Fallbrook Public Utilities District 2013-Present Assistant General Manager/District Engineer

Oversee all operations, engineering and planning functions of the District including maintenance/construction, meter services, purchasing, water system operations and wastewater treatment/water reclamation. Responsible for Planning and setting goals for each department and monitoring performance. Responsible for developing and implementing all capital projects.

EXPERIENCE:

Fallbrook Public Utilities District 2009-2013 **Engineering and Planning Manager**

Served as the head of Engineering and Planning Department. Responsible for planning and overseeing all capital improvements projects for the District Facilities and supporting wastewater and water Operations. The projects include a new groundwater treatment plant and major wastewater reclamation plant rehabilitation as well as water distribution, storage and wastewater collections construction.



Malcolm Pirnie, Inc.

2000-2009

Environmental Engineering Consulting Sr. Project Engineer/Project Manager

Served as project Manager and/or Design Manager on 5-10 projects at any time. Managed overall project budget and resources for projects. Coordinated design and start-up with operations staff. Responsible for technical quality on numerous design projects valued at \$6 to \$50 million dollars in construction. Developed planning studies for facilities or agencies to guide future improvements, detailed design drawings for civil and mechanical and instrumentation and control disciplines and oversee construction of facilities.

EDUCATION:

California State University - San Marcos

2005-2007

Masters of Business Administration

University of Illinois at Urbana-Champaign

1998-2000

M.S. Environmental Engineering

Washington and Lee University

1994-1998

B.S. Physics-Engineering

LISCENCES:

Professional Civil Engineer, State of California.

Grade 4 Water Distribution Operator Grade 4 Water Treatment Operator Grade 4 Wastewater Treatment Operator

PROFESSIONAL ORGANIZATIONS/COMMITTEES:

American Water Works Association – Chair of the Management and Leadership Division: as chair of the Division lead efforts to plan, develop and review standards, manuals and presentations for industry best practices for utility management.

San Diego LAFCO - Advisory Group Member

ACWA, CSDA, WateReuse, California Water Environment Association - Member San Diego County Water Authority - Board Member



James E. Gordon Director, Deer Springs Fire Protection District 415.852.1086

Jegordon888@gamail.com

Professional History

- Director, Berkeley Research Group; October 2012 to 2014
- Managing Director, Navigant Consulting Asia; March 2005 to October 2012.
- Vice President of Pinkerton Consulting & Investigations; March 2001 to March 2005.
- Executive Vice President and CEO of OnlineSecurity; March 2000 to March 2001.
- Managing Director of Kroll Associates; March 1999 to March 2000.
- Managing Director of The Investigative Group, Inc.; June 1990 to March 1999.
- Partner, Philips & Gordon, Litigation Consulting Firm: May 1980 to June 1990.

Former Professional Associations

- American Bar Association (Associate Member)
- · Inter-Pacific Bar Association
- High Technology Crime Investigator Association (HTCIA)

Professional Designations

- Licensed Private Investigator in California
- Chartered Life Underwriter (CLU0)

James Gordon retired in 2014 after a successful international consulting career and is serving his second term (till 2022) as a Director of the Deer Springs Fire Protection District. Mr. Gordon's professional career includes more than 25 years of experience and expertise advising clients faced with complex high stakes business disputes, litigation and investigations, especially in cross-border matters. Mr. Gordon has served as a consulting and testifying expert as well as a third-party neutral in a diverse range of business and discovery disputes.

Mr. Gordon was based in Hong Kong from 2009 to 2012 as Managing Partner for a global expert services and consulting firm. Mr. Gordon was the consulting expert and project lead on a diverse range of complex matters, including: special committee forensic investigations for Boards of U.S. listed Chinese companies; cross-border discovery; allegations of business fraud; undisclosed related third party asset transfers; Foreign Corrupt Practices Act (FCPA) investigations; deep-dive M&A and FCPA due diligence; international arbitration; royalty disputes; intellectual property rights (IPR); and dumping/trade issues.

Mr. Gordon worked on many of the highest-profile regulatory and enforcement investigations in US history, including: the Wall Street IPO Securities Litigation; Tyco; WorldCom; Parmalat; HealthSouth; and Enron. His work involved matters throughout Asia, China, Canada, UK and the United States

advising clients and their counsel in responding to investigations by: U.S. Department of Justice (DOJ); Securities and Exchange Commission (SEC); Federal Energy Regulatory Commission (FERC); the New York Stock Exchange (NYSE); NASDAQ; Federal Trade Commission (FTC); United States International Trade Counsel (USITC) and Congressional and Senate Investigations.

Mr. Gordon was a frequent presenter at In-House Corporate Counsel events, American Bar Association conferences and at the International Pacific Bar Association on topics critical to managing business risks and resolving cross-border disputes including; "Anti-Corruption and Fraud Investigations in Asia," Managing Counterparty Business Risk with Business Intelligence and Analytics," "Developing Cost Effective Strategies for Managing Cross-Border Discovery," "Electronic Discovery in Asia-U.S. Cross-Border Disputes," and "Evidentiary Issues in CIETAC Arbitrations."

Representative Client Assignments

Special Committee Investigation for Chinese Board of US Listed Company

• For a US listed Chinese company, Mr. Gordon was retained by the Board of Directors to conduct an internal investigation in response to whistle blower allegations. Mr. Gordon led an extensive investigation throughout China to drill down on allegations of accounting irregularities; numerous dealings with related undisclosed third parties; and the sale of one of the company's manufacturing facilities that was not an arm's length transaction. Based on Mr. Gordon's investigation, the company restated its financial statements, changed auditors and Mr. Gordon presented his team's findings to US based regulatory agencies.

Audit Committee Internal Bank Investigation

Mr. Gordon worked with the bank's general counsel and the auditors pertaining to a wideranging internal investigation which included: investigating whistle blower allegations; an
in-depth information technology review; investigation of an external data breach; and
investigation of internal misconduct. The summary of Mr. Gordon's findings was provided to
numerous regulatory and law enforcement agencies as well as the AMEX and NASDAQ stock
exchanges resulting in no adverse impact to the client.

Major US Financial Institution - Breach of Contract Dispute

• Mr. Gordon was retained as the Court appointed Third-party Neutral Expert in a matter pertaining to allegations of a breach of an Insurance Recovery Agreement for thousands of real estate properties owned by the bank. Mr. Gordon led a team in analyzing hundreds of millions of fields of data from disparate sources including bank loan foreclosure and real estate owned ("REO") property records, asset manager records, hazard insurance recovery provider data, and insurance claims. The case successfully resolved within a week of Mr. Gordon's testimony.

Robert Thomas POMERADO CEMETERY DISTRICT

14361 Tierra Bonita Road Poway, CA 92064 858.748.5760 bobtpcd@gmail.com

RE: Resume for Special District Advisory Committee

To Whom It May Concern:

August 28, 2019

My professional career consists of working in local government for twenty-seven years in both northern and southern California.

The last year thirteen years before I retired, I was the Community Services Director for the City of Poway overseeing the parks, recreational and cultural activities of the City.

I have been a Trustee of the Pomerado Cemetery District since 2004 appointed by the San Diego County Board of Supervisors. Dearborn Cemetery is a public cemetery serving the communities of Poway, Rancho Bernardo, and portions of North County and Inland San Diego.

I am now completing my first four year term on the Special District Advisory Committee.

Sincerely,

Robert Thomas

Albert C. Lau, P.E., MBA

Qualification Summary

Over 25 years of progressively responsible and successful engineering, planning, and utility management experience, including 18 years in leadership and senior management capacity overseeing in-house staff, consultants, and contractors. In my current position as the General Manager with Santa Fe Irrigation District, I am responsible for interfacing with elected officials, regulatory agencies, and other public agencies. I am also responsible for, under direction of the Board of Directors, planning, organizing, directing and reviewing the overall activities and operations of the District. I receive policy direction from the Board of Directors, and advise and assist the Board of Directors. Additionally, I represent the District's interests at local, regional, State and Federal levels, and coordinates activities with outside agencies and the community.

Education

- M.B.A. (2004), San Diego State University, San Diego, CA
- M.S. Civil Engineering (1994), University of Colorado, Boulder, CO
- B.S., Civil Engineering (1992), California Polytechnic State University, Pomona, CA

Professional Experience

| Position/Employer/Dates | Dates | Responsibilities |
|--|-----------------------|--|
| General Manager Santa Fe Irrigation District Rancho Santa Fe, CA | March '19 to present | Directly responsible for the development of District-wide work plans; assign work activities, projects and programs. |
| Director of Engineering and Planning Padre Dam Municipal Water District Santee, CA | July '9' to March '19 | Member of the executive team for PDMWD. Successful re-organized the department to improved efficiency and effectiveness that has received numerous project awards. |
| Engineering Manager Padre Dam Municipal Water District Santee, CA | Sep '00 to July '09 | Directly responsible for capital project implementation and increased the quality, timeliness, responsiveness, efficiency, and overall production of my working group. |
| Senior Engineer Dudek & Associates Encinitas, CA | Apr '98 to Sep '00 | Project manager/engineer consistently completed assignments/ projects on time and within budget. Maintained strong working relationships with public agencies and clients. |
| Project Manager/Engineer Tetra Tech, Inc. San Diego, CA | July '94 to Apr '98 | Project engineer in charge of civil works for various projects. |

Key Accomplishments

- Provided leadership, under policy directions from the Board of Directors, to develop a fair and equitable rate structure that would fit the unique and diverse consumption profile of Santa Fe Irrigation District.
- Directed the implementation of the East County Advanced Water Purification Program, a partnership between Padre Dam, County of San Diego, Helix Water District and City of El Cajon. This is a \$500M surface water augmentation program, one of the first in the State of California. This regional water supply program will produce up to 30% of East San Diego County drinking water supply locally and provide long term price certainty and enhance local control for the program partners. To date, this program had received

- approximately \$40M in grants and over \$101M in State Revolving Fund and received conditional regulatory approvals. Served as media spokesperson for interviews and conducted key elected official briefings.
- Served on the statewide advisory panel for the State Water Resources Control Board and Division of Drinking Water to investigate and report to the Legislature on the feasibility of developing uniform water recycling criteria for direct potable reuse and reservoir augmentation.

Professional Memberships, Registration, and Certifications

- Registered Professional Engineer Civil (CA 59053)
- ♦ Member, American Society of Civil Engineers (ASCE)
- Committee member, Water and Environment Committee, ASCE region 9
- Member, American Water Works Association (AWWA)
- Committee member, CA-NV AWWA, Advanced Water Operator Certification Committee
- Member, Water Reuse Association
- Member, Water Environment Federation & California Water Environmental Association
- Member, California Special District Association (CSDA)

Recent Professional Recognitions, Publications, and Presentations

- 2016 Leadership Award, Water Environmental Federation, White House Water Summit.
- WateReuse California (2017) "Maximizing Disinfection Infrastructure for Both Potable and Non-Potable Reuse", San Diego, CA, in March, 2017.
- IWA International Conference on Water Reclamation and Reuse (2017) "Modifying Existing Infrastructure to Maximize Pathogen Control for Potable and Non-Potable Reuse", Long Beach, CA in July, 2017.
- WateReuse Symposium (2017) "Potable Reuse Case Study for Full-scale Predesign of RO with 95% Recovery", Phoenix, AZ in September, 2017.
- Lau, A., Huston, P. & Pecson, B., 2016. Padre Dam's Advanced Water Purification Program: Building a Better Future Inspired by Creativity from the Past. J. - AWWA, 108:11:68.
- IWA International Symposium: Potable Reuse (2016) "Reducing the Need for the Environmental Buffer: Results from Padre Dam's Advanced Water Purification Testing", Long Beach, CA, in January, 2016.
- WateReuse California (2016) "Dual Pursuit of Surface Water Augmentation and Groundwater Recharge at Padre Dam", Santa Rosa, CA, in March, 2016.
- WateReuse Symposium (2016) "Maximizing Product Water through Brine Minimization", Tampa, FL in September, 2016.
- AWWA California-Nevada Annual Fall Conference (2016) "Maximizing Product Water through Brine Minimization", San Diego, CA in October, 2016.
- WateReuse California (2015) "Breaking IPR Boundaries at Padre Dam's Advanced Water Purification Demonstration Project" by Brian Pecson, Los Angeles, CA, in March, 2015.
- AWWA Annual Conference and Exhibition (2015) "Pushing the Boundaries of IPR at Padre Dam's Advanced Water Purification Demonstration Project", Anaheim, CA, in June, 2015.

Thomas Kennedy

tkennedy@rainbowmwd.com 760-728-1178

KEY ATTRIBUTES

Experienced practitioner regarding all things related to Special Districts. Deep understanding of LAFCO laws and intergovernmental relations.

EDUCATION

Bachelor of Science, Aerospace Engineering, with emphasis on Flight Mechanics and Propulsion, San Diego State University, 1989

Masters in Public Administration, with emphasis in Public Finance, California State University at Fullerton, 2000

EMPLOYMENT

2014 TO CURRENT General Manager, Rainbow Municipal Water District

2007 TO 2014 (and 1999 TO 2005)
Operations Manager, Olivenhain Municipal Water District

2006 TO 2012

Non-Revenue Water Consultant (Offshore projects - side work)

2005-2006

Vice President, Business Solutions, Nobel Systems

2003 - 2006

Water Treatment Plant Design Consultant (US based projects - side work)

1999 TO 2005

Operations Manager, Olivenhain Municipal Water District

1991 - 1999

Water Superintendent, City of Vernon

AFFILIATIONS

President, San Diego Chapter of the California Special Districts Association – 2016 to present Member, San Diego LAFCO Special District Advisory Committee – 2015 to present Member, San Diego County Water Authority Board of Directors, 2015 to present Advisory Member CSDA Formation and Reorganization Expert Feedback Team President, Bonsall Rotary (2018-2019)
Former Chairman of the GE Water and Process Technology Drinking Water User Group Member American Water Works Association serving on several National Committees

COURTNEY G. PROVO

Courtneyrios@gmail.com | (760) 310-0161

Executive Management

Strategic Planning • Public Sector Engagement • Budget Development • Contract Administration

PROFILE SUMMARY

Accomplished executive with extensive experience in the public sector. Highly skilled in planning, organizing and implementing functions from conception to completion, including business retention, business attraction and diversified programs. Regularly coordinates with various political subdivisions to facilitate change in the community to support organizational objectives. Possess adept skills in budgeting, management of operational services, interdepartmental project supervision, and human resources. Review of analytical data and delivering information in a comprehensible manner. Strong background in relationship management, and team building.

WORK EXPERIENCE

MISSION RESOURCE CONSERVATION DISTRICT General Manager, July 2018 – Present

- Strengthening the District's visibility through proactive networking, community engagement, workshops and public presentations.
- Works directly with diverse stakeholders, including other conservation districts, local, state and federal agencies.
- Directs all services and activities of the District, that includes the expanding and diversifying of staff and additional program opportunities.
- Supervising grant and contract activities such as monitoring deliverables; development and coordination of staff and sub-contractors and building relationships with internal & external stakeholders to sustain future efforts.
- Analyzing of existing economic conditions relative to business operations and program expansion; reviewing modern techniques for implementation to increase employee retention and streamlined operations.
- Coordinating with other agencies to leverage program development and further grant opportunities.
- Preparation of requests for proposal for necessary contract work, including the interview process and compliance with all provisions concerning public works and prevailing wage.
- Development of business proposals to secure District contracts, that consists of proposal presentations, contract negotiations and ongoing monitoring of deliverables.
- Coordinating with various departments in preparation of the District's annual budget, including fiscal year-end activities.
- Implementing necessary marketing efforts to increase visibility of the District's programs
- Monitoring of the District's day-to-day activities and reports directly to the Board of Directors.
- Preparation of monthly Board reports and regular attendance to all meetings, including the preparation of agendas, recommendations with supporting materials and corresponding meeting minutes.

COLLINS COLLINS MUIR + STEWART Legal Assistant, March 2016 – June 2018

- Works directly with Partner and Associate level attorneys at varying skills levels and managing their day-to-day calendars and cases.
- Responsible for overseeing status of all pending case deadlines to ensure both legal compliance and timely submittal.
- Conducts research concerning State and Federal rules to ensure compliance with submission of legal pleadings.
- Reviews and edits pleadings prior to submittal to State, Federal, Appellate and Supreme Courts.
- Collaborates with multiple attorneys and staff on as-needed work with little to no direction.

SEMNAR & HARTMAN LLP

Legal Assistant/Office Manager, May 2013 - March 2016

- Manages all office operations and day-to-day activities, included, but not limited to hiring and training of additional personnel.
- Maintains various attorney's calendars; calendaring all appearances and corresponding deadlines.
- Researching all applicable local State and Federal rules to ensure proper compliance with jurisdictional authority.
- Maintain client accounts and expenses; assists in firm bookkeeping.
- Responsible for maintaining the life cycle of an entire caseload from conception to completion, which includes overseeing all pending deadlines and maintaining client retention.

KHASHAYAR LAW GROUP

Legal Assistant/Office Manager, August 2008 - March 2016

- Development and implementation of a records management system.
- Corresponds with diverse individuals and administrations; attorneys, staff, clientele and various government agencies.
- Manages attorney's day-to-day calendar and caseload to ensure timely completion of pending projects, in addition to daily office maintenance and activities.
- Prepares and reviews all pleadings and other legal correspondence prior to submission.
- Researches local authority to ensure compliance with legal process and procedure.

EDUCATION
MA, Public Administration
Ashford University

BS, Criminal Justice Administration University of Phoenix

Kimberly A. Thorner, Esq. Carlsbad, CA 92009 kthorner@olivenhain.com

| NATION | ALITY | |
|---------|---|-------------|
| | US Citizen, Born on US Army Base, Berlin, Germany | |
| SKILLS | | |
| | - Chief Executive Officer - Public Agency Manager - Lawyer - Legislative Advocate - Project Manager - Community Relations - Financial Management | |
| EXPERIE | NCE | |
| | Olivenhain Municipal Water District, Encinitas, CA General Manager - Management of approx. half billion dollar net worth public agency - Water Supply Planning, Treatment and Maintenance, Wastewater Recycled Water - Parks and Recreation - Legal - Financial - Engineering - Human Resources - Legislative (State & Federal) - Community Relations - Risk & Safety Olivenhain Municipal Water District, Encinitas, CA Assistant General Manager - Management of public agency - Oversight of main functions of District | |
| | Olivenhain Municipal Water District, Encinitas, CA Project Manager - Project Management - Constructed World's Largest Immersed Membrane Treatment Plant - Project Team on the Olivenhain Dam - Environmental Compliance - Contract Negotiations - Public Relations - Budget Oversight and Management | 1996 - 2002 |

Thomas Jefferson School of Law, San Diego, CA

- Juris Doctorate, May 1995
- -Editor for "The Restater" Law School Newspaper 1993-1995
- Teaching Assistant, Legal Analysis 1993-1994
- President-Student Bar Association-1994-1995
- Academic Chairperson-Student Bar Association-1993-1994

University of Colorado, Boulder, CO

- Bachelor of Arts in Political Science, May 1992
- Secondary Emphasis German
- Active member of CU Law Club; CU Election Poll Manager -1991

ACHIEVEMENTS & PROFESSIONAL BOARDS (Last 10 years)

- Certified Special District Administrator from the Special District Leadership Foundation (2008 present)
- WateReuse California Board of Directors (2018 to present)
- 2015 California WateReuse Advocate of the Year
- Founding member and lead for the North San Diego County WateReuse Coalition (2010 to present)
 - Testified before the San Diego Grand Jury which resulted in a commendation for the coalition (2015/2016)
- Association of California Water Agencies Federal Affairs Committee (2006 to present)
- San Diego Local Agency Formation Commission Advisory Committee (2008 to present)
 - Elected Chair (2014 to present)
- Board of Directors of the San Diego North Economic Development Council (SDNEDC) (2007 to present)
 - Elected Chair (2013-2014)
- Integrated Regional Water Management Regional Advisory Committee (2008 to present)
- California Best Places to Work (2007 and 2008)
- Sponsored AB 869 to promote water recycling in California (2017)
- OMWD bond rating increased from A- to AAA under my tenure as General Manager, while our rates
 remained in the lower third in the region for the average user. (2007 to present)
- Issuance of over \$250 million in bond financing and refunding
- Oversaw unprecedented OMWD safety record of over 10 years of no lost time preventable injuries (2007 to present)

COMMUNITY INVOLVEMENT

- Water for People (San Diego Core Committee) Emcee at Annual Lunch (2013 to present)
- Lead Planner and Host for the North County Water Summit with the SDNEDC (2015)
- Board of Management Magdalena Ecke YMCA (2007 2017)
 - Finance Committee Magdalena Ecke YMCA (2007 2015)
 - Alga Norte task Force Magdalena Ecke YMCA (2014-2016)
- Board of Directors (President) Arroyo Vista Homeowner's Association (2009 to present)
- Classroom Volunteer Olivenhain Pioneer Elementary 2012 to 2018
- Hands On San Diego Volunteer
- <u>hikeboss@summittriends.com</u> Annually guide personal and professional friends on ambitious day hikes, including Rim to Rim of the Grand Canyon and Mt. Whitney

2020 LOCAL AGENCY FORMATION COMMISSION NOMINATION / RESUME

| NOMINATED BY: | | | |
|--|---|--|--|
| District Name: | Olivenhain Muncipal Water District | | |
| District Phone: | (760) 753-6466 | | |
| | | | |
| NAME OF NOME | NEE: | | |
| Name: | Kimberly A. Thorner | | |
| Address: | 1966 Olivenhain Road, Encinitas, CA 92024 | | |
| Phone: | (760) 753-6466 | | |
| NOMINATED FO | | | |
| Please check <u>one</u> box Refer to the List of Incumbents. | LAFCO POSITION: () Regular Special District Member (Term expires in 2017) () Alternate Special District Member (Term expires in 2019) | | |
| | SPECIAL DISTRICTS ADVISORY COMMITTEE POSITION: (√) Special Districts Advisory Committee (Term expires in 2019) | | |
| DISTRICT EXPERIENCE: | Ms. Thorner began her tenure with Olivenhain Municipal Water District in October 1996, becoming General Manager on January 1, 2007. Under her direction, OMWD provides water, wastewater services, recycled water, hydroelectricity, and park/recreation facilities on behalf of approximately 86,000 customers over 48 square miles in northern San Diego County. | | |
| LAFCO EXPERIENCE: | Ms. Thorner currently serves as Chair of the San Diego Local Agency Formation Commission's Special Districts Advisory Committee (SDAC). She has served on the SDAC for the past 12 years. She has participated and provided input and guidance on dozens of important LAFCO issues during her tenure and has spoken at many LAFCO hearings on behalf of the SDAC. | | |
| ADDITIONAL INFORMATION: | Ms. Thorner earned a bachelor's degree in political science from the University of Colorado (Boulder) and her Juris Doctorate from Thornas Jefferson School of Law in San Diego. She is past Chair of the San Diego North Economic Development Council's Board of Directors, past member of the Ecke Y Board of Directors, past Chair of the Ecke Y Board Finance Committee, on the WateReuse California Board of Trustees, and the SDCWA Fiscal Sustainability Task Force. Since 2008, she holds her Special Districts Administrator certification from the Special District Leadership Foundation and recently completed the Special District Leadership Academy. | | |

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Brian Boggeln

1364 Tavern Rd® Alpine, CA 91901 Phone: 619-445-2635 © E-Mail: bboggeln@alpinefire.org

Education

- A.S. Degree Fire Protection Technology
- California State Fire Marshal Fire Officer
- California State Fire Marshal Chief Officer
- California State Fire Marshal Fire Instructor I

Experience

| • | 2018 – present | Division Chief of Operations – Alpine Fire Protection District |
|---|----------------|--|
| • | 2004 - 2018 | Fire Captain/Paramedic |
| • | 2001 - 2004 | Firefighter/Paramedic |
| • | 1997 - 1999 | Firefighter Cadet |

Special Assignments

- Emergency Medical Services Coordinator Alpine Fire Protection District
- Chair of Central Zone Training Officers Association
- Chair of Central Zone Operations Chiefs
- Central Zone Representative to San Diego County Regional VHF Radio Project

Experience

- Division Chief of Operations Alpine Fire Protection District Oversee the daily operations of the Alpine Fire Protection District. Supervise the twelve operational personnel in fulfilling the mission of the District.
- Fire Captain Supervise six personnel in daily activities on an engine company. Provide command and control of emergency incidents.
- Emergency Medical Services Coordinator Supervise the emergency medical operations of the Alpine Fire Protection District.

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Mark Robak

619-778-3800 MarkRobak@icloud.com

WATER INDUSTRY - ELECTED OFFICE

2005 - Present Otay Water District

Spring Valley, CA

Board Member, Former President, Vice-President & Treasurer

- Oversee a public agency with \$132M annual budget, providing water and sewer and recycled water to 224,000 customers in a 126 square mile service area. Represent all of the District sewer ratepayers.
- Chair of Finance and Administration Committee. Provide guidance to finance department staff for annual budget cycle and instrumental in Board audits of District finances.
- · Head of current Labor Negations Committee.
- Former Chair of Engineering Committee. Fully engaged in oversight of key District CIP projects.
- Chief advocate at Board level for continuing development of District strategic plan and benchmarking study, including advocating for peer review as presented by AWWA.
- Instrumental in securing a feasibility study to bring recycled water to northern service area of the District.
 Public speaking on expansion of recycling water to the media, including local television.
- Represented District to Water Reuse Association, attending local, state and national level conferences.
- Had District rejoin ACWA in 2017 after a long hiatus.
- Been the Board member involved in Water for People events.
- · Was instrumental in the recent introduction of live streaming of Otay Board meetings.

2005 – Present Water Conservation Garden Board Member/Former President

El Cajon, CA

- Oversaw a joint-powers authority comprised of six public agencies creating an award winning five-acre display area that showcases water conservation to the general public and landscaping professionals.
- Was involved with the Garden when it opened in 1999 and have the most background of any individual.

1997 - Present San Diego Metro Wastewater Joint Powers Authority San Diego, CA Board Member/Former Chairman/Longest serving Board Member

- Oversaw a joint-powers authority comprised of 15 other cities and districts that pay for 35% of the upkeep and capital costs of the City of San Diego's regional wastewater facilities, with 2.2 million customers in a 450 square mile service area, treating 180 million gallons a day.
- Former Member of the Independent Rates Oversight Committee (IROC) for City of San Diego.
- Former member of the Finance Committee, that reviewed and advised on City of San Diego Bond offerings affecting Municipal and Metro systems (approx. \$1.2B placed - May 2009)
- Former head of Strategic Ad-Hoc Committee charged with shaping vision and mission for the organization, along with a plan to achieve those goals.
- Assisted in development of a communications plan and design of organization website.
- Participant in American Assembly II process in 2005 that endorsed Indirect Potable Reuse.
- · Developed a Twitter site for them.

1996 - 2001 Padre Dam Municipal Water District President, Treasurer, Board Member

Santee, CA

- Oversaw public agency with \$40M annual budget, providing water, sewer and recycled water to 135,000 customers in an 85 square mile area.
- While President of the Board the Board (1998), championed a Competitive Challenge program that was instituted comparing the agency to best management practices of the private sector. Has saved Padre Dam ratepayers \$1,800,000 annually to date.
- Represented Santee Lakes area and helped develop a Master Plan for 190-acre Santee Lakes Park & Campground, allowing it to become self-supporting and enhance recreational benefits for the community.
- Assisted in negotiations with employee bargaining unit in securing a new labor agreement.

WATER INDUSTRY

Water Conservation Garden

- Led formation and recruitment of Board Members that led to creation of Friends of the Garden
 foundation to assist in fundraising for the operation of the facility. This entity become the management
 structure for the Garden effective January 2011 and exists to this day. Our goal when we formed it was
 to achieve at least half of our funding from outside the industry, which the Garden did achieve.
- Obtained signage on Jamacha Road through my political connection with former Senator Dennis Hollingsworth. The Garden had previously been rebuffed by Caltrans who has jurisdiction on road.
- Started and maintained their Facebook site, which I turned over to them, as well helping start other social media sites.

Water-Wise AA Degree program/Cuyamaca College

- During my tenure (4 years) as President of the Water Conservation Garden, 1 was the chief advocate
 getting a new Water-Wise AA Degree program implemented in conjunction with Horticulture Department
 at Cuyamaca College. Worked with the College and SDCWA staff to achieve it.
- The program is a model for junior colleges throughout the state.

YesToTap on Twitter

- Developed and maintain the leading Tap Water advocacy site in San Diego County.
- Averages 3,000+ impressions per month. Followers throughout U.S. and world.
- Developed a tapwater pledge for organizations.
- Goal is to develop website and other advocacy methods.

Conservation Action Committee

- Bought the www.ConservationActionCommittee.org for the organization and helped developed their website working with SDCWA staff
- . Developed both their Facebook and Twitter sites
- · Main promoter of their programs in social media

Otay Mark

- Have the leading water Twitter site (non SDCWA) in San Diego averaging approximately 30,000 views per month with a high of approximately 90,000. Followed by opinion leaders throughout the state.
- · Leading advocate of SDCWA's member agencies on their specific accomplishments.
- Also have a website, with Facebook, Instagram, YouTube and Flickr.

Television & Media

- · Have appeared in interview format on local news on water and wastewater issues
- Have relationships with local print, online and television reporters
- Was guest curator for a week on Voice of San Diego's Instagram page for water issues

Political

- Have advised locally elected officials on water issues, including Senator Joel Anderson, when first elected to Padre Dam, prior to higher office.
- · Have extensive connections with locally elected officials throughout San Diego County.
- Have helped develop social media strategy for locally elected officials.

Social Media Instruction

- Taught social media with a focus on Twitter to agencies at the San Diego Chapter of the California Special Districts Association. Analyzed all water agencies for their social media effectiveness.
- · Started the Chapter's Facebook and Twitter sites.
- · Advised agencies on areas of improvement including SDCWA.

Water & Wastewater Technology Program

- Completed Water Distribution Systems WWTR 130 Grade A
- Completed Wastewater Collection Systems WWTR 132 Grade A



TRI-CITY MEDICAL CENTER MEDICAL STAFF INITIAL CREDENTIALS REPORT November 13, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/13/2019 - 10/31/2021)

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 12/13/2019 through 10/31/2021:

- AMUNDSON, Janet MD/Teleradiology (StatRad)
- COLT. Ross MD/Family Medicine (Gary and Mary West PACE)
- DOSHI, Sona MD/Anesthesiology (ASMG)
- HEROLD, Richard MD/Emergency Medicine (TeamHealth)
- MARTIN, Andrew MD/Teleradiology (StatRad)
- MASLIN. Benjamin MD/Anesthesiology (ASMG)
- PRASAD, Nandan MD/Emergency Medicine (TeamHealth)
- WOODWARD, Timothy MD/Anesthesiology (ASMG)
- ZHANG. Clarice DO/Emergency Medicine (TeamHealth)



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – 1 of 3 November 13, 2019

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2020 -12/31/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2020 through 12/31/2021, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- BONOMO. Rica. MD/Emergency Medicine/Active
- BRION, Paul, MD/Rheumatology/Active
- CHAYA. Nina. MD/Anesthesiology/Active
- GUERENA, Michael, MD/Urology/Active
- GUPTA. Anuj. MD/Pain Medicine/Refer and Follow
- HEIFETZ, Susan, MD/Internal Medicine/Refer and Follow
- HELGAGER, James, MD/Orthopedic Surgery/Active
- KARAS. Ir., Stephen, MD/Emergency Medicine/Active
- LAWLER, Abigail, MD/Neurology/Provisional
- MILLER, Donald, MD/Pediatrics/Active
- MOREIRA, Lucila, DO/Pediatrics/Provisional
- MORRIS. Jeffrey, MD/Ophthalmology/Refer and Follow
- PEREIRA, Isabel, MD/Internal Medicine/Active
- PERKOWSKI, David, MD/Cardiothoracic Surgery/Active Affiliate
- ROTUNDA, Edward, MD/Emergency Medicine/Active
- STERN, Mark, MD/Neurological Surgery/Active

UPDATE TO VERBIAGE FROM OCTOBER REPORT

PASHMFOROUSH, Mohammad, MD/Cardiology/Active



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT – 1 of 3 November 13, 2019

Attachment B

RESIGNATIONS: (Effective date 12/31/2019 unless otherwise noted)

Automatic:

- BISHOP. Gregory. MD/Psychiatry
- IOCKIN, Yvette, MD/Pediatric Ophthalmology

Voluntary:

- ANDRADE, Kristine, MD/Teleradiology
- BOBZIEN, Bonnie, MD/Pathology
- BREESE, Mark, DMD/Oral & Maxillofacial Surgery
- COCO, Kathleen, CNM/Allied Health Professional
- GERBER, Michele, MD/Obstetrics & Gynecology
- GRAMINS, Daniel, MD/Cardiothoracic Surgery
- MURILLO. Maria. MD/Obstetrics & Gynecology
- RAMBUR, Tricia, MD/Obstetrics & Gynecology
- SEBAHAR, Michael, MD/Pain Medicine
- SNELL, Christopher, MD/Anesthesiology
- SIRAVO, Bianca, CNM/Allied Health Professional



TRI-CITY MEDICAL CENTER MEDICAL STAFF CREDENTIALS REPORT - Part 2 of 3 November 13, 2019

REOUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by June 30, 2020 would result in these privileges automatically relinquishing.

• AFRA. Robert. MD Orthopedic Surgery

ANTOUN, David, MD
 Internal Medicine

BURKE, Michael, MD
 Interventional Radiology

• COHEN. David. MD Cardiology

HWANG. Janice. MD
 Teleradiology

• IAMSHIDI-NEZHAD, Mohammad, DO General and Vascular Surgery

• SHIN, Heamin, DPM Podiatric Surgery

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring, then were given another 6 months extension. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **February 29, 2020** would result in these privileges automatically relinquishing.

• SINGH. Himani. MD Oncology

ADDITIONAL PRIVILEGE REQUEST (Effective 12/13/2019. unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s):

• EL-SHERIEF. Karim MD Cardiology

• SAMANI, Pargol MD Cardiology



TRI-CITY MEDICAL CENTER CREDENTIALS COMMITTEE REPORT - Part 3 of 3 November 13, 2019

PROCTORING RECOMMENDATIONS

• <u>BUI. Hanh MD</u> <u>Cardiology</u>

• <u>CALAFI, Arash MD</u> <u>Orthopedic Surgery</u>

DEMASCO. Michael PA
Allied Health Professional

• HAIGLER, Heather PA Allied Health Professional

• LISTER, Crystal CNM Allied Health Professional

RAJAMANICKAM, Anitha MD Cardiology

• SAMANI, Pargol MD Cardiology

TUNG, Howard MD Neurosurgery



ADMINISTRATION CONSENT AGENDA November 26th, 2019 CONTACT: Barbara Vogelsang, CNE

| | | CONTACT: | Barbara vogelsang, CNE |
|------------|--|-----------------------------------|-----------------------------|
| <u>lnf</u> | ection Control | | |
| 1. | Bed Bugs, Identification and Control | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 2. | Bloodborne Pathogen Exposure Control Plan Policy | Annual Review, Practice Change | Forward To BOD For Approval |
| 3. | Construction | 3 Year Review, Practice Change | Forward To BOD For Approval |
| | Waterborne Illness | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Int | ensive Care Unit | | |
| | Epicardial Pacing Wires Procedure | 3 Year Review, Practice Change | Forward To BOD For Approval |
| NIC | CU | | |
| 1. | Pulse Oximetry, NICU | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 2. | Transfer of Neonates and Infants | 3 Year Review, Practice Change | Forward To BOD For Approval |
| _ | habilitation Services | | |
| 1. | Audiology Services Inpatient Rehabilitation Services - 801 | 3 Year Review | Forward To BOD For Approval |
| 2. | Discharge Criteria - 501 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 3. | Patient & Caregiver Education - 507 | DELETE | Forward To BOD For Approval |
| 4. | Pre-OP Teaching | 3 Year Review | Forward To BOD For Approval |
| 5. | Speech Pathology Services Department Policy - 802 | 3 Year Review | Forward To BOD For Approval |
| 6. | Supervision Requirements of Minors During Outpatient Rehabilitation | 3 Year Review | Forward To BOD For Approval |
| 7. | Use of Encrypted Email for Outpatient Rehab Services | DELETE | Forward To BOD For Approval |
| Re | habilitation Center (Acute Rehabilitation Unit) | | |
| 1. | Ethical Code of Conduct | NEW | Forward To BOD For Approval |
| 2. | Inpatient Rehabilitation Center Admission, Continued Stay, and Discharge Criteria | NEW | Forward To BOD For Approval |
| 3. | Interdisciplinary Plan of Care | NEW | Forward To BOD For Approval |
| 4. | Interdisciplinary Team Conference | NEW | Forward To BOD For Approval |
| 5. | Mission Statement, Goals and Objectives | NEW | Forward To BOD For Approval |
| 6. | Patient/Family Conferences | NEW | Forward To BOD For Approval |
| 7. | Policies and Procedures | NEW | Forward To BOD For Approval |
| 8. | Pre-Admission Screening | NEW | Forward To BOD For Approval |
| 9. | Utilization Review Plan | NEW | Forward To BOD For Approval |
| Wo | omen & Newborn Services | | |
| 1. | Breast Milk Misadministration | 3 Year Review | Forward To BOD For Approval |
| 2 | Discharge Process | 3 Year Review, Practice Change | Forward To BOD For Approval |



ADMINISTRATION CONSENT AGENDA November 26th, 2019 CONTACT: Barbara Vogelsang, CNE

| | | : Barbara Vogelsang, CNE |
|---|-----------------------------------|-----------------------------|
| Policies and Procedures | Reason | Recommendations |
| Patient Care Services Policies & Procedures | | |
| Consent for Minors Policy | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Glucose Point of Care Testing using the Nova StatStrip Blood Glucose Meter Procedure | Practice Change | Forward To BOD For Approval |
| Haloperidol IV Administration Standardized Procedure | 2 Year Review, Practice Change | Forward To BOD For Approval |
| Needle Thoracentesis of Chest for Pneumothorax in Neonates Standardized Procedure | DELETE | Forward To BOD For Approval |
| 5. Nursing Students Advanced Practice Policy | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Ordering Non-District Provided Services for Patients Policy | 3 Year Review | Forward To BOD For Approval |
| 7. Rapid Response Standardized Procedure | 2 Year Review, Practice Change | Forward To BOD For Approval |
| Administrative Policies & Procedures | | |
| 1. Photo Identification - 436 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Cardiology | | |
| Quality Improvement Policy Echocardiogram Engineering | NEW | Forward To BOD For Approval |
| Access to Secured Doors 5009 | 3 Year Review | Forward To DOD For Assessed |
| Documentation of Site Facility Utility | 3 Year Review, | Forward To BOD For Approval |
| Systems 2014 | Practice Change | Forward To BOD For Approval |
| 3. Engineering Disaster Response Plan 4035 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 4. Fire Smoke Management System 2015 | | |
| Handling And Use Of Compressed Gas Cylinders 5007 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Kitchen Hood Fire Extinguishing System 2012.1 | 3 Year Review | Forward To BOD For Approval |
| 7. Lockout Tagout Procedures 5003.1 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Management of Portable Fire Extinguishers 2012 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 9. Quality Assurance Plan 7000 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| The Operation of the Hospital Electrical Distribution System 5013 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 11. Use of Extension Cords 5002 | 3 Year Review, Practice Change | Forward To BOD For Approval |
| Food and Nutrition | | |
| Food Service Restrictions for Infectious Disease | 3 Year Review, Practice Change | Forward To BOD For Approval |
| 2. Protocols for Nutrition Care | 3 Year Review | Forward To BOD For Approval |

Tri-City Health Care District Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:

11/94

SUBJECT: Consent for Minors

REVISION DATE(S): 09/95, 11/96, 10/97, 07/99, 06/03,

01/06, 06/09, 06/11

Patient Care Services Content Expert Approval:

Clinical Policies & Procedures Committee Approval:

Nurse Executive CommitteeCouncil Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval: Board of Directors Approval:

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09/1510/1709/19

n/a

04/1611/1710/19

11/19

05/16 n/a

05/16

A. **PURPOSE:**

To establish guidelines to obtain a valid consent from all minor patients prior to a therapeutic, diagnostic, or invasive procedure based on California law and en-guidelines set forth in California Hospital Association (CHA) Consent Manual.

B. **DEFINITION(S):**

1. Minor is: a person younger than eighteen (18) years of age.

B.2. Authorized individual: is a parent, legal guardian or other person with the authority to consent to medical treatment for the minor. per-California Hospital Association (CHA) Consent Manual (2017), Chapter 4.

C. **POLICY:**

- 1. By statutory definition, a person under the age of eighteen (18) is unable to consent to medical treatment except as otherwise allowed by law.
- 1-2. **Consent for Minors by Parents or Third Parties:**
 - When a minor needs medical treatment, health care providers must look to patient's authorized individual, unless it is a life threatening emergency or the minor is authorized to consent on his/her own behalf-(see "Minors with Legal Capacity to Consent to their Own Medical Treatment" below)parent, guardian or other-person to consent, unless it is a life threatening-emergency.
 - 2.b. The following may be authorized individuals to consent on behalf of the minor as set forth below:
 - Parents. Either parent may generally consent to treatment for a minor unless there is documentation such as a court order showing the parent does not have that right. If the status of someone claiming to be a child's parent is unclear, the birth certificate or custody order may be used to determine who may legally provide consent.
 - ii. Stepparents or Registered Domestic Partners of a Minor's Parent. A stepparent of a minor or registered domestic partner of a minor's parent, who has not legally adopted a minor, does not have the authority to consent to treatment on the minor's behalf without written authorization from the natural parent or guardian or a valid Caregiver's Authorization Affidavit.
 - iii. Minor's Guardian. A guardian may consent to medical treatment for the

- minor as authorized by the court and the type of treatment. A copy of the official certified letters of guardianship should be obtained and reviewed to determine the scope of the guardian's legal authority to consent to medical treatment and that, if any, of the parents.
- iv. Other Third Parties. A nonparent adult relative with whom a minor is living may authorize medical and dental care for a minor by completing and signing a "Caregiver's Authorization Affidavit." It should be noted that this authority is not as extensive as a parent's authority. In specified circumstances, a third party (not the minor and not the parent/guardian) may consent to medical treatment on behalf of a minor. In these circumstances please consult the Risk Manager/Legal Department and/or Administrative Supervisor on duty.
- c. Documentation: When third parties, other than a parent, consent for treatment of a minor, official documentation showing the authority of the third party must be placed in the medical record. If questions arise concerning with documentation, a form or court order is sufficient, contact the Legal Department.
- i. -- If-the-status of someone claiming-to-be-a-child's parent is unclear, the birth certificate or custody-order may be used to determine who may legally provide consent.
 - b.i. If a patient-is a minor, the minor's parent-may provide consent.
 - c. Guardian a copy of the official certified letter-of-guardianship must be placed in the medical record.
- 3. Where an adult who is not the parent or guardian seeks care for a minor with injury or illness which is not an emergency, the healthcare provider shall request a copy of the authorized individualsparents' authorization and include it in the minor's medical record.
- 4. Even where third party authorization-is-provided, the healthcare-provider shall attempt to contact the authorized individual parent(s) to confirm-consent and to inform the authorized individual parent of the status of the minor. If it is not possible to contact the parent(s) or guardian, the healthcare provider shall apply first aid where necessary.
- 5. Consent issues under California Law-vary-depending upon certain circumstances. See Consent Requirements-for-Medical Treat of Minors-per-CHA Consent Manual Attached to this policy is an easy to use table for a summaryizing of consent issues regarding minors.
- 6. In-specified-circumstances, a third party (not-the-minor and not the parent/guardian) may consent-te-medical treatment on behalf-of-a-minor. In these circumstances-please consult the Risk Manager or Administrative Supervisor on duty.

a. Minors with step-parent:

- A step parent who has not legally adopted a minor does not have the authority to consent to treatment on the minor's behalf without written authorization from the natural parent or guardian or a valid Caregiver's Authorization Affidavit.
- b. Minors with a Registered Domestic Partner Parent(s), or Stepparents:
 - i. State law-gives-registered domestic partners (or former or surviving-registered domestic partners) the same rights and obligations as are granted to spouses in marriage. This includes the rights and obligations of registered domestic partners with respect to a child of their partner. [Family Code Section 297.5]
 - ii. However, becoming the spouse of a parent is not the same as becoming a parent, even for legally married couples. For example, as noted above, even though-a-stepmether is legally married to a minor's father, the stepmether does not have the authority to consent to treatment on the minor's behalf-without written authorization from the father or a valid Caregiver's Authorization Affidavit.
 - iii. These-same rules apply to registered-domestic partners. In order-for the registered domestic partner of a child's parent or stepparent to consent for medical care for that child, the domestic partner or stepparent must do one of the following:
 - 1) The registered domestic partner or stepparent must have legally adopted the shild.
 - 2) The registered domestic partner or stepparent must provide a signed

- third-party authorization form-giving that registered-demostic partner-or stepparent the ability to consent to-medical care for the child.
- iv. The registered-domestic partner or stepparent must complete a valid Caregivers Authorization Affidavit.
- v-ii. If the status of someone claiming to be a child's parent is unclear, the birth certificate or custody order may be used to determine who may legally provide consent.
- 7.3. Minors with Legal Capacity to Consent to their Own Medical Treatment: Self-sufficient Minor:
 - a. Certain minors may consent to medical or surgical care on their own behalf without parental consent if they have the legal capacity to do so. "Capacity" means that the person has the ability to understand the nature and consequences of a decision and to make and communicate a decision, including, in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.
 - b. Minors legally authorized to consent to his/her own care include the following:
 - i. Emancipated Minors. An emancipated minor who has received a court order of emancipation and who holds a Department of Motor Vehicles identification card indicating that the minor is emancipated may consent to his/her own medical, dental or psychiatric care without parental consent, knowledge, or liability. A copy of the identification card shall be placed in the patient's permanent medical record. Parenthood is not an emancipating event.
 - ii. Self-sufficient minors. When a minor of 15 years of age or older is living separate and apart from his/her parent(s) or legal guardian, whether with or without consent or acquiescence of his/her parent(s) or legal guardian, and manages his/her own financial affairs, regardless of the source of income, the minor is capable of giving valid consent for medical or dental care without parental or guardian consent, knowledge or financial liability. The duration of the separate residence is irrelevant. The minor should affirm that these conditions are met and complete the CHA's "Self-Sufficient Minor Information Form." The form shall be placed in the medical record. [Family Code Section 6922, CHA Consent Manual]
 - iii. Active Duty with the U.S. Armed Forces. Minors serving on active duty with any branch of the U.S. armed forces may consent to medical, dental, or psychiatric care without parental consent, knowledge, or liability. A copy of the patient's active duty military identification cares shall be placed in the medical record.
 - iv. Married or Previously Married Minors. A minor who has entered into a valid marriage, whether or not such marriage was terminated, is emancipated and may consent to medical, dental or psychiatric care without parental consent, knowledge, or liability. A copy of the patient's marriage certificate shall be placed in the medical record.
 - i-v. Other Circumstances. A minor may have limited ability to consent to care under certain circumstances, including pregnancy or contraceptive care, communicable reportable diseases, rape victims, victims of sexual assault, outpatient mental health treatment or residential shelter services, drug- or alcohol- related problems, blood donations, or anatomical gifts. In these circumstances please refer to the CHA Consent Manual and/or consult the Risk Manager/Legal Department and/or Administrative Supervisor on duty.
- 4. Telephone consent: may be obtained from authorized individual as needed
 - a. Telephone consent may be obtained only if the person having the legal ability to consent for the patient is not otherwise available. Steps shall be taken to verify the person is in person is the patient's legal representative, i.e., confirming patient's date of birth and other identifying information.

- b. Physician Responsibility. The physician should follow standard protocol for obtaining consent for the medical treatment and provide the patient's legal representative with the information the physician would disclose if the person were present.
- c. TCHD Responsibility. Where the physician states he or she has obtained telephonic consent to treat the patient, hospital personnel should verify that the patient's legal representative and physician have discussed the patient's condition and the recommended treatment and that the patient's legal representative has given consent. The telephone conversation between the patient's legal representative and a TCHD staff member should be witnessed by a second TCHD staff member. The patient's legal representative should be informed that two TCHD staff members are on the phone. Telephonic consent should be documented on the Telephone Consent Form and placed in the patient's medical record.

8.5. Refusal of Treatment:

- a. The person who has legal authority to consent for the treatment of a minor also has the legal authority to refuse treatment.
 - i. If the minor is legally authorized to consent to treatment, the minor also has the legal authority to refuse the treatment. (The minor must also have the capacity to make healthcare decisions.)
- 6. For further clarification regarding situations involving minor's authority to consent, contact Risk Management/Legal Department and/or refer to the current California-Hospital AssociationCHA Consent Manual.

D. FORM(S):

- 9.1. 8740-1046 Telephone Consent Form Sample
- 40.2. Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent Sample
- 11.3. Caregiver's Authorization Affidavit Sample

D.E. RELATED DOCUMENT(S):

- Consent Requirements for Medical Treatment of Minors—Sample
- 2. Self-Sufficient Minor Information—Sample

E.F. REFERENCE(S):

- California Hospital Association Consent Manual (20178). <u>California Hospital Consent Manual</u>. Sacramento, CA: California Hospital Association, Chapter 4.
- 2. California Family Code §§ 297.5, 6922, 7002, 7050(e)(1), 7120
- 1. Consent by Minor, Cal. FAM § 6922 (1992).
- Definitions, Cal. FAM § 297.5 (1999).

| Name of Patient: |
|---|
| Name of person called: |
| Relationship (Circle one): Parent Legal guardian Legal representative |
| Date: Time called: Phone number: |
| Name of person making call (please print): |
| Witness (please print): |
| STATEMENT . |
| I,the parent/legal guardian/legal representative (name) |
| of give my permission to Tri-City Medical Center, and Doctor (Patient's name) |
| to render/perform treatment/surgery |
| on |
| (state procedure for which consent is requested) |
| the basis of informed consent received from Doctor |
| I understand it is necessary for me to confirm this verbal consent by fax to Tri-City Medical Center and will |
| do so immediately. |
| I also agree to the Condition of Admissions form that has been reviewed with me. |
| Comments: |
| (Signature of Person Making Call/1st Witness) Date / Time |
| |
| (Signature of 2nd Witness) Date / Time |
| Affix Patient Label |
| Tri-City Medical Center 4002 Vista Way • Oceanside • CA • 92056 |
| TOVE TIME TOY OCCUPANCE ON PASSAGE |
| TELEPHONE CONSENT FORM |

Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent - Sample SAMPLE

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT (Form 2)

| (I)(We), the undersigned, parent(s) person having legal or | ustody/legal guardianship of (name of minor) |
|--|---|
| , a minor, do hereby author agent(s) for the undersigned to consent to any x-ray example treatment, and hospital care which is deemed advisable by supervision of, any physician and surgeon licensed under medical staff of any hospital, whether such diagnosis or to the hospital. It is understood that this authorization is given in advance being required but is given to provide authority to the abound all such diagnosis, treatment, or hospital care which a authorization, may, in the exercise of his/her best judgment This authorization is given pursuant to the provisions of F(I)(We) hereby authorize any hospital, which has provide provisions of Family Code section 6910 to surrender physiagent(s) upon the completion of treatment. This authorization 1283. These authorizations shall remain effective until [month a sooner revoked in writing delivered to the agent(s) noted a Date: | the provisions of the Medical Practice Act on the reatment is rendered at the office of the physician or at of any specific diagnosis, treatment, or hospital care we described agent(s) to give specific consent to any physician, meeting the requirements of this nt, deem advisable. Family Code section 6910. It treatment to the above-named minor pursuant to the sical custody of such minor to (my)(our) above-named tion is given pursuant to Health and Safety Code and day] |
| Signature: | |
| [Parent/legal guardian/person having legal custody] (circl Signature: | e relationship) |
| [parent] | |
| Medically Relevant Information | - |
| Minor's birth date | |
| Allergies to drugs or food | |
| Conditions for which minor is currently being treated | |
| Current medications | |
| Restrictions on activity | |
| Primary care physician (name and telephone number) | |
| Insurance company | |
| Mother's name, address and telephone numbers | Home Work Other |
| Father's name, address and telephone numbers | Home Work Other |
| Treatment of Minor Lacking Capacity to Consent Tri-City Medical Center | Patient Identification Label |
| \$ 1500:0 \$ | |
| 4002 Vista Way, Oceanside, California 92056 (760) 724-8411 | |

Caregiver's Authorization Affidavit - Sample

SAMPLE

CAREGIVER'S AUTHORIZATION AFFIDAVIT (Form 1)

Use of this affidavit is authorized by Part 1.5 (commencing with section 6550) of Division 11 of the California Family Code.

INSTRUCTIONS:

Name of minor:

Completion of items 1-4, inclusive and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. School related medical care means medical care that is required by state or local governmental authority as a condition for school enrollment, including immunizations, physical exams and medical exams conducted in school.

Completion of items 5-8 inclusive is additionally required to authorize any other medical care. Please print clearly

- I am requesting enrollment of the minor in school and to authorize school-related medical care. Completion of items 1 – 4 only is required.
- I am requesting to authorize medical care not school-related. Completion of items 1
 8 is required.

The minor named below lives in my home and I am 18 years of age or older.

| 2, | Minors birth date: |
|----|---|
| 3. | My name: (adult giving authorization) |
| 4. | My home address: |
| 5. | I am a grandparent, aunt, uncle, or other qualified relative of the |
| | minor (see back of this form for a definition of "qualified |
| | relative**). |
| 6. | Check one or both (for example, if one parent was advised and the |
| | other cannot be located): |
| | - I have advised the parent(s) or other person(s) having legal custody of the |
| | minor of my intent to authorize medical care, and have received no objecti |
| | - I am unable to contact the parent(s) or other person(s) having |
| | legal custody of the minor at this time, to notify them of my |
| | intended authorization. |
| 7. | My date of birth: |
| 8. | My California driver's license or ID card number: |

Consent-Requirements-for-Medical Treatment of Minors - Sample

DELETE: Remove from policy and create separate related document to link to policy.

CONSENT REQUIREMENTS FOR MEDICAL TREATMENT OF MINORS:

| CONSENT REQUIREMENTS FOR MEDICAL TREATMENT OF MINORS: | | | | | | | | |
|--|-------------------------------------|---|--------------------------------------|---|--|--|--|--|
| If Minor is: | Is parental Consent Required? | Are parents responsible for costs? | Is minor's Consent Sufficient? | May M.D. inform parents of treatment without minors | | | | |
| Unmarried, no special circumstances | Yes | Yes | | consent? | | | | |
| Unmarried, emergency care and parents | res | res | No | Yes | | | | |
| not available [Business and Professional Code § 2397] | No | Yes | Yes if capable | Yes | | | | |
| Married or previously married [Family Code §7002] | No | No | Yes | No | | | | |
| Emancipated (declaration by court, identification card from DMV) [Family Code §§ 7002, 7050, 7140] | No | Probably Not | Yes | No | | | | |
| Self-sufficient (15 or older not living at home, manages own financial affairs) [Family Code § 6922] | No | No | Yes | 1 | | | | |
| Not married, care related to prevention or treatment of pregnancy, except sterilization[Family Code § 6925] | No | No | Yes | No | | | | |
| Not married, seeking abortion | No | No | Yes | No | | | | |
| Not married, pregnant, care not related to prevention or treatment of pregnancy and no other special circumstances | Yes | Yes | No | Yes | | | | |
| On active duty with Armed Forces [Family Code § 7002] | No | No | Yes | No | | | | |
| 12 or older, care related to diagnosis or treatment for communicable reportable disease or condition or to prevention of an STD [Family Code § 6926] | No | No | Yes | No | | | | |
| 12 or older, care for rape ¹ [Family Code § 6927] | No | No | Yes | Yes, usually | | | | |
| Care for sexual assault [Family Code § 6928] | No | No | Yes | Yes, usually | | | | |
| 12 or older, care for alcohol or drug abuse¹ [Family Code § 6929] | No ² | Only if parents are participating in counseling | Yes | Yes, usually | | | | |
| 12 or older, care for mental health treatment, outpatient only ¹ [Family Code § 6924; Health and Safety Code Section 124260] | No ² | Only if parents are participating in counseling | Yes | Yes, usually | | | | |
| 17 or older, blood donation only [Health and Safety Code § 1607.5] | No | No | Yes | Probably Not | | | | |

Minors are defined as all persons under 18 years of age.

Note: Notwithstanding the above information, a psychotherapist may not disclose mental health information to a parent who has lost physical custody of a child in a juvenile court dependency hearing unless the parent has obtained a court order granting access to information.

Reference: Welfare and Institutions Code § 14010

¹ Special requirements apply, See Chapter 2 of the Consent Manual or Chapter 3 of Minors & Health Care Law ² Parental consent is required for a minors participation in replacement of narcotic abuse treatment (such as methadone, LAAM or buprenorphine products) in a program licensed pursuant to Health and Safety Code § 11875 et. seq. (now codified at Section 11839 et. seq. [Family Code § 6929(e)]

SELF-SUFFICIENT MINOR INFORMATION

| | or purposes of obtaining diagnosis or treatment a rtified the following facts are true: | t Tri-City Medical Center, the undersigned | | | | | | | |
|-----|--|--|--|--|--|--|--|--|--|
| 1. | I am 15 years of age or older. My date of birth | ı is (mm/dd/yy) | | | | | | | |
| 2. | I am living separate and apart from my parents or legal guardian. | | | | | | | | |
| | (place of residence of patient) (phone number) | | | | | | | | |
| | (place of residence of parents or guardian) | (phone number) | | | | | | | |
| 3. | I am managing my own financial affairs. | | | | | | | | |
| | (place of employment) | | | | | | | | |
| | (other source of financial support – explain) | | | | | | | | |
| 4. | I understand that I will be financially responsible hospital diagnosis, treatment and care and that grounds that I am a minor. | | | | | | | | |
| Da | te: | Time: | | | | | | | |
| (Pa | ntient Signature) | (Patient Name | | | | | | | |
| Da | te: | Time: | | | | | | | |
| (W | itness Signature) | (Witness Name | | | | | | | |

Revised Patient Care Services Policy: Consent for Minors

Page 1 of 1

| (a) Tri-City Me | dical Center | Patient Care Service |
|------------------|--|--|
| PROCEDURE: | GLUCOSE POINT OF CARE TES GLUCOSE METER | TING USING THE NOVA STATSTRIP BLOOD |
| Purpose: | To accurately determine blood glud | cose levels at the patient's bedside. |
| Supportive Data: | diagnosed by conventional means. diagnosis of diabetes. Personnel to program may perform this procedu | o monitor blood glucose in patients who have been The meter is not to be used for screening or ained and assessed through the Point of Care re. Testing is under the supervision of the Laboratory ar the jurisdiction of the Laboratory Medical Director. |
| Equipment: | Alcohol Swab Docking Station Gauze Gloves Luer lock needleless blood samplin Needleless cannula Nova StatStrip Meter Single-use Lancet StatStrip cleaning strips | |

A. **DEFINITION(S)**:

- Critically ill adult: any patient receiving intensive medical intervention/therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
 - Severe hypotension requiring the administration of two or more intravenous vasopressors;
 - Any patient with a core body temperature equal or less than (≤) 35°C;
 - Any patient with Emergency Severity Index (ESI) of one.
- 2. Critically ill neonate: all neonates in the Neonatal Intensive Care Unit (NICU) are defined as critically ill.

B. PREPARE THE METER:

- Touch the screen to activate the meter.
 - a. Note: the meter is designed such that the operator uses his-or her their finger when dealing with the touch screen. Any sharp or abrasive material may damage the meter.
 - b. Blue bar with screen title at the top of the meter will prompt next step.
- 2. From the Welcome screen, Press OK/Login to begin.
 - For troubleshooting hints see the StatStrip Troubleshooting Guide on the Tri-City Healthcare District (TCHD) Intranet under Departments>Clinical>Clinical Products.
- 3. Perform Quality Control (QC) if indicated by meter. Meter is configured to require a QC both high and low every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout L1/L3 QC required if QC not performed. See QC and Calibration section for instructions on completing the QC.
- At the Enter Operator ID Screen, scan or manually enter your Operator Identification (ID). ID
 must be 5 digits long; use zeroes to precede a 3- or 4-digit Employee ID Number (EID). Press
 Ok/Accept.
- At Patient Test screen press accept or select QC.
- 6. At the Enter Strip Lot screen, scan the strip lot from the bottle matches the number displayed on the screen.

| Department Patient Care Service Content ExpertReview | Clinical Policies & Procedures | Nurse Executive Council | Department of Pathology | Pharmacy and Therapeutics | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|--|--------------------------------------|--------------------------------|----------------------------|---------------------------------|-----------------------------------|----------------|--------------------------------------|-----------------------|
| 06/13, 08/16 , 08/19 | 06/13, 08/16, 11/16, 09/19 | 06/13, 01/17 , 09/19 | 04/18 | 09/13, n/a | 10/13, 04/18, 11/19 | 11/19 | 11/13, 05/18, n/a | 12/13, 05/18 |

- 7. At the Enter Patient ID screen, scan the AZTEC symbol from the Patient's armband or manually enter Patient 10 digit Financial Identification Number (FIN#), Press Accept.
 - a. Non-Registered Patients in emergent situations.
 - Emergent patients should be issued a John/Jane Doe packet. Scan the AZTEC symbol from the packet.
 - ii. If packet not available, enter an invalid Patient ID to get to the downtime override key (use the following 10 digit FIN# 1 2 3 4 5 6 7 8 9 0)
 - iii. Fill out the Point of Care Testing Correction Form
 - iv. Available on TCMC Intranet, click on Forms Icon>Electronic Forms>Patient Care Services Forms
- 8. At the Confirm Patient ID screen
 - Valid Patient ID: Verify the FIN# (Account Number) and Patient Name are correct. Press Ok/Accept.
 - b. Invalid Patient ID: The Admission/Discharge/Transfer (ADT) feature was unable to pull Patient Name. This will occur if the meter has not been recently downloaded and does not have current ADT information, if the scanned encounter has been discharged, or if the patient is not yet registered and a John/Jane Doe ID was scanned.
 - i. Verify the Patient ID. If the correct number was scanned, and the encounter is current press Ok/Accept to Override. The Patient ID will be recognized by the data manager, the error resolved, and the result will chart.
 - ii. If the encounter is not current, obtain an armband for the current encounter and continue testing. If staff press OK/Accept and Override a discharged encounter, the result will not chart. Staff must fill out the Point of Care Testing Correction Form and send it to the lab for error resolution.
 - iii. If the patient a John/Jane Doe and is not yet registered, press OK/Accept to Override. When the patient is registered, complete the Point of Care Testing Correction Form.
- 9. At Select Sample Type screen, select the appropriate sample type as Capillary, Venous, Arterial or Neonatal Heel Stick, then press Accept.
- 10. At the Insert Strip screen, insert a test strip into the strip port at the top of the meter. The print should face up and the gold contacts enter the meter.

C. PATIENT PREPARATION:

- 1. Critically ill adult:
 - a. Only arterial or venous whole blood may be used. Do not use serum, plasma, or capillary blood.
 - To obtain whole blood from an arterial catheter, follow procedure for blood sample collection in Online Clinical Skills Arterial Catheter: Blood Sampling.
 - To obtain whole blood from a central venous access device, follow procedure for blood sample collection in Patient Care Services (PCS) Procedure: Central Venous Access Devices, Adults.
 - iii. To obtain whole blood by venipuncture, follow procedure for blood sample collection in PCS Venipuncture for Specimen Collection.
 - Only fresh whole blood or whole blood collected in lithium heparin collection device should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device
 - 2) Fluoride, EDTA, Sodium and Ammonium blood collection devices should not be used.
 - iv. To obtain whole blood from a midline catheter, follow procedure for blood sample collection in PCS Midline Catheter, Adults.
- Critically ill neonates:
 - Collect neonatal arterial or neonatal heel stick samples. The system has not been evaluated for use with neonate venous blood,

- b. The system is not intended for use with neonate Cord blood samples.
- 3. Non-critically ill adult
 - a. Capillary, Arterial, or Venous whole blood may be used. Do not use serum or plasma.
 - b. Only fresh whole blood or whole blood collected in lithium heparin collection devices should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device.
 - c. Sample size is 1.2 uL.
- 4. Obtain single-use lancet
- 5. Select puncture site see Patient Care Service (PCS) Collection of Blood Specimen by Skin Puncture.
 - a. Adult/child finger puncture
 - b. Newborn heel stick
- 6. Use the lancet to puncture the appropriate site see PCS Collection of Blood Specimen by Skin Puncture.

D. <u>SPECIMEN COLLECTION AND PATIENT TEST:</u>

- 1. At the Apply Sample screen, obtain blood sample and touch the test strip to the a drop of blood. Hold the test strip to the blood until the meter begins the 6 second countdown.
 - a. If the strip is not filled completely in the first attempt, you must repeat the test with a new puncture and a new test strip.
 - i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
 - b. Criteria for rejection: If you receive a strip error for insufficient sample application or any other error code, you must repeat the test with a new finger puncture and a new test strip.
 - i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
 - c. When collecting the sample: keep the meter level, or pointed slightly down while wet test strip is in the meter. Do not tilt the meter up while there is any chance that blood can drip down into the meter. If liquid gets into meter, use the cleaning strips to wick the extra fluid as soon as possible.
 - d. Results will display in 6 seconds.
- 2. At the Patient Test screen
 - a. Review results:
 - Results may be read directly from the meter.
 - ii. Results in the normal range display in Blue.
 - iii. Results outside the normal range display in Red.
 - iv.

 † One arrow up indicates the result is high, but not critical.
 - v. ↑↑ Double up arrows indicate the result is critical high.
 - 1) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
 - vi. Une arrow down indicates the result is low, but not critical.
 - vii. It Double down arrows indicate the result is critical low.
 - Follow PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
 - Follow PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
 - 3) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
 - viii. LO indicates the result is below the readable range of the meter, or <10.
 - 1) <10 meter reads LO. Repeat test. Continue with treatment and retest according to standardized procedure for hypoglycemia
 - ix. HI indicates the result is above the readable range of the meter, or >600.
 - 1) Results >600 mg/dL:. Repeat test. Oebtain an order for a STAT lab glucose for a valid result for treatment (Confirmatory Testing).

- 2) Results that do not correlate with prior treatment. Repeat test. Oebtain an order for a STAT lab glucose to verify result.
- b. Enter Comments: After the result displays, you-must enter a comment to describe the sample source-for-testing. Once the comment is selected verify the comments display correctly on the screen. If you fail to select a comment the result-will not automatically be charted after you accept and download the meter.
 - i. Arterial
 - ii. Finger-stick
 - iii. Heel-stick
 - iv. Venous
- c. Accept or Reject:
 - You must ACCEPT the result at the meter for it to be automatically charted.
 - ii. If, for any reason you do not want the result to be charted, select REJECT.
 - iii. If you select neither and the meter turns off, the result will sit in a queue in the lab awaiting resolution.
 - iv. Fill out and submit the Point of Care Testing Correction Form to the LAB.
- 3. Remove strip by pressing down on ejector button on rear of device of remove strip manually. Ensure safe disposal into biohazard container.
- 3.4. Clean and disinfect the meter after each patient. See cleaning under Maintenance section.
- 4.5. Log off meter by selecting logout on Patient Test Screen or dock the meter when you are finished testing. Store the meter in the docking cradle and not in the tote. Battery must charge and data must transmit.
 - a. The Left light is Green when the meter is connected to the network.
 - b. The Center light is Green when data is transmitting
 - c. The Right light is Green when the battery is fully charged and Amber when the battery is charging.
 - d. Auto log off will occur after 6 ½ minutes of inactivity.

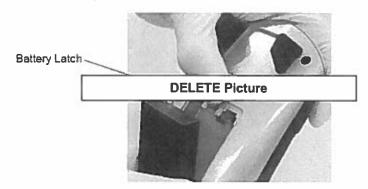
E. DOCUMENTING RESULTS:

- Patients must be identified with the Financial/ Account Number (FIN). Only results identified with the FIN will be charted in CERNER. The FIN number should be scanned from the AZTEC (2D) barcode on the ARMBAND. Linear Barcodes must not be scanned or the results will not transmit to Cerner.
- Dock the meter in the cradle. Results and comments will automatically post to the chart.
- 3. If the result does not immediately chart,
 - a. Verify the meter is properly docked and connected, with green arrow indicating data transfer complete...
 - b. The INTERFACE may be temporarily down; the results will transmit and post when the interface is again functional.
- 4. Result was not ACCEPTED in the meter. Complete the Point of Care Testing Correction Form and send to the lab. The lab will resolve the error and process the result to the chart.
 - a. Patient ID was not recognized. (John/Jane Doe). Use downtime procedure. Select Override button on the meter, continue testing, accept the result and dock the meter. Manually enter the result on the patient's chart for immediate documentation. Complete the Point of Care Testing Correction Form and send the lab. The lab will resolve the error and process the result to the chart at a later time whenever possible.

F. MAINTENANCE:

- Charging the Meter:
 - a. When the battery Low symbol displays on the screen, place the meter into the docking station. If you have a spare battery that is fully charged, you can change the battery.
 - The meter should always be left in the docking station when not in use.
- Cleaning the Meter:

- Never immerse the meter in any cleaning agent or water.
- b. Never spray the meter with a disinfectant solution
- c. Do not get excess liquid into the strip port or docking port or under the touch screen. This will damage the meter.
- d. Clean daily and when visibly soiled
- e. Disinfect the meter after each patient.
- f. Using a hospital-approved disinfectant wipe, remove the wipe and wring out excess liquid, thoroughly clean the outside of the meter, avoiding the bar code scanner and electrical connector. Gently wipe the surface area of the test strip port making sure no fluid enters the port. Allow the meter to dry before docking.
 - Hospital approved bleach wipes may be used if required by patient diagnosis (for example clostridium difficile).
- g. If the screen is 'cloudy' from a buildup of cleaning solution, wipe the screen with a water dampened gauze or alcohol pad then dry with clean gauze.
- h. If Strip port well is filled with, QC solution, blood or other liquid, dry the Strip port.
 - If unable to remove liquid or the liquid dries and cannot be removed, send the meter to the Lab.
- 3. Changing the Battery:
 - a. If the meter needs a reset or is left out of the docking station for more than 8 hours or 40 tests, the battery will need to be recharged. If the meter is needed for immediate use, change the battery.
 - b. Touch the screen or the Sleep Mode Button to wake the meter up. This will allow the operator approximately 2 minutes to change the battery and not lose date/time settings.
 - c. If it takes longer than 2 minutes to change the battery. Dock the meter to reset the date and time.
 - d. Push dewnin on the cover latch to release the cover. Take the battery cover off the back of the meter.
 - e. Push up on the battery latch. Remove the drained battery. Remove the photo below it is unnecessary.



- f. Replace with a fully charged battery. (The battery is keyed to allow only insertion from bottom first then push in the top.)
- g. Replace the battery cover.
- h. Place the drained battery into the docking station to recharge. Be sure the light to the left comes on signifying the correct positioning of the battery.
- Supplies and Storage :
 - a. Nova Stat Strip Glucose Meter (Operates 15 to 40C; 59 to 104F)
 - b. Stat Strip Glucose Test Strips (Store in original bottle 15 to 30C)
 - i. When opened mark each bottle with the expiration date post (180 days/6 months) or manufacture expirationy date, whichever comes first.
 - ii. Once opened, both Stat Strip bottles in the single package must be labeled because there is no safety seal on the individual bottle.

- iii. Stable when stored as indicated for 180 days or until the printed expiration date (whichever comes first).
- c. Stat Strip Glucose Control Solutions, level 1 low and level 3 high (Store 15 to 30C)
 - i. When opened, mark the bottle with the expiration date (90 days/-3-menths).or manufacture expirationy date, whichever comes first.
 - ii. Once opened, stable for 90 days or until the printed expiration date (whichever comes first).
- d. Do not use strips or controls past their expiration date.
- Remove the test strip from the vial only when ready to test and recap vial.

G. QUALITY CONTROL AND CALIBRATION:

- 1. Quality Controls (QC) are used to confirm that the meter and test strips are working correctly.
- 2. Control Frequency:
 - a. Meter is configured to require a QC with both Level 1 low and Level 3 High every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout.
 - b. Perform a QC if a patient test has been repeated and the blood glucose results are still lower or higher than expected
 - Perform a QC any time you have a concern about the function of the meter, i.e it is dropped or problems are identified (storage, operator, instrument)
 - d. Performing a QC with both Level 1 low and Level 3 high solution is required for Alere / Freedom to recognize new operators in the system. This shall be done upon initial and annual competency.
- 3. Perform QC with both Level 1 low and Level 3 high QC solutions to unlock meter: If one QC level fails, repeat the test only for the level that failed.
- Procedure:
 - a. From the Welcome Screen press Login.
 - b. Manually Enter or Scan your Operator ID and press OK/Accept.
 - c. From the Patient Test Screen, press QC.
 - d. At the Enter Strip Lot screen, scan the strip lot from the bottles. Verify the strip lot number matches the number displayed on the screen.
 - e. At the Enter QC Lot screen, scan the QC lot
 - f. At the Insert Strip screen, insert the test strip into the meter.
 - g. Mix the control well by rolling the vial, do not shake.
 - h. At the Apply Sample screen, touch the tip of the test strip to the drop of control and the strip will fill by capillary action. Keep contact with the drop of control until the meter beeps, indicating sufficient sample was obtained.
 - i. The test strip must fill completely on the first attempt. If insufficient sample is obtained, repeat with a new test strip.
 - ii. HOLD THE METER LEVEL or downward WHILE TESTING. This prevents any excess liquid from seeping down the strip and into the meter, causing damage.
 - iii. If liquid gets into meter, dry strip port.
 - 1) If unable to remove liquid or the liquid dries and cannot be removed send the meter to the Lab.
 - i. The QC Result screen will show with a PASS or FAIL Press Ok/Accept.
 - j. If QC fails select comment and, perform corrective action:
 - Verify the correct level of control was scanned and tested.
 - ii. Verify the test strips and control solutions are not expired. If expired, open new strips or controls.
 - iii. Mix the control thoroughly. Repeat the test with a new strip. If the second test fails, contact the lab.
 - k. Log off meter when you are finished testing. Auto log off will occur after inactivity.
 - The meter does not require calibration.

H. PRINCIPLE/CLINICAL SIGNIFICANCE:

- This test is CLIA WAIVED for capillary, venous, and arterial whole blood and neonatal capillaryheel stick whole blood.
- 2. Glucose is measured amperometrically, using an enzyme based test strip.
- 3. The meter is plasma calibrated to allow easy comparison of results with laboratory methods.
- 4. The measurement of glucose is used in the monitoring of carbohydrate metabolism disturbances including diabetes mellitus, and idiopathic hypoglycemia, and of pancreatic islet cell carcinoma.
- 5. Testing by this method is not for diagnosis of or screening for diabetes.
- 6. Limitations
 - a. Capillary blood glucose testing is not appropriate for persons with decreased peripheral blood flow, as it may not reflect the true physiological state. Venous and arterial whole blood is the only sample that shall be used for any patient receiving intensive medical/interventional therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
 - Severe hypotension requiring the administration of two or more intravenous vasopressors
 - ii. Any patient with a core body temperature equal or less than (<) 35°C
 - iii. Any patient with ESI of one
 - b. When performing frequent testing in a patient, try to use the same blood source as consistently as possible.
 - i. Rationale: Venous and capillary blood may differ in glucose concentration by as much as 70 mg/dL, depending on the time of blood collection after food intake. Draw lab serum glucose for the most accurate glucose value.
- A test within 20% of laboratory results is considered accurate.
- 8. Interfering Substances
 - a. The StatStrip Glucose meter exhibits no interference from the following substances at known therapeutic levels: Acetaminophen, Ascorbic acid, Dopamine, Ephedra, D+ Galactose, Ibuprofen, L-Dopa, Methyl-Dopa, Salicylate, Tetracycline, Tolazamide, and Tobutamide.
 - b. The StatStrip Glucose meter exhibits no interference from the following substances at or above the upper clinical normal range concentrations: Bilirubin, Cholesterol, Creatinine, Triglycerides, and Uric Acid.
 - c. The StatStrip Glucose meter exhibits no interference from the following substances at the normal therapeutic levels found in renal dialysis: D(+) Maltose monohydrate, D(+) Maltotetraose, and D(+) Maltotetriose.
 - d. The StatStrip Glucose meter exhibits no interference in blood specimens with hematocrits from 20% to 65% or with varying oxygen content.

I. REFERENCE INTERVALS:

- 1. Meter range 10-600 mg/dL
 - a. <a href="mailto: <a hre
 - >600 meter reads HI. Order lab glucose to obtain a valid number for treatment.
- 2. Reference Range (all in mg/dL)

| | | NORMAĹ | CRITICAL LOW | CRITICAL HIGH |
|----|----------|----------|--------------|------------------|
| a. | Adults | 70 – 110 | ≤ 40 | ≥ 450 |
| b. | Neonates | 45 – 120 | < 30 | none established |

- 3. Critical Results must have follow up documentation of physician notification and any interventions.
- 4. Any result that is questionable or does not correlate with patient symptoms or treatment history should be repeated with a new finger puncture to rule out operator, strip, or meter error. If repeat meter value does not 'make sense', order a lab glucose.

Patient Care Services
Glucose Point of Care Testing using Nova Stat Strip Blood Glucose Meter
Page 8 of 8

J. REFERENCE(S):

- 1. Nova Biomedical. StatStrip Glucose Test Strips Package Insert. Ref 42214. 2016-03.
- Nova Biomedical. StatStrip Glucose Control Solution Package Insert. Ref 41741 & 41743. 2017-03.
- 3. Nova-Biomedical. StatStrip Glucese-Hospital Meter IFU: Ref 55847 H. 2015-06.
- 3. Nova Biomedical. CIB 04-11SS Rev. B. Cleaning and Disinfection Procedure. 2015-06.
- 4. Nova Biomedical. StatStrip Glucose Hospital Meter IFU 1.86 Ref.55848F 2019-01

K. FORM(S):

Point of Care Testing Correction Form

L. RELATED DOCUMENT(S):

- Online Clinical Skills Arterial Catheter: Blood Sampling
- 2. PCS Procedure: Central Venous Access Devices, Adults
- 3. PCS Procedure: Collection of Blood Specimen by Skin Puncture
- 4. PCS Procedure: Critical Results and Critical Tests/Diagnostic procedure
- 5. PCS Procedure: Midline Catheter, Adults
- 6. PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
- 7. PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
- 8. PCS Procedure: Venipuncture for Specimen Collection
- 9. Point of Care Correction Form
- 10. StatStrip Troubleshooting Guide

Point of Care Testing Correction Form

| NURSING Complete this form when 1. Valid R other than the current FIN # (account) was used Complete in full and return to Lab. Result will be | to identify the patient in the meter/instrument. |
|---|---|
| POC Test: Glucose (Nova Statstrip) Hemoglobin (Hemocue 201DM) Urine Dipstick (Siemens Clinitek) ACT (Medtronic ACT Plus) | Reason for Exception: Unregistered Patient (scan John/Jane Doe armband) Scanned Armband of old encounter, bypassed warning Scanned wrong barcode, did not confirm Downtime override used Scanning function not working |
| Date of Test: | accepted Comments: |
| Time of Test: | Operator Name/ID: (Performed Test) |
| Result: Correct Patient ID Verified by: | Correct Patient ID: (fill out or attach chart label) Name: MRN: FIN: |
| | atic tube or Fax to x4048** |
| | E ONLY |
| Corrected by: | Date/Time: |
| Comments: | |



STANDARDIZED PROCEDURES MANUAL PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: HALOPERIDOL (HALDOL), INTRAVENOUS (IV) ADMINISTRATION

I. POLICY:

- A. Function: To provide direction for the use of intravenously administered Haloperidol at Tri-City Medical Center (TCMC).
- B. Circumstances:
 - 1. Setting: Emergency Department (ED), Intensive Care Unit (ICU), **Progressive Care Unit (PCU)**, **Cardiac Cath Lab** or Telemetry at TCMC.
 - 2. Supervision: None.
- C. Definitions:
 - 1. The safe **intravenous** (IV) administration of haloperidol requires that the QTc interval on the 12 Lead electrocardiogram (ECG) be less than 450 milliseconds.
 - 2. The safe IV administration of haloperidol requires that the patient be monitored continuously for cardiac dysrhythmias for two (2) hours after the drug is given.
 - 3. The maximum drug amount for each IV dose of haloperidol is 5mg.
 - 4. The maximum cumulative drug amount for IV haloperidol dosing is 30mg-20mg per 24 hours.
 - 5. QT interval represents the duration of ventricular depolarization and subsequent repolarization measured from the beginning of the QRS complex to the end of the T wave using manual or electronic calipers.
 - 6. QTc interval is a heart rate adjustment measurement for the QT interval. It is measured using a calculation and is not the same measurement as the QT interval.
 - Nursing shall use the QTc interval listed on a 12 Lead ECG.
- D. Exceptions:
 - Haloperidol IV may be given in emergent situations to patients without a 12-lead ECG if the ordering physician determines the benefit to outweighs the risk of treatment.

II. PROCEDURE:

- A. The attending physician initiates the process by ordering IV haloperidol for the patient.
- B. The Registered Nurse (RN) shall check the chart for the most recent 12 Lead ECG.
 - 1. RN shall order a base-line 12 Lead ECG if:
 - i. There is not an ECG that was done within the past 24 hours available on the chart.
 - ii. Patient is at risk for prolonged QT intervals:
 - a) Atrioventricular (AV) blocks
 - b) History of Torsades de Pointes (TdP)
 - c) Long QT Syndrome
 - d) History of Myocardial Infarction (MI)
 - iii. When recommended by pharmacy based on drug interaction that prolongs the QT interval.
 - iv. When the QT interval on an ECG strip measured with calipers, prolongs, exceeding the patient's baseline and/or exceeds 450 milliseconds.

| Patient Care Services Content Expert spartme At Review | Clinical Policies & Procedures Committee | Nurse Executive Committee | Division of Cardiology | Pharmacy ∧ Therapeutics Committee | Inter- disciplinary Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|--|--|----------------------------------|------------------------------|--|-------------------------------------|-----------------------------------|----------------|--------------------------------------|-------------------------|
| 07/12, 09/15, 03/19 | 08/12, 10/15, 04/19 | 10/12, 10/15, 04/19 | 01/16, 06/19 | 11/12, 01/16, 07/19 | 02/13, 07/16, 10/19 | 02/13, 09/16, 11/19 | 11/19 | 10/16, n/a | 0 2/13, 11/16 |

- Patients receiving 30-20mg or more of haloperidol IV per day, order the RN shall order a 12 lead ECG -every other day, if not ordered by the physician, to monitor the QTc.
- C. The RN or physician shall check the QTc interval that is electronically measured and printed on the 12 Lead ECG.
 - Do not administer haloperidol if the QTc interval is greater than 450 milliseconds.
 Discontinue the haloperidol and notify the physician for an alternative route or medication.
 - 2. If the physician specifically orders haloperidol despite QTc greater than 450 milliseconds, document QTc and physician awareness notification of QTc.
- D. The RN shall document the QTc interval on the medication administration record (MAR).
- E. The patient shall be monitored for the following for 2 hours after haloperidol has been administered:
 - 1. Cardiac effects (new onset tachycardia, orthostatic hypotension, hypertension, abnormal T waves, prolongation of the QT from baseline and ventricular dysrhythmias).
 - 2. Signs of neuroleptic malignant syndrome (new fever greater than 37.7 celsius, tachycardia, diaphoresis, labile blood pressure, cardiac dysrhythmias).
 - Extrapyramidal reactions, including:
 - i. Dystonic reactions (neck rigidity, swollen tongue, and oculogyric crisis).
 - ii. Tardive dyskinesia (repetitive, involuntary, purposeless movements, grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may appear as though the patient is playing an invisible guitar or piano).
- F. Physician Notification and Documentation
 - Notify the physician and document in the medical record the presence of the following:
 - i. Cardiac effects
 - ii. Signs of neuroleptic malignant syndrome
 - iii. Extrapyramidal reactions
 - 2. When administering medications or implementing orders from a standardized procedure, the RN shall enter the medication/order into the electronic health record as a standardized procedure.
 - i. Not required if a screening process triggers the order.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current unencumbered California RN license.
- B. Current Advanced Cardiac Life Support cardcertification.
- C. Primary RN staff on unit with continuous cardiac monitoring at TCMC.
- D. Initial Evaluation: During Department Orientation.
- E. Ongoing Evaluation: Annually with skills validation. during Skills Lab.

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

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Haloperidol, Intravenous (IV) Administration Standardized Procedure.

(3)

Tri-City Medical Cent Oceanside, California

DELETE - With 24/7 Neonatology coverage in house, it is no longer needed

PATIENT CARE SERVICE

STANDARDIZED PROCEDURE: NEEDLE THORACENTESIS OF CHEST FOR PNEUMOTHORAX IN NEONATES

POLICY:

- A. Function: To outline the procedure for the Neonatal Intensive Care Unit-(NICU) registered nurse (RN) to perform theracentesis on a neonate.
 - The NICU RN must adhere to the policies of the institution and remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- B. Gircumstances under which the NICU-RN may perform function:
 - 1. Setting:
 - a. Inpatient-neonatal patients
 - b. Neonates being admitted or transferred to and from Tri-City-Medical Center (TCMC) NICU.
 - 2. Supervision:
 - a. The necessity of the procedure will be determined by the RN in verbal collaboration with the attending physician. Ideally the procedure will first be discussed with the physician, but if time does not permit for that, then the attending physician is to be notified as soon as possible after the procedure. Direct supervision will not be necessary once competency is determined as provided for in this standardized procedure.
 - 3. Patient Conditions/Indications (Subjective/Objective):
 - a. Suspicion of a pneumothorax as evidence by:
 - i. Respiratory-distress
 - ii. Unstable vital signs
 - iii. Abnormal pulse eximetry
 - iv. Abnormal blood gas
 - v. Cyanosis
 - vi. Shifted-cardiac impulse
 - vii. Tracheal-shift
 - viii. Asymmetrical/absent breath-sounds
 - Chest-X-ray interpreted as showing
 - i. Mediastinal-shift
 - ii. Pneumothorax
 - Pleural fluid collection (effusion, hemotherax, empyema, and/or chylotherax)
 - e. High intensity transillumination is interpreted as showing a pneumotherax
 - Contraindications:
 - a. Suspected-diaphragmatic-hernia
 - Current-thrombolytic-therapy
 - History-of-known bleeding-disorder
 - d. When the vital signs are stable enough to allow for the placement of a thoracotomy tube instead.

C. Definitions:

| Department Review | Clinical Policies & Procedures | Nursing Executive Council | Department of Neonatology Perinatal Collaborative Practice | Pharmacy & Therapeutics Committee | Interdiscipt inary Committee | Medical Executive Committee | Administra tion | Professional Affairs Committee | Board of Directors |
|-----------------------|--------------------------------------|---------------------------------|--|-----------------------------------|-------------------------------------|-----------------------------------|--------------------|--------------------------------------|-----------------------|
| 11/12, 5/16, 08/18 | 11/12, 6/16, 01/19 | 12/12, 7/16, 01/19 | 08/16 , 04/19 | 01/13, 11/16, 05/19 | 01/13, 01/17, 07/19, 10/19 | 03/13, 02/17, 11/19 | 11/19 | 03/17 , n/a | 03/13, 03/17 |

- 1. Neonate: Any infant less than 30 days old.
- Pneumotherax: The presence of free air or gas in the pleural cavity.
 - a. May be produced by the application of positive pressure to the airway and lung tissue. With ventilation pressures greater than 30 cm water, there is significant rise in risk.

PROCEDURE:

A. Equipment:

- 1. Cardiac monitor, eximeter and/or bedside nurse to monitor apical pulse
- Transilluminator
- Needle-Aspiration Kit;
 - a. 2% chlorhoxidine glucenate
 - b. 2x2 gauzo sponges
 - e. 23 or 25 gauge butterfly needle, or 23 or 25 gauge angiocatheter.
 - Three way stopcock
 - e. T connector (if-using an angiocatheter)
 - Transparent Dressing
 - g. 20 or 35 mL syringe

B. Pre-treatment evaluation:

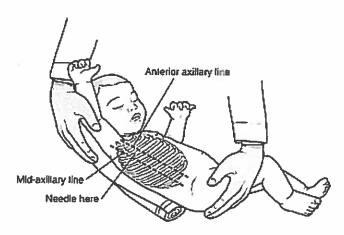
- Notify attending physician of sudden enset of symptoms
- Obtain chest x-ray if possible. If chest x-ray cannot be obtained promptly, transilluminate before placement if pneumotherax is life-threatening, to confirm affected side.
- Ensure that the neonate is pre-medicated for the procedure and that a plan for pain control and developmental management is in place.
- Monitor the patient's cardiorospiratory status and oxygon-status throughout the procedure.
- If time permits inform the family of the treatment plan, otherwise notify them after the procedure is complete.

C. Set-up

- The equipment is assembled as follows:
 - Connect the 3-way stopcock to the syringe.
 - If using a butterfly needle, connect the tubing of the butterfly needle to the 3 way stopcock.
 - If using an angiocatheter, connect stopcock and syringe assembly to a tconnector.

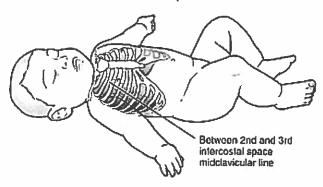
D. Plan:

- Perform a time out per Patient Care Services (PCS): Universal Protocol.
- Positioning of Infant:
 - a. For the lateral approach position the neonate with a blanket roll behind the back, the affected side slightly above the mattress, and the arm of the affected side restrained above the head. The needle or catheter will be inserted into the 4th intercostals space in the mid-axillary or anterior axillary line.



Needle aspiration procedure option 1: Lateral approach.

b. For the anterior approach position the neonate-supine for needle-insertion into the second intercestal space in the midelavicular line.



Needle aspiration procedure option 2: Anterior approach.

- Prep this area with 2% chlorhexidine gluconate, allowing it to dry a minimum of minute.
- Have assistant hold-infant's legs and arms.
- 5. Puncture the skin at a 45 degree angle, angling over the top of the 3rd rib (5th rib for lateral approach) to avoid the artery and nerve located on the inferior surface of the rib. The distance required for needle insertion varies with the neenate's size but is usually less than 15 mm. Avoid trauma to breast tissue. Insert the needle only once, and do not move it back and forth. On entry into the pleural cavity, a slight "pop" is often felt The needle is steadled in this position
 - a. If using an over-the-needle catheter, remove the needle from the catheter while sliding the catheter into the pleural space. Attach the catheter hub to the preassembled T-connector, stopcock, and syringe setup.
 - If-using a butterfly needle, have an assistant gently aspirate the syringe as the needle is inserted-into the pleural space. Step advancing the needle when air is obtained.
- Stabilize the catheter or butterfly-needle, and slowly aspirate the air or fluid. Continue withdrawing until no fluid is aspirated.
- 7. If air is present, there is free withdrawal. Withdrawal continues until resistance is met.
- 8. If plunger is withdrawn to its fullest extent (20/35ml), turn the stepseck off to the patient, then rapidly pushing air out of the syringe from the side port.
- Repeat this process until all of the air is evacuated.
- 10. Observe the infant's vital-signs and listen-for breath-sound improvement.
- 11. Remove the catheter or butterfly needle when no more air or fluid can be obtained.

- Apply pressure with a folded 2 × 2 sterile gauze until any oozing or blooding has stopped.
 Cover the site with a dry, sterile, and occlusive dressing.
- 13. Obtain a chest X-ray to determine continued presence of air or fluid.
- 14. Potential Complication
 - Lung puncture
 - b. Pneumothorax
 - c. Bleeding
 - d. Liver-puncture
 - Infection
 - Hypovolemia if draining a large amount of fluid.
- Documentation
 - Document the following:
 - i. Time procedure started
 - ii. Reason for thoracentesis
 - ii. Infant's status before and after procedure including heart rate, respiratory rate, degree of respiratory effort and blood pressure, Fio2, O2 saturations and pain management.
 - iv. Results of chest x-ray or transillumination
 - v. Size of needle used, and location of insertion
 - vi. Amount-of-air or drainage obtained
 - vii. Infant's telerance of procedure
 - viii. Any complication

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current-California RN license.
- B. Education: The RN shall attend the required TCMC didactic class on Needle Aspiration for Pneumotherax, and pass all written and performance tests. The RN shall demonstrate proper procedure and technique for thoracentesis on a training mannequin or simulation labs.
- C. Initial Evaluation: The NIGU Clinical Nurse Specialist or designee in collaboration with a Division of Neonatology representative shall validate initial competency. The initial competency shall be completed in a simulation lab.
- D. Ongoing Evaluation: The RN shall exhibit knowledge and skills to perform the training annual competency testing on the training mannequin or simulation lab.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with an authorized representative from Nursing Administration, Administration and Medical Staff.

CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All NICU Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Neonatal Thoracentesis Standardized Procedure.

VI. RELATED DOCUMENTS:

A. PCS: Universal Pretecel

VII. REFERENCES:

- A. Karlsen, K. (2013). Procedures: Pneumothorax Evacuaiton: Needle Aspiration of the Chest. The S.T.A.B.L.E. Program, 6th edition.
- B. Mosby's Nursing Skills. (2016). Needle Thoracostemy. Elsevier, Inc.
- C. National Association of Neonatal Nurses. (2011). Procedure: Chest tube Management: Placement, Needle Aspiration, and Maintenance. Policies, Procedures, and Competencies for Neonatal Nursing Care.



PATIENT CARE SERVICES

ISSUE DATE:

02/14

SUBJECT: Nursing Students; Advanced

Practice

REVISION DATE:

POLICY NUMBER: NEW

Patient Care Services Content Expert Approval:

10/19

Clinical Policies & Procedures Committee Approval:

11/1310/19

Nurse Executive Council Approval:

11/1310/19

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

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Administration Approval:

11/19

Professional Affairs Committee Approval:

02/14 n/a

Board of Directors Approval:

02/14

A. POLICY:

- Masters Degree Students
 - Students must be enrolled in a nursing related program.
 - b. Students are responsible for identifying preceptor and obtaining approval through the Education Department.
 - TCMC must have opportunities available to meet the goals of the Masters program.
- 2. Clinical Nurse Specialist
 - Students are responsible for identifying preceptor and obtaining approval through the **Education Department.**
 - i. TCMC must have opportunities available to meet the goals of the Clinical Nurse Specialist program.
- 3. **Nurse Practitioner Students**
 - Nurse Practitioner students receive supervision from a designated physician/nurse practitioner as arranged through the nursing practitioner's program.
 - The physician/nurse practitioner supervisor will ensure that the student functions within the scope of practice
 - Nurse practitioner students shall perform, under the direction of their supervisor, b. assessments and will collaboratively develop appropriate plans of care.
 - Nurse practitioner students may suggest treatments or medications but may not order C. them in the patient's medical record; nor may they dictate.
 - d. Nurse practitioner students may document in the progress note.
 - All care provided shall be discussed with the designated supervisor
- 4. **Nurse Midwife Students**
 - Nurse midwife students receive supervision from a designated physician/nurse midwife as arranged through the nurse midwife's program.
 - The physician/nurse midwife supervisor will ensure that the student functions within the scope of practice
 - Nurse midwife students shall perform, under the direction of their supervisor, assessments b. and will collaboratively develop appropriate plans of care.
 - Nurse midwife students may suggest treatments or medications but may not order them in C. the patient's medical record; nor may they dictate.
 - d. Nurse midwife students may document in the progress note.
 - All care provided shall be discussed with the designated supervisor e.



PATIENT CARE SERVICES

ISSUE DATE:

12/73

SUBJECT: Ordering Non-District Provided

Services for Patients

REVISION DATE(S): 5/88, 9/91, 3/00, 6/03. 9/05

POLICY NUMBER: IV.C

8/08, 7/11

Patient Care Services Content Expert Approval:

06/19

Clinical Policies & Procedures Committee Approval:

11/1407/19

Nursing Executive Council Approval:

11/1409/19

Medical Staff Department or Division:

n/a

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

01/1510/19

Administration Approval:

11/19

Professional Affairs Committee Approval:

02/15 n/a

Board of Directors Approval:

02/15

A. **PURPOSE:**

To provide a means for ordering outside services which are not provided by Tri-City Healthcare District (TCHD).

POLICY:

- Outside services such as beauticians, orthopedic appliance specialists, and any others not contracted will not be arranged by TCHD personnel.
 - If the physician/AHP orders outside services, the written order must include which service shall be contacted. TCHD personnel may then telephone the designated service.
- 2. TCHD personnel may not participate in any way in selecting an outside source except as defined by department specific policy.
- 3. The patient may directly order outside service.
 - The TCHD will not reimburse the provider for such services, nor will it enter into any collection activity as agent for the provider.
- 4. TCHD does not accept liability for any outside vendor or medical equipment/device provider contracted by the patient without a physician/AHP order.



PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: RAPID RESPONSE

I. POLICY:

- A. Function: A systematic method for the Rapid Response Team (RRT) to collaborate with the attending physician in the assessment, diagnosis, evaluation, and management or stabilization of the adult patient exhibiting signs and symptoms of impending respiratory and/or cardiovascular deterioration.
- B. Circumstances:
 - Setting: Adult patients (age 14 years and older) admitted to or being treated at Tri-City Medical Center.
 - 2. Supervision: None Required
- C. The RRT or designated Intensive Care Unit (ICU) Registered Nurse (RN) is available for consultation 24 hours per day, seven days per week and may be activated for all situations where rapid patient evaluation is necessary.
 - 1. The RRT may be initiated in any location of the hospital.
- D. All overhead pages requesting the RRT shall initiate the following responders:
 - 1. Team Leader: An ICU RN
 - 2. Respiratory Care Practitioner (RCP)
 - 3. Administrative Supervisor (AS)
 - 4. Phlebotomist
 - 5. Electrocardiogram (EKG) Technician
- E. The RRT shall assess the patient and initiate life-saving interventions per Code Blue and Emergency Care Standardized Procedure and Rapid Response Standardized Procedure.
- F. The attending physician shall be notified of change in the patient's condition and interventions initiated by the RRT.
- G. In the event of a delay in the attending physician response, where the patient's condition warrants immediate physician consultation, the RRT shall contact the Chair of Critical Care Committee, Medical Director of ICU, or designee for orders.
- H. The Assistant Nurse Manager (ANM)/designee shall provide support to the family/caregiver using social services or chaplain services and by providing regular updates and information.

II. PROCEDURE:

- A. Responsibilities of the RRT are as follows:
 - 1. The ICU RRT Team Leader:
 - a. Conducts physical assessment of patient
 - b. Places patient on an electrocardiogram (ECG) monitor
 - c. Applies a pulse oximeter
 - d. Ensures patent Intravenous (IV) access
 - e. Reassesses vital signs every 5 to 15 minutes or as condition dictates
 - i. If the RRT Leader determines a full team response is warranted, a Code Blue announcement shall be initiated.
 - f. Collaborates with RCP if patient condition warrants.
 - g. Implements initial lifesaving interventions per Standardized Procedure: Code Blue and Emergency Care if situation warrants.

| Patient Care Services Content Expert | Clinical Policies & Procedures | Nursing Executive Council | Critical Care Committee | Pharmacy & Therapeutics Committee | Inter- disciplinary Committee | Medical Executive Committee | Admin | Professional Affairs Committee | Board of Directors |
|---|---|---|-------------------------------------|--|--|--|-------|--------------------------------------|---|
| 01/08, 06/08 03/10, 08/10, 12/13, 07/16, 11/18 | 03/10, 12/11, 01/14, 09/16, 12/18 | 08/10, 04/12, 1/14, 09/16, 12/18 | 08/14, 10/16, 02/19, 06/19 | 08/10, 05/12, 03/14, 03/17, 07/19 | 08/10, 11/12, 09/14, 04/17 , 10/19 | 08/10, 11/12, 11/14, 04/17 , 11/19 | 11/19 | 01/15, 05/17, n/a | 06/08, 08/10, 12/12, 01/15, 05/17 |

- h. Communicates with patient's attending physician/designee and reports assessment, initial interventions with patient responses, and discusses plan of care for any significant intervention using the Situation, Background, Assessment, and Recommendation (SBAR) technique.
- B. Hypotension:
 - If hypotension is due to fluid volume deficit:
 - Administer Normal Saline IV bolus of 500 mL over 30 minutes. If responsive (MAP or SBP increase greater than 10%) but MAP remains less than 65 mm Hg may repeat one time.
 - b. Contact physician for further IV fluid orders.
 - 2. If volume loss is due to acute bleeding draw blood for immediate (STAT) Complete Blood Count (CBC), prothrombin time and partial thromboplastin time (PT/PTT), type and screen, and contact physician to order blood products and IV fluids.
- C. Sepsis:
 - Sepsis shall be considered in all patients with known or suspected infection who have 2
 or more of the following Systemic Inflammatory Response Syndrome (SIRS) criteria:
 - Heart rate greater than 90 beats per minute
 - b. Temperature less than 36°Celcius (C) (96.8°Farenheit [F]) or greater than 38°C (100.4°F)
 - Respiratory rate greater than 20 breaths per minute or PaCO₂ less than 32 mmHg
 - d. White blood count (WBC) greater than 12,000/mm³ or less than 4,000/mm³
 - 2. Severe sepsis: patients that meet sepsis criteria complicated by acute organ dysfunction.
 - 3. Septic shock: patients that meet the above severe sepsis criteria complicated by hypotension that is refractory to fluid bolus and requires vasopressors.
 - Treatment of severe sepsis:
 - a. Administer Normal Saline 500 mL IV bolus. May repeat times one to maintain MAP greater than 65mmHg, Central Venous Pressure (CVP) of 8–12 mmHg, and urine output greater than 0.5 mL/kg/hr. Contact physician for further IV fluid bolus orders (goal is at least 30 mL/kg).
 - b. Draw blood for serum lactate level, Comprehensive Metabolic Panel (CHEM-12), and CBC (complete blood count) with manual differential
 - c. Obtain arterial blood gas (ABG)
 - d. Obtain blood, sputum and urine cultures
 - e. Contact physician for orders regarding:
 - i. Severe Sepsis Power Plan
 - i-ii. Appropriate patient placement (transfer to ICU)
 - ii.ii. Removal of potential infection source (i.e. invasive lines, tubes, drains, or abscess)
 - iii-iv. Broad spectrum antibiotics
 - iv.v. Blood glucose control
- D. Acute Change in Mental Status:
 - Check blood glucose. If blood glucose is less than 70 mg/dL, follow the Patient Care Services (PCS) Standardized Procedure: Hypoglycemia Management in the Adult Patient.
 - 2. If acute cerebrovascular accident (CVA) is suspected due to new onset of one-sided motor weakness, facial droop, slurred speech and/or aphasia, perform National Institutes of Health (NIH) Stroke Scale assessment.
 - a. If new deficits are confirmed, dial 66 to initiate an "In-House Stroke Code" and page the on-call Neurologist (see Patient Care Services (PCS) Stroke Code, In-House policy)...
 - 3. If hypoxia is suspected, apply oxygen via nasal cannula, simple mask, or non-rebreather mask as needed to maintain oxygen saturation greater than 92%. Draw ABG.

- 4. If the patient is receiving sedation or analgesia:
 - a. Stop Patient Care Analgesia (PCA) and sequester equipment if applicable.
 - b. Administer naloxone (Narcan) 0.4 mg IV push for opiate reversal. If necessary, repeat every 2–3 minutes to a maximum dose of 2 mg.
 - c. Consider flumazenil (Romazicon) 0.25 mg IV push for acute benzodiazepine reversal. If necessary, may repeat every 1 minute to a maximum dose of 1mg. Further doses may be required with a Physician Order.
 - d. If a reversal agent has been used the patient shall be monitored for 90 minutes.
- 5. If the patient is agitated or delirious and may be going through alcohol withdrawal, administer lorazepam (Ativan) 2 mg IV push times one dose.
- 6. If the patient is agitated or delirious with no history of alcohol abuse and none of the above treatments apply (i.e. patient is not hypoxic or hypoglycemic), administer Haldol 2 mg IM or IV push times one dose (see PCS SP: Haloperidol IV Administration).
- E. Chest Pain/In-House STEMI Activation:
 - 1. Assess pain quantity, quality, location, radiation, time of onset and precipitating factors.
 - 2. Order STAT ECG and review for ischemic changes.
 - a. If ECG is positive for ***Acute Myocardial Infarction (MI)***, dial 66 to initiate an "In-House Code STEMI" (see Patient Care-Services PCS Policy: Code STEMI policy)
 - Apply oxygen at 4 L/min via nasal cannula.
 - Administer aspirin 162 mg PO if patient has not already taken it and has no contraindications (i.e. Aspirin allergy or active bleeding).
 - 5. Administer nitroglycerin 0.4 mg sublingual every 5 minutes as needed (PRN) for chest pain up to 3 doses. Hold if SBP is less than 90 mmHg.
 - If nitroglycerin is ineffective in relieving chest pain, administer morphine 2 mg IV push times one.
 - Obtain STAT portable Chest X-Ray (CXR).
 - 7. Draw blood for CK, Mb Fraction, Cardiac Troponin (Troponin I), Basic Metabolic Panel (CHEM 7), and PT/PTT.
- F. Respiratory Distress:
 - 1. Apply oxygen via nasal cannula, simple mask, or non-rebreather mask as needed to maintain oxygen saturation greater than 92%.
 - 2. Oral or nasotracheal (NT) suction if the patient is unable to clear secretions.
 - 3. If the respiratory rate is less than 8 breaths per minute, please refer to Acute Change in Mental Status section.
 - 4. Obtain physician order for bi-level (biphasic) positive airway pressure (BIPAP) if the respiratory rate is greater than 25 breaths per minute and as patient condition warrants.
 - 5. Administer nebulized medications for wheezing:
 - Albuterol 2.5 mg and Ipratropium 0.5 mg (DuoNeb inhalation solution) times 1 dose
 - 6. Administer furosemide (Lasix) 40 mg IV push times 1 and draw blood for CHEM 7 and BNP if respiratory distress occurs with signs and symptoms of fluid overload (e.g. intake greater than output, bibasilar crackles, jugular venous distension, edema).
 - 7. Draw ABG.
 - 8. Order a STAT portable CXR.
 - Order STAT ECG.
- G. Hypertensive Crisis:
 - Assess patient for end organ dysfunction due to hypertensive emergency: change in mental status, respiratory distress, visual disturbances, or acute renal failure.
 - a. If present, start nicardipine (Cardene) 5mg/hr to keep diastolic blood pressure (DBP) 100–110 mmHg. Avoid in patients with known or suspected Ejection Fraction (EF) -less than 25%. Lower starting doses of 2.5mg/hr can be considered in patients with renal failure or age greater than or equal to 65.

- b. Decreasing blood pressure too rapidly could result in cerebral hypoperfusion or coronary insufficiency. May increase by 2.5-5 mg/hour every 5 to 15 minutes up to 15mg/hr. The initial goals of treatment should be to decrease the Mean Arterial Pressure (MAP) by 20-25% in the first 1-2 hours and reduce the Diastolic Blood Pressure (DBP) to 100-110 mmHg. Consider reduction to 3mg/hour after response is achieved.
- 2. **Hypertensive Urgency**: If no signs and symptoms of end organ dysfunction are present: (hypertensive urgency): administer Hydralazine 10 mg IV. May repeat in 20 minutes if MAP has not decreased by 20-25% or if DBP is greater than 110 mmHg (contraindicated in acute aortic dissection).
 - a. If the patient has a history of coronary artery disease (CAD) or a heart rate greater than 80 beats per minute, administer Labetalol (Trandate) 20 mg IV. May repeat in 5 minutes if MAP has not decreased by 20–25% or if DBP is greater than 110 mmHg.
- 3. If IV access cannot be obtained, administer Clonidine (Catapres) 0.2 mg PO one time. Bradycardia:
- 1. If the patient is having signs and symptoms of poor perfusion related to bradycardia (i.e. change in mental status, chest pain, hypotension or other signs of shock):
 - a. Prepare for transcutaneous pacing. Pace without delay for second degree type 2 or third degree block.
 - i. Apply pacing pads in the anterior/posterior position.
 - ii. Set initial external pacemaker settings to a rate of 80 and mA of 80.
 - Adjust mA as needed to maintain capture.
 - b. Consider Atropine 0.5 mg IV while awaiting pacer. May repeat every 5 minutes up to 3 mg.
 - c. Consider Dopamine 5 mcg/kg/min continuous IV infusion while awaiting pacer or if pacing is ineffective. May titrate in 2mcg/kg/min in 10 minutes as needed to achieve goal Heart Rate (HR).
 - d. Obtain a STAT 12-lead ECG.
 - e. Draw blood for CHEM 7, CK Mb Fraction, and Troponin I. Draw blood for drug levels (such as digoxin) if applicable.
 - f. Check blood glucose and if less than 70 mg/dL treat per Standardized Procedure: Hypoglycemia Management.
- I. Tachycardia:

H.

- Order STAT ECG.
- Draw blood for CHEM 7, CK Mb Fraction and Troponin I and ABG after treating the patient.
- 3. Stable Tachycardia:
 - a. Regular, Narrow QRS Complex:
 - Attempt vagal maneuvers by having patient bear down or cough.
 - ii. Administer Adenosine (Adenocard) 6 mg IV push over 1–3 seconds. If tachycardia persists, repeat in 1–2 minutes with 12 mg IV push.
 - 1) Reduce dose by 50% (Adnenocard 3mg followed by Adenocard 6mg should tachycardia persist) for the following:
 - 1. Administering through a central line
 - 2. Patient has a history of heart transplant
 - 2.3. On concurrent Cabamazepine or Dipyridamole
 - iii. Administer normal saline 20 mL IV push after each dose of adenosine.
 - b. Irregular, Narrow QRS Complex:
 - i. Administer diltiazem (Cardizem) 10 mg-IV push times 1 dose; may repeat times 1 dose if0 tachycardia persists after 15 minutes. 0.25 mg/kg IV push (recommended dose: 15 mg to 20 mg for initial bolus).
 - iii. If tachycardia persists after 15 minutes, administer second dose of diltiazem 0.35 mg/kg IV push (20 mg to 25 mg for second bolus).

- ii.ii. Consider calling physician for a Diltiazem continuous IV infusion after bolus doses.
- iii.iv. Do not use diltiazem in patients receiving beta blockers or known/suspected EF less than 25%.
- c. Wide QRS Complex:
 - i. Administer amiodarone 150 mg diluted in 100ml of D5W IV over 10 minutes. Infuse through a 0.22 micron filter.
 - Consider calling physician for amiodarone infusion after initial bolus dose.

4. Unstable Tachycardia:

- a. Heart rate is greater than 150 beats per minute and serious signs and symptoms such as chest pain, shortness of breath, decreased level of consciousness, or hypotension are present and believed to be related to rapid heart rate.
 - i. Prepare for immediate synchronized cardioversion.
 - ii. Consider sedation if the patient is conscious and a physician order can be obtained, but do not delay cardioversion.
 - iii. Ensure the defibrillator pads and monitor leads are attached to the patient and the defibrillator is in synchronization mode.
 - iv. Cardiovert with 50 joules and check the patient's rhythm.
 - If necessary, repeat cardioversion at 75, 100, 120, 150 and 200 joules. Be sure to reset the defibrillator to synchronization mode with each increase in joules.

J. Seizures:

- 1. Protect patient from injury. Do not place anything in the patient's mouth.
- 2. Administer Lorazepam (Ativan) 4 mg (if patient weighs less than 40kg, give 0.1 mg/kg) slow IV push over 2 minutes. May repeat one time in 5-10 minutes if seizures continue. Doses not to exceed 8 mg total.
- 3. Draw blood for CHEM 7, Calcium, capillary blood glucose and any applicable drug levels (i.e. Dilantin).
- 4. Obtain physician order for Electroencephalogram (EEG).

K. Anaphylaxis:

- Anaphylaxis is a severe allergic reaction that may occur after exposure to certain foods, drugs, or contrast dye in susceptible patients. Signs and symptoms may include hypotension, rash, swelling of the lips, face, neck or throat, wheezing, and difficulty breathing.
- 2. If patient is experiencing stridor and is in danger of airway occlusion call Code Blue for emergent intubation.
- Severe reaction:
 - a. Administer epinephrine 0.5 mg (using 1mg/ml solution) intramuscularly. May be repeated in 5-15 minutes in the absence of clinical improvement times one dose.
 - b. If patient weighs less than 50 kg, administer epinephrine 0.01 mg/kg intramuscularly (using 1mg/ml solution). May be repeated in 5-15 minutes in the absence of clinical improvement times one dose.
 - c. Obtain physician order to administer normal saline IV at a rate of 999ml/hr for up to 2 liters to restore adequate blood pressure.
 - d. Provide adjunctive therapies as listed below once patient is stable to prevent relapse of the reaction.

4. Mild reaction:

- a. Administer normal saline 500 mL IV fluid bolus if the patient is hypotensive; may repeat one time.
- Administer Albuterol 2.5 mg via nebulizer if the patient is wheezing
- c. Famotidine (Pepcid) 20 mg IV once; obtain physician orders for additional dosing.
- d. Administer diphenhydramine (Benadryl) 25 mg IV push once.

e. Administer hydrocortisone (Solu-CORTEF) 200 mg IV push if severe prolonged reaction is expected.

III. POST EVENT PROCEDURE:

- A. The RRT shall re-evaluate the patient's condition after providing interventions.
- B. A phone call shall be placed to the attending physician to provide an update on patient status or any interventions performed.
- C. Transfer patient to higher level of care if deemed appropriate by the RRT or attending physician.
- D. The RRT shall remain with the patient until patient is stabilized on the unit or transferred to a higher level of care.
 - RRT leader shall provide hand-off communication to the receiving nurse.
 - 2. In the event the patient is transferred to a higher-level of care, the RRT-leader shall provide the staff-nurses with an update on patient's status after transfer.
- E. If patient is maintained on the unit, the RRT Team RN shall place a follow-up call or visit the staff nurse 1 to 4 hours after the event for an update on the status of the patient.

IV. DOCUMENTATION:

- A. The RRT Leader shall document all events in the medical record to include the following:
 - Reason for call
 - 2. Interventions performed, medications administered, and labs or diagnostic tests ordered per standardized procedure
 - 3. Follow-up report
- B. All new physician orders shall be placed in the electronic health record.

V. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- Current unencumbered California RN license.
- B. Minimum of 2 years critical care experience
- C. Education: Successful completion of ACLS course (with current course completion card).
- D. Initial Evaluation: Successful completion of Rapid Response Orientation.
- E. Ongoing Evaluation: Completion of Annually-ICU Skills-Lab and including RRT Standardized Procedure Computer-Based Learning module.

VI. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

VII. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

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

VIII. RELATED DOCUMENT(S):

- A. Patient Care Services Standardize Procedure: Code Blue and Emergency Care
- B. Patient Care Services Standardize Procedure: Haloperidol IV Administration
- C. Patient Care Services Standardize Procedure: Hypoglycemia Management in the Adult Patient
- D. Patient Care Services Policy: Rapid Response Team Activation and Condition Help (H)



ADMINISTRATIVE-POLICY HUMAN RESOURCES

ISSUE DATE:

10/87

SUBJECT: Photo-Identification of

Staff Employees and Non-TCHD

Employees

REVISION DATE(S): 01/09, 04/12, 02/19

POLICY NUMBER: 8610-436

| Administrative Human Resources Content Expert Approval: Administrative Policies & Procedures Committee Approval: Pharmacy & Therapeutics Committee: Medical Executive Committee: | 02/19 06/19 - n/a 08/19 n/a 10/19 |
|--|--|
| Human Resources Committee Approval: | 04/15 |
| Administration Approval: | 11/19 |
| Professional Affairs Committee Approval: | n/a |
| Board of Directors Approval: | 04/15 |

A. DEFINITION(S):

1. <u>Workforce Member:</u> Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

B. PURPOSEPOLICY:

- In-accordance with-regulatory requirements, it is the goal of Tri-City-Hospital District to establish a safe environment by requiring that-all authorized volunteers, employees, independent contractors and vendors have appropriate identification. All TCHD employees and medical staffWorkforce Members must wear their TCHDhospital I.D. issued badge with picture and name clearly visible at all times while at TCHD per Administrative Policy: Secure Environment.
 - Disfiguring or changing any portion of the photo ID badge is not allowed.
- A.2. The ID-TCHD issued badge is the method of identification for access control onto hospitalTCHD's premises during emergency situations. The IDTCHD issued badge should be kept with the employeeWorkforce Member at all times in case of disaster or emergency.
- 1. To provide guidelines for appropriate photo identification of all TCHD employees while on duty.

B. POLICY: RESPONSIBILITY:

- C. The TCHD Security Department is responsible for safeguarding patients, employees, visitors and the property and facilities of the hospital. In this regard, the Security Officers may:
 - D. Issue photo I.D. cards to TCHD employees
 - E. Refuse admittance to TCHD of any employee not displaying their photo I.D.
 - Collect photo I.D.'s from TCHD-employees upon termination
- G.3. Department Heads / Directors or Supervisors must:
 - H.a. Communicate the lidentification requirements of Staff policy to their employees workforce members.
 - Hb. Counsel employeesworkforce members who do not comply with this policy.

PROCEDURES:

K. Employee I.D. Badges:

- L.4. On the first day of employment or engagement, new employeesWorkforce Members must obtain a photo I.D.TCHD issued badge from the Security or through appropriate process (for example, Business Visitors use Reptrax, nursing students through the Education Department).
 - M. The employee's access to areas within the hospital will be pre-determined by their department head prior to the employees start date by utilizing the Badge Access form and forwarding to the Security Department.
 - N.a. Employees requiring access to sensitive/secure areas other than their own must have permission granted by thate department's head-Director prior to authorization of the badge.
 - b. Business Visitors must wear the Reptrax printed badge or other appropriate TCHD vendor/visitor-identification-and check in with the charge nurse prior to entering any clinical area per Administrative District Operations Policy: Business Visitor Visitation Requirements 8610-203.
- 5. Lost TCHD issued badges will be replaced by Security at the Workforce Member's expense. The department Director or Supervisor must create a Badge Access form indicating a badge replacement and send to Security prior to issuing the new badge.
- Q.6. Upon termination, the Workforce Member's TCHD issued badge must be submitted to their Manager or the Human Resources Department (HR).
 - a. The employee's badge must be clearly-visible and-worn above the waist at all-times while in the hospital
- For purposes of security, safety, access control and customer satisfaction, all-employees will-be
 provided a photo identification (ID) badge by Employee-Health Services. The badge must be
 clearly visible and worn above the waist at all times during duty hours while on hospital premises.
- 3. The ID badge is the method of identification for access control onto hospital premises during emergency situations. The ID badge should be kept with the employee at all times in case of disaster or emergency.
- Employee-ID is required in-order to take-advantage of TCHD employee discounts (i.e., cafetoria discounts, payroll deductions at Employee Health Services, gift shop, etc).
- 5. Employees are responsible for acquiring their photo ID badge from Employee Health-Services on their first day of employment.
- 6. --- Disfiguring or changing any portion of the photo-ID badge is not allowed.
- 7. Lost-badges will be replaced in Employee Heath by the Security-Department at the employee's expense. The employee's department-head must create a Badge Access form indicating this is a badge-replacement and send to the Security-Department If this occurs on the weekend or holiday, employee must go to security to obtain temporary badge prior to creating the new badge.
- 8. Upon-termination, the employee's photo ID badge-must be submitted to his/her-manager-er-Human Resources.
- 9.7. Failure to wear a TCHD issued badge properly when on duty may result in disciplinary action up to and including termination (see Administrative District Operations Policy: Secure Environment 204).
- 10. Contractor Badges NOTE: Per 02.22.2019 APP discussion this section may be moved to Administrative Human-Resources Policy: Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employee 8610-451
 - 11. Contractors that are authorized to work at TCHD must sheck in and be vetted by the Facilities Coordinator or designees prior to commencing work in the hospital.
 - 12. The contractor must sign out the Contractor Badge and leave their Driver's License with the Facilties-Coordinator or designees as collateral for the return of the TCHD badge.
 - 13. The contractor shall return the I.D. badge at the end of their work routine to the facilities Coordinator or designee.
 - 14. The contractor must adhere to all TCHD guidelines regarding the displaying of the

Administrative Human Resources

Phote-Identification of Staff-Employees and Non-TCHD Employees Policy 8610-436

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I.D. badge, as well as, all TCHD policies and procedures.

8. 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.

C. FORM(S):

Request for Restricted Badge Access

D. RELATED DOCUMENT(S):

Security-Badge-Access Form

- 1. Administrative District Operations Policy: Secure Environment 8610-204
- 45.2. Administrative District Operations Policy: Business Visitor Visitation Requirements 8610-203



CARDIOLOGY

SUBJECT: Echocardiography Quality Improvement (QI) Policy

ISSUE DATE:

NEW

REVISION DATE(S):

Cardiology Department Approval: 08/19
Division of Cardiology Approval: 10/19
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: n/a
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

A. PURPOSE:

 To establish guidelines for continuous process improvement of case studies and reports leading to high-quality echocardiography studies and interpretations to help to ensure better patient outcomes.

B. POLICY:

- 1. QI Oversight:
 - a. The Medical Director of Non-Invasive Cardiology provides oversight of the QI program which includes but is not limited to:
 - Test Appropriateness
 - ii. Technical Quality Review (Sonographer Performance Variability)
 - iii. Interpretive Quality Review (Physician Interpretation Variability)
 - iv. Final Report Completeness and Timeliness
 - b. Addresses any deficiencies
- Test Appropriateness
 - Test appropriateness will be measured on a minimum of two cases per quarter and categorized as, appropriate, may be appropriate, rarely appropriate. Results are documented, reviewed and discussed at the QI meetings.
- 3. Technical Quality Review (Sonographer Performance Variability):
 - a. Two cases per quarter will be reviewed for image quality, completeness of the study (all views, measurements and Doppler evaluations), and adherence to the protocol. Results will be reviewed/discussed in the QI meetings. The cases selected will represent as many sonographers as possible. The Medical Director will address any deficiencies in the quality and completeness of the studies as well as adherence to the protocol. If concerns exist regarding a specific measurement technique additional training will be scheduled.
- 4. Interpretive Quality Review (Physician Interpretation Variability):
 - a. The interpretive quality review will consist of a minimum of two cases per quarter must be evaluated for the quality and accuracy of the interpretation based on the acquired images. The results are documented, reviewed and discussed at the QI meeting. As many physicians as possible will participate in the review. The Medical Director addresses any differences in interpretation to achieve uniform study interpretations.
- Final Report Completeness and Timeliness:
 - a. A minimum of two random reports per quarter are evaluated and the results documented for report completeness and timeliness of reporting. The time of the completion of the

Cardiovascular Services Echocardiography Quality Improvement (QI) Policy Page 2 of 2

study to initial physician preliminary interpretation to final report are evaluated. The results will be documented, reviewed and discussed at the QI meeting. The Medical Director addresses any incomplete reports, reports not interpreted and finalized in the required timeframe as required by contract.

- 6. Biannual QI Meetings:
 - a. A minimum of two QI meetings per year are held to review/discuss the results of QI measures, other QI-related topics and any additional topics. All staff will participate in at least one meeting per year. Staff attendance and meeting minutes will be documented.
- 7. QI Documentation and Records:
 - Data documented/recorded for the required QI measures, meeting minutes and attendance/participant list will be maintained and available for staff review.

C. REFERENCE(S):

 Intersocietal Accreditation Commission Standards and Guidelines for Adult Echocardiography Accreditation 2018

ENGINEERING SAFETY AND SECURITY

| TRI-CITY MEDICAL CENTER Subject: Access to | |
|---|------------------------------|
| Engineering Policy & Procedure | Locked Engineering |
| Policy Number: 5009 | Page 1 of 1 |
| Department: Hospital-Wide EFFECTIVE: 11/1/87 REVISED: 9/94; 2/97; 5 | - 5/00: 5/03: 06/06: 6/12 |

SUBJECT: Access to Locked-Secured EngineeringDoors

ISSUE DATE:

11/87

REVIEW DATE(S):

REVISION DATE(S): 9/94, 2/97, 5/00, 5/03, 6/06, 6/12

Department Approval Date(s):

Environmental Health & Safety Committee Approval:

Administration Approval:

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

07/19

09/19

11/19

n/a

06/12

A. **PURPOSE**:

1. To establish guidelines for Engineering Department Personnel to utilize, when called upon, to open locked doors within the Medical Center, outlying buildings or off campus facilities.

B. POLICY:

Engineering personnel are not to unlock any room, office or building that is not assigned to the Engineering Department unless there is Engineering Department work to be performed in that location.

1.

C. PROCEDURE:

4-2. If Engineering Personnel -are requested to unlock an unauthorized area, the requestor shall be referred to the Security Department or Nursing Administrative Coordinator for proper access.

ENGINEERING OPERATIONS

| | Section: ENGINEERING DEPARTMENT |
|--------------------------------|---|
| TRI-CITY MEDICAL CENTER | Subject: Documentation of Site Facility Utility Systems |
| Engineering Policy & Procedure | Policy Number: 2014 Page 1 of 2 |
| Department: Hospital-Wide | EFFECTIVE: 9/91— REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12 |

SUBJECT: Documentation of Site Facility Utility Systems

ISSUE DATE:

9/91

REVIEW DATE(S):

REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:

07/19

Environmental Health & Safety Committee Approval:

09/19

Administration Approval:

11/19

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

n/a

A. PURPOSE:

1. To describe and document the systems that are covered by the Utilities Management Program.

B. **GENERAL INFORMATION:**

1. Utilities Systems include: eElectrical, heating ventilaltion and air conditioning (HVAC)HVAC, plumbing, steam and boilers, medical gas and vacuum, communication and transport.

A.C. ELECTRICAL SYSTEM:

- a.1. Normal power distribution provides energy-electricity to all electrically driven equipment and devices deemed necessary for normal, routine and special operations of overall medical facility operation.
- b.2. Emergency power provides energy electricity to selected emergency equipment and devices that are deemed necessary for completion of the medical-facilities mission-in the event of normal power loss.

C.D. HVAC:

a-1. HVAC provides a controlled- adequate temperature, air changes, air filtration and air pressure relationships to facilities environment for patient comfort. It provides a source of fresh air through-filtration thereby reducing the opportunity for airborne infection. HVAC system provides a compatible environment for sensitive electronic equipment.

D.E. PLUMBING:

a.1. The plumbing system provides a means of transporting transports liquids, gases and semi-solid waste. from one location to another. It provides water for drinking and cleaning in an effort to help the medical facility complete its patient care mission.

E.F. STEAM AND BOILERS:

a-1. Boiler generated steam is dispersed throughout the facility to previde is utilized for domestic hot water for cleaning, temperature heating, environmental heat as well as a medium for cooking and sterilization.

F.G. MEDICAL GAS AND VACUUM:

- Medical-gas-and-vacuum system-is-comprised of 4 separate system Providing service to Surgery and other procedural areas, as well as patient rooms.
- N20-Nitrous Oxide an anesthetic gas supplied to procedural areas surgery suites, delivery rooms and procedural areas deemed necessary.
- 2. 02-Oxygen - is delivered to procedural areas and patient rooms-to-facilitate the treatment and cure of patients..
- Medical Air is delivered to procedural areas and patient rooms. to facilitate the treatment and care of patients.
- 4. Vacuum is delivered to procedural areas and patient rooms. is delivered to patient rooms, surgery suites, delivery rooms, as well-as other procedural areas to facilitate the treatment and care of patients.

G.H. COMMUNICATION:

- 2. The communication system of the hospital is comprised of several-independent systems each designed to meet-special requirements by regulatory agencies.
- 1. Fire alarm immediately notifies building occupants hespital staff and Fire Department of fire alarm-status.
- Nurse Call facilitates nursing care and-provides a direct link from patient room to nursing deske station in case of emergency or need for assistance.
- 3. Telephone system allows for interdepartmental and external communication facilitating nursing care and diagnostic procedures, as well as providing a link to outside services.
- 4. Public Address-SystemPaging System allows for immediate contact with all staff-hospital occupants.in any situation requiring immediate action.
- 5. Paging system facilitates contact of personnel in and out of the hospital facility.

H.I. VERTICAL AND HORIZONTAL TRANSPORT:

- 1. Pneumatic tube system provides immediate service between the Lab and Emergency Room and-Lab-resulting in little delay of diagnostic testing.
- 2. Elevators provide vertical transport for patients, hospital staff, visitors and equipment.



ENGINEERING EQUIPMENT

| TRI-CITY MEDICAL CENTER | Section: Emergency Preparedness Management | |
|------------------------------|---|--|
| Safety-Policies & Procedures | Subject: Facilities Management Disaster Implementation Plan | |
| | Policy Number: 4035 Page 1 of 1 | |
| Department: Facilities | EFFECTIVE: 11/88 REVISED: 10/93; 3/97;6/00; 5/09; 6/12 | |

SUBJECT: Facilities ManagementEngineering Disaster ResponseImplementation Plan

ISSUE DATE:

11/88

REVIEW DATE(S):

REVISION DATE(S): 10/93, 3/97, 6/00, 5/09, 6/12

Department Approval: 07/19
Environmental Health & Safety Committee Approval): 09/19
Administration Approval: 11/19
Professional Affairs Committee Approval Date(s): n/a

Board of Directors Approval Date(s):

A. DISASTER ACTIVATION:

- The PBX Operator will announce "Code Orange" three times over the intercom system.
- 2. ON-DUTY HOURS 0730-16700 MONDAY THROUGH FRIDAY
 - a. Staff will report to the Engineering Department and Director of Facilities or designee will determine if assistance is needed by other departments from thewhat Engineering assistance if any is needed. Facilities Director/designee. The Facilities Director of Facilities or /designee will communicate with Incident Command Center via phone, if possible.
 - b. If cGall-back protocol is activated, -- aAll personnel are subject to reporting for duty -(at the discretion of the Director of Facilities or /designee in charge).
 - c. Carpenters and painters will report to the Labor Pool-located in French Room-3.
 - d. 1.1.4 In the event the Engineering Department is the location of the disaster, the employees will report to the Labor Pool located in French Room 3.
 - e-c. The Director of Facilities or /designee will be responsible for completion of departmental status reports and inventory to be delivered to the Incident Command Center via runner.

 Updates to the Command Center will be provided on an hourly basis.
 - f. Call-back protocol activated. All personnel are subject to reporting for duty (at the discretion of the Director of Facilities/designee in charge).
 - g. Staff will-report to the Engineering-Department and determine if assistance is needed by other departments from the Facilities Director/designee.

- OFF-DUTY HOURS
 - a. 1.21 Call-back protocol will be activated and staff will be notified of standby status to report to duty. Personnel will be salled to some in and-work as needed to manage disaster. Personnel called to come in will report to the Engineering Department for instructions.
 - b. 1.2.2 Carpenters and painters will report to the Labor Pool located in French Room 3.



ENGINEERING OPERATIONS

| TRI-CITY MEDICAL CENTER | Section: ENGINEERING DEPARTMENT |
|--------------------------------|---|
| Engineering Policy & Procedure | Subject: Smoke Management System |
| Engineering Foney & Frocedure | Policy Number: 2015 Page 1 of 1 |
| Department: Hospital-Wide | EFFECTIVE: 9/91— REVISED: 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12 |

SUBJECT: Fire Smoke Management System

ISSUE DATE:

9/91

REVIEW DATE(S):

REVISION DATE(S): 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:

7/19

Environmental Health & Safety Committee Approval:

9/19

Administration Approval:

11/19

Professional Affairs Committee Approval:

Board of Directors Approval:

A. PURPOSE:

 To describe the process of managing smoke from a fire by which smoke management occurs throughout the hospital.

B. **GENERAL INFORMATION:**

- 1. If a-Ffire alarm canis be activated by using manual pull stations or by automatic smoke detectors. , in the-Security Signal Devices (SSD), be it a manual, ceiling or duct smoke detector, respectivethe
- 2. The fire alarm will sound throughout the hospital and send an alarm toand-at the the alarm monitoring service vendor who in turn will validate the alarm and notify the fire department if necessary., allert-Security, who will-notify the fire department of the exact-location of the alarm and
- 2.3. PBX will announce the exacthis location of the fire using the overhead pager system so that appropriate departments can respond and inititate initiate fire evacuation and smoke containment procedures.on the public address system.
- 4. During a fire, the affected air handling unit will shut down and the outside dampers will close. The exhaust fans fans in the two buildings will continue to run to remove smoke and toxic fumes from affacted affected the spaces.
- Duct smoke detectors located in various parts of the ducting will not only sound the alarm and secure air handlers but will also electronically cause the dampers to close preventing the spread of smoke.
- 6. Any smoke compartment doors that are held open by electronic devices will be disabled by the fire alarm signal and the doors will close to contain the smoke away from other hospital compartments.

- 3. Duct smoke detectors located in various parts of the ducting will not only sound the alarm and secure air handlers it will electronically cause the dampers to close preventing the flow of fresh air through the duct to the fire.
- 4.7. In other areas of the hospital, smoke detectors and manual pull station sound the chimes and indicate an alarm condition on the panels in PBX Engineering and alarm menitoring company. In the Maternity and South Tower areas there are electrothermal links that melt when activated by the smoke detectors causing the dampers to close, further isolating the fire. Exhaust fans continue operating to remove smoke and toxic fumes.



ENGINEERING SAFETY AND SECURITY

| TRI-CITY MEDICAL CENTER Engineering Policy & Procedure | Section: ENGINEERING DEPARTMENT Subject: Handling And Use Of Compressed Gas Cylinders |
|---|--|
| Department: Hospital Wide | Policy Number: 5007 Page 1 of 2 EFFECTIVE: 11/1/87— REVISED: 9/94; 2/97; 5/00; 5/03, 06/06, 06/12 |

SUBJECT: Handling and Use of Compressed Gas Cylinders

ISSUE DATE:

11/87

REVIEW DATE(S):

REVISION DATE(S): 9/94, 2/97, 5/00, 5/03, 6/06, 6/12

Department Approval: 07/19
Environmental Health & Safety Committee Approval: 09/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 06/12

A. PURPOSE:

To define Safe safe procedures for the handling and use of compressed gas cylinders.

B. **POLICY**

- 1. Only-those personnel trained in proper handling of cylinders, cylinder trucks, cylinder supports and cylinder valve protection caps shall be permitted to use or transport such equipment.
- 2. Cylinder valve protection caps shall be secured tightly in place unless the cylinder is connected for use.
- 3. Cylinders shall be stored in accordance with all applicable NFPA standards.
- 4. Portable liquid oxygen reservoirs shall not be stored in a tightly closed space such as a closet.
- All cylinders shall be transported on a proper cylinder truck or cart constructed for the intended purpose, self-supporting, and previded-with appropriate mounting equipment chains or stays to retain cylinders in place.
- 6. When small size (A, B, C, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to therapy apparatus of sufficient size to render the entire assembly stable.
- 7. Cylinders shall not be dropped, dragged, rolled or picked up by the valve cap.
- 8. Free standing cylinders shall be properly chained or supported in a proper cylinder stand or cart.

 -They shall not be chained-attached in any other way to equipment or building parts.

 portable or movable apparatus such as beds and exygen tents, or supported by radiators, steam pipes and heat ducts.
- Very cold cylinders shall be handled with care to avoid injury.
- Cylinders shall not be handled with hands, gloves or other materials contaminated with oil or grease.
- 11. Contents of cylinders shall be identified by reading the label prior to use. Labels shall not be

- defaced, altered or removed. Cylinders without labels shall not be used.
- 12. Cylinders shall be tagged to reflect their capacity: FULL, IN USE, EMPTY. Cylinders not appropriately tagged should be considered in use.
- Empty cylinders shall be handled as if they were full.
- 14. Cylinder valves shall be opened and connected in accordance with approved procedure listed below. (See Procedure).
- 15. Mixing or transferring of compressed gas from one cylinder to another is prohibited

C. PROCEDURE - OPENING AND CONNECTION OF CYLINDER VALVES:

- Make certain that apparatus and cylinder valve connections and cylinder wrenches are free of foreign materials.
- 2. Turn the cylinder valve outlet away from personnel. Stand to the side, -not in front and not in the back. Before connecting the apparatus to the cylinder valve, momentarily open the cylinder valve to eliminate dust.
- 3. Make connections of apparatus to cylinder valve. Tighten connection and nut securely with appropriate wrench.
- Release the low pressure adjustment screw of the regulator completely.
- 5. Slowly open the cylinder valve to full open position.
- 6. Slowly turn in the low pressure adjustment screw and the regulator until the proper working pressure is obtained.
- 7. Open the valve to the utilization apparatus.

ENGINEERING OPERATIONS

| | Section: ENGINEERING DEPARTMENT |
|--------------------------------|---|
| TRI-CITY MEDICAL CENTER | Subject: Kitchen Hood Fire Extinguishing System |
| Engineering Policy & Procedure | Policy Number: 2012.1 Page 1 of 1 |
| Department: Hospital-Wide | EFFECTIVE: 5/14/91 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12 |

SUBJECT: Kitchen Hood Fire Extinguishing System

ISSUE DATE: 5/91 REVIEW DATE(S):

REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval: 07/19
Environmental Health & Safety Committee Approval): 09/19
Administration Approval: 11/19
Professional Affairs Committee Approval Date(s): n/a

Board of Directors Approval Date(s):

A. POLICY:

 A licensed fire service contractor will test, service and recharge as necessary the kitchen hood system every six (6) months and tag the equipment appropriately.

Any malfunctions or required repairs will be addressed immediately.



ENGINEERING SAFETY AND SECURITY

| TRI-CITY MEDICAL CENTER | Section: ENGINEERING DEPARTMENT |
|--------------------------------|--|
| Engineering Policy & Procedure | Subject: Lockout/Tagout Procedures Policy Number: 5003.1 ——Page 1 of 1 |
| Department: Engineering | EFFECTIVE: 8/30/89 REVISED: 9/94; 2/97; 5/00; 5/03, 06/06, 6/12 |

SUBJECT: Lockout/Tagout Procedure

ISSUE DATE:

08/89

REVIEW DATE(S):

REVISION DATE(S): 9/94, 2/97, 5/00, 5/03, 6/06, 6/12

Department Approval:

03/19

Environmental Health & Safety Committee Approval:

09/19

Administration Approval:

11/19

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

POLICY:

A. DEFINITIONS:

- 1. Lockout An OSHA safety regulation so that anyone working on equipment or a utility system is safe during a service or repair. A lockout involves placing a lock on the part of the machine that controls the energy (i.e. circuit breaker, switch, block, valve, etc.) in order to lock the energy control device in an "off" position to prevent the machine from starting up or releasing energy accidentally. A lockout lock may utilize a key or a combination. However, it cannot be a lock that is used for any purpose other than lockout.
- 2. Tagout in the event a lockout is not possible, a warning tag may be applied to the device to serve as a tagout.
- 3. Energy the quantitative property that must be transferred to an object in order for it to perform work. That energy can be electrical, mechanical, hydraulic or pneumatic. Sometimes the energy is stored, as in springs, steam, or as pressurized air or liquids. Any type of energy, however, can be a serious safety hazard, especially if it powers on a device or is released unexpectedly while servicing or maintaining equipment.

B. PURPOSE:

1. To define Lockout/Tag out procedures that should be taken to ensure that the appropriate lockout or tagout devices are utilized to disable machines, equipment or utility systems and prevent unexpected start-up.

C. **GENERAL INFORMATION:**

- 1. Lockout/tagout training:
 - Lockout/tagout training will be conducted for all new employees. Retraining will be conducted when there is:

- a change in job assignment;
- ii. new hazard due to a change in machine, equipment or process;
- iii. change in procedure; or
- iv. Annual evaluation reveals inadequacies in lockout/tagout procedures or employee knowledge.
- b. When outside contractors are to be used, Contractor needs to follow Engineering Department's lockout and tagout procedures.

2. Authorized personnel:

- a. Personnel authorized to perform lockout/tagouts will be assigned by Engineering Management. Those assigned this responsibility will be trained in specific lockout/tagout procedures and will learn how to recognize the type and amount of energy used by the machines and equipment and how to control that energy.
- b. If a team is used for lockout/tagout, one member of the group must have primary responsibility. That person makes sure that all group members are safe during lockout. Each authorized group member puts his or her own lock or tag on during the group lockout.
- c. Always use your own lock and key.
- Never remove anyone else's lock or permit anyone else to do so.

3. All personnel:

- a. All personnel who work with equipment must be trained in basic lockout procedures. They need to understand why lockout/tagout is important, how the procedure works, and the importance of not attempting to repair or service machinery without going through proper procedures. Other personnel need to be familiar with lockout/tagout procedures, and know the importance of not trying to restart locked or tagged equipment.
- b. Never remove, ignore or bypass locks or tags you find on machinery.

4. Lockout locks must be:

- a. Durable enough for the heat, cold, humidity or corrosiveness in the area where it's used for as long as it is needed.
- b. Standardized by color, shape or size throughout the facility.
- c. Strong enough so it cannot be removed without a heavy force or tools like bolt cutters.
- d. Identified by the name of the employee who installs and removes it.
- e. Report lost keys to your supervisor immediately and have lock destroyed.

D. PROCEDURE:

1. Lockout:

- a. All shut downs are to be approved by Engineering Management.
- b. Locate and identify power sources, potential hazards and all control devices.
- c. Notify all personnel involved and affected by the shutdown.
- d. Turn off all power controls.
- e. Isolate all power sources by blocking, bleeding and venting energy that may be stored in springs, hydraulic systems and pneumatic systems.
- f. Lockout all switches and power controls in the "Off" or "Safe" position.
- g. Test for safety with operating controls in the "On" position. -Before testing, always insure that nobody is in danger of injury.
- h. Return all operating controls to the off position.
- Perform necessary work.
- 2. Remove lockout devices once the equipment is fully operational and all affected employees are notified. Lockout devices must be removed by the person who puts them on:TAGOUT:
 - a. Some equipment cannot be locked out. This does not mean it cannot be dangerous if it starts or is energized accidently. That is where tagout would be

- required. Tagout means using special tags that warn people of the danger of starting up the machine. A tag has a printed warning about what could happen if the equipment starts up. The tags must be special tags, used only for this purpose. Remember, tags do not provide physical restraints they are simply warning devices. Do not let tags provide a false sense of security.
- b. Tagout tags must meet the same standards that the locks do, such as they must be durable, strong, standardized and show the identity of the person doing the work. They must also have the same print and format throughout the facility and be tough enough so they cannot be accidentally removed. The law also states that they must be attached with something similar to nylon cable and cannot be reused. They also must be self-locking and cannot be released with less than 50 pounds of strength. A tagout must be attached at the same location as a lockout device would have been attached.
- 3. Removing a Lockout or Tagout:
 - a. When maintenance or service is done, only the same authorized person who installed the lock or tag may remove it.
 - i. Special circumstances may apply during shift changes or unavailability and in this case Engineering Management is to give direction on removing the lock or tag.
 - b. Make sure all personnel are a safe distance from equipment.
 - c. Remove tools from machine or equipment.
 - d. Reinstall any machine guards.
 - e. Remove lockout devices.
 - f. Turn on energy.
 - 4.g. Notify other personnel that the machines are working again.

ENGINEERING OPERATIONS

| | Section: ENGINEERING DEPARTMENT | |
|--------------------------------|---|--|
| TRI-CITY-MEDICAL CENTER | Subject: Management of Portable Fire Extinguishers | |
| Engineering Policy & Procedure | Policy Number: 2012 Page 1 of 1 | |
| Department: Hospital-Wide | EFFECTIVE: 5/14/91 REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12 | |

SUBJECT: Management of Portable Fire Extinguishers

ISSUE DATE:

5/91

REVIEW DATE(S):

REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval: 07/19
Environmental Health & Safety Committee Approval: 09/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 06/12

A. PURPOSE:

- 1. To describe the process by which the portable fire extinguishers are installed, identified, used, inspected and maintained.
 - 2. <u>Computerized Maintenance Management System</u> (CMMS) A computerized information system used to facilitate the scheduling of inspection, maintenance and documentation.

B. **PROCEDURE:**

- Fire extinguishers shall be installed in accordance with NFPA 10, Chapter 3.
- 2.1. A rester will kept on file of the An inventory will be maintained by the Engineering Department listing fire extinguisher type and their locations., station I.D. number and corresponding I.D. of extinguisher and type of extinguisher.
- 3.2. Quarterly inspection shall be in-accordance with NFPA 10, Chapter 4. Fire extinguishers will be visually inspected on monthly basis to ensure all operating parts are intact, that the fire extinguishers are full and that they are in the designated locations.
- 4-3. Maintenance shall be conducted on all the fire extinguishers by a contracted service or fire extinguishers shall be replaced with new ones on annual basis +/- 30 days.in accordance with NFPA 10, Chapters 4 and 5.



ENGINEERING QUALITY ASSURANCE

| TRI-CITY MEDICAL CENTER | Section: ENGINEERING DEPARTMENT | |
|--------------------------------|--|--|
| Engineering Policy & Procedure | Subject: Quality Improvement Plan | |
| Engineering 1 oney & Procedure | Policy Number: 7000 Page 1 of 3 | |
| Department: Hospital-Wide | EFFECTIVE: 11/7/87 | |
| | REVISED: 9/94; 2/97; 5/00; 5/03; 2/06; 5/09; 6/12 | |

SUBJECT: Quality Improvement-Assurance Plan

ISSUE DATE:

11/87

REVIEW DATE(S):

REVISION DATE(S): 9/94, 2/97, 5/00, 5/03, 5/06, 6/12

Department Approval:

07/19

Environmental Health & Safety Committee Approval:

09/19

Administration Approval:

Professional Affairs Committee Approval Date(s):

11/19 n/a

Board of Directors Approval Date(s):

06/12

A. **PURPOSE:**

- 1. To describe the process by which the Engineering Department analyzes the quality of service it provides.
- 2. The Engineering Department is responsible for the functionality and safe environment of Tri City Healthcare District (TCHD) is facilitiesphysical plant surrounding the functional elements which, directly or indirectly, provide for the care of the patients. In discharging this responsibility Wwe strive, at all times, to maintain these facilities in a manner which will hold them readily and functionally operational in the best interests of our patients, visitors, Medical Staff and hospital empleyees who serve those patients and the public employees.
- 3. Safety, readiness, reliability and efficiency arewill be the goals of our department along with a desire to, at all times, abide by the rules and regulations of the hospital; and to maintain a harmonious relationship with all other departments.

GENERAL INFORMATION:

The Computerized Maintenance Management System (CMMS)—A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

Ç.B. **POLICY:**

- Responsibility The Director of Engineering is responsible for the departmental Quality Assurance Program. The Facilities Manager is responsible for the Plant Engineering and Building engineering Quality Assurance Programs.
- 2. Scope - The Engineering Department provides a wide variety of services to the medical centerTCHD Facilities. These services include but are not limited to:

Safety

i.a. ElectricalBuilding Utility Systems

ii.b. Physical Plant

iii.c. Life Safety

iv.d. Fire Safety

v.e. Equipment Safety

b.f. Emergency Preparedness

e.g. Equipment Management Program

d.h. Utilities Management Program

e.i. Maintenance Support toof Clinical Staff all departments

D.C. <u>IMPORTANT ASPECTS:</u>

Services are provided by the Engineering Department in order to provide a safe, functional and
efficient environment for the delivery of high quality patient care. Important service aspects include
regularly scheduled fire and safety inspections, fire drills, preventive maintenance of equipment
within the medical center, preventive maintenance of utility systems, education and training of
departmental and hospital staff, assuring compliance with all regulatory requirements and the
management of renovation and construction projects.

E.D. OBJECTIVES:

- 1. To promote high quality appropriate and effective service to the medical center.
- 2. To provide consistent documentation as to the quality, appropriateness and effectiveness of services delivered-to-the medical-center.
- 3. To provide for a system of identifying, assessing and resvolving problems which may occur within facilties.-in-providing services to the-medical center..

F.E. INDICATORS:

1. Indicators for the Quality Assurance Program will be identified en a quarterly basisby Engineering Director or designee. An indicator is a well defined, measurable variable related to the structure, process and outcome of service. Indicators should be objective and measurable, and should help direct attention to potential problems or opportunities to improve service.

G.F. THRESHOLDS:

Thresholds for evaluation shall be established that will indicate acceptable or non-acceptable points of compliance for each indicator. Thresholds are the level or point at which intensive evaluation of service is triggered. These t∓hresholds can be based upon many factors, quality assurance literature and on the experience of the department.

H.G. DATA COLLECTION:

Data collection will be assigned to staff review and will occur on a schedule related to the frequency
of the aspect of care surveyed take place as needed to show trends and provide values that
can be analized for process improvement.

H.H. EVALUATION:

Evaluation will occur after data is compiled and summarized. The results will be reviewed first by the Director of Engineering and then discussed at the weekly supervisors meetingwith the Engineering Management Team and other departments if needed. The evaluation will identify areas of improvement, or problems in the quality and/or appropriateness of the aspect of service.

J.I. ACTION TAKEN TO IMPROVE CARE/SERVICES:

 When problems are identified, action plans shall be developed, approved at the appropriate levels, and enacted to solve the problem or improve eareservices.

K.J. ASSESSMENT OF ACTIONS AND DOCUMENTATION OF IMPROVEMENT:

Engineering Manual Quality ImprovementAssurance Plan Page 3 of 3

> The effectiveness of those actions taken shall be assessed and documented by the Director of Engineering or designee. If further actions are necessary to solve a problem or improve services, those actions should be taken and their effectiveness assessed.

L.K. COMMUNICATIONS:

 The findings are documented and reported as specified through a reporting format to the Medical Staff Quality Assurance Committee the Medical Executive Committee, and on through to the Board of Directors, and as otherwise-indicated in the Medical Staff Quality Assurance Plan. Necessary information is communicated to Engineering Team or other areas of service/departments when interdepartmental problems have been identified.



ENGINEERING SAFETY AND SECURITY

| TRI-CITY MEDICAL CENTER Engineering Policy & Procedure | Section: ENGINEERING DEPARTMENT Subject: Training Outline for The Operation and Use of the Hospital Electrical Distribution System | |
|---|---|--|
| | Policy Number: -5013 Page 1 of 2 | |
| Department: Engineering | EFFECTIVE: 3/19/90 REVISED: 9/94; 2/97; 5/00; 5/03, 06/06, 6/12 | |

SUBJECT: Training Outline for The Operation and Use of the Hospital Electrical Distribution System

ISSUE DATE:

3/90

REVIEW DATE(S):

REVISION DATE(S): 9/94, 2/97, 5/00, 5/03, 6/06, 6/12

Department Approval:

07/19

Environmental Health & Safety Committee Approval:

09/19

Administration Approval:

11/19

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

06/12

A. POLICY:

- 1. The need for safety in keeping all-supplies and other equipment away from distribution panels The Hospital Electrical Distribution System is expected to meet the following conditions:
 - a. Transformers:
 - i. Clean and cool
 - ii. Locks in place
 - iii. Area or vault clean and free from storage
 - b. Main switchboards:
 - Inaccessible to unauthorized persons
 - ii. Area clean, dry and free from combustible storage
 - iii. Circuit breakers (switches) clearly marked
 - iv. Panels secured in place
 - v. Circuit breakers cool and clean
 - vi. Open breakers tagged
 - vii. Overcurrent protection provided
 - viii. Panelboards grounded
 - ix. Voltages, current ratings and phases in compliance with panels original design
 - c. Conduits and junction boxes:
 - Exposed rigid metal conduits and/or raceways in good condition
 - ii. Conduits and/or raceways grounded
 - iii. Junction box covers in place
 - iv. Boxes and fittings waterproof where exposed to weather or damp conditions
 - d. Branch circuits:

- i. Panels in good condition
- ii. Latches (locks) on doors in good condition
- iii. Breakers properly marked
- iv. Open breakers tagged
- v. Conductors proper size for listed load
- vi. Unused (disconnected) conductors in panels
- vii. Panels cool
- viii. Check for evidence of breakers arcing
- ix. Breakers clean
- x. Lockout/tagout policy
- e. Based on frequency determined by the Director of Engineering or designee schedule a contractor to perform infrared testing of the electrical distribution system to identify troubles before failure occurs.
 - *i. Correct all troubles by following the priority list produced by the contractor.

ENGINEERING SAFETY AND SECURITY

| TRI-CITY MEDICAL CENTER | Section: ENGINEERING DEPARTMENT |
|--------------------------------|--|
| Engineering Policy & Procedure | Subject: National-Electrical-Code Extension Cords |
| Engineering Foney & Frocedure | Policy Number: 5002 Page 1-of-1 |
| Department: Hospital-Wide | EFFECTIVE: 11/87 REVISED: 9/94; 2/97; 5/00; 5/03, 06/06, 6/12 |

SUBJECT: National Electrical Code-Use of Extension Cords

ISSUE DATE:

11/87

REVIEW DATE(S):

REVISION DATE(S): 9/94, 2/97, 5/00, 5/03, 6/06, 6/12

Department Approval Date(s):

7/19

Environmental Health and Safety Committee Approval Date(s):

9/19

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

A REFERENCE:

1. National Electrical Code

B.A. PROCEDURE:

- Extension cords are not to be issued to the nursing floors or other departments without approval
 of the Engineering Director Manager or his/her designee.
 - a. Note:—When there is a life er-and safety is involved issue, extension cords are permissible, but their use shall be reported to the Engineering Manager-Director or his/her designee.
- All extension cords shall not exceed six feet in length and shall be made of gray-minimum 16 gauge SWG, SO, STO, SJO or STO type, three conductor grounding flexible cord. The plug and connector shall be of the 2 pole, 3 wire grounding type, rated for hospital use (green dot).
- All extension cords shall be inspected for proper polarity and ground continuity prior to being issued.
- 4.— The extension cords intended for use by the Engineering Department shall be yellow in color and shall-meet the criteria with the exception of length.

B. REFERENCE:

- 1. National Electrical Code
- 5. All other extension cords used shall conform to the National-Electric Code as to AWG and length.



FOOD AND NUTRITION SERVICES

SUBJECT: Food Service Employee Health-Work Restriction for Personnel with Infectious Diseases

ISSUE DATE: 04/2006

REVISION DATE: 11/08, 10/10, 10/11, 02/12

Food and Nutrition Services Content Expert Approval:

Infection Control Committee Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval:

03/18

10/19

11/19

11/19

A. PURPOSE

- There are a wide range of communicable diseases and infections that can be transmitted by an infected food employee. Employees must be aware of the symptoms, illnesses, or conditions that must be reported to the supervisor and to Employee Health. In order to prevent the spread of infection to patients or other personnel, the department and District may require that food service employees with particular symptoms and/or illnesses be excluded from work or have work restrictions.
- 2. In addition to the restrictions for personnel with infectious diseases as outlined in Employee Health Policy Work Restrictions for Personnel with Infectious Diseases policy IC.14, food service employees are also potentially subject to additional restrictions and/or exclusions as outlined in the following charts. Staff with symptoms, diagnoses, and/or exposures as outlined below are required to report information to the F&N supervisor who will refer the employee to the Employee Health nurse.

Food service employee shall report any listed symptoms to the F&N supervisor

| Symptom | Exclusion/Restri ction | Duration/Criteria for Return to Work | Regulatory Approval (RA) Required to return to work? |
|---|----------------------------|--|--|
| Vomiting | Exclude from work | Asymptomatic for at least 24 hours <i>or</i> provides medical documentation. Exceptions: Diagnosis of Norovirus, Shigella spp., E. Coli 0157:h7 or other EHEC, HAV, or typhoid fever. | No if not diagnosed with exception. |
| Diarrhea (> 3 loose or watery stool in a 24 hours period) | Exclude from work | Asymptomatic for at least 24 hours or provides medical documentation. Exceptions: Diagnosis of Norovirus, Shigella spp., E. Coli 0157:h7 or other EHEC, HAV, or typhoid fever. | No if not diagnosed with exception. |
| Jaundice | Exclude from work if onset | When approval is obtained from regulatory approval and jaundice | Yes |

| | occurred within last 7 days. | has been for more than 7 calendar days <i>or</i> provides medical documentation. | |
|------------------------------------|--|---|----|
| Sore throat with fever | Exclude from work | When medical documentation is provided stating on antibiotics for Streptococcus pyogenes for more than 24 hours or has at least one negative throat culture or is determined by a health practitioner to be free of a Streptococcus pyogenes infection. | No |
| Infected wound or pustular boil | Restrict by covering wound, cut or boil with an impermeable cover and single use glove (if hand, finger, or wrist) and/or a dry, durable, tight fitting bandage if wound is elsewhere on body. | When infected wound or boil is properly covered (See exception for <i>Staphylococcus aureus</i> lesions in policy IC14) | No |

Summary of Requirements for Diagnosed, Symptomatic *or* Diagnosed but with resolved symptoms Food Service Employees

| Diagnosis | Exclusion | Duration/Criteria for Return to | Regulatory |
|--|---|--|--|
| | | Work | Approval (RA) Required for Return to Work? |
| Hepatitis A virus | Exclude from work if within 14 days of any symptom or within 7 days of jaundice | has been jaundiced for more than 7 days or an anicteric employee has had symptoms for more than | Yes |
| Typhoid Fever | Exclude from work | Approval from RA and medical documentation is provided stating employee is free of a S. Typhi infection. | Yes |
| E. coli 0157:H7 or other EHEC/STEC | Exclude from work based on vomiting or diarrhea symptoms | passed since employee became asymptomatic or was diagnosed. | Yes |
| Norovirus | Exclude from work based upon vomiting or diarrhea symptoms | cleared or more than 48 hours have passed since employee became asymptomatic or was diagnosed. | Yes |
| Shigella spp. | Exclude from work based upon vomiting or | Approval from RA and medically cleared or more than 7 days have passed since employee became | Yes |

| diarrhea | asymptomatic or was diagnosed. | |
|----------|--------------------------------|--|
| symptoms | | |

Summary of Requirements for food service employees with History of Exposure and Absent Symptoms or Diagnosis

3. Reinforce and assure compliance with good hygienic practices, symptom reporting requirements and no bare hand contact with ready to eat foods with all food service employees who report a listed exposure.

| Pathogen Diagnosis | Exclusion/Restri ction | Duration/Criteria for Return to Work | Regulatory Approval (RA) Required for Return to Work? |
|--|---------------------------|--|---|
| Typhoid fever | Restrict | 14 days since last exposure or >14 days since household contact became asymptomatic | No |
| Shigella spp. | Restrict | > 3 days since last exposure or > 3 days since household contact became asymptomatic | No |
| Norovirus | Restrict | >48 hours since last exposure or >48 hours since household contact became asymptomatic | No |
| E. coli 0157:H7 or other EHEC/STEC | Restrict | > 3 days since last exposure or >3 days since household contact became asymptomatic | No |
| Hepatitis A virus | Restrict | Employee is immune from HAV infection due to a prior HAV illness, vaccination against HAV, or IgG administration or >30 days have passed since last exposure or since household contact became jaundiced or employee uses no bare hand contact with ready to eat foods until > 30 days after potential exposure. | No |

B. RELATED DOCUMENT(S):

1. TCMC Policy IC.14 Employee Health Policy – Work Restrictions for Personnel with Infectious Diseases

C. REFERENCE SUPPORT DATA:

US Dept. of Health & Human Services, Public Health Service, FDA: Food Code 209917.

| Clinical Policies & | Procedures-Committee-Approval: |
|---------------------|--------------------------------|
| | y Committee Approval: |
| Medical-Departmen | |
| | Gemmittee Approval: |
| | s Committee Approval: |
| Roard of Directors | |



Food and Nutrition Services

SUBJECT: Nutrition Care Protocols

ISSUE DATE: 05/09

REVISION DATE(S): 02/12; 03/13

Department Approval:

Medical Staff Department/Division Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

Board of Directors Approval Date(s):

02/17

n/a

11/19

11/19

A. POLICY:

- Protocols address the role of the registered dietitian in the assessment of nutritional status of patients, nutritional intervention and delivery of medical nutrition, the development of an individualized nutrition care plan, and provision of education to patients.
 - a. Protocols are developed utilizing standards set by the Business and Professional Standards for dietitians (Section 2585-2586.8) per the state of California. Protocols are approved by the medical staff.
 - b. Protocols are developed to guide the nutritional care of all patients, including neonates, pediatrics, adolescents, adults and geriatrics.
 - i. #101-Nutritional Care and Assessment for Adult & Geriatric Patients
 - ii. #102-Nutritional Care and Assessment for Infants, Pediatrics, and Adolescents
 - iii. #103 Nutritional Care and Assessment for Infants Admitted to NICU
 - c. Guideline: Enteral Nutrition Protocol
 - d. Any nutrition interventions or medical nutrition therapies that are not addressed in the above protocols require a signed order by a Licensed Independent Practitioner.

B. RELATED DOCUMENT(S):

- 1. Food and Nutrition Policy: Nutrition Assessment and Care for Adult Geriatric Patients
- 2. Food and Nutrition Policy: Nutrition Assessment and Care of Adolescents Ped Infants
- 2-3. Food and Nutrition Policy: Nutritional Care and Assessment for Infants Admitted to NICU



INFECTION CONTROL POLICY MANUAL

ISSUE DATE:

08/16

SUBJECT: Bed Bugs, Identification and Control

REVISION DATE(S):

Department Approval-Date(s):

09/1907/16

Infection Control Committee Approval-Date(s):

07/1610/19

Pharmacy and Therapeutics Approval-Date(s):

n/a

Medical Executive Committee Approval-Date(s):

07/1611/19

Administration Approval:

11/19

Professional Affairs Committee Approval-Date(s):

08/16 n/a

Board of Directors Approval-Date(s):

08/16

A. **DEFINITION:**

1. Bed bugs (Cimex lectularius): small, flat, wingless, parasitic insects that feed solely on the blood of people and animals while they sleep.

a. Adult bed bugs are 5-6mm (1/4 inch) & reddish brown in color, while young bed bugs are 1mm-4mm (1/16"-1/4") & translucent.

b. Bed bugs do not transmit disease. Bed bug bites will cause red, raised itchy, reactions on the skin. Scratching can lead to secondary skin infections. Bed bugs are moved from infested areas to non-infested areas on clothing, luggage, furniture, or bedding. They hide during the day in places such as seams of mattresses and box springs, bed frames, dresser, tables and cracks and crevices or objects around the bed. Bed bugs can live

several months without a blood meal

B. PURPOSE:

Provide assistance in identifying and controlling bed bug infestation.

C. POLICY:

1. Movement of the patient to other areas of the hospital should be limited.

a. Use disposable suit to provide containment as needed for infestations during transport throughout facility

D. PROCEDURE:

1. While in the Emergency Department (ED):

- Place patient in Contact Precautions upon realizing or suspecting the patient has bed bugs.
- Examine the patient to determine if bed bugs are present.
- c. Place patient in clean gown and linens upon orders for inpatient admission.
- d. Bag up all personal clothing & belongings and seal the bag tightly. Keep sealed until the patient is discharged. If the patient is being admitted, send clothes and personal belongings home with family if possible.
- e. Contact Environmental Services (EVS) to clean the room once patient has been discharged from bed space. Inform EVS room may have contained bed bugs.
- 2. Upon inpatient admission:
 - a. Continue Contact Precautions.
 - b. Continue to keep all clothes and personal belongings sealed tightly. Send clothes and personal belongings with family if possible.
 - c. Have the patient shower if possible.

- d. Place work order to notify Building Engineering once patient has been admitted to the room. Include the reason: potential bed bug infestation and will need to have pest control inspection once patient has been discharged from room.
- 3. Upon discharge:
 - Once patient is discharged notify Building Engineering so they can contact Pest Control to inspect room.
 - b. Once the room is cleared through Building Engineering (& Pest Control), contact EVS to have room terminally cleaned.

E. REFERENCE LIST:

- 1. http://www.cdc.gov/parasites/bedbugs/fags.html
- 4.2. https://www.cdc.gov/parasites/bedbugs/health professionals/index.html
- 2.3. http://www.edph.ca.gov/healthinfo/discond/Pages/BedBugs.aspx
- 4. https://www.edph.ca.gov/HealthInfo/discond/Documents/BedBugGuidelines.pdf

ALL LIFE STAGES



NYMPHS, OR BABY BED BUGS, ARE SLIGHTLY SMALLER AND NEARLY COLORLESS WHEN THEY FIRST HATCH, BECOMING DARKER AS THEY MATURE. ADULT BED BUGS DO NOT FLY, BUT CRAWL WHEN SEEKING REFUGE OR A HOST.



INFECTION CONTROL

ISSUE DATE:

09/01

SUBJECT: Bloodborne Pathogen Exposure

Control Plan

REVISION DATE(S): 09/02, 09/03, 09/04, 09/05, 10/06,

10/07, 10/08, 10/09, 10/10, 10/12,

10/15, 08/16, 10/17, 08/18

Infection Control Department Approval:

06/1810/19

Infection Control Committee Approval:

07/1810/19

Pharmacy & Therapeutics Committee Approval:

n/a

Medical Executive Committee Approval:

07/1811/19

Administration Approval:

08/4811/19

Professional Affairs Committee Approval: Board of Directors Approval:

n/a 08/18

Α.

INTRODUCTION: Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **DEFINITION(S):**

Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

B.C. **PURPOSE:**

The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect healthcare workers from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

G.D.

This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD)

D.E. **AVAILABILITY TO HEALTHCARE WORKERS:**

To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to healthcare workers at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in orientation and during annual reviews.

E.F. PROGRAM ADMINISTRATION:

1. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program. In conjunction with the Employee Health Services (EHS) with the Infection Preventionist, she/he will review and update the Exposure

- Control Plan at least annually and whenever necessary to include new or modified tasks and procedures. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program.
- To assist the Director of Safety/ Environment of Care (EOC) in carrying out their duties, the
 Environmental Health and Safety (EHSC) Committee and following specific people will be
 contacted as needed.
- 3. Infection Preventionist
 - a. Employee Health
 - Staff-Educator
 - c. Engineering
 - d. Human-Resources
 - e.a. Environmental Service-Managers
- 4.2. The Management/Leadership TeamDirector/Manager/Educator will ensure for each employee for their area/unit of is responsiblresponsibilitye for providing information and training to all employees is provided information and training on thewith potential for exposure to bloodborne pathogens.
 - Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
 - a.b. Periodically reviewing training-programs with the Environment of Care-Officer, Employee Health, Infection Control, and Department Managers/Supervisors to include appropriate new information.
 - b.c. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
 - e.d. Registry and contract staff-are oriented to the hospital's exposure control plan-prior to working.
- 5-3. The Department Management/Leadership TeamDirectors, Managers, and Supervisors are is responsible for compliance in their respective areas. They work directly with the Director of Safety/Environment of Care (EOC) Officer, the Infection Control Department, Education Department, Employee Health and our employees to ensure that proper exposure control procedures are followed.
 - a. The Management/Leadership TeamManagers will support activities that encourage the active involvement of employees in education and safety programs. The Management/Leadership Team Managers-will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
 - Annually, The Management/Leadership Teammanagers will complete the template "Safer Work-Practices" (see Safer Work-Survey) with input from employees with respect te-the procedures performed in their respective work areas or departments-related to safe work practices, engineered safety devices and personal protective equipment (PPE).
 - b. The Management/Leadership TeamManagers will review quality review reports (RL Solutions) their employees complete to document any needlestick occurrence.
 - i. The Management/Leadership TeamManagers will counsel employees who do not use safe practices, PPE, and/or safety devices.
- 6.4. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
- 7.5. The Product Steering Committee has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
 - a. Review and selection Sharps Safety Products will follow established routes and include

- input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See Products Steering Committee Product Evaluation and User Product Evaluation.
- b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environmental Health and Safety of Care or Infection Control Committees related to health care injuries and need for alternative product.
- All products will be judged by specific criteria and selection will be guided by user recommendations.
- 8.6. Workforce Members Employees who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.
 - a. If an employee exposure occurs:
 - i. Employees are to notify their Director/Manager/Supervisor of any exposure immediately.
 - ii. Director/Manager/Supervisor will refer employee for follow to:
 - 1) Employee Health during business hours.
 - 2) Emergency Room after hour and weekends.
 - a) Employee to notify Employee Health within 24 hours of exposure.
 - b. If a Workforce Member other than an employee exposure occurs:
 - Workforce Members must notify Director/Manager/Supervisor of the area of any exposure immediately.
 - ii. Director/Manager/Supervisor will refer employee to the Emergency Room for follow up.
 - iii. The Workforce Member is to notify their employer/agency or workers compensation as appropriate.
 - i.-- Our employees are expected to complete initial-bloodborne-pathogens training and annual review.
 - b.c. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Safer Work Survey).
 - c. Our employees are expected to complete initial bloodborne pathogens training and annual review.
 - Licensed healthcare professionals are required to complete a quality review report (RL Solutions) when a needlestick-injury-occurs. The Director/Manager and-Employee Health will investigate the occurrence.
- 9-7. Employees will participate in the trial and selection of new safety devices.

The (EHSC will-compile and trend the information gathered above. August has been selected as the regular month for annual plan-update.

- Safety rounds are conducted on an annual or as needed -(for patient care units or departments) schedule.
- b. Information from the annual "Safer Work Survey" is compiled by the Director of Safety/Environment of Care (EOC)EOC Officer or designee and reports the resultsed to the Environmental Health and Safety Committee (EHSC), Environment of Care, the Infection Control Committee, and Products Standards Committees.
- c. Risk, Legal and Regulatory Services forwards information from Incident and Quality Review Reports (RL reports) to the Director of Safety/EOC Officer, Infection Preventionist and or Materials Management as appropriate.
- d. The information will be used to update the Exposure Control Plan with respect to:
 - Areas where engineering controls are currently employed.
 - ii. Areas where engineering controls can be updated.
 - iii. Areas currently not employing engineering controls, but where engineering

controls could be beneficial.

- 10.8. Employee Health and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
 - a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
 - b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
 - c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
 - d. Employee-Health identifies products involved in contaminated sharps injuries and reports this information to Material Management so that the number of those devices ordered in the previous year can be reported to the EHSC.
 - e. Recommendations are made to the **MaterialsSupply-Chain** Management- when a need for a safety device or alternative product is detected.
 - f. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
 - g. Employee Health will present sharps Injury data specific to TCHD at the Infection Control Committee meeting annually (i.e. safety devices, work practice changes or engineering).

F.G. EXPOSURE DETERMINATION:

- 1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which employeeWorkforce Members may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employeeWorkforce Members are considered to be exposed even if they wear personal protective equipment).
- 2. See Potential Blood Exposure by Job Category for a list of the job classifications in our facility where all or some employee Workforce Members handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.
- Since not all of the employeeWorkforce Members in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these employeeWorkforce Members to have occupational exposure are listed in Potential Blood Exposure by Job Category.

G.H. ENGINEERING CONTROLS:

- 1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize employeeWorkforce Member exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying employeeWorkforce Members with engineered sharps safety devices.
 - a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
 - If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery,

- administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
- c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
- d. TCHD is exempt from implementation if at least one the following is applicable.
 - The device is not available in the marketplace.
 - ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
 - iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
 - iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
- e. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
- f. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
 - Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
 - ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily
 - iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.
 - iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.
- g. In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.
 - Hand washing facilities and waterless hand cleansers are readily accessible to employeeWorkforce Members with potential for exposure.
 - ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.
 - iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

H.I. WORK PRACTICE CONTROLS:

- In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize employee Workforce Member exposure to bloodborne pathogens.
 - a. EmployeeWorkforce Members follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:
 - i. Semen
 - ii. Vaginal Secretions

- iii. Peritoneal fluid
- iv. Tissue and Organs
- v. Amniotic fluid
- vi. Synovial fluid
- vii. Pleural fluid
- viii. Saliva with visible blood
- ix. Pericardial fluid
- x. Cerebrospinal fluid
- b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
 - Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
 - ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.
- c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.
- d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.
- e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.
 - i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
 - ii. Information regarding the contamination is conveyed to all affected employeeWorkforce Members, the equipment manufacturer, and the equipment service representative.

I.J. PERSONAL PROTECTIVE EQUIPMENT (PPE):

- 1. PPE is the employeeWorkforce Member's 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our employeeWorkforce Members) the Personal Protective Equipment that they need to protect themselves against such exposure. See Standard Precautions-Personal Protective Equipment Table for tasks/PPE suggested. This equipment includes, but is not limited to:
 - a. Gloves
 - b. Fluid resistant gowns
 - c. Glove liners
 - d. Laboratory coats
 - e. Face shield
 - f. Resuscitation bags
 - g. Masks
 - h. Hoods
 - Safety glasses/goggles
 - j. Shoe covers
 - k. Mouthpieces
 - Pocket masks
- Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
 - a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
 - b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
- 3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Standard Precautions-Personal Protective Equipment Table.

- a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
- b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
- Gloves are worn as outlined in Standard Precautions and Standard Precautions-Personal Protective Equipment Table.
 - a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to empleyeeWorkforce Members who are allergic to the gloves our facility normally uses.
 - b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
- 5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Standard Precautions-Personal Protective Equipment Table.

나. ENVIRONMENTAL SERVICES:

- 1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
- 2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
- 3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
 - a. All employeeWorkforce Members are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
 - b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.
 - c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.
 - d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.
- 4. All regulated waste is safely handled by staff according to TCHD policies and procedures. Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual Section 6: Hazard Material Management: Waste Management Policy.
 - See TCMC Waste Disposal Guidelines.
- 5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides should hold the bags away from their bodies when removing waste. During removal, use heavy gloves to protect their hands from possible sharps injury, and do not push down on trash in garbage containers.
- 6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling.
- 7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
 - a. EmployeeWorkforce Members who contact contaminated linen wear appropriate

- protective equipment (gloves and gowns if soiling of clothes is possible).
- b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
- c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
- d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

K.L. FORM(S):

- Potential Blood Exposure by Job Category
- 2. Products Steering Committee Product Evaluation
- 3. Safer Work Survey
- 4. Standard Precautions Personal Protective Equipment
- User Product Evaluation

| ₩M. RELATED DOCUMENT(S):

- Employee Health and Wellness Policy: Injury and Illness Prevention Program
- 2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body_Fluid Secretions
- 3. Environment of Care Policy: Hazardous Material and Waste Management and Communication Plan
- 4. Environment of Care Manual: Waste Management
- 5. Infection Control Procedure: Hand Hygiene
- 6. Infection Control Policy: Standard and Transmission Based Precautions
- 7. TCMC Waste Disposal Guidelines

M.N. REFERENCE(S):

- Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998. https://www.dir.ca.gov/title8/5193.html (accessed 9-11-2019)
- Medical Waste Management Act, California Health and Safety Code, Sections 117600 118360
 California Medical Waste Management Program Information Copy January 201700
 www.cadhs.gov
 - https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWasteManagementAct.pdf
- Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc. Waste Management Chapter 113
 - Wenzel, RP & Nettleman, MD, Principles of Hospital Epidemiology in: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincett, Williams & Wilkins; 1999:1357 1366.
- 4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/jsolation2007.pdf (accessed 9-11-2019)

POTENTIAL BLOOD EXPOSURE BY JOB CATEGORY

| 'ALL' EMPLOYEES | 'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK) |
|---|--|
| Administrative Coordinator | Case Managers/ Clinical Social Worker (during patient |
| Advanced Care Technician | interviews or family conferences) |
| Biomedical Tech Mechanic I & II | Chaplain (during patient or family ministrations) |
| Cardiac Rehabilitation Coordinator | Food Service Worker (during tray delivery, pick-up, or |
| | cleaning) |
| Certified Nursing Assistant | Clinical Dietician |
| EEG Tech and EEG coordinator | Security Officer |
| EKG Tech | |
| Environmental Service Aide and | |
| Supervisor | |
| Emergency Medical Technician | |
| Employee Health Nurse | |
| Occupational Health Nurses & Manager | |
| Infection Control Specialist | |
| Laboratory Assistant/Phlebotomist | |
| Operations Manager | |
| Clinical Laboratory Scientist | |
| Histology Lab Tech | |
| Licensed Vocational Nurse | |
| Lift Team | |
| Nurse Practitioner | |
| Physicians Assistant | |
| Occupational Therapist and Rehab Aid | |
| OR Tech/Sterile Processing | |
| Tech/Perioperative Aide/Surgical | |
| Instrument Aide | |
| Perfusionist | |
| Phlebotomist | |
| Physical Therapist | |
| Physicians | |
| Pulmonary Services Operations | |
| Manager | |
| Radiology Operations Manager & Tech | |
| Registered Nurse | |
| Rehabilitation Services Manager | |
| Respiratory Care Practitioner I, II & III | |
| Security Officer | |
| Wound Care Nurses | |

Products Steering Committee Product Evaluation

| 2. Name of Product 3. Distributed by | ☐ Yes ☐ No |
|---|-------------|
| 4. Description of Use | ☐ Yes ☐ No |
| 5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? 6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit 7. What items would this replace? 8. Cost Standard item cost | □ Yes □ No |
| (hollow-core, blood-filled, or capable of deep injury)? 6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit 7. What items would this replace? 8. Cost Standard item cost | □ Yes □ No |
| 7. What items would this replace? | □ Yes □ No |
| 8. CostStandard item cost | ☐ Yes ☐ No |
| | ☐ Yes ☐ No |
| | ☐ Yes ☐ No |
| 9. Has TCHD rejected the device in the past? ☐ Yes ☐ No | . — |
| 10. Does the device have a passive safety mechanism? | □ Yes □ No |
| 11. Can the safety mechanism be activated with one hand? | □ 163 □ 140 |
| 12. Can the user tell when the safety mechanism has been activated? | ☐ Yes ☐ No |
| 13. Are minimal changes in technique and use required? | ☐ Yes ☐ No |
| 14. Is this product dependent on other products or items? Identify: | ☐ Yes ☐ No |
| 15. Is the device compatible with products currently in use? | □ Yes □ No |
| 16. Does the system/device require a minimal number of parts? | ☐ Yes ☐ No |
| 17. Is the product available in typical size ranges? | ☐ Yes ☐ No |
| 18. Is the product on contract | ☐ Yes ☐ No |
| 19. Product rep available for 24hrs/day in-service? | ☐ Yes ☐ No |
| 20. Does the manufacturer supply free trial products? | ☐ Yes ☐ No |
| 21. Does the manufacturer have adequate supply capability? | ☐ Yes ☐ No |
| APPROPRIATE FOR TRIALS REJECTED | |
| COMMENTS | |
| | |
| | 5 |
| | |

TRI-CITY HEALTHCARE DISTRICT SAFER WORK SURVEY

| The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 shart injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury used to puncture the vascular system, or causes deep injury. |
|---|
| 1. Safety Devices |
| Do you have suggestions for sharp devices with built in protection that would make your job safer? Comments: |
| |
| |
| |
| 2. Safe Work Practices |
| Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays) Comments: |
| |
| |
| |
| 3. Personal Protective Equipment |
| Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection) Comments: |
| |

Standard Precautions Personal Protective Equipment Table

| | Exp | Exposed Body Parts | | | | Contamination of Clothing | | | | | | | | | |
|--|----------------|--------------------|----------------|-------------|--------|---------------------------|--|----------|-------------|----------------|----------|-----------------|------|--|----------|
| R = Required | Hands | | Face | | | Soili | ng | | Satu | ratio | n | Drip | ping | | |
| A = Available | Gloves | | | Fac | e Shie | ld or | Cloth Gown | | Water-proof | | | Shoe Covers | | /ers | |
| N/A = Not Applicable | 0.000 | | Mask & Goggles | | | | Gown | | | | | | | | |
| | R | Α | N/A | R | Α | N/A | R | Α | N/A | Ř | Α | N/A | R | A | N/A |
| REMOVING, OPENING AND MANIPULATING | OR AS | SSIS | TING | WITH | ł THI | E REI | MÖV | | | DLLO | W C | | | OD | |
| BODY FLUID FILLED TUBES, NEEDLES OR C | ATHE | TER | S | | | | | | | | | | | | |
| Abdominal paracentesis catheter | * | | | * | | | | * | | | * | | | + | |
| Angiograph catheter | 1 | | | | | | | | | | | | | | |
| Bronchoscope (as above & to clean) | 1 | 1 | | | | | | | | | | [| | | |
| Central venous catheter | 1 | | | | | | | | | | | | | | |
| Chest tube/vent | | | | | | | | | | | | | | | |
| Endoscope (as above & to clean) | | | | | | | | | ' | | | | | | |
| Intravascular catheters Thoracentesis | 1 | | | | | | | | | | | | | | |
| Inoracentesis Urine catheter | 1 | | | | | | | | | | | | | İ | |
| ASSISTING WITH PROCEDURES | | | 1 | | | | ļ | | | | | | | | |
| | | | | | | | | | | * | | | | T . | _ |
| Angiography | + + | | - | <u> </u> | | - | | * | <u> </u> | - - | | | | | |
| Bone marrow asp/bx Bronchoscopy | + | | | NOS | | - | <u> </u> | * | | <u> </u> | * | | | | * |
| Bronchoscopy (R/O TB) | * | - | - | N95 PAPR | | | | * | | | * | $\vdash \vdash$ | | | - |
| Central venous catheter insertion | - | - | | PAPR | - | | | - | | <u> </u> | * | | | | * |
| Chest tube/vent placement | + | | | \vdash | * | | | * | | _ | * | Н | | <u> </u> | * |
| Childbirth | + | | - | | | \vdash | | | * | * | <u> </u> | $\vdash\vdash$ | - | * | <u> </u> |
| Endoscopy | + | | | * | | - | * | | | <u> </u> | * | | | <u> </u> | * |
| Intubation | * | - | | * | | | - | * | | | | \vdash | | | |
| L.P. (holding R/O meningitis) | * | | Н | * | | | | * | | \vdash | * | | | ├ | - |
| Morgue Release | * | | \vdash | | | * | | | * | <u> </u> | | \vdash | | \vdash | + |
| Proctosigmodoscopy | + | | | | * | | | * | | <u> </u> | * | | | | * |
| Suture or stapling (within 3 ft. of wound) | +- | _ | | * | | | \vdash | * | | | * | | | * | |
| Assisting with Surgery | + | | \vdash | | | - | _ | \vdash | | <u> </u> | - | | | * | <u> </u> |
| Thoracentesis ass. | * | | \vdash | | * | | \vdash | * | | | * | | | | * |
| SPECIMEN COLLECTION | | | | | | | | | | | | | | | |
| ABG | * | | | | * | | | * | | | × | | | | * |
| Blood glucose test | * | | | | * | | | * | - | | * | Н | | _ | * |
| Clean catch urine specimen | + | \vdash | | | * | \vdash | | * | | | * | \vdash | | ├─ | |
| Dipstick urine test | * | | \Box | | * | | | * | | | * | $\vdash \vdash$ | | | |
| Gastric occult. blood test | * | _ | | * | | | | * | | | * | \vdash | _ | | * |
| Nose/throat (R/O infection) | * | | | * | | | - | * | | | * | | | | * |
| Sputum for AFB or TB culture | * | | | N95 | | | | * | | | * | \vdash | | | * |
| Stool | * | | \vdash | | * | Ш | | * | | | * | - | | | * |
| Stool occult blood test | * | | М | | * | \square | _ | * | | | * | | | | * |
| Urine | • | | М | | * | \Box | | * | | | * | | | | * |
| Urine specific gravity | • | | М | | * | | | * | | | * | | | \vdash | * |
| Vaginal or urethral | - | <u> </u> | М | | * | | | * | | | * | | | | * |
| Venipuncture for blood | 1 | | М | | * | | | * | | | * | | | | * |
| Wound or wound drainage | * | | | | * | | | * | | | * | | | | * |
| SPECIMEN PROCESSING | 1. | | | per S.O | | | Lab | | | | | | | | |
| CLINICAL TASKS | | | | 3,0 | | | coat | | | | | | | <u> </u> | |
| Ambu bag: usage | w | | | * | | | | w | | | * | | | | * |
| Bladder irrigation | * | | \vdash | * | | \vdash | | * | | | * | | | | * |
| Revision 08/2018 | | L | | | | | | | | | | | | | |

| | Exposed Body F | | | y Parts Contamination of Clothing | | | | | | | | | | | |
|---|----------------|---|----------------------------------|-----------------------------------|------------------------|-----------------|---------------------|-----|-------------|-------------|----------|----------|---|---|-----|
| R = Required | Hands | | | Face | ace Soiling Saturation | | | | | | Drip | Dripping | | | |
| A = Available N/A = Not Applicable | Gloves | | Face Shield or Mask & Goggles | | Cloth Gown | | Water-proof Gown | | | Shoe Covers | | | | | |
| | R | Α | N/A | R | Α | N/A | R | Α | N/A | R | Α | N/A | R | Α | N/A |
| Blood or blood products administration | * | | | | * | | | * | | | * | | | | + |
| Blood warmer | * | | | | * | | | * | | | * | | | | * |
| Cleaning used instruments | * | | <u> </u> | * | | | | * | | | * | | | | * |
| Urine catheter: insert | * | | | | * | | | * | | | * | | | | * |
| Colostomy irrigation | * | | | * | | | | * | | | * | | | | * |
| Condom catheter application | * | | | | * | | | * | | | * | | | İ | * |
| Contact lense care | * | | | | * | | | | * | | | * | | | * |
| Dressing change | * | | | | * | | | * | | | * | | | | * |
| Emerson pump: use | * | | | | * | | | * | | | * | | | | * |
| Endoscope / Bronchoscopy cleaning | * | | | * | | | * | | | | * | | | | * |
| Enema administration | * | | | * | | | | * | | | * | | | | * |
| Enteral feeding tube (insert or manipulate) | * | | | * | | | | * | | | * | | | | * |
| Fecal disimpaction | * | | | * | | | | * | | | * | | | | * |
| Fecal or gastric occult blood test | * | | | | * | | | * | | | * | | | | * |
| Foley cath insertion | * | | | | * | | | * | | \Box | * | | | | * |
| Gastric lavage | * | | | * | | | | | * | * | | | | | * |
| Hemovac drains-manipulate, empty / DC | * | | | * | | | | * | | | * | | | | * |
| Injections | * | | | | * | | | | * | | | # | | | * |
| Intravenous catheter insertion | * | | | | * | | | * | | | | * | | | * |
| J-P drain care | * | | | | * | | | * | | | * | | | | * |
| Nasogastric tube insertion and DC | * | | | * | | | | * | | | * | | | | * |
| Neonatal suck evaluations (latex-free) | * | | | | * | | | * | | | | * | | | * |
| 1st. Newborn bath | * | | | * | | | | * | | | * | | | | * |
| Normal Saline or Heparin lock irrigation | * | | | | ŵ | | | * | | | | * | | _ | * |
| O2 therapy w/ mucus membrane touch | * | | | | * | | | | * | | | * | | | * |
| Open suctioning of airway or airway tube | * | | | ŵ | | | | * | | | * | | | | * |
| Oral care | * | | \Box | * | | | | * | | | | * | | - | * |
| Oral/nasal airway insertion or DC | * | | | * | | | | * | | | * | | | | * |
| Pleur-evac care | * | | | | * | | _ | * | | | * | | | | * |
| Postural drainage | * | | | \Box | * | | | * | | | * | | | | * |
| Rectal tube insertion | * | | | | * | | | * | | | * | | | | * |
| Resp. Tx, cough inducing | * | | \vdash | * | | | | * | | <u> </u> | | * | | | * |
| Restraint placement | | * | | | * | | | w | | | | * | | | * |
| Seizing patient | | * | | | * | | | * | | | \vdash | * | | | * |
| Sputum Induction for AFB | + | | \vdash | N95 | | $\vdash \vdash$ | | * | | - | \vdash | * | | | * |
| Sputum Induction for AFB R/O tuberculosis | sh- | | \vdash | PAPR | | | | ÷ | | | | * | | | * |
| Total parenteral nutrition administration | * | | | | * | | 20 | * | | | \vdash | * | | | * |
| Jrine bag emptying | * | | | * | | | 797 | * | | - | | * | | | * |
| Vital signs and Weighing patients | | + | | | * | | | * | | | | + | | | ŵ |
| Wound care (without irrigation) | * | | | | * | | | * | | | * | | | | * |
| round care (without inigation) | | | | L | | | L I | ١ ١ | | | | | | | |

User Product Evaluation

| CRITERIA | BETTER | SAME | WORSE |
|--|--------|----------|------------|
| Easy to open package | | | WORLD |
| Ease of assembly | | | |
| Ease of use | | | |
| Comfortable feel for user | | | |
| Length of time required for use | | <u>.</u> | |
| Activation of safety feature | | | |
| Safety feature can't be defeated | | | |
| Has minimum failure rate and functions as intended | | | |
| Good for use with different patients | | · | |
| Safe for healthcare workers | | | |
| Safe for patients | | | |
| Patients complaints | | | |
| Doctors complaints | | | |
| Easy to dispose | | | |
| Compatible with other products | | | |
| Will reduce the risk of injury | | | |
| Reasonable number of parts | | | |
| Available in the sizes you need | | | |
| low many times did you use the product? | | | |
| Vould you recommend purchasing this device? | | | ☐ Yes ☐ No |
| there another safety device you would rather use? | | | ☐ Yes ☐ No |
| pecify: | | | |
| comments? | | 3 | |

Revision 08/2018

INFECTION CONTROL-MANUAL

ISSUE DATE:

09/4998

SUBJECT: Construction

REVISION DATE(S)ED: 04/01, 06/03, 4/07, 10/07, 10/13,

Infection Control Department Approval-Date(s):

07/16096/19

Infection Control Committee Approval Date(s):

07/1607/1910/19

Pharmacy and-& Therapeutics Committee Approval-Date(s):

/-/-

Medical Executive Committee Approval-Date(s):

Administration Approval:

11/19

Professional Affairs Committee Approval-Date(s):

08/16 n/a

Board of Directors Approval-Date(s):

08/16

A. <u>INTRODUCTION</u>

Multiple published studies have linked healthcare associated infection with the dispersal of microorganisms during construction. Before construction begins, the focus of preparations should be on isolation of the construction and/or renovation area. Planning is required prior to construction, renovation and repair projects that are expected to generate a-moderate to high levels of dust or require demolition or removal of any fixed building components and systems as well as new construction projects to assure patient and staff safety. A multidisciplinary team approach will be used.

B. PURPOSE

1. The intent of this policy is to minimize infection risks to patients, staff, volunteers and the public that may arise as a result of exposure to organisms released into the environment during maintenance, construction and renovation activities. The matrix grid format adopted by our facility identifies the number and types of controls and Infection Control interventions necessary to protect patients and decrease dust generation.

C. PROCEDURE

- 1. Infection Prevention is included early in the planning of construction and renovation projects.
- 2. Engineering will collaborate with other department leaders in the planning phase as needed depending on the scope of the project.
- 3. Engineering and Infection Prevention will review the scope of the planned construction, renovation and /or repair. An assessment of infection exposure risk will be documented on the Infection Control Risk Assessment (ICRA): Infection Control Construction Permit prior to beginning the work.
- 4. All construction workers, including subcontractors and hospital staff must follow the infection control procedures described in this policy.
- 5. Expansion or change in scope of the project requires re-assessment and a revision of the ICRA.
- 1.6. Infection Preventionist and Environment of Care Officer will:
 - a. Participate-in-planning to address needs such as handwashing facilities, storage and equipment cleaning areas, appropriate surface finishes and specific products with infection-control and worker safety implications (i.e. sharps disposal unit placement and accommodation for personal protection equipment).
 - Review indication for environmental cultures or volumetric air sampling.
 - Complete an assessment of infection exposure risks to patients, healthcare

workers, volunteers and the public.

Document this assessment on the Infection Prevention Construction Permit.

4. D. ENGINEERING: Engineering-will:

- a. Assist in the coordination of efforts by completing the Assessment of the Impact of Construction Projects prior to or during early planning meetings with the Area Director. The Assessment of the Impact of Construction Projects will be filled out for projects that require a building permit and other high risk projects as determined by Director of Engineering or designee. or will take longer than one (1) week.
- b. Review infection control measures prior to construction with the staff and contract workers. Explain expectations to contractors. Ensure that infection control policies are followed during the construction.
- c. Direct traffic away from the construction site.
- c.d. Review indication for environmental cultures or volumetric air sampling. Include Infection Preventionist and Environment of Care Officer early in the planning of construction and renovations in the hospital.
 - d. Assist-in the coordination of efforts by completing the Assessment of the Impact of Construction Projects prior to or during early-planning meetings with the Area Director. The Assessment of the Impact of Construction Projects will be filled out for projects that require a building permit or will take longer than one (1) week.
- e. Notify the Infection Preventionist and the Safety Officer if mold is encountered during a construction/renovation project and implement precautions in Infection Control Policy: Mold Abatement IC 13.3.
- f. To isolate renovation areas from occupied areas, use airtight barriers. If plastic sheeting/visqueenmust be substituted, Eensure that barriers are it is fire retardant and sealed tightly.
- g. Construction or renovation projects that fall into the Class III or IV category will have containment performed by qualified personnel. See Infection Control Construction Permit (ICRA) Form).
- h. Adequate window seals should be obtained installed and maintained to prevent outside air from —entering the room.
 - ——Check cleanliness of intake-filters in the ventilation system.
- i. Reusable barrier cubes are cleaned after each use. Take outside and hose off both the inside and outside of the container. Spray and wipe with hospital-approved disinfectant and allow the plastic to air dry.
- j. After completion of construction, Engineeringcontractor will perform construction clean-up.
- k. Engineering will notify Environmental Services to perform a terminal clean and disinfection of the involved area prior to placing back into service.
- Newly-constructed-areas should be cleaned thoroughly-before admitting or readmitting patients.
- e. Obtain Infection Control Construction Permit-prior to beginning work.
- f. Review infection control measures prior to construction with the staff and contract workers. Explain expectations to contractors. Ensure that infection control policies are followed during the construction.
- g. Direct traffic away from the construction-site.
- Notify the Infection Preventionist and the Safety Officer if mold is encountered during a construction/renevation-project and implement precautions in Infection Control Policy: Mold-Abatement IC 13.3.
- i. To isolate renovation areas from occupied areas, use airtight barriers. If visquine must be substituted, ensure it is fire retardant and sealed tightly.
- j. Construction or renovation projects that fall into the Class III or IV category will have containment performed by qualified personnel (see Infection Control Construction Permit

- Reference table on page 2).
- Adequate window seals should be obtained maintained to prevent-outside air from entering the room.
- Check cleanliness of intake-filters-in the ventilation system.
- m. Reusable barrier cubes are cleaned after each use. Take outside and hose off both the inside and outside of the container. Spray and wipe with hospital approved disinfectant and allow the plastic to air dry.
- Environmental Services (Common Areas) and Nursing (Patient Care Areas)
- a. Damp dusting-should be done on a regular basis to prevent the accumulation of dust on horizontal surfaces. Use disposable damp cloth and discard immediately rather than return to the cleaning solution to prevent disseminating speres.
- b. Geiling-tiles-and air-duct-grates should be cleaned regularly when reems are not occupied.
- c:- Newly constructed areas should be cleaned thoroughly before admitting or readmitting patients.
- 3. Nursing
- Minimize-exposure of high-risk-patients to construction activities. If possible, diagnostic procedures may be done in the patient's room.
- b. Transport patients via an alternate route or schedule transport and procedures during periods with minimal construction activity. Patients can be masked or provided with other barriers (e.g. covering open wounds).
- Report infection control risks such as unsealed barriers, visible dust, opened doors, etc.
 to Infection Centrol or the Environment of Care Officer.
- d. Coordinate construction and/or renovations with patient relocations.

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

- 1. Infection Control & Construction Fact Sheet for Employees and Patients
- 1-2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak IC. 3
- 2.3. Infection Control Policy: Healthcare Associated Infections, Defined IC. 4
- 3.4. Infection Control Policy: Mold Abatement IC 13.3
- 4.5. Infection Control Policy: Surveillance Program IC. 2

E. FORM(S):

- 1. Assessment of the Impact of Construction Projects
- 2. Infection Control Permit (ICRA)
- 3. Infection Control & Construction Fact Sheet for Employees and Patients

F. REFERENCE(S):

- 1. Bartley, J.M., APIC State of the Art Report: The role of infection control during construction in healthcare facilities. Am J Infect Control 2000; 8 156-69.
- 2. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities, 2008. On-line at APIC.com
- 3. Infection Prevention Manual for Construction & Renovation: APIC 2015APIC Infection Control Tool Kit-Series: Construction and Renovation, 1999
- 3.4. Cotten, B., (2014) APIC Text of Infection Control & Epidemiology (4th ed): Construction & Renovation Chapter 116

Construction Education

| | Tri City Medical Center Assessment of the Impact of Construction Projects | | | | | | | | | |
|-----------|--|---|------------------|-------------------------|---|--|--|--|--|--|
| Proje | | Location | | Start Date: | End Date: | | | | | |
| Proje | ect Coordinator: | 9 | Contra | ctor: | | | | | | |
| | Category | Factors | | Risk Evaluation | | | | | | |
| (A) | Noise | Impact, duration, s | rk | | | | | | | |
| (B) | Air / Dust | Cutting, Grinding, etc. | _ | | · · · · · · · · · · · · · · · · · · · | | | | | |
| (C) | Infection Control | Category of Ris 1 – 2 – 3 – | - 4 | | | | | | | |
| (D) | Vibration | Tool use, demo | | _ | | | | | | |
| (E) | Life Safety impact | Hot work, disablin penetrations, modifications, s | , exit moking | | | | | | | |
| (F) | Security | Site security, acce | ss control | | | | | | | |
| (G) | Disruption of utilities | Planned shutd Construction ne system supp | ar utility | | | | | | | |
| (H) | Emergency Services | Obstruct access to or fire dept | fire lanes | | | | | | | |
| | as of forecasted concerns for any/all | of the Categories | List appropri | ate measure(s) recommen | ided for limiting disruption / code violation | | | | | |
| listed al | pove | 8030 | | verse outcome. | | | | | | |
| (A) | | | | | | | | | | |
| (B) | | | • | | | | | | | |
| (C) | | | | | | | | | | |
| (D) | | | | | | | | | | |
| (E) | | | | | | | | | | |
| (F) | | | | | | | | | | |
| (G) | | | | | | | | | | |
| (H) | | | | | | | | | | |





Infection Control & Construction Fact Sheet for Employees and Patients



What is the concern?

Aspergillus is a mold that is present almost everywhere, but is most often found around decaying cellulose debris, water and dust. The spore most often attaches itself to dust particles to become more buoyant and allows for airborne spread. It is a very adaptable germ; it can tolerate almost any temperature and needs only 2-3 days to grow in a water source. Patients can breathe in these spores and become colonized or infected. Invasive disease (Aspergillosis)—in high risk—patients can lead to death. In general, the higher the concentration of spores in the air, the higher a patient's risk—of acquiring infection.

Who is at risk?

In-general, only high-risk-immunocompromised patients acquire-invasive disease leading to-death. The patients highest at risk for construction-related Aspergillosis are the following:

- Bone marrow transplant (BMT) patients
- Patient with hematologic malignancy
- Patient receiving a solid-organ transplant
- AIDS patient with-a-GD4 count < 50 AND one-of the following:</p>

Prolonged neutropenia Chronic steroid-use

How-do you prevent acquisition?

Dust prevention methods are the most efficient means of preventing colonization—and infection in patients. Controlling—the dust related to construction activities is imperative. Infection—Control is involved in all construction activities that potentially affect high risk—patients, including inside—and outside projects. Dust control measures are recommended by Infection—Control for each project and monitored for compliance.

What-are some common dust-control measures?

- Wet mopping a construction area with disinfectant at the end of each workday.
- Use of walk off-mats to collect dust-and prevent the spread-throughout the-hospital.
- Use of floor-to-ceiling partitions.
- Covering-debris-removal containers and only transporting them during low activity.
- Spraying of water or-chemical onto-construction-site to decrease amount of-dust in air.
- Sealing-windows that surround construction sites to prevent leakage of dust.
- More frequent checking and changing of air handling filters.
- Avoiding use of carpets in clinical areas, especially areas of frequent spillage:

What are other ways to prevent the spread of Aspergillus?

- Recognition of mold growth areas and proper decontamination of these areas.
- Prevention of freestanding water sources, which-promote mold-growth.
- High-risk patients are instructed to wear masks when-being transported on campus.

INFECTION PREVENTION CONSTRUCTION PERMIT

| Project Tit | le | | <u> </u> | Project Start | Nate | | | | |
|---------------------------------|--|--|---|--|--|--|--|--|--|
| | ect Coordinator | | | Estimated Cor | | | | | |
| General Co | | | Pager # | OSHPD Permi | | | | | |
| Contractor | Superintendent | | | | nt Telephone # | | | | |
| | · | MATRIX: Infection Cont | rol Permit required | for Class III and Class | | | | | |
| | LEVEL | TYPE A | TYPE B | TYPE C | TYPE D | | | | |
| G | Group 1 | I | 11 | II | III / IV | | | | |
| | Froup 2 | I | II | III | IV | | | | |
| | Group 3 | 1 | III | III / IV | IV | | | | |
| | Group 4 | II | III / IV | III / IV | IV | | | | |
| CLASS I | Immediately Rapid cleanu | k by minimizing raising replace any ceiling tile p and disposal of waste ye means to prevent all | displaced for visua to minimize dispe | l inspection. | ere | | | | |
| CLASS II | Water mist w Seal unused Block off and Wipe work st Contain cons Wet mop and Place dust m | vork surfaces to control doors with duct tapes. I seal air vents. urfaces with disinfectan truction waste before t I/or vacuum with HEPA at at entrance and exit | it. ransport in tightly of filtered vacuum be | | | | | | |
| CLASS III | Obtain Infection Control Permit before construction begins. Isolate HVAC system in area where work is being done to prevent contamination of duct system Complete all critical barriers or implement barrier cube before construction begins. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. | | | | | | | | |
| DATE | Environments 6. Vacuum work 7. Wet mop are 8. Remove barr construction. 9. Contain cons 10. Cover transp | Do not remove barriers from work area until complete project period is thoroughly cleaned by Environmental Services Vacuum work with HEPA filtered vacuum. Wet mop area with disinfectant. Remove barrier materials carefully to minimize spreading of dirt and debris. associated with construction. Contain construction waste before transport in tightly covered containers. Cover transport receptacle or carts. Tape covering. Remove or isolate HVAC system in areas where work is being performed. | | | | | | | |
| CLASS IV DATE INITIALS | Isolate HVAC Complete all Maintain negs Seal holes, p Construct and before leaving leave the word All personnel each time the Do not remove Services Dep Vacuum work Wet mop with Remove barri Contain consi Cover transport | critical barriers or implative air pressure withi ipes, conduits, and punteroom and require all g the work site or they rk site entering a work site are worker exits the work a art. | work is being done ement barrier cube n work site utilizing actures appropriate personnel to pass to can wear cloth or re required to wear a site. If a wacuums. If a minimize spreading appropriate in tightly of tape covering. | to prevent contaminate before construction be HEPA equipped air filt ly. through this room using paper coveralls that are shoe covers. Shoe cover all project is thoroughly on the project is thoroughly on the project containers. | egins. ration units. a a HEPA vacuum cleaner e removed each time they | | | | |
| Date | | uninterrupted exchang | e Date | Exceptions/A | Additions to this permit | | | | |
| Initials Permit P | equested By: | | Initials | Authorized By: | attached memoranda | | | | |

Revised Infection Control Policy: Construction

CONSTRUCTION ACTIVITY TYPES

| TYPE A | Inspection and Non-Invasive Activities. Includes but is not limited to, removal of ceiling tiles for visual inspection limited to one tile per 50 square feet, painting (but not sanding), wall covering, electric trim work, minor plumbing, and activities which do not generate dust or require cutting of walls or access to the ceiling other than for visual inspection. |
|--------|--|
| ТҮРЕ В | Small scale, short duration activities, which create minimal dust. Includes, but is not limited to, installation of telephone and computer cabling, access to chase spaces, cutting of walls or ceiling where dust migration can be controlled. |
| TYPE C | Any work, which generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. Includes but is not limited to, sanding of walls for painting or wall covering, removal of floor coverings, ceiling and case work, new wall construction, minor duct work above ceilings, major cabling activities, and any removal which cannot be completed within a single work shift. |
| TYPE D | Major demolition and construction projects. Includes, but is not limited to, activities which require consecutive work shift, requires heavy demolition or removal of a complete system, and new construction. |

INFECTION CONTROL RISK GROUPS

| Group 1 | Group 2 | Group 3 | Group 4 |
|--|---|---|---|
| Lowest | Medium | Medium High | Highest |
| X Office areas X Storage Rooms without patient care equipment or supplies X Waiting Rooms X Assembly Rooms | X Cardiac Rehab. X Pulmonary Rehab X Linen room X Materials Storage X Admission areas | X Emergency Room X Imaging/MRI X PACU/SPRA X Postpartum X Newborn Nurseries X Nuclear Medicine X Discharge units X Physical Therapy - tank areas X Food Preparation Center X Cafeteria X All Nursing Units except those listed in Group 4 | X All Operating Rooms X Sterile Processing Areas X Adult Critical Care Units X Cardiovascular Recovery X Labor and Delivery X NICU X Cardiac Cath. Lab X Interventional Imaging X Dialysis X Oncology X Laboratory X All endoscopy areas X Pharmacy Admixture |



Infection Control Policy Manual

ISSUE DATE: 9/01 SUBJECT: Waterborne Illness

REVISION DATE: 9/04, 10/07, 10/10, 10/13

Infection Control Department Approval: 10/1610/19 Infection Control Committee Approval: 10/1610/19

Pharmacy & Therapeutics Committee Approval: n/a

Medical Executive Committee Approval: 10/1611/19

Administration Approval:

11/19 **Professional Affairs Committee Approval:** 01/17 n/a

Board of Directors Approval:

01/17

A. INTRODUCTION

Legionellosis is a collective term describing infection produced by the pathogen Legionella, a bacterium found in water environments. Most hospital hot water systems are colonized with Legionella, which is introduced into institutional water distribution systems from public/municipal water systems (that do not routinely screen water for the presence of Legionella). Since legionellaeLegionella is chlorine tolerant, it will survive many of the standard municipal water treatment protocols. The transmission of Legionella in healthcare facilities is by the linhalation of aerosolized water contaminated with Legionella bacteria.

PURPOSE

This plan describes how the organization will establish and maintain a utility systems management program to reduce the potential for organizational-acquired illness related to waterborne illness. The plan provides processes to decrease the risk of transmission through contaminated patient care equipment. Steps for investigation of outbreaks and remediation are outlined if potential nosocomial infections were identified.

C. SCOPE

- This plan applies to all aerosolizing water systems in Tri-City Medical Center (for example: cooling towers, domestic hot water taps, evaporative coolers, and etc.) and to all immunocompromised patients admitted to the hospital.
- 2. **Program Administration**
 - The Director Manager of Safety/Environment of Care is responsible for the implementation, maintenance and administration of the Environmental Health & Safety Committee.
 - To assist the DirectorManager of Safety/Environment of Care in carrying out their duties b. the Environmental Health & Safety Committee, Engineering Department, Infection Control Department, and Microbiology Department and following specific people-will be contacted as needed.
- **Engineering**
- Infection-Control Department
- Microbiology Laboratory Manager
 - a.c. Engineering is responsible for the following (See Appendix A)
 - i. Perform an initial assessment of the environmental risk from the plumbing system. Identify factors with potential to amplify growth of waterborne microorganisms such as the domestic hot water heater, dead legs of low flow conditions, water temperature, and maintenance.
 - ii. Perform an initial assessment of the environmental risk from the heating, cooling and humidifying system that produces aerosolized water or involves standing water.

- iii. Develop and document maintenance schedules to decrease risk (i.e. drift eliminatorsblow down hot water tanks, cleaning cooling towers and use of an effective biocide)-using-recognized experts-such ASHE.
- iii.d. Infection Control Department is responsible for the assessment of the clinical risk of the organization's patient population including the following: (See Appendix B)
 - iv.i. Identify the treatment/care areas for patients at greatest risk of contracting Legionellosis.
- b.e. Ongoing surveillance for facility acquired Legionellosis.
 - i. Microbiology Laboratory: Preprinted order for bronchoscopy specimen includes include screening for Llegionella.
 - ii. Laboratory methods used at Tri-City Medical Center for diagnosis of legionella infection include the following
- 6.3. Urinary antigen is relatively inexpensive, simple, and rapid.
- 7.4. Enzyme-linked immunoassay (EIA)
- 8.5. Legionella cultures
 - a. If the culture grows positive for Legionella, our Laboratory will perform serotyping for Legionella species. If it is not serogroup 1, the Laboratory will final the report out as Legionella species, not Legionella pneumophila serogroup 1.

D. RISK ASSESSMENT

- See Appendix A for a table outlining the environmental assessment.
- 2. See Appendix B for a table outlining the clinical risk of TCMC's patient population.
- 3. See Appendix C for a table of remediation-water treatment methods.
- See Appendix D for a Legionella Fact Sheet.

E. PRIMARY PREVENTION

- Develop a management plan as a result of the assessment that includes standard operating procedures (SOP's) for maintenance and operation of water systems
 - a. Develop a system to document and log findings as a result of these SOP's such as temperatures, blow down of hot water tanks, cooling tower inspections etc.
 - b. Maintenance and audit program for any systems that are currently installed to limit Legionella amplification in aerosolizing systems such as cooling towers and /or potable water treatment systems (e.g. copper silver or chlorine dioxide).
 - c. Inspect cooling towers/evaporative coolers to ensure that they are in proper condition and operate as designed. Install drift eliminators **if needed**.
 - d. Use an oxidizing biocide continuously to prevent the formation of biofilms and control biological growth. (E.g. bromine, chlorine, iodine, chlorine dioxide, ozone, etc.) And intermittently a non-oxidizing biocide (e.g. DBNPA, isothiazoline, etc.).
 - e. Maintain towers according to manufacturers recommendations or alternative equipment maintenance program. If the tower/cooler is subject to extended shutdown, equipment should be cleaned and treated prior to shutdown and again before starting up.
- 2. Incorporate Infection PreventionControl strategies in the facilities patient care policies.
 - a. Use sterile water or rinsing nebulization devices and other semi-critical respiratory-care equipment after such items have been cleaned and /or disinfected.
 - b. Use sterile water to fill reservoirs of devices used for nebulization.
 - c. Use sterile water to flush nasogastric tubes.
 - d. Large-volume room air humidifiers-use is discouraged and those used are subjected to high-level disinfection daily and filled with sterile water.
 - e.d. Protecting patient-care devices and instruments from inadvertent tap water contamination during room cleaning
- 3. Remediation (if an outbreak of Legionellosis is suspected or identified)
- 4. Outbreak is defined as at least one case of laboratory-confirmed case of legionellosis that occur in patients who have been hospitalized continuously for >10 days before the onset of illness

- and/or a possible case (i.e., laboratory-confirmed infections that occur 2 9 days after hospital admission.
- 5. A multidisciplinary team, comprised of members of the Infection Control and Environmental Health & Safety Committees will be utilized to organize the facilities response. A report will be made to the appropriate public health agencies.

| Epidemiologic Investigation | Environmental Investigation |
|--|---|
| Review medical and microbiologic records. | Risk factors among potential environmental |
| | exposures (e.g., showers, cooling towers, |
| | respiratory-therapy equipment, etc.) |
| Initiate active surveillance to identify all recent or | Collect water samples from environmental |
| ongoing cases | sources implicated by epidemiologic investigation |
| Develop a line listing of cases by time, place, and | Other aerosolized water sources |
| person. | |
| | |
| Determine the type of epidemiologic investigation | |
| needed for assessing risk factors. | |
| Case-control study | |
| - Cohort study | |
| Gather and analyze epidemiologic information | |
| Subtype strains of Legionella spp. cultured | |
| from patients & environmental sources | |
| Review autopsy records and include | |
| autopsy specimens in diagnostic testing | |
| | |

| Control Measures: if water is contaminated with Legionella spp. | Remediation of potable water: in response to identified nosocomial cases |
|--|--|
| Restrict patients from taking showers and provide clean water for sponge baths | Superheating of water (at least 149degreeseF) |
| Provide sterile water for drinking, tooth brushing, or for flushing nasogastric tubes. | "Shock" hyperchlorination >10 mg/L of chlorine in water |
| Remove showerheads and faucet aerators monthly for cleaning. | |
| Use a 1:100 solution of chlorine bleach to disinfect showerheads and aerators. | |
| Cooling towers should be designed and constructed so that tower drift is directed away | |
| from the hospital's air intake system and the volume or aerosol drift is minimized. | |

F. RELATED DOCUMENTS:

- 1. Engineering Infection Control: Managing Biological Agents to Prevent Waterborne Illness
- 2. Infection Control Policy: Surveillance Program
- 3. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak

G. <u>REFERENCES</u>:

- CDC Guideline for Preventing Health Care Associated Pneumonia,
 2003http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm (accessed 9.11.19)
- 2. CDC Guideline for Environmental Infection Control in Health-Ceare Facilities HICPAC 2003 Updated: July 2019 https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf

Infection Control Waterborne Illness – IC.13.1 Page 4 of 11

- 2. http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf
- 3. ASHRAE 188: Legionellosis: Risk Management for Building Water
 Systems http://www.cdc.gov/legionella/health-depts/ashrae-faqs.html (accessed 9.11.19)
- CDC: Legionnaires' Disease Fact-Sheet http://www.cdc.gov/legionella/downloads/fs-legionnaires.pdf
- 5. Joint Commission Environment of Care Standard (EC.02.05.01) Updated 9.20.17
- 6. OSHA: Occupational Safety & Health Administration: Legionellosis (Legionnaires' Disease & Pontiac Fever) https://www.osha.gov/SLTC/legionnairesdisease/index.html (accessed 9.11.19) Technical Manual, Section III: Chapter 7, Legionnaires Disease http://www.osha-slc.gov/dts/osta/otm/otm_iii/otm_iii_7.html

Environmental Risk Assessment

1) Municipal water is treated with chloramine. Data suggests that use of monochloramine is effective in eradicating Legionella. Monochloramines can reach distal points in a water system and can penetrate into bacterial biofilms more effectively than free chlorine.

| EQUIPMENT | Location | Scale, Rust, or Biofilm Growth | Water Temp. | COMMENTS |
|---|---|--|--|--|
| Domestic Cold Water | Oceanside Main @ Thunder Dr. 10" | None | Ambient | Oceanside receives water from Municipal Water District of Southern California, all water treated with Chloramine Disinfectant @ 2.5 to 3.0 mg / I level. All backflow regulators are inspected and tested annually. |
| | Oceanside Main @ Vista Way, 10" | None | Ambient | Same as above. |
| | Vista Irrigation Main @ Thunder Dr., 8" | None | Ambient | Same as above. |
| | Hospital piping system. | None | Ambient | Entire domestic cold water system is run in copper and brass piping to prevent scale, rust or bio-film. |
| | (2) 10,000 gallon refill tanks on Pavilion roof top. | None, tanks are rubber lined. | Ambient | Tanks are routinely opened and inspected-annually. Tanks are not used for storage but replenished constantly. Water is supplied up to tanks and then pressure and gravity feed down to building. |
| Domestic Hot Water | Steam fed Heat Exchangers (6) throughout hospital | None | Monitored by computer to supply Title 22 required temperature water, 105 to 120 degrees F. | Domestic hot water piping is all run in copper and brass to prevent scale, rust or bio-film. All hot water systems are circulated constantly in order to provide constant temperature at sinks. |
| Reverse Osmosis and De- Ionized Water | Throughout facility, main system in penthouse of center tower, booster tanks located at Lab and 2 Pavilion. | None | Ambient | This system is highly filtered and treated water (Ultra Violet). System main function is for Sterile Processing and Lab Equipment and is routinely tested and monitored by our in-house laboratory System main function is for Dialysis and is routinely tested and monitored by our in-house laboratory |
| Irrigation Water | Grounds | None | Ambient | Irrigation water is supplied from Vista Irrigation District (VID) who obtains their water from MWD, same as above. |
| Heating Hot Water | Throughout Facility, used for heating only, does not come in contact with patients. | cility, used for depending on to prating only, does outside air temperature, | | Closed loop system, chemicals installed to stabilize water to prohibit corrosion of system. |

| EQUIPMENT | Location | Scale, Rust, or Biofilm Growth | Water Temp. | COMMENTS |
|-----------------------------|---|---|---|---|
| Chilled Water | Throughout Facility, used for cooling (air conditioning), does not come in contact with patients. | None | Varies depending on outside air temperature and demands of building, usually ranges between 42 to 55 degrees F. | Closed loop system, chemicals installed to stabilize water to prohibit corrosion of system. |
| Condenser Water Loop | Isolated to the Central Plant only. Cooling Tower is part of Air Conditioning System. Located 300 ft. away from main building. | Minor Bio- film, potential for rust and scale. | | Requires most attention to ensure bio-film is kept to a minimum. Water is treated with sulfuric acid, bleach and biocides. A carefully designed and monitored program has been developed by **Frident Technologies**-a consultant. Water is tested daily*-by facilities staff to ensure we are within parameters. |
| Thermal Ice Storage Loop | Isolated to Central Plant only. Part of Air Conditioning system. | None | Temperature range is from 18 to 40 degrees F. | Glycol and water mix to specific gravity mix, closed loop system. |
| | Throughout, used for sterilization of instruments, heating hot water & domestic hot water through heat exchangers & humidification. | None | | Basically a closed loop system except for discharge at sterilizers and humidifiers. Due to high temperature, not an issue. |

Infection Control Risk Assessment

- No cases of nosocomial Legionellosis have been identified at Tri-City Medical Center within the past ten years.
 Legionnaires cultures are performed on bronchoscopy cultures and urinary Legionella antigen test is available in house.

| High-Risk Patients | Unit | Prevention Strategies |
|---------------------------|--|---|
| Chemotherapy and Oncology | TELEMETRY | Showers 1) The degree to which contaminated water is aerosolized into respirable droplets; 2) The proximity of the infectious aerosol to the potential host |
| COPD | Pulmonary Services | Sterile water used in nebulizers |
| End-stage renal disease | Dialysis | Filters are used in water lines in dialysis units, for the purpose of providing bacteria-free water for instrument reprocessing. Additionally, a reverse osmosis (RO) unit is usually added to the distribution system leading to PE areas. |
| Endoscopy | Surgery Services | Filters are used in water lines for the bronchoscope and endoscope washer/disinfectors. |
| Others | ICU, TELEMETRY, Med/Surg, Surgery, Pediatrics, Maternal/Child Services, NICU and ED | Naso-gastric tubes are flushed with sterile water. Reusable respiratory treatment devices that aerosolize fluids are rinsed with sterile water after use. |



| | Comparison Chart of Water Disinfection Methods in a Hospital Environment | | | | | | | | | |
|--|--|---|--|--|--|------------------------------------|---|---|--|---|
| Item | | | | Combination Disinfection Systems | | | | | | |
| | Super-Heating & Flush | Auto - Chlorinating / Inhibitor-System | Auto-Chloramine System (Mono- Chloramine) | Chlorine Dioxide | Copper-Silver Ionization System | Ozoniation | Ultraviolet | Ultraviolet & Auto- Chlorinating / Inhibitor-System | Ultraviolet & Auto- Chloramine System (mono-chloramine) | Ultaviolet & Chlorina Dloxide |
| USED ON DOMESTIC COLD WATER SYSTEM | No | Yes | ¥es | Yes | FEASIBLE RETURN LOOP WITH FIXTURE / EQUIPMENT BACK FLOW PREVENTION REQUIRED | Yes | Yes | Yes | Yes | Yes |
| USED ON DOMESTIC HOT WATER SYSTEM | Yes | Yes | ¥05 | ¥es | Yes | ¥es | Yes | ¥es | ¥06 | ¥ es |
| CHEMICAL | None | SODIUM HYPOCHLORITE | CHLORAMINE (CHLORINE-& AMMONIA) | CHLORINE DIOXIDE (SODIUM CHLORITE) | COPPER-& SILVER (MINERALS) | NONE | NONE | SODIUM HYPOCHLORITE | CHLORAMINE (CHLORINE & AMMONIA) | CHLORINE DIOXIDE (SODIUM CHLORITE) |
| BY PRODUCT | None | TRIHALOMETHANES (THM'S) | TRIHALOMETHANES (THM'S) (FAR LESS THAN CHLORINE) | SOME CHEMICAL DECOMPOSITION IN FORM-OF CHLORITE-AND CHLORATE | NONE | BROMATE | OZONE | TRIHALOMETHANES (THM'S) | TRIHALOMETHANES (THM'S) (FAR LESS THAN CHLORINE) | SOME CHEMICAL DECOMPOSITION IN-FORM-OF CHLORITE AND CHLORATE |
| EFFECTIVE MAX. | None | 7.8-pH | 9-pH | 40-рH | 8-pH | NA | NA | 7-8-pH | 9-pH | 40-pH |
| TASTE & ODORS | None | YES CAN CAUSE TASTE AND ODOR PROBLEMS | YES CAN CAUSE TASTE AND ODOR PROBLEMS | NONE (BELOW-8 PPM) - REMOVES MOST TASTE AND ODORS PROBLEMS | NONE | YES WILL ADD ODOR | NONE- PROVIDED HIGH INTENSITY OZONE LAMPS ARE NOT-USED | YES—CAN-CAUSE TASTE AND ODOR PROBLEMS / ONLY IF-HIGH-INTENSITY OZONE LAMPS ARE USED | YES CAN CAUSE TASTE AND ODOR PROBLEMS / ONLY IF HIGH INTENSITY OZONE LAMPS ARE USED | NONE (BELOW 8 PPM) REMOVES MOST TASTE AND ODORS PROBLEMS / ONLY IF-HIGH INTENSITY OZONE LAMPS ARE USED |
| IMPACT ON EQUIPMENT AND SYSTEMS | Potential | POTENTIAL CORROSION PROBLEMS | MINIMAL POTENTIAL CORROSION PROBLEMS | MINIMAL POTENTIAL CORROSION PROBLEMS | MINIMAL POTENTIAL DEPOSITION OF-COPPER ON-MILD STEEL/ LOCALIZED CORROSION- NONE REPORTED | POTENTIAL CORROSION PROBLEMS | POTENTIAL- CORROSION PROBLEMS IF-HIGH INTENSITY OZONE LAMPS ARE USED | POTENTIAL CORROSION PROBLEMS / ADDITIONAL CORROSION PROBLEMS IF HIGH INTENSITY OZONE LAMPS ARE USED | MINIMAL POTENTIAL CORROSION PROBLEMS: ADDITIONAL CORROSION PROBLEMS:IF-HIGH INTENSITY OZONE LAMPS ARE USED | MINIMAL POTENTIAL CORROSION PROBLEMS / ADDITIONAL CORROSION PROBLEMS IF HIGH INTENSITY OZONE LAMPS ARE-USED |

| IMPACT ON DALYSIS E QUIPMENT | None | NONE (BELOW 4 PPM) CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE AND BY- PRODUCTS | SIGNIFICANTLY DIFFICULT-TO REMOVE CHLORAMINES (MONO- CHLORAMINES) AND BY-PRODUCTS AT-4-PPM AND BELOW-CARBON FILTERS EFFECTIVE-RO MEMBRANE NOT EFFECTIVE- MEMBRANE DAMAGE | NONE (BELOW.8 PPM) - CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE DIOXIDE AND BY PRODUCTS | INFORMATION CURRENTLY NOT AVAILABLE | INFORMATION CURRENTLY NOT AVAILABLE | NONE | NONE-(BELOW 4 PPM)- CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE AND BY- PRODUCTS | SIGNIFICANTLY DIFFICULT TO REMOVE CHLORAMINES (MONO- CHLORAMINES) AND BY-PRODUCTS AT 4 PPM AND BELOW—CARBON FILTERS EFFECTIVE, RO MEMBRANE NOT EFFECTIVE, MEMBRANE DAMAGE | NONE (BELOW8 PPM)—CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE DIOXIDE AND BY-PRODUCTS |
|---|--|--|--|---|--|---|------|---|---|--|
| ENVIRONMENTAL LHEALTH EFFECTS | WATER IS AT SCALDING TEMPERATURE | PRODUCES CARCINOGENIC THM:S, | PRODUCES CARCINOGENIC THM'S (less than chlorine). | NONE DOES NOT PRODUCE THM'S AND CAN DESTROY SOME THM'S. | COPPER IS ACUTELY TOXIC TO MANY AQUATIC SPECIES AT LEVELS LOW AS 50 PPB. SYSTEM OPERATES BETWEEN 200 -600 PPB COPPER, 10 TO 60 PPB SILVER. | NONE- BROMITE IDENTIFIED AS AN ANIMAL CARCINOGEN -EFFECTS ON HUMANS UNKNOWN | NONE | PRODUCES CARCINOGENIC THM'S. | PRODUCES CARCINOGENIC THM'S (less than chlorine). | NONE DOES NOT PRODUCE THM'S AND CAN DESTROY SOME THM'S, |
| EPA APPROVED PRIMARY DRINKING WATER DISINFECTANT | No | YES (below 4 ppm) | ¥5S (below 4 ppm) | YES (below .8 ppm) | NO | NO | NO | YES (below 4-ppm) | YES (below 4 ppm) | YES (below .8 |
| BREAKS-DOWN BOFILM (AT NOMINAL OPERATING CONDITIONS) | Yes | NO @ BELOW-50 PPM MINIMAL ABOVE 50 PPM (SYSTEM OPERATES BETWEEN 2 - 3 PPM) | NO-(SYSTEM OPERATES AT-2-3 PPM) | ¥ES | YES / NO - DEPENDING ON-PPM | NO | NO | NO @ BELOW 50 PPM _ MINIMAL ABOVE 50 PPM (SYSTEM OPERATES BETWEEN 2 - 3 PPM) | NO - (SYSTEM OPERATES AT 2-3 PPM) | YES |
| INHIBITS BIOFILM (AT NOMINAL OPERATING CONDITIONS) | No | MINIMAL | MINIMAL | YES | YES / NO - DEPENDING ON PRM | NO | NO | MINIMAL | MINIMAL | YES |
| SHORT TERM RESIDUAL EFFECTIVENESS AGAINST LEGIONELLA (SYSTEM NOT OPERATING) | YES- (APPROX. ONE WEEK) | YES | YES_FAR LESS EFFECTIVE AS CHLORINE | ¥ES | ¥ES | NO | NO | YES | YES (FAR LESS EFFECTIVE AS CHLORINE) | ¥ES |

Appendix D

| | | | | | | | | | | Appendix D |
|--|-------------------------|-------------------------------|-------------------------------|---|---|------------------|-----------------------|--------------------|--------------------|--|
| LONG TERM RESIDUAL EFFECTIVENESS AGAINST LEGIONELLA (SYSTEM NOT OPERATING) | None | NONE | NONE | MINIMAL - SOME RESIDUAL PROTECTION UNTIL BIOFILM IS RE- ESTABLISHED- NONE FOR BULK WATER | YES FOR HOT WATER SYSTEMS ONLY (LONG TERM STUDIES [4 YEARS] INDICATE LEGIONELLA MAY DEVELOP A TOLERANCE TO SILVER.) | NONE | NONE | NONE | NONE | MINIMAL SOME RESIDUAL PROTECTION UNTIL BIOFILM IS RE- ESTABLISHED NONE FOR BULK WATER |
| FLUSHING REQUIRED AT ALL-FIXTURES AT-START-UP AND ON PERIODIC BASES | ¥es | ¥ES | YES | YES | ¥ES | ¥ ES | ¥ES | YES | YES | ¥ES |
| CHLORINE SHOCKING-OF WATER-SYSTEM REQUIRED PRIOR-TO SYSTEM OPERATING (SHOCKING E-FECTS-BULK WATER-ONLY- NO-EFFECT-ON BOFILM) | NA | ΛES | ¥E\$ | NOT-REQUIRED | NOT REQUIRED | ΥES | YES | ¥ES | YES | NOT REQUIRED |
| ESTIMATED FOR A 600 GPM SYSTEM (NOT INSTALLED) | NA | \$ 9,000 (арргох.) | \$ 9,000 (approx.) | \$12,000 | \$36,000 | NOT AVAILABLE | \$ 27,00 0 | \$36,000 (approx.) | \$42,000-(approx.) | \$39,000 |
| ESTIMATED INSTALLATION COST | NA | \$5,000 (approx.) | \$5,000 (approx.) | \$3,000 | \$5,000 | NOT AVAILABLE | \$10,000 | \$15,000 (approx.) | \$15,000-(approx.) | \$13,000 |
| ESTIMATED ANNUAL MAINTENANCE COST | \$12,500 (PER EVENT) | \$8,000 | \$8,000 | \$16,650 @ 1-LB CIO2 OR \$28,250 @ 2 LBS CIO2 | \$25,25 0 | NOT AVAILABLE | \$12,600 | \$20,600 | \$20,600 | \$20,000 @ 1 LB CIO2 OR \$32,000 @ 2 LBS CIO2 |

Prepared by Gregory Bova - JHH Facilities Engineering (Last updated January 30, 2001)

Fact Sheet for Legionellae

Infection and Disease

Legionellae are bacteria. When Liegionellae are present in aquatic environments, the risk of catching an infection depends on several factors: conditions favorable for growth of the organism, a way of releasing the bacteria (e.g., aerosolization of colonized water), the organism reaches a site where it is capable of causing infection, which specific strains of bacteria are involved, and the susceptibility of the host. Over 40 species of *Legionella* have been identified; *L. pneumophlla* appears to be the easiest to catch and causes approximately 90% of cases of Legionellosis. Older persons and those who smoke tobacco or have chronic lung disease are more likely to become infected. Persons whose immune system is decreased (certain drugs or underlying medical conditions) are at particularly high risk.

Habitats

Legionellae bacteria are commonly present in natural and man-made water environments. The organism is occasionally found in other sources, such as mud from streams and potting soils. In natural water sources and municipal water systems, Llegionellae are generally present in very low or undetectable concentrations. However, under certain circumstances within manmade water systems, the concentration of organisms may increase markedly, a process termed "amplification." Conditions that are favorable for this amplification include water temperatures of 25-42°C (77-108°F), stagnation, scale and sediment, biofilms, and the presence of amoebae.

Legionellae infect and multiply within several species of free-living amoebae, as well as ciliated protozoa. The initial site of infection in humans with Legionnaires' disease is the pulmonary macrophage. These cells engulf Liegionellae and provide an environment that is remarkably similar to water protozoa. Within these cells the bacteria can grow and multiply. Hence, Liegionellae may be considered protozonotic; i.e., they naturally infect free-living amoebae and incidentally infect the phagocytic cells within human lungs under certain circumstances.

There is an indication that certain materials influence growth of Legionella. Natural rubbers, wood, and some plastics have been shown to support the amplification of *Legionella*, while other materials such as copper inhibit their growth. Generally, *Legionella* thrive in diverse, complex microbial communities because they require nutrients and protection from the environment. Controlling the populations of protozoa and other microorganisms may be the best means of minimizing *Legionella*.²

Transmission of Legionnaires' Disease

Investigations of outbreaks of Legionnaires' disease supply most of the information we have about how the disease is passed to humans. These studies suggest that, in most instances, transmission to humans occurs when water containing the organism is aerosolized in respirable droplets (1-5 micrometers in diameter) and inhaled by a susceptible host. A variety of aerosol-producing devices have been associated with outbreaks of Legionnaires' disease, including cooling towers, evaporative condensers, showers, whirlpool spas, humidifiers, decorative fountains, and a grocery store produce mister. Aspiration of colonized drinking water into the lungs has been suggested as the mode of transmission in some cases of hospital-acquired Legionnaires' disease.

The most effective control for most diseases, including Legionellosis, is prevention of transmission at as many points as possible in the disease's chain of transmission. If one preventive measure fails, others will be in place and act as fail-safe mechanisms. With this philosophy in mind, it may be desirable to design measures to prevent transmission of Legionellosis at as many points as possible in the disease's chain of transmission. The Waterborne Illness policy outlines the preventative steps Tri-City Medical Center has taken to break this chain of transmission.



| Tri-City Me | dical Center | Distribution: Intensive Care Unit | | | | | |
|------------------|---|---|--|--|--|--|--|
| PROCEDURE: | EPICARDIAL PACING WIRES | | | | | | |
| Purpose: | To outline the nursing responsibilities for: 1. Dressing epicardial pacing wires sites 2. Attaching epicardial pacing wires to A-V sequential pulse generator 3. Assisting with removal of epicardical pacing wires 4. Performing an atrial electrogram | | | | | | |
| Supportive Data: | Epicardial pacing wires are attache Teflon-coated, stainless steel wires out through the chest wall at the rig right ventricle and brought out on the dress epicardial pacing wires and a | d to the epicarduim during cardiac surgery. Two may be implemented on the right atrium and brought the subcostal area. Two wires are re-implanted on the ne left sucostal area. Only trained staff are allowed to attach epicardial pacing wires to a pulse generator. ove epicardial wires. Licensed staff may assist with | | | | | |
| Equipment: | See sections below. | | | | | | |

A. <u>DRESSING EPICARDIAL PACING WIRES SITES:</u>

- 1. Equipment:
 - a. Disposable gloves
 - b. Two 2x2 gauze pads
 - c. Roll of plastic tape
 - Roll of silk or paper tape
 - e. 70% chlorhexidine gluconate and 30% alcohol or povidone iodine
- Procedure:
 - a. Change epicardial pacing wire dressings every 72 hours, when soiled, or whenever the patient takes a shower.
 - b. Perform hand hygiene and don gloves
 - c. Cleanse each site with chlorhexidine/betadine.
 - Cover sites with 2x2 gauze pads.
 - e. Coil epicardial wires, place on top of dressing and secure to chest with silk or paper tape. Do not put tension on epicardial pacing wires when coiling them,
 - f. Cover **isolated** epicardial wire ends with plastic tape folded with the end tabs.

B. <u>ATTACHING EPICARDIAL PACING WIRES TO A-V SEQUENTIAL PULSE GENERATOR AND SINGLE CHAMBER GENERATOR:</u>

- Supportive Data:
 - a. —Epicardial pacing wires are attached via a connecting cable to an A-V sequential or single chamber pulse generator. The pulse generator is activated and the ability of the wires to conduct electricity and initiate depolarization of atria and ventricles (capture) is assessed.
- 2. Equipment:
 - a. A-V sequential or single chamber pulse generator with 9-velt battery. Allow time for self-test to review if battery is showing "low battery" and replace if necessary.
 - b. One or Two pacing connector cables
 - c. Disposable gloves
 - d. Two 2x2 gauze pads
 - e. Roll of tape
 - f. Gloves
- 3. Procedure:

| Review/Revision DateIntensive Care Unit Department | Clinical Policies & Procedures Division of GVS | Patient Care Quality Committee | Medical Department Review Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors Approval |
|---|--|--------------------------------------|--|-----------------------------------|----------------|--------------------------------------|---|
| 06/93, 12/10, 04/11, 03/19 | 09/05, 03/08, 01/11 | 10/05, 04/08 | n/a | 11/05, 04/08 , 10/19 | 11/19 | 01/06, 06/08 , п/а | 06/93, 07/03, 01/06, 06/08, 05/11 |

- a. Follow procedure in Mosby's for Pacing: Temporary Transvenous and Epicardial.
- a.b. Perform hand hygiene, den gleves, and remove existing-dressing covering-epicardial wires. Do not put tension on epicardial pacing wires while removing dressings. Wearing gleves minimizes the possibility of stray current passing through the wire to the myocardium.
- b.c. Identify atrial-wires (to the right of the sternum) and ventricular wires (to the left of the sternum).
- e.d. Attach one pacing connector cable to two atrial wires and one cable to two ventricular wires. Either wire may be inserted into the positive and negative openings. A wire becomes negative when it is inserted into negative opening.
- d.e. Tighten screw-clamps, located on the sides of connector, for each wire. Do not over tighten connections.
- e-f. Attach connector cable to A-V sequential pulse generator: atrial pins to atrial posts, ventricular pins to ventricular posts.
- f.g. Set dial settings per physician's order: atrial milliamps (mA), ventricular mA, rate, A-V interval and sensitivity.
- g.h. Turn pulse generator on
- h.i. Observe sense and-pace light illumination.
- i.j. Run-rhythm strip and look-for appropriate spike with capture.
- j.k. Perform site-care and tape wires-securely to chest.
- k.l. Hang pulse-generator on pole above patient or secure to patient gown-

C. ASSISTING WITH REMOVAL OF EPICARDIAL PACING WIRES:

- Equipment:
 - a. Disposable gloves
 - b. Two 2x2 gauze pads
 - c. Scalpel
- 2. Procedure:
 - a. Explain the procedure to the patient.
 - Ensure patient IV access.
 - c. Place patient in supine position
 - d. Have materials available for the physician.
 - e. Leave exit sites open to air. If exit site is oozing redress with sterile 2x2 gauze pad.

D. PERFORMING AN A TRIAL ELECTROGRAM

- Supportive Data:
 - a. -An atrial electrogram (AEG) is a method of recording electrical activity originating from the atrial myocardium by using temporary atrial epicardial pacing wires. Evaluate the atrial electrogram for the presence of atrial activity and its relationship to ventricular activity. Compare with surface ECG for interpretation. Atrial electrograms will enhance the atrial activity often masked on the surface ECG, allowing for clarification of the dysrhythmia origin.
- 2. Equipment:
 - a. Nonsterile gloves
 - b. Temporary atrial epicardial wires placed during cardiac surgery
 - a.c. Bedside ECG monitor and recorder
 - b.d. One or two alligator clips for continuous monitoring, OR ECG electrodes for quick view
 - c.e. Materials to dress epicardial wires
- 3. Procedure:
 - 3.a. Follow procedure in Mosby's for Atrial Electrogram.
 - a.b. Don gleves. Gleves shall be wern whenever handling the epicardial wires to prevent microshock.

- b.c. Gennect one of the atrial wires to the V (precerdial)-lead of the 5 lead cable of the ECG menitor with an alligator clip-OR
- e.d. Connect one of the atrial wires to the left arm (LA) limb lead and the other to the right arm (RA) limb lead of the 5 lead cable of the ECG monitor with alligator clips. Connection of the epicardial wire to the ECG monitor allows for the detection and recording of atrial electrical activity.
- d.e. Select the V lead on the lead-selector of the ECG-monitor and record a tracing OR select lead II or lead-III with the lead-selector on the ECG-monitor and record a tracing. Use of the precordial lead-will allow detection of the atrial electrical activity between the V-lead and an indifferent limb-lead in a unipolar configuration.
- e.f. Redress epicaridal wires to prevent infection and microshock.

E. **DOCUMENTATION:**

 Document procedure, including patient's tolerance and any difficulties during technique in the medical record.

F. REFERENCE(S):

- 1. Lynn McHale Wiengard. (2011)., D.J., and Carson, K.K. (2005). AACN procedure manual for critical care (6th-ed.). (5th-ed.). St. Louis, MO: Elsevier. Weingard, D. L. (2017). AACN procedure manual for high acuity, progressive, and critical care (7th ed.). St. Louis, MO: Elsevier
- 2. Perry, A.G. & Potter, P.A. (2013). (eds). Clinical nursing skills and techniques, (8th ed.). 6th edition. St. Louis, MO: Mosby——; Mosby
- 3. Urden, L.D., Stacy, K.M., and Loguh, M.E. (2013). (2006). Thelan's critical care nursing: diagnosis and Management (7th ed.). (5th-ed.). St. Louis, MO: Mosby

G. RELATED DOCUMENTS:

- 1. Mosby's Clinical Skills Pacing: Temporary Transvenous and Epicardial
- 2. Mosby's Cllinical Skils Atrial Electrogram

| Tri-City Me | dical Center | Distribution: | Women & Newborn Services, NICU | | | | |
|------------------|--|---|---|--|--|--|--|
| PROCEDURE: | PULSE OXIMETRY, NICU | | | | | | |
| Purpose: | To outline the nursing responsibilities for noninvasive; monitoring of anthe infar arterial oxygenation saturation using pulse oximetry. | | | | | | |
| Supportive-Data: | emitting diode (LED) connected by with eximetry capabilities. Light was back by exygenated and deexygen processed by the eximeter, which a saturation monitoring is the most w | d-with-exygen a cable to an- ves emitted by ated and hem- calculates-puls idely-used me by a respirator | . A pulse-eximeter is a probe with a light- eximeter or a cardio-respiratory monitor the LED are absorbed and then reflected eglebin molecules. The reflected light is e exygen saturation (SpO ₂). Oxygen thed of assessing exygenation status. The therapist or registered nurse (RN) as an | | | | |
| Equipment: | Pulse Oximeter, pulse oximeter ca | able, oximete | r probe, velcro wrap | | | | |

A. POLICY:

- Oxygen use requires a physician/licensed independent practitioner (LIP)AHP order including the desired oxygen saturation (SpO2) range.
- Oxygen saturation goals for infants less than or equal to 23-30 weeks
 - a. Target saturation goals are 88-90% with SpO2 alarm limit set low 85% high 92%
- 3. Oxygen saturation goals for infants 30 1/7-34 6/735 weeks
 - a. Target saturation goals are 90-94% with SpO2 alarm limit set low 88% high 96%
- 4. Oxygen saturation goals for infants greater than or equal to 35 0/7 weeks
 - a. Target saturation goal are 94-98% with SpO2 alarm limits set low 92 high 100%

B. PROCEDURE:

- Verify physician/AHP orderPerform hand hygiene.
- 2. Assemble equipment and take it to the infant's bedside. Ensure the pulse eximeter or cardio-respiratory-monitor has power.
- 3. When choosing a site, consider peripheral circulation and/or clinical condition. Always choose a site that will completely cover the sensor's detector window.
- 4.4. Attach the sensor to the selected site ensuring that the emitter (red light) and the photo detector are properly aligned before connecting to the pulse oximeter or cardio-respiratory monitor if possible. Cover the probe with a Velcro wrap.
- 2. Choosing-a-site
 - a. Choose a site that is well-perfused.
 - . Always choose a site that will completely cover the sensor's detector window.
 - Clean-site-of-debris prior to sensor placement.
- Attach the sensor to the selected-site ensuring that the emitter (red light) and the photo detector are properly aligned before connecting to the pulse eximeter or cardio respiratory monitor if possible. Cover the probe with an epaque cover. Ensure the probe is connected to the patient cable, the cable is connected to the pulse eximeter or cardio respiratory monitor eximetry module and that the equipment's power has been activated.
- Ensure the display window is free of alarm and system failure messages.
- 5. On the display, verify that high and low alarm limits for SpO₂ match ordered corrected gestational age criteria or physician/AHP ordered goals.
 - a. High and low alarm limits for SpO2 and pulse-rate.
 - b. The reading for SpO2 and pulse rate.

| NICU Department Review/Revision | Perinatal Collaborative Practice Division of Neonatology | Pharmacy and Therapeutics | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|--|--|------------------------------|-----------------------------------|----------------|--------------------------------------|-----------------------|
| 11/06, 05/08, 4/09, 07/15 , 8/19 | 8/07; 07/15 | n/a | 11/15, 11/19 | 11/19 | 9/07, 6/09, 01/16, n/a | 9/07, 6/09, 01/16 |

- 6. Wait 10-30-seconds for SpO₂-and pulse-rate reading to stabilize. Motion artifact is the most common cause of inaccurate readings.
- Refer to the equipment's manual as needed for the setting and adjustment of alarm limits.
- 8.6. Determine with the physician when oxygen should be administered or increased based on SpO₂ and/or blood gas results and the infant's clinical presentation.
- 9. Dispose of trash in the appropriate receptacle and perform hand hygiene.
- 40.7. When responding to alarms, assess the infant per NICU Standard of Care and for the following:
 - a. Pulse rate on the oximetry reading corresponds with infant's pulse rate monitor or apical heart rate.
 - Oxygen equipment is assembled and functioning properly.
 - Good connection of the sensor to the skin site.
 - d. Light source on the probe is functioning and oximetry cables are properly connected.
 - e. Velcro wrapOpaque cover is in place over the sensor.
 - Limb being used is not being moved excessively.
 - g. Hypothermia.
 - h. Hypotension.
 - Vasoconstriction.
 - Diaphoresis.
- 11.8. Rotate the sensor site a minimum of once every 4-68 hours and document new probe site in the EMR..
- 9. Document the following SpO₂-and sensor site-changes in the electronic health-record (EHR) in the EMR with every oximeter check:
 - a. Time
 - b. oxygen mode
 - c. oxygen concentration
 - d. oxygen flow (if applicable)
 - e. saturation
 - a. alarm limits
 - 12.b.

C. REFERENCES:

- 1. Gardner. S, et al. (20161) Merenstein & Gardner's handbook of neonatal intensive care, 87th Ed. St. Louis, MO: Elsevier Mosby.
- 2. Bowles, S.Ikuta, L. & Beauman, S. (20194) Policies, procedures, and competencies for neonatal nursing care. National Association of Neonatal Nurses. Glenview, IL:NANN.
- 3. Goldsmith, Jay P., Edward H. Karotin, Martin Keszler, and Gautham Suresh. Assisted ventilation of the neonate: an evidence-based approach to newborn respiratory care. Philadelphia, PA: Elsevier, 2017. p161.
- 2.4. -MacDonald M. & Ramagethu J. (2007). Atlas of procedures in neonatology, 5th Ed. Lippincott Williams & Wilkins.
- 3.5. Mintz-Hittner, H., Kennedy, K. & Chuang, A. (2011) Efficacy of intravitreal bevacizumab for stage 3+ retinopathy of prematurity. The New England Journal of Medicine. 364(7) 603-615.



WOMEN'S AND NEWBORNCHILDREN'S SERVICES MANUAL — NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 8/06

SUBJECT:

TRANSFER OF NEONATES AND

INFANTSInterfacility Transfer of the

NICU Patient

REVISION DATE: 06/09, 6/11, 8/12

NICU Department Approval: Perinatal Collaborative Practice Approval: Pharmacy & Therapeutics Committee App 08/19 10/19

Pharmacy & Therapeutics Committee Approval: Medical Executive Committee:

n/a 11/19

Administration Approval:

11/19

Professional Affairs Committee: Board of Director Approval:10/13

n/a

A. PURPOSE:

1. The purpose of this policy is to ensure the safe and appropriate transfer of neonates and infants both within the hospital and to other-hospitals. It is not intended to replace national guidelines established to manage the care of the critically ill neonate/infant.

B. POLICY:

1. This policy is intended to provide a standard procedure, which ensures that all sick neonates and infants are transferred safely. It also provides staff with a clear course of action for transferring patients both internally and externally. The policy includes a procedure for assessing the level of risk involved in the transfer and the mechanisms to minimize the risk. The procedures to be followed when considering transferring a critically ill neonate or infant, as well as contacting the specialized neonatal transport team are included. It also considers the needs of the parent/caregiver.

C.----DEFINITIONS

- · Internally: from one clinical-area to another-within the hospital
- Externally: from-a clinical area within the hospital to another area outside the hospital
- Tertiary Center: a major hospital that usually has a full complement of services or a specialty hospital dedicated to a specific sub-specialty care (i.e., pediatrics)
- CHET: Children's Hospital Emergency Transport
- CPeTS: California Perinatal Transport System
- NICU: Neonatal Intensive Care-Unit
- NCPTS: Northern California-Perinatal Transport System
- NRP: Neonatal Resuscitation-Program
- RCA: Regional-Cooperative Agreement
- SCPTS: Southern California Perinatal Transport System
- TCMC: Tri-City-Medical Center
- UCSD: University of California San Diego

D. GENERAL PROCEDURE:

- 1. Neonates and infants are always potentially at risk whenever they are moved out of areas of relative-clinical safety. This procedure is to be adhered to for any neonate or infant who requires transfer-either within the hospital or to another facility. Transfers can be categorized into one of three types:
- A. <u>INTERFACILITY (EXTERNAL) TRANSFER</u>PROCEDURE:

Women's and Children's Policy Manual - NICU Transfer of Neonates and Infants Page 2 of 7

- 1. <u>:</u> Neonates and infants who require transfer from the NICU to another hospital are always transferred by a Neonatal Transport Team (CHET, UCSD, etc.)
- 2. TCHD will maintain at least one Regional Cooperative Agreement with nearby tertiary center to provide expert transfer services from this facility to other facilities.
- In compliance with California Assembly Bill 4439, external transports require the use of the California Perinatal Transport System (CPeTS) form.
- 4. The medical team caring for the patient will assess the risk of transfer and will ensure that appropriate transport/staff is arranged.-
- 5. The CCS-paneled Transport Physician will determine the necessary personnel for transfer to another facility.
- 6. The transport team determines whether or not parents may accompany a patient on transfer to another facility. Contact information for the receiving facility and unit should be provided to the parents.
 - a. There are RCA's with Rady-Children's Hospital and UCSD for the transport for neonates and infants in the NICU. The vast majority of transports will be performed by either the CHET-Team or the UCSD NICU-Transport Team. In compliance with California Assembly Bill 4439, external transports require the use of the CPeTS form.
 - i. Phone Numbers:
 - 1) CHET Team: 858.277.3404
 - 2) UCSD-NICU: 619.543.6560
 - 3) SCPTS (Monday Friday during normal business hours): phone:714.921.9755, fax:714.921.9766
 - 4) NCPTS (non-business-hours): phone:650.723.6307, fax:650.724.5851
 - i. -
 - o. INTRAFACILITY (INTERNAL) TRANSFER: Neonates and infants transferred from one area of the hospital to another area within the hospital require transfer by personnel formally trained in NRP, as well as having the specialty skills required to assess and manage potential emergencies.
 - c. TRANSFER OF A NEONATE/INFANT TO THE MORGUE: See Policy on Deceased Patient Care and Disposition located in the Patient Care Services Policy Manual.
 - 2. PRIOR-TO TRANSFER of a neonate or infant, the level of risk to the patient should be assessed so appropriately qualified staff can be identified to undertake the transfer. The RN caring for the patient-will assess the risk of the transfer in relation to the individual neonate-or-infant. The RN will-also assure that appropriate transport-and/or escort staff is available to accompany the patient.
 - 3.——It can be very difficult to assess and categorize neonates and infants, but all patients categorized as "high-risk" must be transferred by expert medical and nursing staff.—The following are suggestions of what to consider when categorizing neonates and infants:
 - a. Levels of Risk:
 - i. Low Risk
 - Thermodynamically stable
 - 2) Hemodynamically-stable
 - 3) Initial medical-surgical-needs met and condition-is stabilized
 - 4)— Main medical needs-are limited to growth sare, chronic care, or hospice care
 - ii. Intermediate Risk
 - 1) Adjusted Gestational Age <32 weeks (Very Low-Birth-Weight Thermoregulation Procedure must be instituted immediately)
 - 2) Requires exygen
 - 3) Any trauma
 - iii. High Risk
 - 1) Adjusted Gestational Age < 28 weeks (Very Low Birth Weight Thermoregulation Procedure must be instituted immediately)
 - a) At risk for intracranial hemorrhage: minimal handling
 - 2) Hemodynamically-unstable
 - Thermodynamically-unstable

- 4) Artificial-Airway or airway adjunct
- 5) Requires medical, surgical or diagnostic services not available within-TCMC
- 6) High risk-for abrupt deterioration requiring-rescue efforts of any kind
- a) --- Prolonged or recurrent seizures
- b) Bactorial moningitis
- c) > 40%-exygen
- d) Cardiac dysrhythmias
- Vasoactive-drugs required-for hemodynamic stability
- f)——Shock
- g) Moderate-significant hypevolemia (requiring >-10 ml/kg fluid resuscitation)
- h) Complex fluid management

b. THE TRANSPORT TEAM

- TCMC has 2 RCA's for the expert transfer of neonates and infants from this facility to other facilities. Those agreements are held with:
- 1) Rady Children's Hospital CHET Team: 858.277.3404
- 2) Rady-Children's NICU: 858.966.5888
- 3) UCSD Medical Center NICU: 619.543,6560
- ii. If a newborn or infant is unable to be transferred due to lack of beds, Southern California

 Perinatal Transport System (SCPTS) or Northern California Perinatal Transport

 System (NCPTS) must be notified immediately.

a.

- a-b. In the event-of-a-mass evacuation, as with-disasters, the-Southern California Perinatal Transport System (SCPTS) should be contacted for assistance and notification. Mass evacuations impact county and state transport and hospital resources. Refer to NICU Disaster Procedure for mass evacuations.
- 1) Note: SCPTS is only available during regular business hours. In the event that a mass evacuation is occurring outside of regular business hours, then the NCPTS should be called.
- 2) SCPTS or NCPTS should be notified with as much advance notice as possible in the event of a disaster (o.g. fires, etc.) that may require evacuation at a future time. This will allow more optimal disaster preparedness and utilization of county and state resources.
- 3)— SCPTS (Monday Friday during normal business hours): -562.945.6484 NCPTS (non-business hours): -650.723.6307
- iii. —In the event of high-volume transfer, as with closure of unit due to infectious disease issues or facility issues, SCPTS or NCPTS should also be notified. If the local transport teams are unable to meet the needs of transferring or evacuating neonates and infants, SCPTS or NCPTS will assist in allocation of resources to assist.
- 6. PRIOR TO TRANSFER: This section is applicable to INTERFACILITY (EXTERNAL)

 transfer.
- i.7. The Uunit Ssecretary shall:
 - 4)a) Contact the film library for all film discs and reports.
 - b) Obtain two copies of infant face sheets, one copy of mom's face sheet, copies of prenatal records (if available), copies of relevant interdisciplinary notes, & copies of lab results., Copy from electronic medical-record all progress notes, history and physical, mother's L&D record, lab results, and clinical notes. Compiles all records and places in envelope.
 - 2)c) Complete Newborn Screening Form if not already obtained.
- ii.8. The physician shall-make the initial:
 - 4)a. Make initial Gcontact te-with the CCS-paneled transport physician to discuss the condition of patient necessitating the transport.
 - 2)b. If the referring neonatologist is not able to make the initial call due to the emergent care needs of the patient, then an RN will call the transport team.
 - 3)c. Upon availability, the referring neonatologist will contact the transport coordination physician for hand-off communication regarding the patient's condition and care.
 - 4)d. Contact the parents if they are not in the NICU when the decision to transfer is made and

- a designated hospital is decided upon.
- 5)e. If parents are unavailable for consent, and transport is emergent, the physician may sign authorization for transport to a higher level of care. Continued efforts to get in touch-with the parents shall continue until they can be contactedOnce able to reach parents, notify them of transfer.
- f. Notify the patient's primary care physician of the transfer.
- 6)g. Complete a physician discharge note prior to transfer. Print history and physical, all clinical/progress notes and discharge note.
- iii.9. The <u>Assistant Nurse Manager or other designated personnel</u> will call the receiving unit and confirm readiness to accept the baby.
- iv.10. The RN-nurse caring for the neonate or infant ensures that shall (may designate duties):
 - 1)a. Ensure∓ the family is aware of the reason for the transfer.
 - 2)b. Ensure Consent has been obtained (when applicable).
 - 3)c. Verify that the transport team or transfer personnel have been contacted.
 - 4)d. Verify estimated time of arrival.
 - 5)e. Gather Aall appropriate patient medical record documentation, including physician discharge note, and imaging studies are readied.
 - 6) A physician discharge note-should be completed and a copy must-accompany the patient on transport/transfor.
 - 7) Any medications-necessary should-accompany the patient.
 - 8) An-emergency drug sheet-calculated to the-patient's current-weight should accompany the patient.
 - 9) Monitoring-devices should be attached to the patient and secured to prevent falling or harm to the patient.
 - 10) Infusing devices should be secured to a pole or frame, not laid in the bed with the patient.
 - 41)f. Complete the transfer packetehecklist. Document vital signs on CPeTS form at the time of acceptance for transfer.
 - 12)g. For patients transferring to another unit-or another institution, place Place patient belongings in a bag. Label the bag with the patient's information. The bag must either accompany the patient or be given to the parents/caregivers.
 - 13) Clinical observation should-be-recorded prior to transfer. The risk-assessment will determine how close to transfer the clinical observations should-be recorded:
 - a) High-risk category: no more-than 15 minutes-prior to transfer
 - b) Intermediate-risk: no more than 30 minutes prior to transfer
 - e)h. Low risk: no more than 60 minutes prior to transferContinue with standard of care until arrival of transport team.
- 14) The transport team-determines whether or not parents may accompany a patient on transfer to another facility. The parent/caregiver will be given a map to the facility the infant is being transferred to, as well as contact information for the unit the infant is being transferred to.
- 15) Required paperwork-is-provided to the transport team. Required Paperwork-(RN or Designee) includes:
 - a) CPeTS All-California Neonatal Transport Form
 - b) Patient transfer-acknowledgement/consent
 - If applicable, Hospital Report of Newborn Screening Specimen Not Obtained (DHS 4089)
 - d) Infant's face sheets, all progress notes, history and physical, mother's L&D record, lab results, and clinical notes. Paperwork that is not ready when the transport team leaves can be faxed to the receiving hespital
 - e) Any legal-paperwork (CPS holds, etc.)
 - Documentation regarding status of hearing-screen, metabolic screen, and substance exposure. Beneficiary-Advisory of Financial Responsibility
- 16) When interdisciplinary team members have been involved in the care of the patient prior to transfer, include copies of relevant clinical documentation from patients electronic medical record.

B. MODE OF TRANSFER

1. All infants less than or equal to 32 weeks gestational age and/or less than 1500 grams will be

Women's and Children's Policy Manual - NICU Transfer of Neonates and Infants Page 5 of 7

- transported in an incubator (Very Low Birth Weight Thermoregulation Precedure).
- 2. Infants being transferred with an intermediate or high risk level will be transported in an incubator.
- Low risk level infants can be transferred in an open crib based on RN's evaluation of patient's safety needs.

C. TRANSFER PERSONNEL

- The RN caring for the baby, in collaboration with the physician and RCP, and in consideration of the baby's risk level, will determine the appropriate personnel required to transfer the infant from one unit to another.
- Intubated patients or patients with an unstable, unprotected airway require the presence of an RCP.
- The CCS-paneled Transport Physician will determine the necessary personnel for transfer to another facility.

D. <u>DURING TRANSFER</u>

- The newborn's identification band will be shocked using 2 patient identifiers, consistent with hospital policy (Identification of Newborns Policy).
- 2. The restraint of an infant during transport is a complex matter and requires consideration by all staff involved in the transfer. For internal transports, the RN is responsible to assure the infant is safe and secure during transport. For external transports, the transport team is responsible for the safety of the infant during transport. In all cases, every member of the health care team should advocate for the safest possible method for the transport of the baby.
- Transport personnel should be experienced in transferring of newborns and also be trained in Basic Life Support, NRP and/or PALS when appropriate.
- 4. Sick patients requiring internal transfer must be accompanied an RN trained in the care of sick infants. They may be accompanied by a neonatal/pediatric/other specialty physician if the infant is considered intermediate or high risk. The RN is responsible to ensure the appropriate trained staff is present on transfer.
- All invasive lines, tubes and drains must be secured to prevent them from being disledged or disconnected during transport.
- 6. Drainage and collection systems that can be emptied must be emptied and the amount recorded on the fluid balance sheet prior to transfer.
- Safety rails should be up and in the locked position.
- Appropriate manual handling techniques should be used when moving the infant.
- 9. The infant will be continually observed by an RN (minimum) during the transfer. The clinical observations will be recorded regularly and as the infant's condition dictates. At a minimum, Vital Signs (including temperature) and a brief assessment will occur before leaving the area and upon arrival to the receiving area. Every transfer requires an assessment.
- a. Example: when moving the infant from Labor & Delivery to NICU, at a minimum, a set of vital signs and a brief assessment will be documented just prior to leaving L&D and upon arrival to the NICU.
- Example: when moving a infant from NICU to MRI back to NICU, a set of vital signs and a brief
 assessment will be documented just prior to leaving the NICU, upon arrival to MRI, and upon arrival to
 the NICU.
- 10. Equipment will be checked during the transport to assure it is functioning properly. Any equipment that fails or malfunctions during a transport should be removed from service, a QRR written, and a work order place.
- 11. The transfer should occur in an orderly fashion. The receiving area should be notified that the patient in en route.
- 12. Family centered care: The parents are invited to accompany the patient on transport/transfer within the facility. If they are not able to attend, the physician and primary NICU RN will update the parents about the patient's clinical status. Document parent/caregiver update in EMR.

ON ARRIVAL AT TRANSFER DESTINATION:

 The escort team will formally hand over the patient to the receiving health care team. A detailed hand-off communication will occur. All lines, tubes and drains

- will be shecked by both the transferring-RN and the receiving RN. All-drip rates and medications will be reviewed by both-RNs as well.
- 2. The receiving team will be-updated on the-parent/caregivers-knowledge of the transfer.
- 3. Vital-Signs (including temperature)-and clinical observations will be-recorded.
- 4. When applicable, record-clinical data-as-appropriate to situation and in the appropriate-place.
 - Oxygen and vent-settings

ON COMPLETION OF TRANSFER:

- All-equipment will-be cleaned-per-hospital protocol-and returned-to-its proper storage-place.
- All electrical equipment should be plugged into a wall socket in its proper charging place (after being cleaned).
- 3. Any equipment issues should be reported to the nurse in charge of the area.

 Follow hospital policy and remove this equipment from service, a work order placed to fix the equipment.
- 4. Any medications used for transport should either be appropriately disposed of or returned to its proper secure-storage place (per hospital policy).
- Document and report any events or problems encountered while transferring the baby.
- 6. Decument-how infant tolerated the transport.
- 7. An incident-report should-be completed if any unexpected events occurred during the transfer.

G.B. PERFORMANCE/QUALITY IMPROVEMENT:

- 1. In order-to-provide better-outcomes for extreme prematurity-and/or sick infants that require support-and/or treatment beyond the scope of practice for a community NICU, it is imperative that a streamlined process for this transfer to be in-place.
- 2.1. Data from all transfers will be reviewed on a multidisciplinary level to evaluate outcomes.
 - Transport data (CPeTS Form) will be reviewed quarterly with the regional center (UCSD Medical Center, Rady's Children's Hospital, or both) and the SCPTS.
 - 4. Results of data review and any practice changes that may occur will be communicated to the NICU-staff.

H.C. REFERENCES:

- California Children's Services, 1999. California Department of Health Care Services. (1999).
 California Children's Services Manual of Procedures: Chapter 3.25.
- California Perinatal Quality Care Collaborative (CPQCC), 20129.
- 3. AAP/ACOG () Guidelines for Perinatal Care, (2012) 7th-edition American Academy of Pediatrics (AAP) and American College of OB & GYN (ACOG). (2017). Guidelines for Perinatal Care, 8th ed. -
- 4. National Association of Neonatal Nurses. (2012). Guidelines for Neonatal Nursing Policies, Procedures, Competencies, and Clinical Pathways.
 - 5. High Dependency Care for Children Report of an expert advisory group for the Department of Health 2001.

APPROVAL PROCESS:

- 1. Clinical Policies & Procedures Committee
- 2. Nurse Executive Council
- 3. Medical-Executive Committee
- 4. Professional Affairs Committee
- 5. Board of Directors

J.D. ATTACHMENTS:

2.1. Appendix A: Criteria for External Transfer

Appendix A

Criteria for External Transfer

Criteria for neonatal and/or infant transfer to another institution (if deemed stable by MD) shall include includes, but net-beis not limited to:

- 4.1. Insurance reasons
- 5.2. Parent/caregiver request (on a bed available basis)
- 6.3. Evacuation
- 4. Unit closure
- 7.5. Census/Staffing
- 6. Higher level of care: infant's condition requires complex medical services from sub-specialists that are obtained at a tertiary center or at the discretion of physician.
 - a. PDA ligation
 - b. Surgery
 - Diagnostic and/or therapoutic cardiac-procedures
 - d. Less than 26-weeks and 0/7-days gestation
 - e.a. Complex respiratory modalities



REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Audiology Services

ISSUE DATE:

12/02

REVISION DATE(S): 1/06, 1/09, 5/12, 03/16

Rehabilitation Department Approval-Date(s):
Department of Medicine Chiefs Approval-Date(s):

Pharmacy and Therapeutics Approval-Date(s):

Medical Executive Committee Approval-Date(s): 02/1610/19

Administration Approval:

11/19

n/a

Professional Affairs Committee Approval-Date(s):

03/16 n/a

07/1505/18

02/1610/19

Board of Directors Approval-Date(s):

03/16

A. POLICY:

- Audiology Service Provider is accountable through the Leadership Structure of Rehabilitation Services and the referring physician for maintaining a competent level of practice. The department is also accountable through the appropriate Administrative Executive for carrying out the policies and procedures as approved by the Governing Board.
- 2. Audiology Staff reports to the Leadership Structure in fulfilling duties responsibilities

B. **REQUESTS FOR SERVICE:**

- a. All requests for audiology services must be in the form of a written prescription from a licensed physician or non-physician practitioner.
- b. Verbal requests for audiology services will be accepted, but must be followed by a written.
- c. The speech pathology department will notify the licensed and contracted audiologist.

C. HOURS OF SERVICE:

1. The audiologist will respond to order within 72 hours and will set up a time to complete the evaluation.

D. **RESPONSIBILITIES:**

- Provides audiology evaluations and treatment as prescribed by a licensed physician or nonphysician practitioner.
- 2. Administers a pure tone audiometric assessment using standardized testing equipment and techniques to evaluate patient's hearing status.
- Develops recommendation for each individual based upon the individual's medical condition, assessment and personal goals.
 - a. Makes recommendations regarding assistive hearing devices as needed.
 - b. Refer patients for further assessment or to other services and agencies as needed.
- Documents patient treatment and treatment outcomes in patient's legal record.
- 5. ASHA Preferred Practice Patterns for the Profession of Audiology. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.
- 6. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.

Rehabilitation Services Manual Audiology Policy Page 2 of 2

- Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.
- 8. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

E. <u>REFERENCE LIST:</u>

- 1. American Speech-Language-Hearing Association. (2004). Scope of practice in audiology. Available from www.asha.org/policy.
- Centers for Medicare & Medicaid Services. (2015, May). Therapy Services. Retrieved from www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf
- Centers for Medicare & Medicaid Services. (2015, May). Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf. Retrieved from www.cms.gov



REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Discharge Criteria POLICY NUMBER: 501

ISSUE DATE:

REVISION DATE(S): 1/91, 1/94, 4/95, 9/97, 3/00, 1/06, 3/12, 03/16

Rehabilitation Department Approval-Date(s): 07/1505/18 Department of Medicine Chiefs Approval-Date(s): 02/1610/19

Pharmacy and Therapeutics Approval-Date(s): n/a

Medical Executive Committee Approval-Date(s): 02/1610/19 **Administration Approval:** 11/19

Professional Affairs Committee Approval-Date(s): 03/16 n/a

Board of Directors Approval-Date(s):

03/16

A. **POLICY:**

To establish guidelines for discharging patients from Physical Therapy, Occupational Therapy, Speech Therapy, and Therapeutic Recreation Services.

B. PROCEDURE:

- Criteria
 - a. Rehabilitation Services are no longer clinically indicated and medically necessary for the treatment of the individual's illness or injury.
 - There are no longer valid expectations for significant practical improvement in the level of functioning within a reasonable length of time. Care is at a maintenance level.
 - c. Specified goals and/or prior level of function have been met.
 - d. With surgery or major medical complication, patient treatment will be put on hold or the patient will be considered for discharge pending physician or non-physician practitioner orders.
 - e. The patient's mental function is insufficient to participate or recall information and no family nor caregiver available for training.
 - Appointment Cancellation or Ffailure to show for two scheduled consecutive outpatient therapyappointments visits without notification.
 - Patient is unable or repetitively refuses to follow through with the established treatment g. plan as established upon therapy evaluation.
 - h. Patient is transferred to another facility, discharged from the hospital, or expires.

2. **Process**

- It is the responsibility of the physician to determine discharge from the Rehabilitation Service the patient is receiving.
- b. In the course of treatment, the therapist may determine the patient no longer requires therapy services, or that intervention for the medical problem for which services were being provided is no longer indicated, and is documented in the Medical Record.
- Ç. A discharge summary may be documented in the medical chart showing progress or lack of progress made during the therapy sessions. A final progress note or discharge summary is sent to the referring physician for Outpatient Services.

TRI-CITY MEDICAL CENTER 4002 Vista Way, Oceanside, Cali

REHABILITATION SERVICES POLICY

DELETE this policy. This information is included in the **Dept Policy and Documentation**

ISSUE DATE: 7/94

REVISION DATE: 9/97, 3/00, 12/03, 1/06

REVIEW DATE: 1/03, 1/09, 4/12

SUBJECT: PATIENT AND CAREGIVER EDUCATION

STANDARD NUMBER: 507 **CROSS REFERENCE:**

APPROVAL:

Rehabilitation Department Approval Date(s): 08/1505/18 Department of Medicine Chiefs Approval Date(s): 02/1610/19 Pharmacy and Therapeutics Approval Date(s): n/a

Medical Executive Committee Approval Date(s): 02/1610/19 11/19

Administration Approval:

Professional Affairs Committee Approval Date(s): 03/16 n/a 03/16

Board of Directors Approval Date(s):

This Policy / Procedure applies to the following-Rehabilitation-Services' locations:

4002 Vista Way, Oceanside, CA

2124 El Camino Real, Suite 100, Oceanside, CA

6250 El Camino-Real, Carlsbad-GA

PURPOSE

1. To define the role of Rehabilitation Services in patient/caregiver-education.

- 1. Patient and caregiver education is an integral aspect of evaluation and treatment in the Rehabilitation Services-Department.
- 2. Patients and caregivers will-be instructed in the aspects of rehabilitation as they-pertain to the individual patient with consideration of level of alertness, age-specific considerations, cultural, religious-practices, emotional barriers, desire and motivation to learn, physical-and cognitive limitations, language barriers, and financial-implications of care choices, and as-identified through the evaluation process.
- 3.—Areas of patient or caregiver education may-include but are not limited to instruction in the use
 - a. Home-exercise program
 - b. Home evaluations
 - c. Worksite evaluations
 - d. Safety awareness including precautions specific to diagnosis
 - e. Leisure counseling
 - f. Adaptive equipment

PROCEDURE

- 1. A variety of training-methods are used, such as demonstrations, handouts, booklets, multimedia, and verbal-discussions.
- 2: The therapist assesses the patient's/caregiver's learning needs, abilities, preferences, and readiness to learn.
- 3: The therapist ensures that the patient or caregiver is competent to follow through with the therapy instructions and home exercise programs and observe precautions through demonstration by the patient and/or family. If competency is not achieved, reasons are documented (e.g. patient refusal, cognition impaired, etc.) The therapist will-document evidence of any patient/caregiver training, as well as response to instruction in the therapy progress notes in the medical chart.



REHABILITATION SERVICES POLICY MANUAL

SUBJECT:

Pre-Op Teaching

ISSUE DATE:

6/93

REVISION DATE(S): 2/94, 1/97, 6/97, 1/06, 1/09, 5/12, 03/16

Rehabilitation Department Approval Date(s):

08/1505/18

Department of Medicine Chiefs Approval-Date(s):

02/1610/19

Pharmacy and Therapeutics Approval Date(s):

n/a

Medical Executive Committee Approval-Date(s):

02/1610/19

Administration Approval:

11/19

Professional Affairs Committee Approval-Date(s):

03/16 n/a

Board of Directors Approval Date(s):

03/16

A. **PURPOSE:**

A physical therapist and occupational therapist will provide education for total joint replacement patients at the Pre-Op Class, including precautions, safety instructions with daily activity, and exercise plan.

B. PROCEDURE:

- The Pre-Op Class schedule will be provided by the Ortho-Spine Institute and patients will be 1. encouraged to attend.
- 2. The pre-op teaching will include emphasis on safety and early mobilization.
- 3. The following is an overview of the anticipated course of treatment:
 - Initial visits (Day of Surgery or Post-Op Day 1):
 - b. Instruction by a therapist to include:
 - i. Evaluate affected joint range of motion
 - ii. Evaluate unaffected joints range of motion and strength
 - iii. Evaluate general mobility:
 - 1) Bed mobility
 - 2) Transfer to side of bed; dangle
 - 3) Stand with walker; attempt steps
 - Evaluate Activities of Daily Living (ADLs), discuss Durable Medical Equipment iv. (DME)
 - Instruct in precautions ٧.
 - vi. Weight bearing status if applicable
 - Fall prevention education and provide equipment resource information. vii.
 - viii. Follow-up visits (try to remember to ask for pain medication prior to therapy
 - Transfer and bed mobility; keep in mind THR precautions ix.
 - X. Gait training:
 - Instruct in use of walker or crutches, whichever is appropriate for each 1) individual patient
 - 2) Training on stairs or curb
 - xi. Exercise program: Review protocol exercises.



REHABILITATION SERVICES POLICY MANUAL

SUBJECT:

Speech Pathology Services Department Policy

ISSUE DATE:

7/88

REVISION DATE(S): 1/91, 1/94, 3/97, 1/00, 1/03, 1/06, 1/09, 5/12, 03/16

Rehabilitation Department Approval-Date(s):

08/1506/18

Department of Medicine Chiefs Approval-Date(s):

02/1610/19

Pharmacy and Therapeutics Approval-Date(s):

n/a

Medical Executive Committee Approval-Date(s):

02/1610/19

Administration Approval:

11/19

Professional Affairs Committee Approval-Date(s): Board of Directors Approval-Date(s):

03/16 n/a

03/16

A. DEFINITION(S):

- Speech: The production, intelligibility and fluency of verbalization, to include articulation of phonemes, rate of speech, prosody, phrasing and motor planning, and sequencing of speech.
 - Disorders of speech may include:
 - Dysarthria: Distorted articulation and/or prosody, secondary but not limited to i. cerebrovascular accident, brain injury, Parkinson's disease, amyotrophic lateral sclerosis, myasthenia gravis, multiple sclerosis, cerebral palsy, or oral cancer.
 - Apraxia of Speech: Inability to plan and sequence motor movements efficiently ii. for speech production, secondary but not limited to cerebrovascular accident or brain injury.
 - iii. Developmental Phonological or Articulation Delay or Disorder: Misarticulations, phonological processes or deficits in phonological awareness.
 - Dysfluency: Repetitions of sounds or words, inappropriate cessation of speech or iv. secondary characteristics involving facial or body movements, or abnormally fast or irregular speech rate
- 2. Language: The arbitrary set of symbols which has meaning and which is used for interpersonal communication. Receptive language skills involve the comprehension of spoken, visual, or written language. Expressive language skills involve the formulation of verbal, gestural, augmentative or written language to communicate thoughts and needs.
 - Disorders of Language may include:
 - Receptive Aphasia: Impaired comprehension of verbal or written language. i.
 - Expressive Aphasia: Impaired expression of verbal or written language. ii.
 - iii. Alexia: Impaired comprehension of written language.
 - iv. Agraphia: Impaired expression of written language.
 - Developmental Language Delay: Impairment in development of language V. function.
 - vi. Pragmatics: Interpretation and use of nonverbal language including facial expression, body language, gestures, appropriateness of actions based on setting, company and prosody
- Voice: Phonation through respiratory support and approximation of the vocal cords, in the 3. parameters of quality, pitch, loudness and resonance.
 - Disorders of Voice may include impairments in the following areas:
 - i. Volume: Vocal loudness insufficient or excessive for the speaker's size, age, or gender.
 - Pitch: Vocal pitch inappropriate for the speaker's size, age, or gender ii.

- Quality: Altered vocal quality, including hoarseness, breathiness, harshness, or aphonia.
- iv. Resonance: Imbalanced nasal resonance
- 4. Cognition: The skills of orientation, attention, memory and executive function.
 - a. Disorders of Cognition may include:
 - Disorientation: Inability to identify personal, temporal, spatial, and general information
 - ii. Decreased attention: Inability to attend to stimuli appropriately.
 - iii. Memory impairment: Decreased short-term, long-term immediate and working memory for information presented in verbal, visual, written or tactile modalities.
 - iv. Executive function impairment: Decreased insight, awareness of deficits, problem-solving, safety awareness, reasoning, thought organization, insight and/or initiation, management off attention.
- 5. Swallowing: The functional oropharyngeal process involved in swallowing various consistencies of food, liquids, and own oral secretions.
 - a. Disorders of swallowing many include:
 - i. Oral or pharyngeal dysphagia: Impairment in oral or pharyngeal swallow function.
 - Oral feeding disorder: Inability to tolerate various consistencies of foods and/or liquids secondary to but not limited to oral weakness, dyscoordination, aversion or tactile defensiveness.

B. POLICY:

 Speech-Language Pathology services will be available to inpatients, acute rehabilitation patients, and outpatients at Tri-City Medical Center.

C. PROCEDURE:

- Speech Pathology service personnel are accountable per rehabilitation services leadership structure and/or the Medical Director of each program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate administrative executive to the administrator for carrying out the policies and procedures as approved by the Governing Board.
 - Administer appropriate assessment.
 - b. Provide a written plan/report for each individual including history, results, recommendations, plan, treatment and education with designated goals based upon the individual's medical status, evaluation and test results, considering personal goals, when appropriate Provide Speech Therapy evaluation and treatment as prescribed by a licensed physician.
 - c. Provide Speech Therapy treatment as the licensed therapist deems appropriate with a plan of care signed off on by a licensed physician, nurse practitioner, or physician's assistant.
 - Implement initial and ongoing treatment program utilizing specific activities or methods to develop or restore functional communication, cognition, or swallowing, compensate for dysfunction or minimize debilitation.
 - e. Modify treatment program or diet consistency recommendation based upon progress, lack of progress or regression, or as requested by the patient's physician.
 - f. Provide documentation of patient's progress in medical chart on a daily, weekly and/or monthly basis.
 - g. Provide patient's physician with a written summary of the patient's progress and recommended discharge plan.
 - h. Maintain all therapy equipment in safe and functional condition.
 - Secure and conserve therapeutic equipment and supplies.
 - j. Maintain and implement the departmental budget in a manner that maintains designated income and expense ratios.
 - k. Maintain appropriate operational and administrative records.

Rehabilitation Services Manual Speech Pathology Services Department Policy Page 3 of 3

- Maintain ongoing reporting and consultative roles with appropriate health care professionals regarding patient's current communicative and swallowing status.
- m. Provide educational in-services regarding speech pathology evaluation and treatment approaches, the nature of communication and swallowing disorders, diagnostic and therapeutic approaches to the deficits, and measures to prevent or alleviate communication and swallowing disorders.

D. REFERENCE(S):

- https://www.asha.org/policy/SP2016-00343
- 2. Business & Professions Code BPC Division 2. Healing Arts [500 4999.129], (Division 2 enacted by Stats. 1937, Ch. 399.hapter 5.3. Speech-Language Pathologists and Audiologists [2530 2539.14], (Heading of Chapter 5.3 amended by Stats. 1992, Ch. 427, Sec. 2.)



REHABILITATION SERVICES POLICY MANUAL

SUBJECT: Supervision Requirements of Minors During Outpatient Treatment

ISSUE DATE: 01/07 REVISION DATE(S): 01/09

Department Approval-Date(s): 06/1505/18

Department of Medicine Approval-Date(s): n/a
Pharmacy and Therapeutics Approval-Date(s): n/a

Medical Executive Committee Approval-Date(s): 09/1510/19

Administration Approval: 11/19

Professional Affairs Committee Approval-Date(s): 10/15 n/a

Board of Directors Approval-Date(s): 10/15

A. POLICY:

 Parent/Guardian shall accompany their minor child for all outpatient treatments until the child reaches the age of 18 years. Parent/Guardian shall be present at the child's session or remain in the waiting area for the duration of the session. The level of parent participation depends on the child's age and prior agreement with the treating therapist.

2. Exceptions may be made to this rule with prior signed consent by the minor's parent authorizing treatment in absence of the parents' presence. This may apply to teenagers that are driving themselves to their appointments (i.e. minor children age 16 and older). Other limited (single-visit) exceptions may be considered for emergencies and would have to be arranged between the parent and therapist for agreement on feasibility of the treatment session without the parent's presence at the facility.



REHABILITATION SERVICES POLICY MANUAL

DELETE this policy.Covered under Administrative IT Policy 604,Section E 3.d ii and Attachment A

SUBJECT: Use of Encrypted Email

ISSUE DATE: 10/15 REVISION DATE(S):

Rehabilitation Department Approval Date(s):

Department of Medicine Approval Date(s):

Pharmacy and Therapeutics Approval Date(s):

Medical Executive Committee Approval Date(s):

Administration Approval:

Professional Affairs Committee Approval Date(s):

Board of Directors Approval Date(s):

07/1505/18

n/a

n/a

09/1510/19 11/19

10/15 n/a

10/15

PROCEDURE:

- Outpatient Rehab services-will utilize an encrypted email-ID-created by the Information Technology Department.
- A common email password will be provided to all front office staff so that they have access to the secure email address.
 - a. The common email password will be changed when any current team member terminates from duties relating to accessing the secure-email account.
- 3. Upon Patient/Physician Office-request for submission of orders, authorizations, etc. via email-the Frent-Office-team member will forewarn-the-caller via a scripted message as follows:
 - a. "There is an inherent risk whenever information is shared electronically via an unencrypted-email format such as that from-personal email accounts. By-requesting to send us your medical information by this means, you are accepting this risk".
- 4. Our Front office will then-provide the email address to the Individual/Office
- 5. OP Rehab team member accesses the secure email folder to access the patient documents.
- A confirmation email is sent-back to the Patient/Physician Office-upon receipt of the email-to-the secure TCMC email address.
- 7. Front Office team member directs the documents received to the fax server for access by team members completing the Scheduling and Registration process.
- Front-Office team member deletes the received email from the secure email folder.



SUBJECT: Ethical Code of Conduct

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval: 05/18
Department of Medicine Chiefs Approval: 10/19
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

A. POLICY:

1. The Tri-City Rehabilitation Center will adhere to the Tri-City Healthcare District Code of Conduct.

 Code of Conduct defines ethical practices in patient management that may include altruism, respect and dignity, freedom from abuse/harassment, setting boundaries and restrictions on patient/professional relationships, compassionate care, legal and professional obligations. All clinical staff providing care to rehabilitation patients shall follow the conduct rules and regulations and code of ethics set forth by their professional organization and/or licensing body.

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

Tri-City Healthcare District Code of Conduct

C. REFERENCES(S):

- American Academy of Physical Medicine and Rehabilitation American Nurses Association
- 2. American Occupational Therapy Association Code of Ethics American Physical Therapy Association Code of Ethics American Psychological Association
- 3. American Speech and Hearing Association
- American Therapeutic Recreation Association Code of Ethics National Association of Social Workers
- 5. National Therapeutic Recreational Society



SUBJECT: Inpatient Rehabilitation Center Admission, Continued Stay, and Discharge Criteria

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval: 05/18
Department of Medicine Chiefs Approval: 10/19
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

- All inpatient rehabilitation services provided in the Tri-City Rehabilitation Center IRF shall meet
 the appropriate medical necessity criteria and all care provided in the IRF shall be reasonable
 and necessary as it applies to decisions for admission, continued stay and determination of the
 timing for discharge.
 - a. Admission Criteria:
 - i. The patient must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:
 - 1) Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation
 - 2) 24-hour availability of nurses skilled in rehabilitation; and
 - Treatment by multiple other licensed rehabilitation professionals (such as physical therapists, occupational therapists, speech language pathologists, and prosthetics/orthotics) as needed in a time-intensive and medicallycoordinated program.
 - ii. The medical stability of the patient and management of medical or surgical comorbidities are considered to be:
 - 1) Manageable in the rehabilitation program; and
 - 2) Permit simultaneous participation in the rehabilitation program
 - iii. The patient presents as capable of fully participating in the inpatient rehabilitation program as evidenced by:
 - A mental status demonstrating responsiveness to verbal, visual, and/or tactile stimuli and ability to follow simple commands.
 - 2) An ability to actively participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day five days per week).
 - iv. The patient has objective and measurable functional goals identified to warrant the admission that:
 - 1) Offer practical improvements; and
 - 2) Are expected to be achieved within a reasonable period of time
 - v. The patient has a reasonable probability of benefiting from the inpatient rehabilitation program.
 - vi. The patient, in most circumstances, has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.
 - b. Exclusions to Admission
 - i. The following medical conditions are excluded from IRF admission:

- 1) Ventilator dependent patients;
- 2) Presence of an untreated psychiatric disorder as a primary diagnosis or on suicidal precautions and/or unstable psychiatric condition;
- Profound anemia with declining Hemoglobin/Hematocrit of unknown etiology;
- 4) Patients with chest tubes;
- 5) Individuals requiring telemetry
- 6) Active TB or any other respiratory infection requiring respiratory isolation;
- 7) Patients with a Rancho Los Amigos Head Injury scale score 1 3; and
- Patients on cardiac medication drips (e.g., dopamine).
- ii. The following medical conditions may be admitted upon Medical Director approval with an established plan of care that is evidenced in the History and Physical.
 - 1) Patients with a terminal illness and a prognosis less than six months;
 - 2) Patients with MRSA, VRE, C-Diff and other infections requiring contact isolation;
 - 3) Patients on neutropenic precautions WBC <4.0;
 - 4) Patients with a Rancho Los Amigos Head Injury scale score 4;
 - 5) Patients requiring radiation and/or chemotherapy;
 - Spinal cord injury patients with strength less than 2/5 that are not receiving low molecular weight heparin or have not had placement of a venous filter catheter; and
 - 7) Patients under 18 years of age.
- c. Continued Stay Criteria
 - Acute inpatient rehabilitation requires evidence of an interdisciplinary, coordinated rehabilitation team review at least once weekly, which should document ALL of the following:
 - Evidence of active participation in a multi-disciplinary rehabilitation program; AND
 - Evidence of progress toward stated goals documented by objective functional measures; AND
 - Identification of range and severity of the individual's problems, including medical status and stability, self-care, mobility, psychological status, and communication status; AND
 - 4) Consideration of special equipment needs when appropriate; AND
 - 5) Goal modification based on current status, progress, and potential for improvement; AND
 - 6) Projected length of stay and discharge/disposition planning; AND
 - 7) Status of training provided to the patient and family members/caregivers by various rehabilitation disciplines regarding post discharge care; AND
 - 8) Identification of barriers to progress, including any medical complications likely to impede progress; AND
 - 9) Information regarding the status of the underlying medical condition
 - ii. In general, the documentation should provide evidence that the individual is benefiting from the program, that there is progress towards reasonable goals, and that acute inpatient rehabilitation continues to be the most appropriate level of care.
- d. Discharge Criteria
 - i. Discharge from acute inpatient rehabilitation is appropriate if one or more of the following is present.
 - Treatment goals necessitating the inpatient setting were achieved; OR
 - 2) Absence of participation in an interdisciplinary rehabilitation program; OR
 - The individual has limited potential for recovery (e.g. the individual's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame; OR

Rehabilitation Center Inpatient Rehabilitation Center Admission, Continued Stay, and Discharge Criteria Page 3 of 3

- 4) Individual is unable to actively participate in an intensive rehabilitation program (most typically defined as at least 3 hours of multidiscipline therapy per day, at least 5 days per week): OR
- The overall medical status is such that no further progress is anticipated or only minimal gains that could be expected to be attained with either less intensive therapy or regular daily activities.

B. **REFERENCES:**

- Medicare Benefit Policy Manual, Ch. 1-110-Inpatient Hospital Services Covered Under Part A Inpatient Rehabilitation Services
- 2. 42 CFR § 412.23 (b)
- 3. 42 CFR § 412.25 (a)(2)
- 4. 42 CFR § 412.29
- 5. 42 CFR § 412.622 (a)(3)-(5)



SUBJECT: Interdisciplinary Plan of Care

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval: 05/18
Department of Medicine Chiefs Approval: 10/19
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

A. POLICY:

Every patient at the Rehabilitation Center receives a comprehensive individualized treatment program designed to meet the patient's unique needs. Programs are developed jointly by the patient, the family and team of rehabilitation specialists under the direction of the Medical Director, or designee. There shall be evidence of participation from each appropriate rehabilitation discipline in the establishment of an interdisciplinary treatment plan.

B. **PROCEDURE:**

- The physician will conduct a post-admission evaluation which identifies any relevant changes that may have occurred since the preadmission screening, as well as a review of the patient's prior and current medical and functional conditions and comorbidities in the documented history and physical examination. The post-admission physician evaluation will be completed within the first 24 hours of admission.
- 2. Nursing will complete their initial nursing assessment and initial goal setting within the first 24 hours of admission.
- 3. Patients are assessed and treatment initiated within 36 hours of admission by the therapy services (OT, PT, and SLP) that have been ordered by the attending physician.
- 4. The Interdisciplinary plan of care is established within 96 hours of admission with input from the interdisciplinary team. The interdisciplinary plan of care coordinated by the physician includes:
 - a. Rehab problem/diagnoses
 - b. Date of onset of injury or illness
 - c. Specific type, number and frequency of services to be rendered by each discipline.
 - Address current health status and recommendations for additional resources/consultations necessary to achieve predicted outcomes
 - e. Treatment goals that are realistic, achievable and relevant to the patient
 - f. Measures to assess effects of treatment
 - g. Factors to facilitate and potential barriers for goal achievement
 - h. Individual's (patient's) expressed goals
 - i. Prognosis
 - j. Estimated length of stay
 - k. Discharge planning including expected disposition
 - Signature of physician



SUBJECT: Interdisciplinary Team Conference

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval: 05/18
Department of Medicine Chiefs Approval: 10/19
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

- 1. Team conferences are held at least biweekly, on Tuesdays and Thursdays at 1:00pm, or as otherwise arranged by the Care Coordinator.
- 2. The conference schedule will be posted on the interdisciplinary schedule.
- 3. The patients and their family/support system shall be made aware of the interdisciplinary team conference dates.
- 4. The meeting consists of a brief report from each discipline on the patient's progress, goals, and expected outcomes of rehabilitation stay. Team members reporting include, but are not limited to:
 - a. Registered Nurse (RN)
 - b. Physical Therapist (PT)
 - c. Occupational Therapist (OT)
 - d. Speech Language Pathologist (SLP)
 - e. Therapeutic Recreation (TR)
 - f. Dietician
 - g. Social Worker
 - h. Medical Director
 - Care Coordinator
- 5. Summary of Team members' reports are documented directly into the electronic health record (EHR) by physician in attendance at the conference.
- 6. Estimated length of stay, discharge plan, needed equipment, and resources are reviewed and modified as needed per the patient's progress. Home evaluation and family/caregiver training if required are reviewed. Discharge date is reviewed and modified as needed.
- 7. Social Worker will report to patient/family after the team conference an overall summary of the conference, including functional report, estimated length of stay, and needed equipment.



SUBJECT: Mission Statement, Goals and Objectives

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval:

Department of Medicine Chiefs Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

- Tri-City Rehabilitation Center is an Inpatient Rehabilitation Facility that is dedicated to provide comprehensive, individualized and high quality healthcare to advance the health and wellness of the community we serve.
- 2. The Inpatient Rehabilitation Facility (IRF) is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.
- 3. Goals and Objectives:
 - a. To render high quality rehabilitation services to assist each patient in reaching their maximum functional potential so they may assume their rightful place in society, while learning to live within the limits of their capabilities.
 - b. To enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result.
 - c. To alleviate pain, restore function, and improve quality of life by using evidence based techniques and approaches in physical, occupational, speech, audiology and therapeutic recreation. These include standardized tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate.



SUBJECT: Patient/Family Conferences

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval:

Department of Medicine Chiefs Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

- Patient/family conferences are held as needed to discuss patient progress toward goals and opportunities to maximize patient outcomes.
- The patients/families will be notified by the Care Coordinator of the date and time of their conference.
- The conference schedule will be posted on the interdisciplinary schedule.
- 4. The meeting consists of a brief report from each discipline on the patient's progress, goals, and expected outcomes of rehabilitation stay. Team members reporting include, but are not limited to:
 - a. Registered Nurse (RN)
 - b. Physical Therapist (PT)
 - c. Occupational Therapist (OT)
 - d. Speech Language Pathologist (SLP)
 - e. Therapeutic Recreation (TR)
 - f. Dietician
 - g. Social Worker
 - Medical Director
 - Care Coordinator
- Team members' reports are documented on the weekly conference forms.
- 6. After team reports, the interdisciplinary team meets with the patient and family member to discuss the patient's case.
- 7. Each discipline will report to the patient and family the progress, goals and expected outcomes of the rehab stay. The team will respond to patient/family questions.
- 8. Estimated length of stay, discharge plan, needed equipment, and resources are reviewed and modified as needed per the patient's progress. Home evaluation and family/caregiver training if required are reviewed. Discharge date is reviewed and modified as needed.
- 9. The conferences forms will be placed or scanned into the patient's medical record



SUBJECT: Policies and Procedures

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval: 05/18
Department of Medicine Chiefs Approval: 10/19
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

- The Tri-City Rehabilitation Center will develop and maintain policies and procedures specific to the Rehabilitation Center when the Hospital (Tri-City Medical Center) policies do not cover necessary regulatory, business, or practice needs.
- 2. A list of all new, revised, and reviewed Rehabilitation Center Policies and Procedures shall be submitted to Rehab Leadership Team for review and for approval by the Chief Operating Officer. Rehab Policies and Procedures will be submitted according to hospital policy. Interdisciplinary Rehabilitation policies and procedures will be maintained online and be available to staff.
- 3. Each Rehabilitation Department (Rehabilitation Services, Nursing, Social Services, Case Management, and Diet and Nutrition) shall maintain a departmental Policy and Procedure Manual, which is reviewed and updated in accordance with applicable regulations and Tri-City Medical Center (TCMC) Policy.



SUBJECT: Pre-Admission Screening

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval:

Department of Medicine Chiefs Approval:

Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

A. POLICY:

1. A pre-admission assessment shall be completed for referrals to the Rehabilitation Center. Patients will be evaluated at the optimal assessment period and an admitting decision will be made based on the established admission criteria. Patients who do not meet the established admission criteria for level of care and program will be denied admission or deferred for further evaluation and reassessment. All rehab admissions must be medically accepted by the Medical Director, or designee.

B. PROCEDURE:

- The rehabilitation referral is received and placed into the patient's Electronic Medical Record.
- 2. The Care Coordinator and Medical Director, or designees, will jointly review the referral via chart review and/or in person with the patient and/or family.
- 3. The patient is accepted by the Medical Director, or designee, and financial clearance is obtained.
- 4. The Rehab Pre-Admission screen is completed and the Medical Director, or designee covering admissions, reviews the packet.
- 5. The referring facility is notified of acceptance and transportation is arranged by the sending facility.
- 6. If the patient is not accepted, the referring facility is notified with an explanation of denial reasons.
- 7. The referring facility is given the nurse's station phone number so report and handoff can be received.
- 8. A documented preadmission assessment contains:
 - a. Diagnosis
 - b. Medical history
 - c. Complications
 - d. Comorbidities
 - e. Ongoing medical management
 - f. Mental status
 - g. Premorbid and current level of function
 - h. Support systems
 - i. Prognosis
 - j. Scope of services recommended
 - k. Intensity of services recommended
 - I. Related to the scope and intensity of services recommended:
 - i. The willingness of the patient to participate
 - ii. The ability of the patient to tolerate the care proposed
 - iii. Medical necessity for the level of care

Rehabilitation Center Pre-Admission Screening Page 2 of 2

- iv. The potential of the patient to benefit
- m. Estimated length of stay
- n. Additional needs may include:
 - i. Cultural
 - ii. Dietary
 - iii. Equipment
 - iv. Medications
 - v. Services
- o. Funding
- p. Alternative resources to address additional needs such as hiring caregivers, home modifications, or equipment procurement



SUBJECT: Utilization Review Plan

ISSUE DATE: NEW REVISION DATE(S):

Rehabilitation Department Approval: 05/18
Department of Medicine Chiefs Approval: 10/19
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/19
Administration Approval: 11/19
Professional Affairs Committee Approval: n/a

Board of Directors Approval:

A. POLICY:

- 1. The purpose of the Tri-City Medical Center (TCMC) Utilization Review (UR) Plan is to review and facilitate the delivery of high quality, safe, appropriate, efficient and effective healthcare services. The program provides an organized, collaborative, system-wide approach to clinical resource management across the continuum of care, and is structured in compliance with The Center for Medicare and Medicaid Services and California Department of Health Services Acute Inpatient Rehabilitation regulations. The Rehab Leadership Team (RLT) is delegated the authority and responsibility to provide oversight, and carry out utilization management and related quality improvement functions.
- 2. TCMC Rehabilitation Center will differentiate the licensed Inpatient Rehabilitation Facility beds from the Acute Care Services Beds. The TCMC Rehabilitation Center transfers will require a new account number when transferring in and out of TCMC Rehabilitation Center.
- 3. The UR plan is approved by the Rehab Leadership Team (RLT). The RLT provides oversight and general supervision of the plan. The Medical Director and the Director of Case Management are responsible for the development, implementation and maintenance of the UR plan.

B. PROCEDURE:

- Objectives:
 - a. To review and evaluate admissions to the Inpatient Rehab Facility (IRF) including whether the admission is reasonable and necessary.
 - Review and evaluate medical necessity prior to and during the admission.
 - c. To review denials of payments for hospital days and services.
 - d. To evaluate effective use of resources and review departmental outcome data.
 - e. To provide ongoing education and distribute meaningful clinical utilization information regarding individual practice patterns and monitor response.
 - f. To ensure appropriate discharge planning that promotes efficient continuity of care, services, and evaluates delays in discharges.
 - g. Evaluate the effective and efficient use of resources to achieve the goals of the department mission.
- 2. Utilization Review Committee
 - The UM Committee will meet at minimum monthly. The UM Committee must have representation from the following disciplines:
 - i. TCMC Rehabilitation Center Medical Director.
 - ii. Therapy Services Director and/or Manager.
 - iii. Director of Case Management.
 - iv. Nursing Manager(s) of inpatient rehab units.

- b. The UR Committee will review charts to ensure approved preadmission criteria is applied equally to all patients. Review of readmissions, payment denials, length of stay, length of stay efficiency, payer mix, Functional Independence Measure(FIM) change, tier mix, rehabilitation unit census, discharge destination mix, case mix index, short stays, Medicare efficiency, and may include high risk case mix groups and analysis, interrupted stays, disease onset days.
- 3. Patient Population
 - a. Due to the complexity of the nursing, medical management, and rehabilitation needs, acute rehab patients require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.
 - b. Each patient assessment and treatment plan must be individualized to the unique care needs of the patient. The treatment plan is developed based on the information from the preadmission screen, the Post-Admission Physician Evaluation, and the information garnered from therapy assessments. The assessment must be synthesized by a rehabilitation physician and completed within 4 days of the IRF admission. At the time of admission, a physician must generate admission orders for the patient's care that must be retained in the patient's medical record at the Inpatient Rehab Facility (IRF).
 - c. The Inpatient Rehabilitation Facility- Patient Assessment Instrument (IRF-PAI) must be contained in the patient's medical record at the IRF. All IRF-PAI documentation and outside facility medical records will be submitted electronically to the TCMC Electronic Medical Record. The information in the IRF-PAI must correspond with all of the information provided in the patient's IRF medical record. IRF Medical Necessity Criteria is as follows:
 - i. Multiple therapy disciplines
 - 1) Intensive rehabilitation therapy program
 - 2) Ability to participate in therapy program
 - 3) Physician supervision
 - 4) Interdisciplinary team approach to the delivery of care
 - ii. For this purpose, "therapy disciplines" include:
 - 1) Physical therapy
 - 2) Occupational therapy
 - Speech-language pathology
 - 4) Orthotics/prosthetics
 - d. All IRF patients must require an intensive rehabilitation therapy program on admission to the IRF. This is demonstrated in IRFs by the provision of therapies at least 3 hours per day with a minimum of 5 days per week, or an average of at least 15 hours per week, and must be documented in the medical record. A week is a 7 consecutive day period starting with the day of admission. Required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations may constitute the initiation of therapy services. Therapy evaluations "count" for the purposes of demonstrating the intensity of therapy requirement.
 - e. When the acute medical conditions are of primary importance, the patient belongs in an acute medical licensed bed. When the patient's rehabilitation needs are of primary importance, the patient may receive care in Tri-City Medical Center (TCMC) Rehabilitation Center. The patient must be medically stable to tolerate at least 3 hours of therapy/day six days per week and be willing to participate in an Acute Rehabilitation Care Plan. If a brief interruption of stay occurs, the reasons for the brief interruption of no more than 3 consecutive days must be well-documented in the patient's medical record at the IRF.
 - f. Physician visits during an IRF stay are face-to-face visits by the Medical Director, or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the IRF stay.
- 4. Pre-Admission Screening and Intake Process
 - a. A pre-admission screening evaluation shall be completed for referrals to the Rehabilitation Center. Patients will be evaluated within 24 hours of admission, and an admitting decision will be made based on the established admission criteria. Patients who do not meet the

- established admission criteria for level of care will be denied admission for inpatient care, or deferred for further evaluation. Admissions to the Rehabilitation Center must be approved by the Medical Director, or designee, for case review.
- b. The Pre-Screen must be signed by the Admitting Physician within 48 hours prior to admission.
- c. The Care Coordinator will verify insurance eligibility and obtain authorization to admit, obtain the discharge plan prior to patient admission, coordinate transfer into the Rehabilitation Center, and communicate with the accepting Interdisciplinary Team, and referring facility.
- 5. Interdisciplinary Team
 - a. The complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to care. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.
 - b. The team has the responsibility of assessing the individual's progress towards the rehabilitation goals; considering possible resolutions to any problems that could impede progress towards the goals; reassessing the validity of the rehabilitation goals previously established; and monitoring and revising the treatment plan, as needed.
 - c. The team shall consist of a minimum of a rehabilitation physician with specialized training and experience in rehabilitation services; registered nurse with specialized training or experience in rehabilitation; social worker or a case manager (or both); licensed or certified therapist from each therapy discipline involved in treating the patient.
- 6. Impairment Groups Appropriate for Rehabilitation Center:
 - According to the Rehab Medicare Exemption Criteria from the Medicare PPS, specified in Transmittal 938 at least 60% of the Acute Inpatient Rehabilitation cases shall fall into one of the following categories:
 - i. Stroke
 - ii. Brain Injury
 - iii. Neurologic Disorders
 - iv. Spinal Cord injury
 - v. Systemic vasculidities
 - vi. Amputation
 - vii. Burns
 - viii. Congenital deformity
 - ix. Fracture of femur (Hip fracture)
 - x. Major Multiple Trauma
 - xi. Severe or advanced Osteoarthritis
 - xii. Active polyarticular rheumatoid arthritis, psoriatic arthritis & seronegative arthropathies
- 7. Medical Necessity for Acute Rehabilitation
 - a. All patients will continue to be monitored by the interdisciplinary team for the need for a continued stay in TCMC Rehabilitation Center. During the weekly conference there will discussion regarding the need for continued stay, and discharge dates and needs. When a patient is no longer requiring the utilization of Inpatient Rehabilitation Facility, the team will collaborate to determine the need for discharge from acute rehab. All discharge needs will be coordinated for the patient with follow up care documented by the team in the Electronic Medical Record.
- 8. Insurance Denial Management
 - a. All insured patients will be reviewed at least 1 time per week by the Care Coordinator with the payer source. All denials received regarding TCMC Rehabilitation Center patients will be reviewed by the Care Coordinator and Case Manager/Social Worker and the Leadership Team for the Rehab Department, and the Medical Director. The Coordinator and Medical Director will determine if the case warrants and appeal process. If an appeal letter is agreed upon, the Medical Director will complete the required letter, and submit it for reconsideration. This includes appeals from all sources.
- 9. Confidentiality Policy

Rehabilitation Center Utilization Review Plan Page 4 of 4

a.

All UR information and data shall be considered confidential and protected from inappropriate use. Written consent of the patient is required for release of information to persons not otherwise authorized to receive this information. All data and documented review activity submitted to any monitoring agency is in accordance with that organization's confidentiality policy. The patient medical records are the property of the hospital and may not be released from the hospital's jurisdiction and safekeeping except in accordance with court order, subpoena, or statute.

| Tri-City Me | | Distribution: Women's & and Children's Services/NICUNewborn Services | | | |
|------------------|--|--|--|--|--|
| PROCEDURE: | BREAST MILK MISADMINISTRATION | | | | |
| Purpose: | To provide guidelines for action when an infant is fed "unprocessed" human milk from a mother in Women and Newborn Services (WNS) the NICU other than his/her own mother. | | | | |
| Supportive Data: | Despite significant prevention effort, infants may inadvertently be fed another mother's milk in error. This misadministration of human milk results in anxiety for both family and staff. Much of this anxiety is the result of misinformation about the potential infectious risks to the recipient infant and uncertainty as to how to evaluate the risk. In most cases, the risk of transmission of infectious disease is extremely low. With increasing Joint Commission focus on patient safety and medical error reporting by hospital systems, a plan of care should be available in the (hopefully) rare instance when a mother's milk is given to the wrong infant. It is imperative that the confidentiality of the donor mother be maintained. | | | | |

A. **DEFINITIONS**:

- 1. Misadministration an infant given the wrong mother's milk, "i.e., any mother's milk other than his/her own mother's milk.
- 2. Recipient Infant The infant given the wrong mother's milk.
- 3. Source Mother Mother whose milk is fed to the wrong infant.
- Recipient Mother Mother of infant who receives the wrong milk.

B. **PROCEDURE:**

- If an infant receives the wrong breast milk:
 - a. The RN/LVN will notify the shift supervisor or charge nurse and the physician of both the source and the recipient infant's identity.
 - b. The shift supervisor or charge nurse will notify the source and recipient parents or legal representatives. The recipient parents are informed and counseled regarding the possible risks from the exposure, including assessment of the donor mother's STD status drawn at delivery. Both the donor and recipient mother are tested for HIV, HBV, HCV, HTLV1/11, and CMV.
 - c. The physician will review the source mother's chart for maternal history and order appropriate lab work on the source mother which includes:
 - i. HIV 1 and 2 antibody
 - ii. Hepatitis C antibody
 - iii. Hepatitis B surface antigen
 - iv. Additional lab work may include:
 - 1) HTLV 1 and 2 antibody
 - 2) Syphilis Serology (RPR or VDRL)
 - 3) CMV antibody screen
- 2. The physician will obtain source mother's informed consent for HIV test and authorization of disclosure of the results if the results are not available in the source mother's chart.
- 3. If the source mother refuses to consent to testing, the recipient newborn, with the parent's consent, should be followed up with the appropriate tests for HBV, HBC, HIV, HTLV I/II, and CMV at three months and six months after the incident.

| Women and Newborn Services Department Review/Revisie | Department of Pediatrics | Department of OB/GYN | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors Approval |
|--|-----------------------------|-----------------------|-----------------------------------|----------------|-----------------------------------|--------------------------------|
| 10/06, 05/08, 4/09, 6/11, 12/14, 09/15 | 03/15, 02/19 | 8/07, 06/15, 06/19 | 8/07, 8/15, 10/19 | 11/19 | 9/07, 6/09, 09/15. n/a | 9/07, 6/09, 09/15 |

- 4. If the source mother is HbsAg positive, the newborn is to receive HBV immunoglobulin and HBV vaccine immediately. The HbsAg status of the mother should be available on the prenatal record; if not available, it should be done as an immediate (STAT) test.
- 5. If the dener-source mother is positive for HIV, a decision needs to be made immediately regarding antiretroviral prophylaxis, as it should start within 1 to 2 hours after the exposure.
- 6. If the denor-source mother is CMV positive and the recipient mother is CMV negative, the recipient newborn's urine is to be tested for CMV no sooner than eight weeks post exposure.
- 7. The physician will notify the primary physician of the recipient infant to provide follow-up care as needed. Refer to UCSD mother/child and adolescent HIV program, (619) 543-8080 as resource, if appropriate.
- 8. The RN will complete and obtain signature on the consent for HIV test form and authorization for disclosure of the results of HIV test form if needed.
- The RN/shift supervisor/charge RN will process any ordered lab tests on the source mother oral recipient mother with a universal requisition form marked, "no charge to patient" charge to infection control shared service account.
- 10. Note on the recipient infant's chart, the date of the occurrence and lab studies that were ordered. Also indicate which follow-up labs may be needed.
- 11. The infection control practitioner will notify the appropriate state agencies of the test results where applicable.

C. RELATED DOCUMENT(S):

- 1. Neonatal Intensive Care Unit Procedure: Breast Milk Management in the NICU
- 2. OnlineElsevier Skills: Breast Milk: Collection, Storage and Administration (Neonatal) (available via external link: https://point-of-care.elsevierperformancemanager.com/skills/1236/quick-sheet?skillId=NN_005)

C.D. REFERENCE(S):

- Dougherty, D. Mother's Milk, but Whose Mother? AHRQ Patient Safety Network.
 November 2010. https://psnet.ahrq.gov/webmm/case/228/mothers-milk-but-whose-mother
- 2. How One Children's Hospital Virtually Eliminated Breast Milk Administration Errors. https://www.childrenshospitals.org/Newsroom/Childrens-Hospitals-Today/Articles/2017/
- Lawrence R. & Lawrence R. (2005). Breastfeeding: a guide for the medical profession, 6th-Ed. Mosby, Inc., pp. 761-776.
- Human Milk Banking Association of North America. Best practice for expressing, storing and handling human milk in hospital, homes and child care settings.
- 3. APIC Test of Infection Control and Epidemiology, (2005). Association for Professionals in Infection Control and Epidemiology, Inc.
- 3. Sauer, C.W., & Marc-Aurele, K.L. Parent Misidentification Leading to the Breastfeeding of the Wrong Baby in a Neonatal Intensive Care Unit. American Journal of Case Reports 2016:17: 574-579. DOI: 10.12659/AJCR.898864.
- 4. Steele, C., Czerwin, A. & Bixby, C. Breast Milk Bar Code Scanning Results in Time Savings and Staff Efficiency. Journal of the Academy of Nutrition and Dietetics. http://dx.doi.org//10.1016/j.jand.2014.06,360
- 5. Warner, B.B. & A. Sapsford. Misappropriated Human Milk. Fantasy, Fear and Fact Regarding Infections Risk. www.medscape.com/viewarticle/472406.
- 6. What to do if an Infant or Child Is Mistakenly Fed Another Woman's Expressed Breast Milk. Obtained 8/7/2018 from: CDC.gov/breastfeeding/recommendations/other_mothers_milk.htmc



WOMEN AND NEWBORN SERVICES POLICY MANUAL

ISSUE DATE:

10/94

SUBJECT:

Discharge Process

REVISION DATE(S): 01/00, 06/03, 02/10

Women and Newborn Services Department Approval: 10/18 Glinical Policies & Procedures Committee Approval: 02/13

Nurse-Executive Committee Approval: 02/13

Medical-Department Approval:

Department of Pediatrics Approval: 02/19
Department of OB/GYN Approval: 06/19
Pharmacy & Therapeutics Committee Approval: n/a

Medical Executive Committee Approval:

Administration Approval:

Professional Affairs Committee Approval:

05/4310/19
11/19
06/43 n/a

Board of Directors Approval:

06/13

A. **DISCHARGE PRIVILEGES:**

- 1. Only those physicians with active privileges at Tri-City Medical Center are able to discharge patients.
- 2. Problems arising about such privileges should be referred to the medical staff office or the administrative coordinator during off hours.

B. <u>DISCHARGE PLANNING:</u>

- Discharge planning begins upon admission.
- 2. Social Service referrals should be implemented for the following (including but not limited to):
 - Patients presenting Tri-City Medical Center with no prenatal care.
 - b. Adolescent mothers.
 - Mothers not living in the family home, (e.g. a recovery center).
 - Mothers admitted as antepartum patients.
 - e. Actual or potential NICU admission of infants.
- 3. Depending on the prenatal care provider, patients may be evaluated by case managers, discharge coordinators, etc. from either Tri-City Medical Center or an outside agency.

C. **DISCHARGE NOTIFICATION:**

 Notification of a transfer within the facility, pending discharge, and actual discharge is done via the hospital information system.

D. **DISCHARGE CRITERIA:**

- Maternal discharge criteria incorporates:
 - Stability of physiologic parameters.
 - b. Readiness of the home environment.
 - c. Psychological coping ability and readiness for independent functioning of the parent/caregiver.
 - d. Psychological coping ability and readiness for independent functioning after discharge.
- 2. Newborn discharge criteria incorporates:
 - a. Stability of physiologic parameters.
 - b. Readiness of the home environment.
 - Psychological coping ability and readiness for independent functioning of the parent/caregiver.

E. <u>DISCHARGE ORDERS:</u>

- Maternal Discharges
 - Transfer/discharge orders are to be completedelectronically entered written by the obstetrician.
 - b. Minimum content for orders for transfer of service within the facility will include:
 - Transfer to (e.g. ICU).
 - ii. Designate the physician to whom care is being transferred, if applicable.
 - Minimum content for transfer to other facilities will include:
 - i. Transfer to (name of facility)
 - d. Minimum content for discharge will include:
 - Discharge to (i.e., home, recovery center)
 - Time frame for follow-up care.
 - iii. Diet
 - iv. Medications (if applicable).
 - v. Self-care and/or treatments.
 - vi. Infant care.

e.2. Newborn discharge

- i.a. Transfer/Discharge orders are to be completedelectronically entered-written by the pediatrician/family practice physician:
 - 1)i. Transfer orders may also be written by the neonatologist.
- ii-b. Minimum content for discharge will include:
 - 4)i. Discharge to (e.g., home, foster care).
 - 2)ii. Time frame for follow-up care.
 - 3)iii. Feedings and diet.
 - 4)iv. Medications (if applicable).
 - 5)v. Treatments (if applicable).

F. DISCHARGE DOCUMENTATION:

- Intra/Interfacility transfer
 - Transfer within the facility will include the medical record.
 - b. Refer to:
 - WCS Women and Newborn Services (WNS) Standardized Procedure: "Medical Screening Exam to Rule Out Labor".
 - ii. TCMC Administrative Policy 506: "EMTALA: Emergency Medical Screening" for required documentation for a maternal transfer to another facility.
- Discharge of newborn to parent(s)/caregiver(s):
 - Copy of completed newborn discharge instructions.
 - b. Discharge instructions include:
 - i. Signs and symptoms of potential complications.
 - ii. Educational information.
 - iii. Instructions for follow-up appointment(s).
 - iv. Instruction in use of equipment and/or treatments.
- 3. Discharge of mother
 - Copy of completed maternal discharge instructions.
 - b. Discharge instructions include:
 - i. Signs and symptoms of potential complications.
 - ii. Educational information.
 - iii. Instructions for follow-up appointment(s).
 - iv. Instruction in use of equipment and/or treatments.
 - v. Completed newborn teaching record.

DISCHARGING A PATIENT(S) FROM WOMEN AND NEWBORN SERVICES:

 All patients to be discharged from Tri-City Medical Center must be accompanied by women's and children's WNS services staff or volunteer. Women and Newborn Services (WNS) Discharge Process Policy Page 3 of 3

- Refer to infant security policy.
- Mothers are discharged via wheelchair.
- Newborns are discharged:
 - a. a. In the arms of mother/caregiver seated in wheelchair.
 - Held by the mother and/or banded significant other (SO) or father of the baby (FOB).
- 4. Instruct the person providing transportation to move the vehicle to the designated entrance.
 - a. If family/caregiver does not have transportation to their residence after the discharge order is processed, contact the WNS wemen's and children's services clinical manager/charge nurse, wemen's and children's services social worker, case manager, or administrative coordinator for further assistance in obtaining transportation.
 - Transport of mothers and/or infants to their homes is NOT to be done by staff members.

Community Healthcare & Alliance Committee (No meeting held in November/December, 2019)

Finance, Operations & Planning Committee (No meeting held in November/December, 2019)

Professional Affairs Committee (No meeting held in November/December, 2019)

Audit, Compliance & Ethics Committee (No meeting held in November/December, 2019)

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

October 31, 2019 – 3:00 o'clock p.m. Assembly Room 1 – Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 3:00 p.m. on October 31, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez Director George W. Coulter Director Leigh Anne Grass Director Julie Nygaard Director Larry W. Schallock Director Tracy M. Younger

Absent was Director RoseMarie V. Reno

Also present were:

Steven Dietlin, Chief Executive Officer
Barbara Vogelsang, Chief Nurse Executive
Dr. Mark Yamanaka, Chief of Staff
Susan Bond, General Counsel
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

- 1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 3:00 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.
- Approval of Agenda

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

3. Public Comments – Announcement

Chairperson Grass read the Public Comments section listed on the October 31, 2019 Regular Board of Directors Meeting Agenda.

There were no public comments.

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

Chairperson Grass made an oral announcement of the items listed on the October 31, 2019 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Schallock and seconded by Director Chavez to go into Closed Session. The motion passed (6-0-0-1).

- 6. The Board adjourned to Closed Session at 3:05 p.m.
- 8. At 3:30 p.m. in Assembly Rooms 2 and 3, Chairperson Grass announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez Director George W. Coulter Director Leigh Anne Grass Director Julie Nygaard Director Larry W. Schallock Director Tracy M. Younger

Absent was Director RoseMarie V. Reno

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Dr. Mark Yamanaka, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairperson Grass reported the Board in Closed Session heard a report concerning one potential litigation matter and took no action.

The Board in Closed Session approved Closed Session minutes.

- 10. Director Younger led the Pledge of Allegiance.
- 11. Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.
- 12. Special Recognition

a) Life Sharing "Platinum Recognition Award for 2019"

Ms. Barbara Vogelsang introduced Mr. Patrick Balakian and Mr. Matthew Kidder, from LifeSharing, the organ procurement organization that serves northern San Diego County.

Mr. Balakian and Mr. Kidder recognized Tri-City Medical Center with the Workplace Partnership for Life Platinum Recognition Award for 2019. He stated this is the third consecutive year Tri-City has been recognized at the Platinum level which is the highest level granted to the Workplace Partnership for Life Program. Mr. Kidder explained the Workplace Partnership for Life Program is an initiative that unites the U.S. Department of Health and Human Services and organ donation community with workplaces throughout the nation. More than 13,000 community focused organizations have joined as workplace partners and Tri-City is one of them. This year alone Tri-City has saved 38 lives from eight (8) donors.

Mr. Kidder and Balakian gave special recognition to Ms. Merebeth Richins and the entire Donor Committee at Tri-City for their efforts.

Chairperson Grass invited members of the Donor Committee to the podium for a photo opportunity accepting the award.

Mr. Aaron Byzek, Chief Governmental External Affairs officer showed a touching film that illustrated a donor's gift of lives and the honor walk that is done here at Tri-City. The video is being shown on social media and to others to try and encourage individuals to sign up as organ donors themselves.

13. TCHD Foundation – Jennifer Paroly, Foundation President

Ms. Jennifer Paroly, Foundation President invited Foundation Board Chairperson, Rita Geldert and several members of the Tri-City Hospital Foundation Board to the podium for a special check presentation.

On behalf of the Tri-City Hospital Foundation, Ms. Geldert presented a check in the amount of \$1,266,900.00 which represents the first (and likely the largest) installment for the new 3.0T MRI system. Ms. Geldert also commented on the impact that the hospital has on everyday lives and generosity of the community members in a variety of ways.

Board Chairperson Grass expressed her appreciation to the Foundation and commented on the huge impact the new MRI system will have on the community.

Ms. Paroly reported the Diamond Ball will be held on November 16th at 5:30 p.m. at the Park Hyatt Aviara and only 20 tickets remain. All proceeds from the event will go towards the MRI project.

Ms. Gelbert expressed her appreciation for everyone's efforts in promoting the Diamond Ball.

14. Educational Presentation - Finance 101 - Ray Rivas, Chief Financial Officer

Mr. Ray Rivas, Chief Financial Officer provided an educational session on finance terms and formulas while "drilling down" on some of the pieces in the monthly financial report. Mr. Rivas's presentation included information on Operating Revenue, Operating Expense, EBITDA, EROE, Revenue, Expenses, Profit (Loss), Financial & Patient Indicators, Patient Days vs. Adjusted Patient Days and Cash on Hand. Mr. Rivas's presentation also included an analysis on Adjusted Patient Days and Average Length of Stay.

Mr. Rivas also provided a detailed explanation on how bad debt is recorded and options available to the uninsured such as attempting to qualify for charity care and cash rates.

A copy of the T.C.M.C. Finance Terms & Formulations presentation will be attached to the file copy of today's minutes for reference.

15. TCHD Auxiliary - Jeff Marks, President

Mr. Jeff Marks, Auxiliary President reported currently there are 544 volunteers, which represents a savings of labor to the hospital of approximately \$1,000,000/year. Of those 544 volunteers, 83 are college students and 80 are high school students. The volunteers range in age from 15-96. 15 volunteers have served more than 20 years and Mr. Howard Jones, Auxiliary Escort has provided us with over 35 years of service and over 15,000 hours.

Mr. Marks distributed copies of the newly upgraded quarterly magazine which will go out to all Auxiliary members and will be available in the Gift Shop and in the lobby for members of the community. The magazine is all inclusive and covers every conceivable area that the Auxiliary is involved in.

In addition to the upgraded quarterly magazine, the Auxiliary's website is also being updated with a modern, clean, professional look and will be accessible by the public and provide on-line volunteer applications, information on events and contact information.

Mr. Marks commented that Tri-City Hospital Gift Shop is one of only three in the state of California that is run by a non-profit auxiliary. All profits from the Gift Shop come back to the hospital in the form of a check.

Lastly, Mr. Marks introduced, Ms. Carol Saunders who runs the Auxiliary's Advocacy Department, one of the most unusual and effective departments, within not just this hospital but within the county of San Diego.

Ms. Saunders provided a summary of the Advocacy Department's role in the hospital which benefits both patients and staff. The department was established in April of 2013 and at that time the main focus was to encourage participation in the patient satisfaction surveys. The program has evolved and the advocates see approximately 600-650 patients per month who have been here 1-2 days or longer or at the request of the nurse. The Advocates provide readers, library and coloring books, puzzles, as well as a family guide which can be used for patients to make notations for their physicians. The advocates can also schedule chaplain visits, social worker visits and therapy dog visits.

Board members expressed their appreciation to all the Auxilians for their timeless efforts.

- 16. September 2019 Financial Statement Results Mr. Ray Rivas, Chief Financial Officer
 - Mr. Ray Rivas reported on the YTD financials as follows (Dollars in Thousands):
 - ➤ Net Operating Revenue \$86,457
 - ➤ Operating Expense \$89,765
 - ➤ EBITDA \$1,779
 - ➤ EROE (\$1,728)

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

- > Average Daily Census 146
- Adjusted Patient Days 25,284
- ➤ Surgery Cases 1,594
- ➤ ED Visits 14,361

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

- > Net Operating Revenue \$27,963
- Operating Expense \$29,144
- ➤ EBITDA \$412
- ➤ EROE (\$759)

Mr. Rivas reported on current month Key Indicators as follows

- > Average Daily Census 151
- > Adjusted Patient Days 8,642
- ➤ Surgery Cases 517
- ➤ ED Visits 4,638

Mr. Rivas reported on the following indicators for FY20 Average:

- Net Patient Accounts Receivable \$44.6
- Days in Net Accounts Receivable 56.1

Mr. Rivas noted we are behind in coding but expect that to turn around soon which will decrease the days in Accounts Receivable.

No action taken.

- 17. New Business none
- 18. Old Business none
- 19. Chief of Staff

Consideration of October 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 28, 2019.

It was moved by Director Schallock to approve the October 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 28, 2019. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES: Directors:

Chavez, Coulter, Grass, Nygaard,

Schallock and Younger None

NOES: Directors: ABSTAIN: Directors: Directors:

None Reno

20. Consideration of Consent Calendar

It was moved by Director Schallock to approve the Consent Agenda. Director Chavez seconded the motion.

It was moved by Director Nygaard to pull item 20 (1) g) 1) Infant Safety and Security policy.

It was moved by Director Schallock to pull item 20 (5) California Special District's Association 2020 Renewal.

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

AYES:

Directors:

Chavez, Coulter, Grass, Nygaard,

Schallock and Younger

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT: Directors:

Reno

21. Discussion of items pulled from Consent Calendar

Director Nygaard who pulled the Infant Safety and Security Policy requested a minor typographical revision to the policy.

It was moved by Director Nygaard to approve the Infant Safety and Security Policy with amendment. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Chavez, Coulter, Grass, Nygaard,

Schallock and Younger

NOES:

Directors:

None

ABSTAIN:

Directors:

None

ABSENT:

Directors:

Reno

Director Schallock who pulled the California Special District's Association 2020 Renewal stated he is not in favor of renewing the membership as its primary focus is non-healthcare special districts.

It was moved by Director Schallock to refrain from renewing the California Special District's Association 2020 Renewal. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Coulter, Schallock and Younger NOES: Directors: Chavez, Grass and Nygaard

ABSTAIN: Directors: None ABSENT: Directors: Reno

The motion failed.

- 22. Reports (Discussion by exception only)
- 23. Comments by Members of the Public

Chairperson Grass recognized Mr. Vincent Loughney, a resident in Oceanside. He spoke on a variety of topics from Behavioral Health to seismic compliance and suggested there be open dialogue with the voters on important issues, a yearly state of the hospital address and suggested Town Hall meetings.

24. Comments by Chief Executive Officer

Mr. Steve Dietlin commented on the Memorandum of Understanding that Tri-City recently entered into with the County of San Diego to pursue a 16-bed inpatient Behavioral Health Unit on our campus. Mr. Dietlin stated a tentative agreement will come back to this Board and the County Board of Supervisors in January.

Mr. Dietlin congratulated Merebeth Richins and the Donor Committee as well as the many individuals who were involved in the LifeSharing program. Mr. Dietlin stated to receive the platinum recognition year after year and the number of lives saved is truly amazing. Mr. Dietlin also commented on the honor walks which are powerful emotional events which recognize those individuals who give the gift of life.

Mr. Dietlin expressed his appreciation to the Foundation for their generous check for \$1.2 million which represents the first deposit towards the 3T MRI. It will be the only 3T MRI here in our community and in our entire region and is a great benefit to the community we serve.

Mr. Dietlin reported Tri-City became the first hospital in North County to earn Advanced Stroke Care Certification (Thrombectomy-Capable Stroke Center) and just the 36th hospital nationwide to earn this elite designation. Mr. Dietlin stated Tri-City has been in the fore-front on stroke and heart care for decades and was one of the first hospitals where tPA was administered.

Mr. Dietlin expressed his appreciation to Mr. Jeff Marks, and the Tri-City Hospital Auxiliary that is comprised of over 500 members that are seen in virtually every

department of this hospital. He also commented on the Scholarship program which is an investment in tomorrow's leaders today and the Tri-City Gift Shop where all proceeds come back to the hospital.

Mr. Dietlin stated he recently attended the NAACP Blue & Gold Event and the business community impact award went to Mr. Aaron Byzak, Chief External Government Affairs Officer. Mr. Dietlin also recognized community member Gwen Sanders, a lifelong member of the NAACP committee member.

Lastly, Mr. Dietlin reported Tri-City recently received an unexpected award from Mira Costa College, the Mira Costa College Foundation Commitment to Education award which is a fine example of community investing in community.

25. Board Communications

Director Younger extended her congratulations to staff for the LifeSharing Platinum award. She also commented on the very moving and incredible video highlighting the honor walk.

Director Coulter stated it is easy to become a "giver" just by getting the red dot put on your driver's license.

Director Chavez commented that the Board's Community Healthcare & Alliance Committee of which he is honored to be the Chairman will be meeting on January 16th at 12:30 p.m. He encouraged today's speaker to attend the meeting and learn about many of the good things Tri-City is doing and engage with representatives from the business community, education community as well as Board members and community leaders.

Director Chavez acknowledged the new members who were recently recommended by the committee and approved by the Board including Gwen Sanders, representing the City of Oceanside, Mary Lou Clift, representing the City of Vista and Jacqueline Simon, representing the City of Carlsbad.

Lastly, Director Chavez commented on a recent article in the San Diego Union Tribune related to Behavioral Health that discussed a regional long term solution and investment that the county is doing. Director Chavez stated the article highlighted one of the North County leaders that is providing additional inpatient Behavioral Health beds is Tri-City Medical Center. Additionally, the new Crisis Stabilization Unit in Oceanside will be at the county's new facility on Mission Avenue.

Director Nygaard wished everyone a happy and safe Halloween.

Director Schallock reported the *Coast News* recently ran an article on the hospital's educational relationship with the high schools. The program gives students the opportunity to get first hand insight into healthcare positions. Director Schallock stated the article was very complimentary and emphasized it is an inter-relationship with the school districts and the hospital.

Lastly, Director Schallock reported the Turkey Trot is on Thanksgiving morning and is a family-friendly fun event.

26. Report from Chairperson

Chairperson Grass congratulated staff on the LifeSharing Platinum award.

Chairperson Grass encouraged everyone to get their ticket to the Diamond Ball which will be held on November 16th.

Lastly, Chairperson Grass reported November is Alzheimer's and Diabetes Awareness month as well as Hospice month. Additionally, Nurse Practitioner week begins December 12th.

27. There being no further business Chairperson Grass adjourned the meeting at 4:40 p.m.

| | Leigh Anne Grass, Chairperson |
|-------------------------|-------------------------------|
| ATTEST: | |
| | |
| Julia Nygaard Sacretary | - |

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

October 31, 2019 – 2:00 o'clock p.m. Assembly Room 3 – Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 2:00 p.m. on October 31 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director George W. Coulter Director Rocky J. Chavez Director Leigh Anne Grass Director Julie Nygaard Director Larry W. Schallock Director Tracy M. Younger

Absent was Director RoseMarie V. Reno

Also present were:

Steve Dietlin, Chief Executive Officer Teri Donnellan, Executive Assistant Rick Crooks, Executive Protection Agent

- 1. The Board Chairperson, Director Grass, called the meeting to order at 2:00 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Younger led the Pledge of Allegiance.
- 2. Public Comments Announcement

Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

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

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

Chairperson Grass made an oral announcement of the item listed on the October 31, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Evaluation: Chief Executive Officer.

5. Motion to go into Closed Session

It was moved by Director Chavez and seconded by Director Coulter to go into Closed Session at 2:05 p.m. The motion passed unanimously (7-0).

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

Chairperson Grass reported the Board in Closed Session conducted an evaluation of the Chief Executive Officer and recommended that the Board approve the First Amendment to the December 14, 2017 agreement.

 Consideration of amendment to extend employment contract with Chief Executive Officer

> It was moved by Director Younger to extend the employment contract with the Chief Executive Officer for a total duration of four years commencing November 1, 2019. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:

Directors:

Chavez, Coulter, Grass, Nygaard,

Schallock and Younger

NOES:

Directors:

None

ABSTAIN: ABSENT:

Directors:

None Reno

11. There being no further business, Chairperson Grass adjourned the meeting at 2:25 p.m. p.m.

| ATTEST: | Leigh Anne Grass Chairperson |
|----------------------------|---------------------------------|
| Julie Nygaard Secretary | |

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

October 24, 2019 – 10:30 o'clock p.m. Assembly Room 3 – Eugene L. Geil Pavilion 4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:35 a.m. on October 24, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez Director Leigh Anne Grass Director Julie Nygaard Director RoseMarie V. Reno Director Larry W. Schallock

Absent were Director George W. Coulter and Director Tracy M. Younger.

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief Government Affairs Officer
Gene Ma, Chief Medical Officer
Jeremy Raimo, Senior Director, Business Development
Eva England, Cardiovascular Service Line Director
Jennifer Paroly, President, TCHD Foundation
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

- 1. The Board Chairperson, Director Grass, called the meeting to order at 10:35 a.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Chavez led the Pledge of Allegiance.
- Public Comments Announcement

Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

Approval of agenda.

It was moved by Director Nygaard to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (5-0-0-2) with Directors Coulter and Younger absent.

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

Chairperson Grass made an oral announcement of the items listed on the October 24, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter involving Potential Litigation, Reports Involving Trade Secrets with various disclosure dates and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

6. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Schallock to go into Closed Session at 10:40 a.m. The motion passed (5-0-0-2) with Directors Coulter and Younger absent.

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

Chairperson Grass reported the Board heard reports on various Trade Secrets and took no action.

Chairperson Grass reported the Board heard Reports of the Hospital Medical Audit or Quality Assurance Committees and took no action.

10. There being no further business, Chairperson Grass adjourned the meeting at 1:00 p.m. p.m.

| ATTEST: | Leigh Anne Grass Chairperson |
|---------------|---------------------------------|
| Julie Nygaard | |

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

November 12, 2019 - 1:00 o'clock p.m.
Tri-City Wellness Center
6250 El Camino Real
Conference Room
Carlsbad, CA 92008

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 6250 El Camino Real, Carlsbad, CA at 1:00 p.m. on November 12, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez Director George W. Coulter Director Leigh Anne Grass Director Julie Nygaard Director RoseMarie Reno Director Larry Schallock Director Tracy M. Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Scott Livingstone, Chief Operations Officer
Barbara Vogelsang, Chief Nurse Executive
Aaron Byzak, Chief Governmental & External Affairs Officer
Gene Ma, M.D., Chief Medical Officer
Mark Yamanaka, M.D., Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Jim Rice, PhD, Board Facilitator
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

- 1. The Board Chairperson, Leigh Anne Grass called the meeting to order at 1:00 p.m. in the Conference Room at the Tri-City Wellness Center with attendance as listed above. Director Younger led the Pledge of Allegiance.
- 2. Approval of Agenda

It was moved by Director Nygaard to approve the agenda as presented. Director Younger seconded the motion. The vote on the motion passed unanimously (7-0).

3. Public Comments - Announcement

Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

New Business

- (a) Board of Directors Public Workshop for the purpose of review and discussion of:
- 1) Board Self-Assessment

Chairperson Grass introduced and welcomed Dr. Jim Rice, Board Facilitator. Dr. Rice provided a brief summary of his background, noting he facilitated Workshops with the Board previously in 2015 and 2017.

Dr. Rice provided three documents for today's discussion which included the following:

- Board Self-Assessment Results
- Governance Enhancement Planning 2020
- > Encouraging a Culture of Innovation

Dr. Rice reviewed the Board Self-Assessment Results which was comprised of answers to 167 questions in 10 areas including the following:

- 1. Mission, Values and Vision
- 2. Strategic Direction
- 3. Leadership Structure and Governance Processes
- 4. Quality and Patient Safety
- 5. Community Relationships
- 6. Relationship with the CEO
- 7. Relationships with the Medical Staff
- 8. Financial Leadership
- 9. Community Health
- 10. Organizational Ethics

Mr. Rice complemented the Board on improvements in their self-assessment scores over 2017.

The Board participated in three table exercises for the following topics:

- Strategies to Enhance Board Member Onboarding
- Traits of High Functioning Healthcare District Board Member
- 3. Enhanced Board Education Programming

Following the meeting Dr. Rice will provide a document which will accompany today's minutes that captures the good ideas that surfaced from the discussions related to the table exercises previously mentioned.

In closing, attendees gave their impression of today's workshop and all were positive and appreciative of the time and effort put forth.

5. Comments by Members of the Public

There were no comments by members of the public.

| ATTEST: | Leigh Anne Grass Chairperson |
|----------------------------|---------------------------------|
| Julie Nygaard Secretary | |



Governance Enhancement Plan 2020

Tri-City Medical Center

Tri-City Medical Center and its board, medical staff and executive leaders will face a number of challenges and opportunities over the next 3-5 years. The operating environment for future board work is expected to be characterized by the interplay of at least these issues:

- o Steady calls for coordinated and integrated care models for superior health care along the complex continuum of care for people with chronic disease.
- o A new governance model that builds on board members elected within 7 subdistrict communities with diverse needs and resources.
- Continuing pressures to prepare for bundled care payments and value for money contracting.
- The potential for a majority of new board members to join the board in the last quarter of 2020, with unknown levels of health sector experience.
- o Calls for integrated care for physical health with mental and behavioral health.
- Pressure to be cost effective, and with transparency in reporting to the public and payers on price, quality and safety.
- Continuing to explore strategic alliances to gain scope and scale to address access to specialty physicians, payer clout, and operational efficiencies.

Following an in-depth review of a positive profile on Board Members' perspectives of their performance within a number of board work best practice dimensions, the full board, and medical staff and executive leaders exchanged insights into how the governance work at Tri-City Medical Center could be enhanced in three aspects:

- 1. Strategies to Enhance the Board Member Onboarding Process in 2020
- 2. Traits of High Performing Board Members that could guide community leaders interested in standing for election to the board in 2020.
- 3. Strategies to enhance board education opportunities in 2020.

This report provides a summary of the ideas suggested in the November 12, 2019 Board Performance Review Session held at the Tri-City Wellness Center. Participants are encouraged to discuss this summary and provide refinements as needed.

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Strategies to Enhance Board Member Onboarding:

While the participants in the review session acknowledged that current orientation and onboarding programs for board members have been comprehensive and of value, recognition of new challenges suggest the following aspects could help enhance the utility of the onboarding program for new board members joining the organization later in 2020. These suggestions will benefit from further discussion and refinement by the leaders of Tri-City over the next few weeks.

Ideas suggested are shared here in random order and will need prioritizing and ranking:

- Continue use of current orientation programming that relies on a mix of executive and medical staff as "faculty".
- 2. Design and develop a special orientation program for all candidates as soon as they have filed to stand for election.
- 3. Tri-City Strategic plans and competitor analysis, pattern in market share by service.
- 4. Rely on publications about the functioning of, and trends in, the US and local health systems from other organizations like Modern Healthcare, American Hospitals Association, California Hospital Association, Association of California Healthcare Districts, Institute for Healthcare Improvement.
- 5. Explore the engagement of community health leaders to explain Community Health Needs and perceptions of Tri-City Medical Center's services, plans, marketing, image and facilities.
- 6. Invite ideas from a health care futurist early in 2020.
- 7. Consider assigning a "Board Buddy" or "Mentor" for the first six months of their service to accelerate getting up to speed on the governance work and culture.
- 8. Include signatures by each member that they understand and comply with their updated position description, conflict of interests, and ethical policy documents.
- 9. Organize short tours of TCMC delivery sites.
- 10. Enable one-on-one orientation opportunities with each C-Suite leader.
- 11. Develop easy to use "infographics" on the funds flows and service delivery within Tri-City.
- 12. Organize discussion and introductions with groups of department managers to understand their roles and service responsibilities.
- 13. Include overview of Social Determinants of Health (SDOH) and their relationship to our Community Health Needs Assessments and responsive plans.
- In-depth demographic profile of the people living within each of the seven sub-districts.
- 15. Ensure full orientation by legal counsel on District Law and board role, as well as the Brown Act.



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- 16. How to use our board portal for 24/7 access to our decision support tools and information.
- 17. Update various policies such as harassment and labor laws
- 18. Explore input from other district healthcare and other special district boards to learn their approaches for great board work.
- 19. Define the balance of role of board for strategic focus and policy, and CEO is on operations. Discuss how to guard against micro-management.
- 20. Spread out the orientation (e.g. over 3 days) so we do not have to "drink from a firehose" all in one day.
- 21. Others?



Traits of High Functioning Healthcare District Board Member:

The session participants exchanged several excellent insights about the characteristics of a community leader who serves on a healthcare district board, like the Tri-City Medical Center Board. These discussions were surfaced in anticipation of several new community leaders standing for election to the board in 2020.

To encourage future talented, experienced, effective, and collaborative board colleagues, the following traits can be discussed, prioritized, and refined for publication/sharing with the media, community leadership groups, and the general public well in advance of the filing processes and deadlines. The availability of such a profile could help encourage enhanced candidates campaigning to serve the people of the District.

These are in random order. Please edit, refine and prioritize these traits before the end of 2019 for use in early 2020:

- 1. Committed to enhanced health of the people in the district
- 2. Enthusiastic champion for the vitality of the Tri-City health system
- 3. Collaborative team player with well-formed ideas and opinions
- 4. Servant Leader, service above self
- 5. Curious and inquisitive. Eager to learn and enhance their effectiveness
- Knowledgeable about Social Determinants of Health (SDOH) and the contributions other
 organizations in the district make to health and wellbeing, like housing, food, exercise,
 employment, behavioral health, and education
- Capable to build strategic alliances and partnerships with other health providers and community wellbeing organizations
- 8. Thick skin and sense of humor
- 9. Understands process of innovation and continuous improvement
- 10. Entrepreneurial experience and approach
- 11. Understands "emotional intelligence"
- 12. Pragmatic problem solver
- 13. Change champion
- 14. Familiar with clinical dimensions of health services delivery
- Comfortable with operational and capital budgeting
- 16. Knowledgeable about a hospital's sources and uses of funds
- 17. Ask wise questions that advance the interests for the collective good and mission for TCMC



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- 18. Non-partisan
- 19. Ability to share sincere praise for other board members, executives, and physicians
- 20. Able to put the organization's plans above personal agendas
- 21. Effective verbal and written communicator
- 22. Capacity to be a respected ambassador for the organization
- 23. Embraces honesty and integrity
- 24. Respected community activist and organizer
- 25. Strategic thinker and planner
- 26. Champion and loyal to the mission and plans of the medical center
- 27. Humble and willing to listen to the ideas of others
- 28. Positive, can-do attitude to pursue high performance policies and plans
- Capacity to understand quantitative reports for finance, quality, safety and employee morale and engagement
- Open to, but independent from community groups such as League of Women's Voters, Rotary Clubs, Faith Communities, Unions, Payer and Provider organizations' ideas, insights, and opinions
- 31. Experienced in continuous process and service improvement
- 32. Effective champion for superior patient experiences
- 33. Understands the value of balanced roles between board (strategic and policy) and management (tactics and operations)
- 34. Others?



Enhanced Board Education Programming:

Tri-City Medical Center leaders identified a series of educational topics judged important for the successful work of the future board. They also suggested various sources for these important educational program topics and elements.

Topics to be addressed in future board member education programming:

- 1. Changing health policy and regulatory trends at state and federal levels
- 2. Health economics and health services financing
- 3. Governance best practices
- 4. Brown Act and related open meetings
- 5. Bundled payment reforms from government and commercial payers
- 6. Human capital staff planning and development
- 7. Establishing a best employer culture
- 8. Positive media relations
- 9. Staff and executive compensation trends
- 10. Business planning and problem solving
- 11. Role of TCMC as a major employer and source of economic vitality in region
- 12. How to engage with diverse community segments and the general public
- 13. Demographic trends that drive health gain and health care
- 14. Quality processes and outcomes
- 15. Patient safety
- 16. Trends in price and quality transparency
- 17. Team work and collaboration
- 18. Social determinants of health
- 19. Community health partnerships with Live Well San Diego
- 20. Other topics?



Methods of Board Education and Development:

- 1. Periodic briefings/readings from CEO and his team of department managers
- Speakers or short workshops from health policy makers, associations, labor unions, media, our auditors and legal counsel, public health practitioners, social welfare and housing organizations, schools, economic development staff
- 3. Establish budget for member publication subscriptions
- 4. Invest in board member attendance at state conferences
- 5. Support for members to attend at least one educational program per year relevant to TCMC strategic challenges and imperatives
- 6. Quarterly book discussion program
- 7. Customized program tailored to the development needs of each board member
- 8. Design joint education programming with other hospital boards in the County
- 9. Preload some readings in board portal for 24/7 access
- 10. Other methods?



ADVANCED HEALTH CARE

Building Operating Leases Month Ending October 31, 2019

| STATE OF THE PARTY | HISTORY I | Base | DEC | A STATE OF THE PARTY OF THE PAR | LeaseTerm | STATE OF THE PARTY | THE TRUST OF THE PERSON OF THE | THE PERSON NAMED IN |
|--|-----------------|----------|-----|--|-----------|--|--|---------------------|
| | | Rate per | 133 | Total Rent per | Beginning | | | |
| Lessor | Sq. Ft. | Sq. Ft. | 200 | current month | Ending | | Services & Location | Cost Center |
| 6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024 | Approx 9,552 | \$3.59 | (a) | 46,367.60 | 07/01/17 | | OSNC - Carlsbad 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011 | 7095 |
| American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904 | Approx 1,558 | \$2.47 | (a) | 5,268.79 | 01/27/17 | 05/31/20 | PCP Clinic - Venus 2067 W. Vista Way, Ste 160 Vista, CA 92083 | 7093 |
| Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 V#83204 | 10,218 | \$2.58 | (a) | 42,018.83 | 07/01/17 | 06/30/22 | OSNC - Oceanside 3905 Waring Road Oceanside, CA 92056 | 7095 |
| Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981 | Approx 6,200 | \$2.70 | (a) | 21,112.00 | 02/01/15 | 01/31/20 | PCP Clinic Vista 1926 Via Centre Drive, Ste A Vista, CA 92081 | 7090 |
| CreekView Orhopaedic Bidg, LLC 1958 Via Centre Drive Vista, Ca 92081 V#83025 | Approx 4,995 | \$2.58 | (a) | 19,346.91 | 07/01/17 | 06/30/22 | OSNC - Vista 1958 Via Centre Drive Vista, Ca 92081 | 7095 |
| Effin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575 | 3,140 | \$2.62 | (a) | 10,101.37 | 12/01/15 | | PCP Clinic - Clancy 2375 Melrose Dr. Vista Vista, CA 92081 | 7091 |
| Meirose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849 | 7,347 | \$1.35 | (a) | 10,399.54 | 07/01/16 | | Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083 | 7320 |
| OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250 | 4,760 | \$4.12 | | 27,850.00 | 10/01/12 | 10/01/22 | Chemotherapy/Infusion Oncology Center 3617 Vista Way, Bldg.5 Oceanside, Ca 92056 | 7086 |
| SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589 | 3,864 | \$3.45 | (a) | 39,949.11 | 08/08/19 | 05/31/21 | Encinitas Medical Center 351 Santa Fe Drive, Sulte 351 Encinitas, CA 92023 | 7095 |
| Tota | 1 | | | \$ 222,414,15 | | | | |



ADVANCED HEALTH CARE

Education & Travel Expense Month Ending October 2019

| Cost | | | | | |
|---------|--|------------|----------|---------|-------------------|
| Centers | Description | Invoice # | Amount | Vendor# | Attendees |
| 7095 | CERNER TRAINING | 92419 EDU | 236.81 | 83608 | JILL TOPPRICH |
| 7570 | ACLS RECERTIFICATION | 82819 EDU | 220.00 | 83594 | ALLISON BURNS |
| 8390 | CSHP SEMINAR - PHARMACY MEETING | 102519 EDU | 492.29 | 79349 | TORI HONG |
| 8470 | CCRN & ADVANCED CRITICAL CARE COURSE | 100219 EDU | 200.00 | 83598 | OUVIA DEDAD |
| 8470 | MS NURSING - EDUCATION | 101119 EDU | 2,375.00 | 83532 | TINA BARTON |
| 8532 | CERNER TRAINING | 101119 EDU | 417.30 | 83606 | LYNNE LUEDTKE |
| 8532 | CERNER TRAINING | 92419 EDU | 604.61 | 79669 | JENNIFER HILL |
| 8532 | CERNER TRAINING | 92419 EDU | 722.84 | 83595 | JANETT GONZALEZ |
| 8620 | JOINT LEGISLATIVE AUDIT COMMITTEE | 92519 EDU | 798.64 | 82854 | LEIGH ANNE GRASS |
| 8650 | EMPLOYEE LAW SEMINAR | 102819 EDU | 129.00 | 19983 | AMEE CRAMOND |
| 8710 | NATIONAL ASSOCIATION - QUALITY CONFERENCE | 101919 EDU | 2,410.61 | 82501 | JAMES L JOHNSON |
| 8740 | ONS/ONCC CHEMOTHERAPY RENEWAL COURSE | 92019 EDU | 103.00 | 83593 | GINA BAUTISTA |
| 8740 | AHA ACLS UPDATE | 100219 EDU | 150.00 | 80175 | JOYCE J. FERRER |
| 8740 | AHA ACLS UPDATE | 100219 EDU | 150.00 | 83597 | DAYNA BONNER |
| 8740 | AHA ACLS UPDATE | 101419 AHA | 180.00 | 82902 | SAUL SAAVEDRA |
| 8740 | NATIONAL SOCIETY FOR HISTOTECHNOLOGY | 102519 EDU | 200.00 | 23245 | CARRIE M. DOLAN |
| 8740 | CCRN & ADVANCED CRITICAL CARE COURSE | 100219 EDU | 200.00 | 78656 | ANGELA PEREZ |
| 8740 | CCRN & ADVANCED CRITICAL CARE COURSE | 100219 EDU | 200.00 | 81355 | SHANNON REXRODE |
| 8740 | ETHICS & EMDR COURSE | 102519 EDU | 200.00 | 82946 | SUDABEH ZARIFIFAR |
| | ACLS RECERTIFICATION | 101119 EDU | 200.00 | 83223 | CAMPBELL, KEISHA |
| | CCRN & ADVANCED CRITICAL CARE COURSE | 101819 EDU | 200.00 | 83345 | TONYA LEROY |
| | CCRN & ADVANCED CRITICAL CARE COURSE | 92019 EDU | 200.00 | 83592 | YVONNE DELANEY |
| | GREINER GLOBAL SUMMIT ON BEST PRACTICE IN PREANALYTICS | 102519 EDU | 200.00 | 83616 | ROGER NERIS |
| | ACLS RECERTIFICATION | 102519 EDU | 200.00 | 83618 | DORIS TURNER |
| | BACHELORS OF SCIENCE IN HEALTH CARE ADMINISTRATION | 101119 EDU | 2,000.00 | | MARGARET STRIMPLE |
| 8740 | RN-BSN | 102519 EDU | 2,500.00 | 83617 | CLAUDIA PERKETT |

^{**}This report shows reimbursements to employees and Board members in the Education

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

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

HASDIC ANNUAL MEETING

LOCATION: LA JOLLA

DATE: NOVEMBER 14, 2019

REASON FOR ATTENDING: To hear healthcare information on a local, regional and national basis and how these subjects may be applied to our area and facility.

TOPICS:

The first keynote speaker was Nicholas Webb who is noted for his involvement in promoting innovation in healthcare and with future trends. His talk focused on the ever evolving role of new ideas in enhancing success in a very competitive marketplace. It is necessary for providing services, connection with consumers, better managing of finances as well as hiring and retaining the best employees. Those businesses that do not move forward will merge, be sold or fail in their business.

A second area of discussion from several speakers was best practices and trends related to care coordination especially with the homeless and low income persons and the role of the community and government partnerships to address these issues. A reminder that this is not an easy task as there is the interrelationship with housing, food and nutrition, finance, healthcare, personal care and safety. There are multiple silos in each area and they have to be broken down in order to achieve integration. As related to healthcare, these relationships have to be coordinated through the multiple systems to yield long term quality care with meaningful outcomes. One example reviewed was the Project 25 program in San Diego from several years ago. The goal with the homeless was to reduce high use of ED and hospitals. Through the use of multiple agencies there was a significant decrease in the hospital utilization. Today there are many more entities involved in integrating and providing these services. Two of the speakers, Jeffrey Norris, MD from Father Joe's Villages and Barbara DiPietro, PhD with the National Healthcare for Homeless Council discussed the many challenges of services to funding in today's world and the need to be innovative in thinking "out of the box" to provide improved, positive outcomes.

Larry W. Schallock

THE BIG PROBLEM WITH HOUSING AS A HEALTH DETERMINANT

- Federal resources vastly inadequate to meet needs
- There's a critical shortage
- There's no profit in developing affordable housing
- It's funded completely differently than health care; investments made in one budget area realized in another budget area
- An entirely different area of expertise

NATIONAL BEALTH CARE for the HOMELISS COUNCIL

HOMELESSNESS & HOSPITALS

- Length of stay: 4.1 days longer
- Cost of care: ~\$4,000 more per admission
- Number ED visits: 3x higher
- 30-day ED readmission rate: 6x higher
- Inpatient readmission rate: 2x higher





HOMELESSNESS & HEALTH

- Poor health causes homelessness
- Homelessness causes new health problems & exacerbates existing ones
- The experience of homelessness makes it harder to engage in care and receive appropriate services



NATIONAL BEALTH CARE for the HUMELESS COUNCIL

Health Status & Utilization



Chronic, acute & behavioral health conditions



Use of EDs, hospitals, SNFs, inpatient MH, detox, jails, EMT, police, etc.



Social services needs such as housing, food, transportation, case mgmt

Barriers to Health Care Access



ID, mailing address/phone, transportation, paperwork, income



Ability to engage in followup care, medication mgmt, insurance requirements



Rigid treatment models, stigma, distrust, admin hurdles