TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
October 28, 2021 – 3:30 o'clock p.m.

In accordance with the current State of Emergency and the Governor's Executive Order N- 25-20, of March 4, 2020, and N-33-20 of March 19, 2020 a virtual platform and/or teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will be able to participate by telephone, using the following dial in information:

Dial in #: (669-900-6833) To Listen and Address the Board when called upon: Meeting ID: 834 9004 5039; Passcode: 473884

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 min.	Standard
3	Roll Call/Pledge of Allegiance	3min.	Standard
4	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
5	September, 2021 Financial Statement Results	10 min.	CFO
6	New Business – a) External Affairs Update – Aaron Byzak	15 min.	Chief External Affairs Officer
7	Old Business – None		
8	Chief of Staff a) Consideration of October 2021 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 25, 2021.	5 min.	COS

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 760-940-3348 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
9	Consideration of Consent Calendar ***Requested items to be pulled <u>require a second</u>.*** (1) Consideration to approve the addition of Rod Serry, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology-STEMI for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022. (2) Consideration to approve the addition of Hannah Kirby, M.D. to the currently existing ED On-Call Coverage Panel for Orthopedics for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022. (3) Consideration to approve the addition of Michael Ammar, M.D. to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months, beginning October1, 2021 and ending September 30, 2022. (4) Consideration to approve the addition of Deena Elwan, M.D. and Berk Suntay, M.D. to the currently existing On-Call Coverage Panel for OB/GYN for a 12 month term, beginning October 1, 2021 and ending September 30, 2022. (5) Consideration to approve the establishment of the Cesarean Section Assistant call panel with services by Coastal Surgical Physician Assistants, Inc., James Hilton, PA-C and Stephanie Wallace (PA-C), Inc. for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022, with annual and total term cost not to exceed $172,800. (6) Consideration to approve the renewal of the agreement with The Neurology Center to provide comprehensive coverage/directorship for ARU, Stroke, Neurology, Epilepsy, and APC coverage for a term of 24 months beginning October 1, 2021 and ending September 30, 2023, for an annual cost not to exceed $575,364, and a total cost not to exceed $1,150,728. (7) Consideration to approve a purchase agreement with Zoll Medical Corporation for the purchase of 50 defibrillators at a total cost not to exceed $586,075. (8) Consideration of Resolution 804, a Resolution of the Board of Directors of the Tri-City Healthcare District Re-Ratifying the State of Emergency and Re-Authorizing Remote Teleconference Meetings. (9) **Administrative Committee** **A. <u>Patient Care Services Policies & Procedures</u>** 1. Fire Prevention and Management in Invasive Procedure Areas Procedure 2. Magnesium Sulfate, Administration in Obstetric Patients Procedure 3. Sterile Technique Policy **B. <u>Allied Health Professional Manual</u>** 1. Cardiology Standardized Procedures **C. <u>Cardiac Cath Lab</u>** 1. Angiojet Procedure 2. D. State Flowable Procedure	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	3. Export Catheter Procedure 4. Right Heart Cath and Prep of Swan-Ganz Catheter Procedure **D. <u>Medical Staff</u>** 1. Medical Record Documentation Requirements 8710-518 **E. <u>NICU</u>** 1. Education Plan, NICU Policy (DELETE) **F. <u>Outpatient Behavioral Health</u>** 1. Appointment of Representative Form Policy 2. Daily Schedule 3. Department Safety 4. Downtime Procedures 5. Emergency Evacuation 6. Exchange and Replacement of Medication 7. Financial Assessment 8. Fire Safety 9. Food Service Procedures 10. Inclement Weather and Critical Incident Policy 11. Orientation of New Patients 12. Pastoral Care 13. Practicum Student Placement 14. Staff Meetings 15. Staffing Levels **G. <u>Pulmonary Rehab</u>** 1. Six Minute Walking Test Monitoring 2. Supplemental Oxygen and Oximetry Monitoring (10) Minutes – Approval of: a) September 30, 2021, Regular Meeting (11) Meetings and Conferences – None (12) Dues and Memberships – a) 2022 CSDA Membership Renewal - $8,195.00		
10	Reports (a) Dashboard – Included (b) Lease Report – (September, 2021) (c) Reimbursement Disclosure Report – (September, 2021)		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Public Comments	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard

	Agenda Item	Time Allotted	Requestor
16	Total Time Budgeted for Open Session	1.0 hour	
17	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
October 18, 2021

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 10/29/2021 – 7/31/2023)

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 10/29/2021 through 7/31/2023:

- **BELANGER, Tanya CNM/Allied Health Professional (TrueCare)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER

INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – Part 1 of 3

October 18, 2021

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 11/01/2021 – 10/31/2023)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/01/2021 through 10/31/2023, 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:

- **BIERMAN, Andrew, NP/Allied Health Professional**
- **HEINEN, John, PA/Allied Health Professional**
- **HUNT, Cris, AuD/Allied Health Professional**

RESIGNATIONS: (Effective date 10/31/2021 unless otherwise noted)

- **Haigler, Heather, PA-C/Allied Health Professional**
- **KREIFELDT, Kimberly, PA-C/Allied Health Professional**
- **WINKEL, Bradley, PA-C/Allied Health Professional**

ANNUAL EVALUATIONS: The following providers have received annual evaluations and have been recommended for continued AHP membership

- Ahumada, Alejandro G., AuD
- Alasantro, Lori H., PHD
- Allen, Danielle M., AuD
- Allen, Matthew G., PAC
- Alston, Vickie S., CNM
- Bierman, Andrew J., NP
- Bishop, Leslie, NP
- Brownsberger, Richard N., PAC
- Bulger, Jeffrey, PAC
- Byrd, Kristina C., AuD
- Carlton, Vivian W., PAC
- Carnelian, Alissa A., AuD, CNIM
- Christensen, Anna, PAC
- Cowan, John W., PAC
- Crespo, Christopher N., PAC
- DeMasco, Michael A., PA
- Elamparo, Kaye L., NP
- Fazzino, Dolores L., NP, RNFA

Attachment B

- Fisher-Gamez, Lori K., NP, RNFA
- Forbes, Beth, RNFA
- Frost, Robert, PAC
- Guthrie, Lesli A., AuD
- Hamilton Jr., James N., PAC
- Hammonds, Tommy D., PAC
- Heinen, John P., PA
- Hermann, Linda, PAC
- Hermanson, Kathleen H., PA
- Huang, Stephanie K., PAC
- Hunt, Cris T., AuD
- Jaramillo, Elizabeth C., AuD
- Jenkins-Sebastiani, Christina L., AuD
- Kaup, Allison R., PHD
- Kaur, Manpreet, PAC
- Kelly, Katherine M., CNM
- Kimber, James H., PAC
- King, John F., AuD
- Kolt, Thomas L., PAC
- Luu, Jackie, PA
- Martinez, Melinda W., PAC
- Mateo, Marie E., CNM
- McNally, Paul D., NP
- Momberg, Jessica L., CNM
- Nguyen, Diana T., CNM
- Perlman, Tamara L., CNM
- Pregerson, Heather A., PAC
- Renne, Brittany A., AuD
- Rice, William M., PAC
- Rosen, Jay W., PHD
- Ross, Jessica L., NP
- Savic, Jessica, PA
- Schillinger, Stephan B., PAC
- Schroeder, Mary L., CNM
- Scott, Katie L., PAC
- Stabler, Holly, PAC
- Stenzel, Alison N., PA
- Tebon, Renee, PAC
- Weichert, Rachel A., AuD, CNIM

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
October 18, 2021

AUTOMATIC RELINQUISHMENT OF PRIVILEGES

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 therefore the listed privileges will automatically expire as of **October 29, 2021**

- **ALLEN, Matthew, PA-C** — **Emergency**
- **DEMASCO, Michael, PA-C** — **Emergency**
- **HAIGLER, Heather, PA-C** — **Emergency**
- **LUU, Jackie, PA-C** — **Emergency**
- **SCHILLINGER, Stephan, PA-C** — **Emergency**
- **SCOTT, Katie, PA-C** — **Emergency**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT– Part 3 of 3
October 18, 2021

PROCTORING RECOMMENDATIONS

- **ROSEN, Jay PHD** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
October 13, 2021

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 10/29/2021 – 9/30/2023)

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 10/29/2021 through 9/30/2023:

- ALUNNI, Marisa MD/OB/GYN (Kaiser)
- BAKSHI, Ankur MD/Cardiothoracic Surgery (North County CVT Surgery)
- ELWAN, Deena MD/OB/GYN (TrueCare)
- FARNSWORTH, William MD/Neurology (The Neurology Center)
- KADAKIA, Hemal MD/Internal Medicine – Telemedicine (Sound)
- KIRBY, Hannah MD/Orthopedic Surgery
- LIN, Han-Ming MD/Internal Medicine (Kaiser)
- MANGINANI, Sridevi MD/Internal Medicine – Telemedicine (Sound)
- MANY, Sherin MD/Family Medicine – Telemedicine (Sound)
- MOON, Richard MD/Internal Medicine (Kaiser)
- MOORE IV, George MD/Internal Medicine (Kaiser)
- MULLINS, Jennifer DO/Internal Medicine (Kaiser)
- MYATT, Toby MD/Emergency Medicine (TeamHealth)
- OTTINO, Jennifer DO/General Surgery (Minimally Invasive Surgeons of North County)
- SAHA, Pamela MD/Psychiatry (Array Behavioral Care)
- SEDRAK, Sara MD/Anesthesiology (ASMG)
- TRAN, Billy MD/Anesthesiology (ASMG)
- UCHINO, Catherine MD/OB/GYN (Kaiser)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
October 13, 2021

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 11/01/2021 – 10/31/2023)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/01/2021 through 10/31/2023, 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:

- **AMUNDSON, Janet, MD/Teleradiology/Provisional**
- **BANSEL, Preeti, MD/Pediatric Ophthalmology/Refer and Follow**
- **BHALLA-REGEV, Sandhya, MD/Internal Medicine/Provisional**
- **BROOKS, Jeffrey, DPM/Podiatric Surgery/Provisional**
- **BROWN, Dorothy, MD/Emergency Medicine/Active**
- **BUI, Hanh, MD/Cardiology/Active**
- **CIZMAR, Branislav, MD/Obstetrics & Gynecology/Active Affiliate**
- **DANG, Paul, MD/Internal Medicine/Active**
- **FLORES, Edna, MD/Oncology/Active Affiliate**
- **GUALBERTO, Gary, MD/Neurology/Active**
- **HALIM, Neil, MD/Family Medicine/Refer and Follow**
- **HALL, Andrew, MD/Internal Medicine/Refer and Follow**
- **HARDY, Tyrone, MD/Neurological Surgery/Active**
- **HOKE, Eileen, MD/Neonatology/Active**
- **HOTCHKISS IV, John, MD/Teleradiology/Active Affiliate**
- **KLEIN, Martina, MD/Psychiatry/Active**
- **KRAMER, Melissa, MD/Pediatrics/Provisional**
- **LLOYD, Amanda, MD/Dermatology/Refer and Follow**

Attachment B

- MALHIS, Safouh, MD/Pulmonary/Active
- MARTIN, Andrew, MD/Teleradiology/Active Affiliate
- MATAYOSHI, Amy, MD/Nephrology/Active
- MCMULLEN, Meredith, MD/Obstetrics & Gynecology/Provisional
- PARK, Ronald, MD/Pediatrics/Active
- PASHMFOROUSH, Mohammad, MD/Cardiology/Active
- PATTENGILL, Catherine, MD/Obstetrics & Gynecology/Provisional
- PRASAD, Nandan, MD/Emergency Medicine/Provisional
- SAINI, Arvind, MD/Ophthalmology/Active
- VAYSER, Dean, DPM/Wound Care/Active
- ZAVERI, Maulik, MD/Ophthalmology/Active Affiliate
- ZHANG, Clarice, DO/Emergency Medicine/Provisional

CHANGE OF STATUS:

- KARAS JR., Stephen, MD/Emergency Medicine

UPDATE TO PREVIOUS REAPPOINTMENT:

- KABRA, Ashish, MD/Cardiology/Provisional

RESIGNATIONS: (Effective date 10/31/2021 unless otherwise noted)

Voluntary:

- COLT, Ross, MD/Family Medicine
- DOAN, Lien, MD/Teleradiology
- HEROLD, Richard, MD/Emergency Medicine
- SHARIF, Mohamed, MD/Psychiatry
- SMITH, Richard, DO/Psychiatry

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
October 13, 2021

AUTOMATIC RELINQUISHMENT OF PRIVILEGES

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 therefore the listed privileges will automatically expire as of **October 29, 2021**

- **SHABRANG, Cyrus, MD** — **Interventional Radiology**
- **RAJAMANICKAM, Anitha, MD** — **Interventional Cardiology**

ADDITIONAL PRIVILEGE REQUEST (Effective 10/29/2021, unless otherwise specified)

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

- **BARCARSE, Erin MD** — **OB/GYN**
- **FLINN, Anna DO** — **OB/GYN**
- **HARIPOTEPORNKUL Nora MD** — **OB/GYN**
- **LINGENFELTER, David MD** — **OB/GYN**
- **MOON, Nah Yong MD** — **OB/GYN**
- **TAO, Amy MD** — **OB/GYN**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES

The following providers relinquished the following privileges.

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
October 13, 2021

PROCTORING RECOMMENDATIONS

• AFRA, Yuan, MD	Orthopedic Surgery
• AMMAR, Michael, MD	Ophthalmology
• COFFLER, Elaine, MD	Internal Medicine
• KHARADJIAN, Talar, MD	Nephrology
• LIN, Yuan, MD	Cardiothoracic Surgery
• PANSARA, Megha, MD	Pediatric Ophthalmology
• PRASAD, Nandan, MD	Emergency Medicine
• RAJAMANICKAM, Anitha, MD	Interventional Cardiology
• SUNTAY, Berk, MD	OB/GYN
• SHABRAND, Cyrus, MD	Interventional Radiology
• ZENZEN, Charles, MD	Ophthalmology

TCHD Board of Directors
DATE OF MEETING: October 28, 2021
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, STEMI

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

Vendor's Name: Rod Serry, M.D.

Area of Service: Emergency Department On-Call: Cardiology-STEMI

Term of Agreement: 12 months, Beginning, October 1, 2021 – Ending, September 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

Rate/Day	Panel Annual Cost	Panel Total Term Cost
$1,000 - STEMI	$365,000	$365,000

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Sherry Miller-Manager, Medical Staff / Gene Ma, M.D., Chief Medical Officer

Motion:
I move that the TCHD Board of Directors approve the addition of Rod Serry, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology-STEMI for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022.

TCHD Board of Directors
DATE OF MEETING: October 28, 2021
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Orthopedics

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

Physician's Names: Hannah Kirby, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

Term of Agreement: 12 months, Beginning, October 1, 2021 – Ending September 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of physician to current shared call panel; no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
Monday-Friday: $1,500	FY21 & FY22: 261	$391,500
Saturday-Sunday: $1,650	FY21 &FY22: 104	$171,600
	Total Term Cost:	**$563,100**

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene Ma, Chief Medical Officer

Motion: I move that the TCHD Board of Directors approve the addition of Hannah Kirby, M.D. to the currently existing ED On-Call Coverage Panel for Orthopedics for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022.

TCHD Board of Directors
DATE OF MEETING: October 28, 2021
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Michael Ammar, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, October 1, 2021 – Ending, September 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

Rate/Day	Panel Annual Cost	Total Term Cost
$300	$109,500	$219,000

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Sherry Miller, Manager-Medical Staff Services / Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors approve the addition of Michael Ammar, M.D. to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022.

TCHD Board of Directors
DATE OF MEETING: October 28, 2021
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

Physician's Name: Deena Elwan,M.D. and Berk Suntay, M.D.

Area of Service: Emergency Department On-Call: OB/Gyn

Term of Agreement: 12 months, beginning October 1, 2021, ending September 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value:
Addition of physicians to current panel at same rates; no increased cost to district

OB-GYN - Rate/Day	Panel Days during Term	Panel Term Cost
Weekday $800	261	$208,800
Weekend/holiday $1000	104	$104,000
	Total Term Cost:	**$312,800**

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Sherry Miller, Medical Staff Manager /Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize the addition of Deena Elwan, MD and Berk Suntay, MD, to the currently existing ED On-Call Coverage Panel for OB/GYN ED for a term of 12 months, beginning October 1, 2021 and ending September 30, 2022.

TCHD Board of Directors
DATE OF MEETING: October 28, 2021
MEDICAL STAFF AGREEMENT for Cesarean Section Assistant Coverage

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

Vendor's Name: Coastal Surgical Physician Assistants, Inc., James Hamilton, PA-C, and Stephanie Wallace, PA-C

Area of Service: Cesarean Section Assistant

Term of Agreement: 12 months, beginning October 1, 2021- September 30, 2022

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

Shift Rate	Maximum Cost/Month	Annual Cost
$360/12 hr. shift	$14,400	$172,800(NTE)

Description of Services/Supplies:

- New call panel to provide support for Obstetricians for surgical assistants during Cesarean Sections.
- Coverage includes nights on weekdays and both days and nights on Saturdays/Sundays.

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

Person responsible for oversight of agreement: Gene Ma, Chief Medical Officer.

Motion:
I move that the TCHD Board of Directors authorize the establishment of the Cesarean Section Assistant call panel with services provided by Coastal Surgical Physician Assistants, Inc., James Hamilton, PA-C, and Stephanie Wallace, PA-C for a term of 12 months, beginning October 1, 2021 and ending, September 30, 2022, with an annual and total term cost not to exceed $172,800.

TCHD Board of Directors
DATE OF MEETING: October 28, 2021
COMPREHENSIVE COVERAGE/DIRECTORSHIP AGREEMENT FOR NEUROLOGY, ARU, STROKE, EPILEPSY AND ADVANCED PRACTICE CLINICIAN(APC) COVERAGE

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

Vendor's Name: The Neurology Center

Area of Service: Emergency Department On-Call for Neurology. Medical Directorship and clinical coverage for ARU, Stroke care, Epilepsy Monitoring and General Neurology.

Term of Agreement: 24 months, Beginning October 1, 2021 - Ending September 30, 2023

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Renewal of comprehensive coverage with no increase in expense

Service Rate	Hours per month(NTE)	Hours per Year(NTE)	Monthly Cost(NTE)	Annual Cost(NTE)	24 Month Term Cost(NTE)
ED Neurology Call Coverage $780/24 hr	N/A	N/A	$23,725	$284,700	$569,400
Stroke Medical Director- $200/hr	12	144	$2,400	$28,800	$57,600
Neurology Medical Director-$200/hr	8	96	$1,600	$19,200	$38,400
Epilepsy Monitoring/Director $200/hr	4	48	$800	$9,600	$19,200
ARU Medical Director $165/hr	80	960	$13,200	$158,400	$316,800
APC Coverage $61/hr	102	1224	$6,222	$74,664	$149,328
			Not to Exceed Cost	**$575,364**	**$1,150,728**

Description of Services/Supplies:

- The Neurology Center to provide comprehensive coverage and directorship services for all areas of service requiring clinical neurological care and oversight.
- Provide 24/7 patient coverage for all Neurological specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

Person responsible for oversight of agreement: Gene Ma, Chief Medical Officer.

Motion:

I move that the TCHD Board of Directors authorize the renewal of the agreement with The Neurology Center to provide comprehensive coverage/directorship for ARU, Stroke, Neurology, Epilepsy, and APC Coverage for a term of 24 months beginning October 1, 2021 and ending September 30, 2023, for an annual cost not to exceed $575,364, and a total term cost not to exceed $1,150,728.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: OCTOBER 28, 2021
ZOLL MEDICAL DEFIBRILLATOR PURCHASE PROPOSAL

Type of Agreement		Medical Directors		Panel	X	Other: Capital Purchase
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Zoll Medical Corp

Area of Service: Nursing Services - Defibrillators

Maximum Totals:

Total Cost
$586,075

Description of Services/Supplies:

- Purchase of 50 Zoll Defibrillators to replace all of the defibrillators on crash carts throughout the organization.
- This purchase upgrade will ensure state of the art cardiac critical care.

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

Person responsible for oversight of agreement: Tom Moore, Director-Materials Management / Ray Rivas, Chief Financial Officer, Candice Parras, Chief Patient Care Services

Motion:
I move that the TCHD Board of Directors authorize the purchase agreement with Zoll Medical Corp for the purchase of 50 defibrillators at a total cost not to exceed $586,075.

LAW OFFICES OF
JEFFREY G. SCOTT
16935 WEST BERNARDO DRIVE, SUITE 170
SAN DIEGO, CA 92127

(858) 675-9896
FAX (858) 675-9897

JEFFREY G. SCOTT

Of Counsel
JAMES R. DODSON

DATE: October 25, 2021

TO: Board of Directors
Steven L. Dietlin, CEO
Susan Bond, General Counsel
Tri-City Healthcare District

FROM: Jeffrey G. Scott, Board Counsel

RE: Resolution No. 804 Re-Ratifying the State of Emergency and Re-Authorizing Remote Teleconference Meetings

As noted at the September 30, 2021, meeting of the Board of Directors, AB 361 was signed last month by the Governor and added Government Code section 54953(e) to the Brown Act. The legislation allows for public agency Boards of Directors to continue holding remote teleconference meetings during times of a declared emergency.

Holding in-person public meetings at the hospital during the pandemic raises logistic and serious health and safety concerns for patients, employees, and members of the public. The California Department of Public Health Officer has mandated that all healthcare workers and visitors in acute health care settings are required to be vaccinated.

In order to continue to have the flexibility to hold remote public meetings, AB 361 requires the public agency's Board of Directors to pass a resolution re-ratifying the state of emergency and re-authorizing remote teleconference meetings on a monthly basis. Attached is Resolution No. 804 which makes the proper findings and will allow the Board to continue meeting remotely during the time of a declared emergency.

It is recommended that the Board approve Resolution No. 804 to continue the remote meeting flexibility.

RESOLUTION NO. 804

RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT RE-RATIFYING THE STATE OF EMERGENCY AND RE-AUTHORIZING REMOTE TELECONFERENCE MEETINGS

WHEREAS, Tri-City Healthcare District ("District") is committed to preserving and fostering access and participation in meetings of its Board of Directors; and

WHEREAS, Government Code section 54953(e) makes provisions for remote teleconferencing participation in meetings by members of a legislative body without compliance with the requirements of Government Code section 54953(b)(3), subject to the existence of certain emergency conditions; and

WHEREAS, a required condition is that a state of emergency is declared by the Governor pursuant to Government Code section 8625, proclaiming the existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions as described in Government Code section 8558; and

WHEREAS, a proclamation is made when there is an actual incident, threat of disaster, or extreme peril to the safety of persons and property within the jurisdictions that are within the District's boundaries, caused by natural, technological, or human-caused disasters; and

WHEREAS, it is further required that state or local officials have imposed or recommended measures to promote vaccines, masking, and social distancing, and that meeting in person at the hospital would present imminent risks to the health and safety of attendees; and

WHEREAS, the Board of Directors previously adopted Resolution No. 803 on September 30, 2021, finding that the requisite conditions exist for the Board of Directors of the District to conduct remote teleconference meetings without compliance with paragraph (3) of subdivision (b) of Government Code section 54953; and

WHEREAS, as a condition of extending the use of the provisions found in Government Code section 54953(e), the Board of Directors must reconsider the circumstances of the state of emergency that exists in the District, and the Board of Directors has done so; and

WHEREAS, emergency conditions persist in the District and vaccine compliance, masking, and social distancing measures are required to be followed on the premises of the hospital for the continued health and safety of the patients, workers, and public; and

WHEREAS, as a consequence of the local emergency persisting, the Board of Directors does hereby find that the District shall conduct its meetings without compliance with paragraph (3) of subdivision (b) of Government Code section 54953, as authorized by Government Code section 54953(e), and that such meetings shall comply with the requirements to provide the public with access to the meetings as prescribed in Government Code section 54953(e);

THEREFORE, BE IT RESOLVED by the Tri-City Healthcare District Board of Directors as follows:

Section 1: Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2: Affirmation that a Local Emergency Persists. The Board of Directors hereby considers the conditions of the state of emergency in the District and proclaims that a local emergency persists throughout the District.

Section 3: Re-Ratification of the Governor's Proclamation of a State of Emergency. The Board hereby ratifies the Governor's Proclamation of a State of Emergency.

Section 4. Remote Teleconference Meetings. The District's Chief Executive Officer is hereby authorized and directed to take all actions necessary to carry out the intent and purpose of this resolution, including conducting open and public meetings in accordance with Government Code section 54953(e) and other applicable provisions of the Ralph M. Brown Act.

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PASSED AND ADOPTED at a regular meeting of the Board of Directors of Tri-City Healthcare District held on October 28, 2021, by the following roll call vote:

AYES: Directors _____

NOES: Directors _____

ABSTAIN: Directors _____

ABSENT: Directors _____

_____
Rocky J. Chavez, President
Board of Directors

ATTEST:

_____
Tracy M. Younger, Secretary
Board of Directors

ADMINISTRATION CONSENT AGENDA
October 19th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Fire Prevention and Management In Invasive Procedure Areas Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
2. Magnesium Sulfate, Administration in Obstetric Patients Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
3. Sterile Technique Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Allied Health Professional Manual		
1. Cardiology Standardized Procedures	2 Year Review	Forward To BOD For Approval
Cardiac Cath Lab		
1. Angiojet Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
2. D-Stat Flowable Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
3. Export Catheter Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
4. Right Heart Cath and Prep of Swan-Ganz Catheter Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
Medical Staff		
1. Medical Record Documentation Requirements 8710-518	Practice Change	Forward To BOD For Approval
NICU		
1. Education Plan, NICU Policy	DELETE	Forward To BOD For Approval
Outpatient Behavioral Health		
1. Appointment of Representative Form Policy	3 Year Review	Forward To BOD For Approval
2. Daily Schedule	3 Year Review, Practice Change	Forward To BOD For Approval
3. Department Safety	3 Year Review	Forward To BOD For Approval
4. Downtime Procedures	3 Year Review, Practice Change	Forward To BOD For Approval
5. Emergency Evacuation	3 Year Review	Forward To BOD For Approval
6. Exchange and Replacement of Medication	3 Year Review	Forward To BOD For Approval
7. Financial Assessment	3 Year Review, Practice Change	Forward To BOD For Approval
8. Fire Safety	3 Year Review	Forward To BOD For Approval
9. Food Service Procedures	3 Year Review	Forward To BOD For Approval
10. Inclement Weather and Critical Incident Policy	3 Year Review	Forward To BOD For Approval
11. Orientation of New Patients	3 Year Review	Forward To BOD For Approval
12. Pastoral Care	3 Year Review	Forward To BOD For Approval
13. Practicum Student Placement	3 Year Review	Forward To BOD For Approval
14. Staff Meetings	3 Year Review	Forward To BOD For Approval
15. Staffing Levels	3 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
October 19th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Pulmonary Rehab		
1. Six Minute Walking Test Monitoring	3 Year Review	Forward To BOD For Approval
2. Supplemental Oxygen and Oximetry Monitoring	3 Year Review	Forward To BOD For Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**FIRE PREVENTION AND MANAGEMENT IN SURGERY AND INVASIVE PROCEDURE AREAS**
Purpose:	To outline the necessary elements for a fire to occur, describe factors to reduce the risk of fire in **surgery and** invasive procedures, and outline responsibilities of each team member in the event of a fire in the **surgery and** invasive procedure area. To heighten awareness of increased fire risk during airway, head, neck, and upper chest surgeries, and outline protocol to mitigate fire risk during these procedures.
Supportive Data:	Communication between healthcare team members is essential in order to provide a safe environment in surgery. All staff involved with head and neck surgery shall collaborate before and during the surgical procedure to prevent or manage a fire. National Fire Protection Agency (NFPA) Emergency Care Research Institute (ecri.org)
Equipment:	CO_2 Fire Extinguisher Transport gurney/bed

~~A. DEFINITIONS:~~

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

~~B.~~A. **BACKGROUND:**

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

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/09, 5/12, 06/18, **09/20**	05/12, 06/18, **10/20**	05/12, 0718, **12/20**	07/18, **04/21**	n/a	06/12, 09/18, **09/21**	10/18, **10/21**	07/12, n/a	07/12, 11/18

~~C.~~B. **FIRE PREVENTION IN THE SURGERY AND INVASIVE PROCEDURE AREA:**

1. Manage ignition sources appropriately:
   a. Follow all safety guidelines when using cautery, lasers, high-speed drills, burrs, fiber-optic light sources, and defibrillators.
   b. Control electrosurgical units carefully:
      i. Holster electrocautery pencils while not in use. Do not allow heat sources (such as cautery tips or activated light cords) to contact the drapes.
      ii. Verbally confirm heat source settings with the surgeon/**procedural physician** and use the lowest settings possible.
      iii. The electrocautery device should be hand-controlled, with an on/off switch.
      iv. Allow the electrocautery device to be activated only by the person wielding it.
      v. Deactivate the electrocautery device before removing it from the surgical site.
      vi. If open O_2 sources are employed, use bipolar electrocautery whenever possible and clinically appropriate (i.e., for cauterization during head and neck surgery, including tracheal and oral surgery). Bipolar electrocautery creates little or no sparking or arcing.
      vii. Never use insulating sleeves cut from catheters over electrocautery active electrode tips.
      viii. Electrocautery is not recommended to enter the trachea during tracheostomy. If deemed necessary to use electrocautery to enter the trachea, the surgeon/procedural physician and ~~A~~anesthesiologist must confer prior to the procedure. The anesthesiologist shall be provided adequate warning before the trachea will be opened.
   c. Fiber-optic light cable management:
      i. Fiber-optic light cables may provide an ignition source if they are disconnected from the working element (e.g., scope). Avoid contact of fiber-optic light cord tip to drapes, sponges, or other fuel sources.
      ii. The end of the scope may become hot if an attached light cord has been on. Never place the scope down on the patient or drapes. During periods of non-use, place the light source in standby mode and place the scope on a mayo stand or basin.
      iii. Members of the surgical team shall communicate changes in light source status~~,~~ (i.e., standby versus on).
   d. Laser management ~~(contracted service)~~:
      i. A laser-trained technician **or nurse** will operate the laser, and will not leave the procedure area while the laser is in use.
      ii. Place the laser in stand-by mode when not in active use.
      iii. Activate the laser only when the tip is under the surgeon's direct vision.
      iv. Allow only the ~~contract~~ laser technician **or nurse** to operate/activate the laser.
      v. Deactivate the laser and place it in standby mode before removing it from the surgical site.
      vi. When performing laser surgery through an endoscope, pass the laser fiber through the endoscope before introducing the scope into the patient. This will minimize the risk of damaging the fiber. Verify the fiber's functionality before inserting the scope in the patient.
      vii. During lower-airway surgery, keep the laser fiber tip in view and make sure it is clear of the end of the bronchoscope or tracheal tube before laser emission.
      viii. Use appropriate laser-resistant tracheal tubes during upper-airway surgery. Follow the directions in the product literature and on the labels, which typically include information regarding the tube's laser resistance and use of dyes in the cuff.
      ix. To indicate a puncture, use saline fill to prevent cuff ignition, and immediately replace the tube if the cuff becomes punctured.

2. Coordinate with the anesthesiologist to manage oxygen sources appropriately:
   a. At all times, the minimum concentration of oxygen shall be used to provide for adequate oxygenation of the patient.
   b. The anesthesiologist shall administer oxygen at FiO_2 of 0.30 **or lower**.
      i. The anesthesia provider shall alert the surgical team of the need to increase the inspired oxygen concentration if acceptable oxygen saturation is not obtained using this concentration.
      ii. Oxygen shall be titrated up incrementally to achieve adequate oxygen saturation.
      iii. **For** FiO_2 of 0.35 or greater, the surgical**/procedural** team shall re-assess the fire safety precautions planned for the procedure and make any adjustment necessary to ensure ignition potential and fuel sources have been minimized.
   c. The anesthesiologist shall be provided adequate warning before an ignition source is activated in the presence of open gas delivery. If possible, stop supplemental O_2 delivery at least one minute before and during use of an electrocautery device or laser, or decrease the oxygen concentration to the minimum required to avoid hypoxia. If possible, stop the use of nitrous oxide one to three minutes before and during use of an electrocautery device or laser.
   d. BIPAP machines are not allowed in the Operating Room. Continuous Positive Airway Pressure (CPAP) modality is available on the North American Dragaer Apollo® anesthesia machines.
   e. Minimize the buildup of O_2 and N_2O (i.e., from an uncuffed tracheal tube or open oxygen delivery) beneath the drapes.
      i. Use a properly applied incise drape, if possible, to help isolate head and neck incisions from O_2-enriched atmospheres and from flammable vapors beneath the drapes. Proper application of an incise drape ensures that there are no gas communication channels from the under-drape space to the surgical site.
      ii. Use active gas scavenging of the space beneath drapes during open O_2 delivery, or of the oropharynx of an intubated patient. When scavenging beneath drapes, exercise caution so the space beneath the drapes does not collapse.
      iii. During surgery in the oropharynx, consider using suction to scavenge the field prior to use of an ignition source. Metal suction tips are preferred over plastic suction tips in this situation.
      iv. Use suction as near as possible to any potential breathing gas leak to scavenge the gases from the oropharynx of an intubated patient.
      v. Consider delivery of 5-10L/minute of air under the drapes to wash out excess oxygen.
      vi. Never use the drapes as a tent to enrich the oxygen atmosphere as a spark can ignite them. It is possible for the drapes to become engulfed in flames. **Place drapes over the patient's head in a manner that allows oxygen to flow freely and prevents accumulation under the drapes.**
3. Use of flammable agents:
   a. When using flammable agents for surgical skin preps, such as alcohol-based products:
      i. Allow adequate time for prep to dry and vapors to dissipate before applying drapes and using surgical equipment. Follow prep manufacturer's instructions for use (IFU) for recommended dry time.
      ii. Avoid pooling or wicking of flammable liquid preps. If pooling has occurred, it must be corrected and site must be allowed adequate dry time, before surgical drapes are applied.
      iii. Solution-soaked materials must be removed from the surgical field prior to draping and use of surgical devices.
   b. Be aware of the flammability of tinctures, solutions, and dressings used during procedures, and take steps to avoid igniting their vapors.
   c. Avoid the use of petroleum-based eye ointments, as they are potentially flammable.

4. Coat hair (including eyebrows, beard, and mustache) near the surgical site with water-soluble surgical lubricating jelly to make the hair nonflammable.
5. Moisten sponges and gauze when used in proximity to ignition sources.
6. Have solutions on the surgical field (saline and/or water) at the start of each case to quickly douse fire if needed.
   a. In addition to ordered irrigation fluids, water is required to be on the surgical field at the start of the case (with the exception of open heart cases, in which other fluids are used).
   b. In all head and neck surgeries, a 30-60mL syringe of saline shall be available on the surgical field.
7. Know the type and locations of fire extinguishers in the **surgical/**procedure area.
8. Always have a bed or transport gurney available immediately outside of the **operating/**procedure room for easy accessibility in the event of evacuation.
9. Continuously monitor throughout the procedure for early warning signs of fire, including an unexpected flash, flame, smoke or heat, unusual sounds (e.g., a "pop", "snap" or "foomp") or odors, unexpected movement of drapes, discoloration of drapes or breathing circuit, or unexpected patient movement or complaint.
10. **Perform a Fire Risk Assessment before the start of all surgical procedures.**
    a. **To complete the Fire Risk Assessment, answer the following three questions and note the associated score (0-1) for each question:**
       i. **Is the surgical or incision site above the xiphoid process? Yes=1; No=0**
       ii. **Is oxygen being administered by face mask or nasal cannula? Yes=1; No=0**
       iii. **Is an ignition source present? Yes=1; No=0**
    b. **Add the scores from the above three questions for a total Fire Risk Assessment Score (final score will be 0-3). Results and associated interventions are:**
       i. **Score of zero (0) indicates no elevated fire risk for the procedure. Follow standard fire safety precautions, including:**
          1) **Allow alcohol-based prep solutions at least three (3) minutes to dry and fumes to dissipate before draping.**
          2) **Avoid pooling of prep solutions.**
          3) **Remove prep-soaked materials from the field prior to draping.**
       ii. **Score of one or two (1-2) indicates low fire risk for the procedure. Implement standard fire safety precautions, plus the following interventions for low fire risk:**
          1) **Protect heat sources (see "Manage ignition sources appropriately", above).**
          2) **Employ standard draping procedures.**
       iii. **Score of three (3) indicates high fire risk for the procedure. Implement standard fire safety precautions, plus the following interventions for high fire risk:**
          1) **Employ tenting to minimize oxygen buildup under drapes.**
          2) **If possible, use oxygen less than or equal to 3L per minute.**
       iv. **When using electrocautery with an open oxygen delivery system, implement the following additional interventions:**
          1) **Stop supplemental oxygen at least one (1) minute before and during cautery use.**
          2) **Use wet, rather than dry, sponges.**
          3) **Keep sterile water or saline solution available for fire suppression.**
          4) **Keep a syringe full of saline solution available (for procedures in the oral cavity).**
          5) **Protect heat sources.**
          ~~9.~~6) **Use the lowest possible electrocautery setting.**

~~10. For all procedures above the xiphoid process (i.e., surgeries/procedures in the airway, head, neck and upper chest) perform a Fire Safety Time Out before the start of the procedure. The Fire Safety Time Out shall include the following:~~

~~a. If open delivery of oxygen is necessary, the anesthesiologist and surgeon shall confirm the oxygen concentration.~~
~~i. Consider the use of medical air rather than oxygen, if patient condition permits.~~
~~ii. Assess the need for 100% oxygen during open delivery; limit oxygen concentration to 30%, if possible.~~
~~iii. Consider the use of suction to scavenge under the drapes when open delivery of oxygen is used.~~
~~iv. Changes in oxygen concentration delivered shall be communicated to the team throughout the procedure.~~
~~b. Arrange drapes to minimize oxygen build-up (i.e., no tenting of drapes).~~
~~c. Apply an incise drape to the surgical area to isolate the head and neck area from oxygen and flammable vapors, if possible.~~
~~d. Confirm water is available on the sterile field, in a labeled basin/pitcher. Saline may be used in the event that water is contraindicated on the field for a particular procedure (e.g., open hearts).~~
~~e. Coat hair within the prep area with water soluble lubricating jelly.~~
~~f. Set heat sources on the lowest settings possible.~~
~~g. During tracheal/oral surgery:~~
~~i. Use bipolar electrocautery, if possible.~~
~~ii. Scavenge the field with a metal suction tip prior to using an ignition source.~~
~~iii. Consider packing wet sponges around an uncuffed endotracheal (ET) tube to minimize leakage of gases.~~
~~h. During laser surgery:~~
~~i. Use a laser resistant ET tube.~~
~~ii. Use a cuffed ET tube, if possible, inflated with saline and dye in the cuff to act as a marker for cuff puncture.~~
~~iii. Consider packing the back of the throat with wet sponges.~~

~~D.~~C. FIRE MANAGEMENT IN THE INVASIVE PROCEDURE AREA:

1. If a fire occurs on the sterile field, immediately announce to the procedural team that there is a fire, halt the procedure, and institute "RACE".
   a. Rescue
      i. Immediately douse the fire with water or saline, if possible.
      ii. If feasible, immediately stop the delivery of oxygen or nitrous oxide until the fire is extinguished.
      iii. If fire persists, pull the burning drapes to the floor (away from the patient, personnel, and equipment, if possible).
      iv. Protect the patient to limit injury.
      v. If the fire continues, control bleeding, cover the wound in a sterile manner (if possible), and prepare to move the patient and personnel to a safe area.
   b. Activate
      i. Dial "66" and state "Code Red in (state location)".
      ii. Call for help to the location of the fire.
   c. Contain
      i. Keep doors of procedural area closed to prevent spread of smoke and/or fire to other areas.
   d. Extinguish/Evacuate
      i. If fire continues, attempt to extinguish with fire extinguisher.
         1) Know the type and location of fire extinguishers in the procedural area, what type of fire you have and how it is to be extinguished.
         2) Each OR is equipped with a CO_2 fire extinguisher.
      ii. If fire persists, the patient and personnel must be horizontally evacuated to a safe area on the same floor.
      iii. Maintain an accurate count of patients and staff members during the evacuation.

iv. After evacuation of the procedural room, the last person to leave the room should close the doors and place a wet towel or blanket at the base of the door.
v. Turn off medical gas supply to the room as directed by the anesthesiologist.

2. Roles of Procedural Team Members during a fire (as applicable to the procedural area):
   a. Circulating Nurse
      i. Alert necessary personnel by activating the fire alarm system- Call "66" and state "Code Red in (state location)."
      ii. Ensure patient's safety by remaining with him / her and offering support.
      iii. Extinguish small fires or douse with liquid if appropriate.
      iv. Remove any burning material from the patient or sterile field, and extinguish it on the floor.
      v. Prevent fire from spreading to shoes or clothing by not stepping on burning materials.
      vi. Provide the scrub person and anesthesia care provider with needed supplies.
      vii. Collaborate with the anesthesia care provider on the need to turn off the medical gas shutoff valves (when applicable).
      viii. Carefully unplug all equipment if the fire is electrical.
      ix. Be aware of the safest route for evacuation.
      x. Obtain a transport gurney if necessary.
      xi. Remove IV solutions from poles and place them with the patient for transporting out of the invasive procedure area.
      xii. Help the anesthesia care provider disconnect any leads, lines, or other equipment that may be needed for transporting the patient without delay in leaving the procedural area.
   b. Scrub Nurse/Technician
      i. Remove materials from the patient that may be on fire and douse the fire on the field with water or saline.
      ii. Assist with the conclusion of the procedure, if possible.
      iii. Obtain sterile towels or covers for the surgical site and instruments.
      iv. Gather a minimal number of instruments onto the Mayo Tray or Basin and place them with the patient for transport.
      v. Assist with patient transfer from the procedure table to the Gurney / Bed for transport out of the procedural area.
   c. Surgeon/Procedural Physician
      i. Remove materials from the patient that may be on fire and douse fire on the field with water or saline.
      ii. Control bleeding and prepare the patient for evacuation.
      iii. Place sterile towels or covers over the surgical site.
      iv. Conclude the procedure as soon as possible if the patient is not in immediate danger.
      v. If necessary, help move the patient for evacuation out of the procedure area.
   d. Anesthesiologist
      i. Shut off the flow of oxygen/nitrous oxide to the patient or field and maintain breathing for the patient with a valve mask respirator (i.e., Ambu bag).
      ii. Collaborate with the circulating nurse on the need to turn off the medical gas shutoff valves.
      iii. Disconnect all electrically powered equipment on the anesthesia machine.
      iv. Disconnect any leads, lines, or other equipment that may be anchoring the patient to the area.
      v. Maintain the patient's anesthetic state and collect the necessary medications to continue anesthesia during transport.
      vi. Place additional IV fluids on the bed for transport with the patient, if time permits.
   e. Shift Supervisor/Manager
      i. Document time the fire started.

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

f. Ancillary Personnel
i. Help clear corridors for evacuation.
ii. Secure equipment for transporting the patient as directed by the circulating nurse.
iii. Follow instructions for evacuating the patient if needed.
iv. Assist as directed.

3. For a fire in the airway or breathing circuit, as fast as possible:
~~a. Remove the tracheal tube.~~
a. Stop the flow of all airway gases.
b. Remove the tracheal tube.
c. Remove all flammable and burning materials from the airway.
d. Pour saline or water into the patient's airway.
e. If the airway or breathing circuit fire is extinguished, the Anesthesiologist will reestablish ventilation by mask, avoiding supplemental oxygen and nitrous oxide if possible.
f. Extinguish and examine the tracheal tube to assess whether fragments were left in the airway.
i. Consider bronchoscopy to look for tracheal tube fragments, assess injury, and remove residual debris.
g. Assess the patient's status and devise a plan for ongoing care.

4. Ongoing care involves management of the burn. Call for specialty consults as directed by the surgeon/procedural physician.
5. Keep accurate records of all events surrounding the incident.
6. Continue to provide follow-up medical and/or surgical care until patient is discharged to post-procedural area.
7. After the fire, quarantine all of the involved equipment and materials, and have it checked and catalogued by Biomed.
a. The Safety Officer, Biomed, and the Fire Marshall may conduct a thorough investigation of the cause of the fire.
8. Debrief the staff involved in the incident, and evaluate systems and procedures to prevent fires in ~~the~~ **surgery/**procedural area and to effectively manage fires that occur.
9. Report instances of procedural fires as a means of raising awareness and ultimately preventing the occurrences of fires in the future. Reports can be made to The Joint Commission, ECRI (Medical Device Safety Reports), and the Food and Drug Administration.

~~E.~~D. RELATED DOCUMENT(S):

1. Code Red Fire Drill Evaluation Form

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

1. Practice Advisory for the Prevention and Management of Operating Room Fires, An Updated Report by the American Society of Anesthesiologists Task Force on Operating Room Fires: Anesthesiology, 2013; 118:00-00.
~~2. Connor, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.~~
2. **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**
3. **Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition*. St. Louis, MO: Elsevier.**

~~3. Rothrock, J. C. (2015). Alexander's Care of the Patient in Surgery (15th ed). St. Louis, MO: Elsevier.~~

Tri-City Medical Center	~~Distribution:~~ **Patient Care Services**
PROCEDURE:	**MAGNESIUM SULFATE, ADMINISTRATION IN OBSTETRIC PATIENTS**
Purpose:	To provide guidelines for the safe administration of intravenous magnesium sulfate for the treatment of patients with hypertensive disorders complicating pregnancy (pre-eclampsia/eclampsia), pre-term labor and for neuroprophylaxis in the preterm fetus and reducing cerebral palsy.
Supportive Data:	Magnesium sulfate competes with the calcium necessary for conduction of nerve impulses by blocking the release of acetylcholine at the synapses, thus decreasing neuromuscular irritability for seizure prevention. For tocolysis, magnesium sulfate ~~interfers~~**interferes** with the transport of calcium, which impairs myometrial contraction, resulting in muscle relaxation. Excretion of Magnesium sulfate is exclusively through the kidneys.
Equipment:	1. 1000mL IV solution as ordered by physician for primary IV line 2. Pre-mixed magnesium sulfate solution (4 g magnesium sulfate in 100mL sterile water **from pyxis, 6g bolus must be mixed in pharmacy**) for loading/bolus dose (IV piggyback) 3. Pre-mixed magnesium sulfate solution (20) grams magnesium sulfate in 500mL sterile water) for maintenance infusion ~~for secondary infusion~~ (piggyback IV) 4. IV administration set (2), Buretrol (1), 3-lead extension set (1) 5. Secondary infusion set 6. Volumetric infusion pump (Alaris) 7. Pulse oximeter 8. Electronic fetal monitor 9. Ambu bag 10. Functional oxygen and suction set up at the bedside 11. Calcium gluconate 1 gram (10mL of a 10% solution) for slow IV administration with magnesium toxicity 12. Reflex hammer

A. **POLICY**:

1. A qualified **registered nurse** (RN) may administer magnesium sulfate. A qualified RN is defined as one who has completed Magnesium Sulfate Administration (or appropriate) Education module
2. A staffing ratio of 1:1 must be maintained during the loading dose and any bolus, and through the first hour of magnesium sulfate administration.
3. For maintenance magnesium sulfate rates ~~for~~**of stable antepartum or post-partum patients (starting 2 hours after delivery).**, ~~which are usually set at 2 gm/hr~~, a staffing ratio of no more than 1 nurse: 3 patients shall be assigned. **For intrapartum patients, a staffing ratio of 1:1 will be maintained until 2 hours post-delivery.**
   ~~a. If the patient condition/acuity requires a magnesium sulfate maintenance rate greater than 3gm/hr and/or the patient requires more intense monitoring; staffing adjustments shall be made for a 1:1 ratio, or the patient relocated to a unit that can provide the required staffing ratio.~~
4. Magnesium Sulfate administration requires a two **RN**~~nurse~~ check **per Patient Care Services Policy: Medications, High Risk/ High Alert/ Look Alike Sound Alike**. An independent verification of the patient order, drug concentration, infusion rate, pump settings, and line attachment checks shall be performed at:
   - **i. Initiation of order**
   - ~~i.~~**ii.** Transfer of care and shift changes
   - ~~ii.~~**iii.** Rate changes and/or when a new infusion bag is hung

Review/ Revision Date	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Department of OB/GYN	Pharmacy & Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
6/96, 4/97, 7/97, 4/00, 3/03, 6/06, 8/09; 07/13, 03/20	11/09;9/13, 03/20	12/09;9/13, 04/20	06/21	11/09,09/13, 07/21	1/10,10/13 09/21	10/21	2/10, 11/13, n/a	2/10, 12/13

5. Contraindications to a magnesium sulfate administration include:
   a. Myasthenia gravis
   b. Heart Block
   ~~c. Renal Failure/anuria~~
   ~~d.~~c. Myocardial damage
6. **Caution should be used in patients with renal failure/anuria. They may still receive a loading dose if they are naïve to magnesium therapy and a lower maintenance dose should be considered with serial magnesium levels to guide therapy.**
7. Administration precautions/ ~~L~~labeling practices:
   ~~8.~~a. Magnesium Sulfate effects may be potentiated when used with narcotics, central nervous system (CNS) depressants, ~~and~~ calcium channel blockers, ~~.~~ **and beta blockers**
   ~~a.~~b. Clearly label the following with color-coded labels:
      i. Magnesium sulfate IV bag (Maintenance and Piggy backs)
      ii. ~~ii.~~ Magnesium sulfate tubing line, at the point as it enters the infusion pump
      iii. ~~iii.~~ Magnesium sulfate tubing line, at the point it enters the patient's main IV line

~~9.~~8. Magnesium sulfate SIDE EFFECTS are dose dependent and may include:
   a. Facial flushing, a sense of internal warmth
   b. Nausea
   c. Vomiting
   d. Headache
   e. Muscular weakness, lethargy
   f. Blurred vision
   g. Drowsiness
   ~~g.~~h. **Palpitations**

~~10.~~9. Therapeutic magnesium sulfate serum levels:
   a. 4-7 ~~mg/dl~~**mEq/L**
   b. For values greater than 7.0 ~~mg/dl~~**mEq/L**, monitor for signs of toxicity, discontinue the infusion, and notify the provider.

~~11.~~10. Signs and symptoms of magnesium sulfate **TOXICITY** can include:
   a. Nausea and vomiting
   b. Disappearance of Deep Tendon Reflexes (DTR) (usually an early sign)
   c. Progressive muscle weakness, difficulty swallowing
   d. Respiratory depression (RR < 12/minute)
   e. Shortness of breath
   f. Chest heaviness/discomfort
   g. Urine output < 30 mL/hour or <120 mL/4 hours
   h. Decreased level of consciousness
   i. Respiratory arrest
   j. Cardiac arrest

~~12.~~11. Magnesium sulfate **TOXICITY** management shall include:
   a. Discontinue magnesium sulfate infusion
   b. Provide airway and ventilatory support as needed
   c. Notify provider
   d. Draw a stat serum magnesium level
   e. Initiate cardiac monitoring ~~as needed~~ ~~AND~~ **BEFORE** giving Antidote.
   f. Administer ANTIDOTE: calcium gluconate per provider's order
      i. Calcium gluconate (10% solution) 1 gram Intravenous Push (IVP) over 3 minutes. **May repeat in 1 hour. If tertiary dose is needed, contact provider for further orders.** ~~May repeat every hour as needed. Maximum 8 doses in 24 hours.~~
      ii. Shall be administered SLOWLY to prevent adverse cardiac effects (arrhythmias)
      iii. Ensure patent IV prior to administration as it is a vesicant and can cause tissue damage
         ~~iii.~~

~~A.~~B. ADMINISTRATION ~~PROCEDURE :~~PROCEDURE:

1. Obtain provider order.
2. Verify bolus and maintenance doses.
3. Assemble equipment and supplies
   a. 100 mL ~~bag of~~**bag** ~~magnesium~~**of magnesium** sulfate (4 **or 6** gm): Bolus/ Loading Dose
   b. 500 mL bag of magnesium sulfate (20 gm): Maintenance Dose
   c. Safety-controlled infusion pump, ~~portless tubing, and~~ Burette infusion set
   d. Emergency supplies readily available at bedside or in Pyxis/ Crash Cart
      i. VS Machine
      ii. Pulse Oximeter
      iii. Functional O2 delivery means (mask/ self-inflating bag) and suction set up
      iv. Antidote: Calcium Gluconate
4. Assess maternal status for baseline values prior to infusion:
   a. Vital Signs
   b. Deep tendon reflexes (DTR) – DTRs must be present
   ~~b.~~**c. Presence of clonus**
   ~~c.~~**d.** Baseline O_2 saturation levels
   ~~d.~~**e.** Breath sounds
   ~~e.~~**f.** Level of consciousness (LOC)
   ~~f.~~**g.** Urine output
   ~~g.~~**h. Symptoms of headache, vision changes, nausea/vomiting, and/or epigastric pain**
5. Provide education to the patient about reasons for Magnesium sulfate administration and side effects.
6. Start mainline IV (if not already infusing) per provider order.
7. Infuse Magnesium sulfate via an IV burette infusion set on infusion pump with hub attached closest to the patient.
   a. Loading dose/ bolus is usually administered over 30 minutes, and shall be given using pre-mixed 4gm magnesium piggyback on a pump.
   b. The nurse is required to remain at the bedside during the loading and bolus doses for patient monitoring.
   c. If the patient is also receiving Pitocin, ~~consider utilizing~~**utilize** a (3) lead extension set on the patient's IV site.
   d. After the loading or bolus dose is infused, obtain pre-mixed magnesium sulfate solution (20 grams of magnesium sulfate in 500 mL sterile water) for maintenance dosing.

EXAMPLE RATES

20 grams magnesium sulfate in 500 mL sterile water
1 gram magnesium sulfate per **25mL** sterile water
2 grams magnesium sulfate per **50 mL** sterile water
3 grams magnesium sulfate per **75 mL** sterile water
4 grams magnesium sulfate per **100 mL** sterile water

8. Strict Intake and Output (I&O) shall be implemented per provider order.
9. Monitoring considerations:
   a. Loading/ Bolus Dose: Vital signs, continuous oxygen saturation (O2 Sat) levels, **DTRs/clonus, LOC, breath sounds, presence of headache/vision changes** every 15 minutes x 4, then every 30 minutes x2. ~~See Intrapartum/Antepartum standards of care for ongoing VS monitoring~~.
   Maintenance Dose: **These are the guidelines, VS and Assessments may need to be done more frequently depending on patient condition and provider orders.**

	Vital Sign and Assessment Frequency		
	Antepartum *	**Intrapartum***	**Postpartum***
BP, Pulse, Respirations, SpO2	**Every 4 hours**	**Hourly**	**Every 4 hours**
Lung Sounds	**Every 4 hours**	**Every 4 hours**	**Every 4 hours**
Level of Consciousness, Edema, DTRs, clonus, Assessment for headache, visual disturbances, epigastric pain (RUQ)	**Every 4 hours**	**Every 4 hours**	**Every 4 hours**
Fetal Status and uterine activity	**Every shift**	**Continuous**	**N/A**
Temperature	**Per Department Standards of Care**		
I& O	**Every 2 hours**	**Every 2 hours**	**Every 2 hours**

~~B. Vital signs and O2 Sats every 4 hours or per provider orders.~~

~~i. c. For Intrapartum/ Antepartum: See Fetal Heart Rate(FHR) Surveillance procedure for FHR monitoring or per provider orders~~

~~ii. d. Assess DTR's, Breath Sounds, and LOC at a minimum every 4 hours or more frequently based on patient condition.~~

C. **PROVIDER NOTIFICATION:** (Notify of the following):

1. Change in respiratory status
   a. Adventitious breath sounds (suggestive of pulmonary edema)
   b. Dyspnea
   c. Heaviness in chest
   d. O_2 saturation – decrease > 5% of baseline level
   e. RR ≤ 12/minute or ≥ 24/minute
2. Bradycardia or tachycardia
3. Urine output less than 30 mL/hour or less than 120 mL/4 hours
4. Disappearance of DTR's
5. Seizures
6. Change in level of consciousness or neurologic status
7. Serum magnesium levels greater than therapeutic range (> 7.0 ~~mg/dL~~**mEq/L**)
8. Signs of magnesium sulfate toxicity

D. **COMMUNICATION/ HANDOFF:**

1. When care is transferred to another nurse, both the nurse transferring care and the nurse assuming care will independently verify the pump settings for both the magnesium sulfate and the mainline IV fluids and review the provider orders.

E. **PATIENT EDUCATION:**

1. Explain the indications for magnesium sulfate.
2. Symptoms **and side effects** that may be experienced during the initial bolus and maintenance infusions.
~~2.~~**3. Signs and symptoms of Magnesium Toxicity**
~~3.~~**4.** When and how to notify the RN.

F. **DOCUMENTATION:**

1. Document patient assessment, magnesium sulfate infusion I&O, fetal monitoring (if intra or antepartum), nursing actions and interventions, maternal/fetal responses, and patient education in the patient's electronic medical record.

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

1. **Patient Care Services Policy: Medications, High Risk/ High Alert/ Look Alike Sound Alike**

~~G.~~**H. REFERENCES:**

1. **American Academy of Pediatrics** (AAP) & **American College of Obstetricians and Gynecologists** (ACOG). (201~~2~~7). Guidelines for Perinatal Care, ~~7~~8th Edition. Washington, DC
2. Simpson, K.R. & Creehan, P. (2020~~008~~). AWHONN Perinatal Nursing (5th ~~3~~rd Ed.) Lippincott, Williams & Wilkins: Philadelphia, PA.
3. Doyle, L.W., Crowther, C. A., Middleton, P. and Marret, S. (2009). Antenatal Magnesium Sulfate and Neurological Outcome in Preterm Infants: A Systematic Review, Obstetrics & Gynecology, Vol 113, No 6.
4. **California Maternal Quality Care Collaborative. (2014). CMQCC Preeclampsia Toolkit, Preeclampsia Care Guidelines. *California Department of Public Health.***
5. **Agency for Healthcare Research and Quality. (2017). AHRQ Safety Program for Perinatal Care Safe Medication Administration Magnesium Sulfate. No. 17-0003-19-EF**
~~3.~~6. **Norwitz, E. (2020). Preeclampsia: Management and prognosis. Retrieved from www.uptodate.com on 2/20/20**

~~B. **FORMS:**~~

~~Pre-Magnesium Sulfate Checklist Attachment A~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: ~~NEW~~04/16 **SUBJECT: Sterile Technique**

REVISION DATE(S): 04/16

Department Approval ~~Date(s)~~:	~~06/15~~03/20	
Clinical Policies and Procedures Approval ~~Date(s)~~:	~~09/15~~05/20	
Nursinge Leadership~~Executive Committee~~ Approval ~~Date(s)~~:		~~09/15~~06/20
Operating Room Committee Approval ~~Date(s)~~:	~~01/16~~0920	
Infection Control Committee Approval ~~Date(s)~~:	~~03/16~~10/20	
Pharmacy and Therapeutics Approval ~~Date(s)~~:	~~03/16~~05/21	
Medical Executive Committee Approval ~~Date(s)~~:	~~03/16~~09/21	
Administration Approval:	10/21	
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/16~~ n/a	
Board of Directors Approval ~~Date(s)~~:	04/16	

A. **PURPOSE:**

1. To provide guidelines ~~for establishing and maintaining a sterile field~~**on the principles and processes of sterile technique**.

B. **DEFINITIONS:**

1. Sterile: The absence of all living microorganisms. Synonym: aseptic.
2. Sterile field: The area surrounding the site of the incision or perforation into tissue, or the site of introduction of an instrument into a body orifice that has been prepared for an invasive procedure. The area includes all working areas, furniture, and equipment covered with sterile drapes and drape accessories, and all personnel in sterile attire.
3. Sterile technique: The use of specific actions and activities to **maintain sterility and** prevent contamination ~~and maintain sterility~~ of ~~identified areas~~**the sterile field and sterile items** during operative or other invasive procedures.

C. **PREPARING THE STERILE FIELD:**

1. **Prepare a sterile field for patients undergoing operative or other invasive procedures.**
2. **Perform surgical hand antisepsis and don a sterile gown and gloves before preparing or using a sterile field.**
3. **Prepare the sterile field as close as possible to the time of use.**
4. **Open the sterile field for only one patient at a time.**
5. **One patient at a time should occupy the operating room (OR) or procedure room.**
6. **Prepare the sterile field in the OR or procedure room where it will be used and do not move it to another room.**
7. **Only sterile items should come into contact with the sterile field.**
8. **For procedures that involve different wound classifications (i.e., clean, clean-contaminated, dirty), keep sterile fields and instrumentation separate and do not use them interchangeably on the cleaner wound.**
9. A sterile field shall be ~~constantly~~ **continually maintained and** monitored ~~and maintained~~**for contamination and potential breaks in sterile technique.**
   a. **Breaks in sterile technique shall be corrected immediately, unless the patient's safety is at risk, in which case it shall be corrected as soon as it is safe for the patient.**
   b. **Consider instruments contaminated when they are found:**

i. **Assembled or clamped closed**
ii. **With organic material (e.g., blood, hair, tissue, bone fragments) on or in the instrument**
iii. **With other debris (e.g., bone cement, grease) on or in the instrument**
iv. **When contaminated instruments are found in an instrument set, consider the entire set contaminated.**

c. **When an item or items are found to be contaminated, take the following corrective actions, at a minimum:**
i. **Remove the contaminated item(s).**
ii. **Remove any other items that may have come in contact with the contaminated item(s).**
iii. **Change the gloves of any team member who may have touched the contaminated item(s).**
~~1.~~iv. **Take any additional corrective actions required after assessment and based on the specific factors associated with the individual event.**

~~a. Sterile fields shall be prepared as close as possible to the time of use.~~
~~b. The sterile field should be prepared as near as possible to the location where it will be used.~~
~~c.~~d. **Cover the sterile field when it will not be used immediately (i.e., procedural delay, sterile field for closure, multiple tables) or during periods of increased activity (i.e., pre-incision, repositioning). If the field is in use, the portion of the sterile field that will not be immediately used (i.e., implants, instruments not in use) may be covered.**~~Sterile fields may be covered with a sterile drape if there is an unanticipated delay, or during periods of increased activity.~~
i. ~~When sterile fields are covered, they shall be covered~~**Cover the sterile field with a sterile drape** in a manner that allows the cover to be removed without bringing the part of the cover that falls below the sterile field above the sterile field.
ii. **Use two "cuffed" drapes that overlap in the middle of the sterile field:**
1) **Place the first drape horizontally over the table or other area to be covered with the cuff at or just beyond the half-way point. Place the second drape from the opposite side of the table with the cuff positioned so that it completely covers the cuff of the first drape.**
~~i.~~2) **Remove the drapes by placing the hands within the cuff of the top drape and lifting the drape up and away from the table and toward the person removing the drape. Remove the second drape from the opposite side in the same manner.**

~~d.~~e. ~~Unguarded~~ **Unmonitored** sterile fields shall be considered contaminated.
~~e. Every team member shall observe for events that may contaminate the sterile field and initiate corrective action.~~
f. **Limit nonessential conversations in the presence of a sterile field.**~~Conversation shall be minimal in the presence of a sterile field.~~
g. **Keep doors to the operative or invasive procedure room closed as much as possible except during entry and exit of patients, required personnel, and necessary equipment.**
h. **Keep the number and movement of individuals in an operative or invasive procedure room to a minimum.**
~~g.~~i. Non-perforating devices shall be used to secure equipment to the sterile field.
~~h.~~j. Non-sterile equipment brought into or over the sterile field shall be draped with sterile material.

~~2.~~10. Sterile drapes shall be used to establish a sterile field.
~~a. Surgical drapes shall be selected according to Association of Perioperative Registered Nurses (AORN) recommended practices for protective barrier materials.~~
~~b.~~a. **Place S**sterile drapes ~~shall be placed~~ on the patient, ~~and on all~~ furniture, and equipment ~~to be included~~ in the sterile field **in a manner that prevents contamination of the sterile field.**

~~c.~~**b.** **Handle** ~~S~~sterile drapes ~~shall be handled~~ as little as possible **and in a controlled manner that prevents contamination.**

c. Place sterile drapes in a manner that does not require the scrubbed team members to lean across an unsterile area and that prevents the sterile gowns from contacting an unsterile surface.

d. During draping, the draping material shall be compact, held higher than the surface to be draped and draped from the operative/procedural site to the periphery.

e. During draping, sterile gloves shall be ~~protected~~ **shielded** by cuffing the **interior portion of the** draping material ~~back~~ over the **sterile gloves**~~hand~~.

f. ~~Once the sterile drape is placed in position, it shall not be moved~~**Do not move the portion of the sterile drape that establishes the sterile field after initial positioning.**

g. Cover unsterile equipment (i.e., the mayo stand) on the top, bottom, and sides with a sterile drape before introducing to or bringing over a sterile field. Cover unsterile equipment that will be positioned immediately adjacent to the sterile field with a sterile drape.

h. Consider only the top of the sterile drape to be sterile. Consider items that fall below the level of the sterile field to be contaminated.

i. When a C-arm is moved into lateral position, consider the upper portion of the C-arm drape to be contaminated and do not bring the sterile drape that is below the level of the OR bed up into the sterile field.

~~f.~~**j. Use iodophor-impregnated adhesive incise drapes according to manufacturer's instructions for use (IFU). Adhesive incise drapes without anti-microbial properties are not recommended.**

~~3. Items used within the sterile field shall be sterile.~~

~~a. Packaging materials shall meet AORN recommended practices for selection and use of packaging systems.~~

~~b. Methods of sterilization, storage and handling of sterile items shall meet AORN recommended practices for disinfection, storage and handling.~~

~~c. All items presented to the sterile field shall be checked for expiration date, correct size/style, proper packaging, processing, moisture, seal integrity, package integrity, and appearance of sterilization indicator.~~

~~4.~~**11.** All items introduced onto the sterile field shall be opened, dispensed and transferred by methods that maintain sterility and integrity **of the item and the sterile field.**

a. Introduce sterile items to the sterile field as close as possible to the time of use.

b. Immediately before presenting items to the sterile field, inspect sterile items for:

i. Sterility of the contents, as noted on the packaging

ii. The expiration date, when applicable

iii. Package integrity

iv. Product integrity (i.e., discoloration or particulate formation in medications and solutions)

v. Verification that the external chemical indicators have changed to the correct color, indicating that the parameters for sterilization have been met

c. Deliver items to the sterile field in a manner that prevents unsterile objects or unscrubbed team members from leaning or reaching over the sterile field.

~~a.~~**d.** Vendors/Industry Representatives are not allowed to open **any items to the sterile field, including, but not limited to,** sterile implants, instruments ~~or~~**and** supplies. ~~onto the sterile field.~~

e. Inspect rigid sterilization containers for intact external locks, secured latch filters, valves, and tamper-evident devices, and for the correct color change to external chemical indicators, before they are opened onto a clean, dry, flat surface. Open the rigid sterilization container in the following order:

i. Unscrubbed person should lift the lid up and toward himself or herself while moving the lid away from the container.

ii. **The unscrubbed person should inspect the integrity of the lid filter or valve and consider the contents to be contaminated if the filter is dislodged, damp, or not intact (i.e., holes, tears, punctures).**

iii. **A scrubbed team member should lift the inner basket(s) out of an above the container without contacting the unsterile surfaces of the table or container.**

iv. **Before the instruments are placed on the sterile field, the scrub person should examine the internal chemical indicator for the correct color change and inspect the inside surface of the container for debris, moisture, contamination, or damage.**

v. **If there are any filters in the bottom of the container, an unscrubbed person should inspect the integrity of the filters.**

f. **Inspect wrapped sterile packages for intact tape and the correct color change for external chemical indicators before they are opened. An unscrubbed person should open the wrapped sterile package by:**

i. **Opening the farthest wrapper flap and securing the flap in the hand that is holding the item.**

ii. **Opening each of the side flaps, one at a time, and securing the flaps in the hand that is holding the item.**

iii. **Opening the nearest wrapper flap and presenting the items to the scrubbed team member.**

iv. **Visually inspecting the entire wrapper for integrity (i.e., no holes, tears, punctures) and presence of moisture before the sterile item is placed onto the sterile field.**

v. **Wrapper edges shall be secured when supplies are presented to the sterile field.**

g. **Inspect paper-plastic pouches (i.e., peel packs or peel pouches) for intact seals and for the correct color change of external chemical indicators. Present the pouch to the scrubbed team member or opened on to the sterile field by pulling back the flaps without touching the inside of the package, allowing the contents to slide over the unsterile edges of the package, or tearing the package.**

~~b. When opening wrapped supplies, unscrubbed persons shall open the wrapper flap farthest away from them first, then the side flaps, and the nearest flap last.~~

~~c. Wrapper edges shall be secured when supplies are presented to the sterile field.~~

~~d.~~**h.** **Present S**sterile items ~~shall be presented~~ **directly** to the scrubbed person or placed securely on the sterile field.

~~e.~~**i.** Sharp or heavy objects shall be presented to the scrubbed person or opened on a separate **clean, dry** surface, to avoid making a hole in the sterile barrier.

~~f. If organic material (eg blood, hair, tissue, bone) or other debris is found on an instrument or item in a sterile set, the entire set is considered contaminated and personnel should take corrective actions immediately, including, at a minimum, removing the entire set and any other items that may have come into contact with the contaminated item from the sterile field and changing gloves of any team members for may have touched the contaminated items.~~

~~g.~~**j.** When dispensing solutions to the sterile field, the entire bottle contents shall be poured into the receptacle and/or the remainder discarded.

i. **Transfer medications to the sterile field as close to the time of use as possible.**

~~i.~~**ii.** Solutions and medications shall be labeled **immediately** on the sterile field per Patient Care Services Procedure: Labeling Medication/Solutions On and Off a Sterile Field.

~~ii.~~**iii.** Solution receptacles shall be placed near the edge of the table, or held by the scrubbed person.

~~iii.~~**iv.** Solutions shall be poured **in a slow, controlled manner**~~slowly~~ to avoid splashing.

~~iv.~~**v.** Sterile transfer devices (i.e., sterile vial spike) shall be used when transferring medications or solutions to the sterile field.

~~v.~~vi. Stoppers shall not be removed from vials for the purpose of pouring medications unless specifically designed for removing and pouring by the manufacturer.

~~vi.~~vii. The edge of the container should be considered contaminated after the contents have been poured. **Pour medications or sterile solutions from the container only once, and do not replace the cap. Discard any remaining fluids in the opened container at the end of the procedure.**

12. ~~All persons moving within or around a sterile field shall do so in a manner to maintain the integrity of the sterile field~~**Move within or around a sterile field in a manner that prevents contamination of the sterile field**

~~5.~~a. **Scrubbed team members should:**~~.~~

~~a.~~i. ~~Scrubbed persons shall r~~**R**emain close to the sterile field and **touch only sterile areas or items.**~~shall not leave the room.~~

ii. ~~Scrubbed persons shall k~~**K**eep **their** arms and hands at or above **waist** ~~the~~ level ~~of the sterile field~~**at all times**.

~~b.~~iii. **Not fold their arms with their hands positioned in the axillary area.**

~~c.~~iv. ~~Scrubbed persons shall a~~**A**void changing levels,~~ and shall~~ **and** be seated only when the entire surgical procedure will be performed at ~~this~~ **that** level.

~~d.~~v. ~~Scrubbed persons shall c~~**C**hange positions by ~~moving~~ **turning** face-to-face or back-to-back, maintaining a safe distance between each other**, the sterile field, and unsterile areas during position changes**.

vi. ~~Scrubbed persons shall a~~**A**lways face the sterile field**, not turn their backs on the sterile field**.

~~e.~~vii. **Use shielding devices (e.g., lead aprons, mobile shields) that reduce radiological exposure in order to stay near the sterile field when radiology equipment is used.**

b. Unscrubbed **team members should:**

i. **Face the sterile field on approach.**

ii. **Not walk between sterile fields or scrubbed persons.**

iii. **Not reach over uncovered sterile fields.**

iv. **Stay as far back from the sterile field and scrubbed persons as possible.**

~~f. persons shall face sterile areas, maintaining an awareness of distance so as to avoid contacts with sterile areas~~.

D. ISOLATION TECHNIQUE:

1. **Use isolation technique during bowel surgery and procedures involving resection of metastatic tumors.**
   a. **Organize the sterile field in a manner that minimizes the risk of sterile field exposure to intestinal tract bacteria or cancerous cells from metastatic tumor excisions.**
   b. **Initiate isolation technique immediately before resection of the bowel or metastatic tumor and concluding when the resection or anastomosis is complete.**
   c. **Isolate and no longer use instruments or items that had contact with inside of the bowel lumen after it has been closed, or that were used for metastatic tumor excision.**
   d. **Remove contaminated instruments and items from the sterile field or place them in a separate area that will not be touched by members of the sterile team.**
   e. **Change surgical gloves and the surgical gown when soiled.**
   f. **Cover existing sterile drapes with new sterile drapes.**
   g. **Use clean instruments to close the wound after anastomosis or resection.**
2. **Isolation technique may be implemented using either a single sterile field or dual sterile field.**

~~D.~~E. SURGERY/INVASIVE PROCEDURE AREAS:

1. All members of the surgical team shall demonstrate competence in understanding the basic principles and practices of ~~asepticsterile~~ technique.

2. All personnel entering the ~~Operating Room (~~OR~~)~~ or invasive procedure room for any reason shall wear clean ~~scrub~~**surgical** attire and **a surgical** head cover**ing** according to Patient Care Services Policy: Surgical Attire.
3. Personnel shall perform hand hygiene before entering the OR or invasive procedure room ~~where sterile supplies have been opened~~**and before opening sterile supplies**.
4. Personnel shall wear a clean surgical mask that covers the mouth and nose and is secured in a manner to prevent venting **at the sides of the mask** when open sterile supplies are present and when preparing, performing, or assisting with surgery or invasive procedures.
5. Scrubbed persons shall wear sterile gowns and gloves.
   a. ~~Materials for gowns shall be selected according to recommended practices for protective barrier materials~~**The surgical gown should be selected by task and anticipated degree of exposure to blood, body fluids, or other potentially infectious materials, as determined by the following factors:**
      i. **Team member's role**
      ii. ~~.~~**Type of procedure (i.e., minimally invasive versus open)**
      iii. **Procedure duration**
      iv. **Anticipated blood loss**
      v. **Anticipated volume of irrigation fluid**
      vi. **Possibility of handling hazardous medications**
      ~~a.~~vii. **Anticipated patient contact (i.e., splash, soaking)**
   b. **Select the surgical gown needed for the procedure according to the barrier performance class stated on the product label, considering the anticipated risk of exposure to fluids, splash, and pressure on the gown:**
      i. **Barrier Level 1 = Minimal anticipated risk of exposure**
      ii. **Barrier Level 2 = Low anticipated risk of exposure**
      iii. **Barrier Level 3 = Moderate anticipated risk of exposure**
      iv. **Barrier Level 4 = High anticipated risk of exposure**
   c. **Select and wear surgical gowns that wrap around the body and completely cover the wearer's back. The gown sleeves should be of sufficient length to allow gloves to completely cover the cuffs and be of sufficient length to prevent the cuffs from being exposed when the wearer's arms are extended.**
   d. **Scrubbed personnel may wear a surgical helmet system when splash, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and facial contamination can be reasonably anticipated.**
      i. **Don the unsterile helmet and a surgical mask before performing surgical hand antisepsis.**
      ii. **Don the sterile visor hood that covers the unsterile helmet before donning the sterile gown and gloves.**
      iii. **Remove the mask in accordance with the manufacturer's IFU during donning of the sterile visor hood.**
      iv. **Turn the fan in the unsterile helmet on after gowning is completed.**
   ~~b.~~**e.** Surgical hand scrubs/surgical hand **antisepsis**~~asepsis~~ shall be performed before donning sterile gown and gloves**, and hands and arms shall be completely dry prior to donning the gown**.
   f. **The scrubbed person shall don sterile gown and sterile gloves from a sterile field away from the main instrument table.**
   g. **Sterile technique shall be used when donning and wearing a sterile gown and gloves.**
      i. **Only touch the inside of the sterile gown when picking it up for donning.**
      ii. **Sterile gloves should not be opened directly on top of the open sterile gown.**
      iii. **Do not touch the sterile glove wrapper or gloves until the sterile gown has been donned.**
   ~~c. The scrubbed person shall don sterile gown and sterile gloves from a sterile field away from the main instrument table.~~
   ~~d.~~**h.** Sterile gowns shall be considered:

i. Sterile from the chest to the level of the sterile field on the front of the gown
ii. Sterile sleeves from **the cuff to** two inches above the elbow ~~to the cuff~~, circumferentially
iii. Unsterile at the neckline, shoulders, ~~underarm~~**maxillary regions, gown** back and sleeve cuffs **after the scrubbed team member's hands pass through and beyond the cuff**

i. Sterile technique shall be used when donning, wearing, and changing sterile gloves.
i. When gloving without assistance, only the inside of the gloves shall be touched.
j. Scrubbed team members should wear two pairs of sterile surgical gloves (i.e., double glove) and use a perforation indicator system.
k. Gown cuffs shall be completely covered with the gloves.
~~e.~~**l.** The scrubbed person shall inspect gloves for integrity after donning ~~them.~~**, before contact with the sterile field, throughout use, and when an outer glove perforation is discovered and outer gloves are changed.**
i. When a perforation occurs in the outer pair of double gloves, change the outer gloves and inspect the inner gloves.
ii. Change gloves in a location away from the sterile field.
~~i.~~**iii.** The preferred method for changing contaminated gloves is for one member of the sterile team to glove the other.
~~ii.~~**iv.** The alternative method for changing contaminated gloves is by the open-glove method.
~~f.~~**m.** Surgical gloves worn during invasive surgical procedures should be changed:
i. After each patient procedure
ii. When suspected or actual contamination occurs
iii. After touching a surgical helmet system hood or visor
iv. After ~~adjusting~~**touching** optic eye pieces on the operative microscope
~~iv.~~**v. After touching a fluoroscopy machine**
~~v.~~**vi.** Immediately after direct contact with methyl methacrylate
~~vi.~~**vii.** When gloves begin to swell, expand, and become loose on the hands as a result of the material's absorption of fluids and fats
~~vii.~~**viii.** When a visible defect or perforation is noted or when a suspected or actual perforation from a needle, suture, bone, or other object occurs
ix. Every 90 to 150 minutes

n. Surgical gloves worn during invasive surgical procedures may be changed:
i. After draping is complete
ii. After handling of heavy, coarse, or sharp instrumentation
iii. After manipulation of rough edges of bone
~~viii.~~**iv. Before handling implants**

~~6. Isolation technique should be used during bowel surgery and during procedures involving resection of metastatic tumors.~~

~~E.~~F. RELATED DOCUMENTS:

1. Patient Care Services Procedure: Labeling Medication/Solutions On and Off a Sterile Field
2. Patient Care Services Policy: Surgical Attire
~~2.~~**3. Pharmacy Procedure: Sterile Products Preparation**

~~F.~~G. REFERENCES:

1. ~~AORN Guidelines for Perioperative Practice, 2015 Edition.~~ **AORN, Inc. (2020). *Guidelines for Perioperative Practice.* Denver.**
~~1.~~

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Cardiology Standardized Procedures

Approvals

Cardiology Division (Signature):	June 2, 2021
Medicine Department (Signature):	March 17, 2021
Interdisciplinary Practice Committee (Date):	~~July 14, 2017~~July 19th, 2021
Medical Executive Committee (Date):	~~July 24, 2017~~September 27, 2021
Administration (Date):	October 19, 2021
Professional Affairs Committee (Date):	~~August 10, 2017~~n/a
Board of Directors (Date):	August 28, 2017

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

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

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Cardiology NP will:
   a. Assume responsibility for the *Cardiac* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Cardiology division Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Cardiology division Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve health care and patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for the Cardiology Division are as follows:

i. CARD ACS, CP, CAD
ii. CARD CHF Beta Blockers and Calcium Channel Blockers
iii. CARD Cath Lab PTCA Stent
iv. CARD Cath Lab Post Procedure
v. CARD Cath Lab Pre Procedure
vi. CARD Elective Cardioversion Post
vii. CARD Elective Cardioversion Pre
viii. CARD Heart Failure
ix. CARD Integrilin
x. CARD Post Cath Lab Teach (subphase)
xi. CARD Transesophageal Echocardiogram PRE
xii. CARD Pericardiocentesis

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of cardiology.

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

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

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

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
    2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
    3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
    4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – Cardiology and the NP Cardiovascular Health Institute Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date

Tri-City Medical Center	~~Distribution:~~ Cardiac Catheterization Lab
PROCEDURE:	**ANGIOJET**
Purpose:	To assist physician with insertion of angiojet catheter via femoral artery using a uniform set-up for invasive procedures in the cardiac catheterization laboratory ~~to be performed by RN, LVN, RCIS, CVT and RT.~~
Supportive Data:	Angiojet unit guidelines for set-up from ~~company.~~**Boston Scientific**
Equipment:	Angiojet motor drive unit~~,~~ ~~pump set, Angiojet catheter, guide wire~~, **AngjioJet spiroflex Thrombectomy Set** 1-Heparinized saline **(2 units/ ml),** 500 ml **bag** ~~5000 U/liter,~~ temporary pacing cable ~~and~~ temporary pacer ~~box/~~generator.
Issue Date:	**02/05**

A. **POLICY**

1. All cardiac catheterization laboratory (CCL) staff will be knowledgeable and comply with the procedure set forth for angiojet insertion and use. ~~Physician will obtain patient consent~~.

~~B. PROCEDURE:~~

~~1.~~**2.** Upon arrival to the CCL, the patient is prepped for a left heart ~~cardiac~~ catheterization. Angiojet is considered after visualization of coronary arteries, **Physician's preference**.

~~a. Oxygen by nasal canula on at 2-4 L/minute.~~

~~b. Angiojet motor drive unit.~~

~~2.~~**3.** **Possibly will need to place a temporary pacemaker, physician's preference, if so** A 6 French sheath **is** inserted in the femoral vein **for placement of a temporary pacemaker**.

~~3.~~**4.** Temporary pacemaker lead is inserted,~~follow cardiologist preferences for temporary pacer settings, must be set before angiojet use. *Note: Angiojet will cause dysrhythmias.~~

~~2. Follow cardiologist protocol for setting of temporary pacer, must be set before angiojet use. *Note: Angiojet will cause dysrhythmias.~~

~~C. Observe monitor and record ECG rhythm strips PRN.~~

B. **PROCEDURE:**

~~Room Set Up~~

~~D. Visualization of coronary artery via 7F or 8F guiding catheter by physician. If blood clot visualized during coronary injections, Angiojet motor drive unit is set up.~~

~~E. Turn drive unit on. (Angiojet drive unit is stored in the Interventional Radiology 9800 room)~~

~~a.~~**1.** **Hand off sterile Angiojet Spiroflex Monorail thrombectomy set to scrub person** ~~Open pump set and catheter onto sterile filed.Scrub person to inspect the catheter to ensure that no damage is present~~

a. Sterile person hands off **the** ~~thrombectomy set to~~ pump set ~~to~~ circulating person, keeping ~~the end with~~ the catheter ~~connections~~ on the sterile filed.

b. **Scrub person to inspect the catheter to ensure that no damage is present**

~~c. Scrub person connects the sterile end of the pump set to the catheter.~~

2. Motor Drive Unit:

a. Turn drive unit on, power button is located at the top of the machine (power), the console drawer will open.

b. Hang **a 500 ml heparinized** saline bag, **per Physician order,** onto the hook located on the ~~left~~ **left/right** side of the ~~drive unit~~**console, the scrub person will hand off pump set back, spike the heparinized saline bag with the spike tubing.**

Cardiac Catheterization Lab Review/Revise	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/05: 06/05, 03/09, 05/20	06/21	07/21	09/21	10/21	n/a	08/11

~~ISSUED:~~	~~REVIEWED:~~		~~REVISED:~~	~~APPROVED:~~
~~02/05~~	~~05/05, 03/09~~		~~06/05~~	

a.c. Insert the pump into the console, ensure that the waste bag tubing aligns in the roller pump, then push the button to close the console, grey button located just above the doors

d. Place the foot pedal nearest the physicianHang the empty collection bag onto the hooks located on the right side of the drive unit.

e. Remove the mandrel form the catheter by pulling on the wire loop visible at the tip of the catheter and prime the catheter by completely submerging the tip in heparinized saline and pressing the foot pedal, continuing priming until the time display reaches zero seconds.

f. Confirm system set-up is successfully completed by removing foot form foot pedal. Status panel displays ready and green icon is illuminated.

3.g. Attach a syringe filled with saline to the flushing tool and insert the top of the catheter into the tool. Depress the syringe until saline exits the proximal end of the guidewire.

i. A flushing tool is included in the package for the purpose of flushing the guidewire lumen

4.h. Wipe the catheter shaft to activate the hydrophilic coating.

5. The "load pump" light must be on. The silver pump is loaded by placing the ball of the pump into the socket at the top of the pump bay. While holding the ball in place, pull the pump down until it is on the base of the pump bay and slide into place. Close locking mechanism – push down

F. "Connect saline supply" light must be on. *Note: This does not mean spike heparin bag.

a. Place saline tubing into the Inflow Bubble Detector.

b. Clamp tubing and spike bag. Fill drip chamber completely.

c. Unclamp tubing and wait for the well in the pump to fill and trigger the prime stroke.

d. If saline does not flow freely into the pump, squeeze the bag to get it started.

2. The "Install roller pump tubing" light must be on.

a. Lay the collection bag tubing across the roller pump making sure that the tubing is under the tubing guides – two arrows up – on either side of the roller.

b. Close lever.

c. Tug on roller tubing so it rests in the out flow bubble detector.

d. Connect the collection bag tubing to the pump set tubing.

3. The "Mode selection" light must be on. Select the mode; this is labeled on the catheter packaging and on the strain relief at the base of each catheter. After the mode is selected, the "ready" light will become visible.

4. Place the tip of the catheter into sterile saline or water and activate foot switch for 20 seconds to purge catheter. Reset any under pressure or outflow alarms that may occur. If more than 3 under pressure alarms occur then "burp pump". Reset timer and proceed with case.

Burping Pump:

1. Unlock pump and pull out of pump bay.

2. Pull up on piston to allow air to rise, then replace.

3. Replace pump in bay and reset any alarms.

For Technical Support 888-848-7677

C. REFERENCE(S):

1. Angiojet (2015). *Thrombectomy System and Set-up.* Boston Scientific Corporation.

Tri-City Medical Center	~~Distribution:~~ Cardiac Catheterization Lab
PROCEDURE:	**D STAT (FLOWABLE)**
Purpose:	For local management and control of bleeding from vascular access sites.
Supportive Data:	~~N/A~~**Vascular Solutions D-Stat Flowable Hemostat**
Equipment:	~~Thrombin vial (5000 u), collagen (200 mg), contained 10 ml syringe with attached mixing luer; Diluent vial (5 ml), mixing accessories (10 ml syringe and needleless, non-coring vial access device, applicator tips (1 small bore tip, 1-20 gauge 2.75" needle 1-20 gauge 3.0" right angle needle)~~ **D-Stat Flowable Hemostat package**
Issue Date:	**05/05**

A. PROCEDURE:

1. It is indicated for use **under the direction of a healthcare professional for the local management and control of bleeding from vascular access sites, percutaneous catheters and tubes, and prepectoral pockets**~~as an adjunct treatment in sealing residual oozing of tissue tracts of femoral access sites/collagen based hemostatic devices~~.
2. Contraindicated in persons with **known** sensitivity to bovine-derived materials.
3. **Preparation:**
   a. Remove caps from thrombin and diluent vials to expose the rubber stoppers.
   b. Using the 10 ml mixing syringe and non-coring vial access device, withdraw all diluent from the diluent vial and transfer it into the thrombin vial.
   c. Gently rotate the vial to reconstitute. DO NOT SHAKE.
   d. When the thrombin is completely dissolved, withdraw the thrombin from the vial again using the mixing syringe and vial access device. Remove the vial access device from the mixing syringe.
   e. Attach the collagen syringe with attached mixing luer to the mixing syringe.
   f. Vigorously push the thrombin into the collagen syringe.
4. **Application:**
   a. Disconnect the mixing syringe containing the D-Stat and attach the desired applicator tip. Physician will apply D-Stat according to recommendation treatment.
      i. Scrub person may apply topical D-Stat **per Physician order**.
   b. Follow manufacturer's guidelines for application and use.

~~ISSUED:~~	~~REVIEWED:~~	~~REVISED:~~	~~APPROVED:~~
~~05/05~~	~~05/05; 08/09~~		

Cardiac Catheterization Lab Review/Revise	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/05; 08/09, 05/20	06/21	07/21	09/21	10/21	n/a	08/11

Tri-City Medical Center	~~Distribution:~~ Cardiac Cath**eterization** Lab
PROCEDURE:	**~~EXPORT CATHETER~~ MANUAL ASPIRATION/EXTRACTION OF CORONARY THROMBUS**
Purpose:	~~Removal~~**Manual** aspiration of ~~embolic~~ **soft coronary thrombus** ~~material from vessels of the arterial systems.~~
Supportive Data:	~~Medtronic Export~~ **Vendor-specific** Catheter guidelines for set-up ~~**by Vascular Solutions.**~~
Equipment:	Aspiration catheter ~~, sterile set-up tray~~**Sterile cath table with ~~interventinal~~interventional equipment**~~, 6French arterial sheath, guide catheter, aspiration line and locking aspiration syringe.~~
Issue Date:	**05/05**

A. **PROCEDURE**

1. Scrub Tech **will:**
   - **a. ~~Will r~~Receive sterile kit, inspect for damage**
   - **b. Transfer the dispenser coil with the ~~Pronto~~ extraction catheter into the sterile field**
   - **c. Remove the ~~Pronto~~ extraction catheter from the dispenser coil and remove the packaging mandrel from the guidewire lumen**
   - **d. Drawn up 5 mL~~l~~ of heparinized saline into the 30 ml syringe~~,~~**
   - **e. Connect the syringe to the stopcock and extension line and connect the attached extension line to the catheter.**
   - **f. Flush the entire connection to remove all air from the catheter, extension line, stopcock and syringe.**
   - **g. Turn the stopcock to the "OFF" position**
     - **i. With the Stopcock in the "Off" position, pull back the plunger on the 30 ml syringe.**
     - **ii. Twist the plunger to lock the syringe in the vacuum position.**
     - **iii. PRECAUTION: check to make sure are fittings are secure so that air in not introduced into the extension line or syringe during extraction**

~~Fill aspiration syringe with 5-10 ml of heparinized saline and attach to aspiration line and syringe to export catheter.~~
~~Remove the packaging mandrel at the distal end of the export catheter.~~
~~Open stopcock on aspiration lines and flush the entire length of the catheter using all of the heparinized solution. Close stopcock.~~
~~Retract the plunger of the aspiration syringe and pull until it locks at the fully extended positions.~~
~~Physician:~~
~~Lead and advance export catheter over guide wire to the tip of the guide catheter.~~
~~Under fluoroscopy advance export catheter to desired site.~~
~~1. Begin aspiration by opening the stopcock on the aspiration line. Follow manufacturers recommendations for embolic removal.~~

2. Removal of the aspiration catheter:

~~3. Withdraw catheter.~~
- ~~4.~~**a. After completing the extraction process, turn the stopcock to the "Off" position and remove the catheter or attach second syringe and repeat extraction.**
- **b.** ~~Slowly retract and withdraw the export catheter. If necessary, loosen the tuohy borst of the rotating hemostatic valve to allow easy withdrawal of the distal shaft.~~

B. **REFERENCE(S):**

Department Review	Department Revision	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/05; 05/09, 02/20	n/a	06/21	07/21	09/21	10/21	n/a	

~~ISSUED:~~	~~REVIEWED:~~		~~REVISED:~~	~~APPROVED:~~
~~05/05~~	~~05/05; 05/09~~			

~~5.~~1. Vascular Solutions, Inc. (2017). *Pronto LP Extraction Catheter.* Minneapolis, Minnesota: Vascular Solutions, Inc.

Tri-City Medical Center	~~Distribution:~~ Cardiac Catheterization Lab
PROCEDURE:	**Right Heart Catheterization and Prep of a ~~Swan-Ganz~~ Pulmonary Artery Catheter**
Purpose:	**To insure uniform setup ~~for invasive procedures in the Cardiac Catheterization Laboratory to be performed by RN, LVN, RCVT and CVT.~~**
Supportive Data:	**None**
Equipment	**Sterile cardiac cath tray** **~~Swan-Ganz~~ Pulmonary artery catheter;** **~~-~~Sheath 8 Fr;** **-Two port manifold~~;~~** **Angioplasty pack** **~~;~~ vented contrast spike~~;~~** **Transducer; ~~500 ml Heparin solution; 1% Xylocaine 20 ml; Heparin;~~** **3-3 ml Heparinized syringes ~~x 3;~~** **Pressure line** **~~;~~ Sterile gloves;** **Stopcocks ~~x 1.~~**
Issue Date:	**05/88**

A. **PROCEDURE**

1. Table will be cleaned with ~~antibacterial~~**~~super sani~~ disinfecting** solution, Allow table to dry for ~~23 minutes~~ **manufacturer's recommended time**.
2. Angio pack will be opened in a sterile fashion.
3. Sterile supplies will be added.
4. ~~Swan-Ganz~~ **Pulmonary artery catheter** will be flushed with Heparinized solution and a stopcock will be placed on the proximal injectate **per physician order**
5. 1.5 ml of air will be injected into the balloon port with a 3 ml syringe to make sure the balloon is intact.
6. Connect the stopcock to the transducer.
7. Connect pressure line to the transducer and to the port closest to the catheter port on the manifold.
8. Connect the solution spike to the other port on the manifold.
9. Attach the bag of Heparin solution to the solution spike **per physician order**.
10. Flush the lines and transducer until free of air.
11. Open the transducer to air and to balance the amplifier.
12. Connect the manifold to the distal infusion port on the ~~Swan-Ganz~~ **pulmonary artery** catheter and flush the lumen.
13. **Precautions:**
    a. **Make sure the syringes are Heparinized properly. Check for balloon patency.**

Department Review	Department Revision	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/97; 10/00; 03/03; 05/05; 9/12, 05/20	06/97; 04/03; 06/05; 08/09; 9/12	06/21	07/21	09/21	10/21	n/a	05/88

~~Issued:~~	~~Reviewed:~~	~~Revised:~~		~~Approved:~~
~~05/88~~	~~06/97; 10/00; 03/03; 05/05; 9/12~~	~~06/97; 04/03; 06/05; 08/09; 9/12~~		~~05/88~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**07/01**	**SUBJECT:**	**Medical Record Documentation Requirements**
REVISION DATE(S):	**07/07, 03/08, 09/08, 06/09, 09/09 11/09, 07/11, 05/12, 08/12, 02/15, 12/15, 02/18, 08/18**	**POLICY NUMBER:**	**8710-518**

Medical Staff Department Approval:	**~~12/18~~07/21**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/19~~09/21**
Administration Approval:	**~~01/19~~10/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/19**

A. **PURPOSE:**
1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. **POLICY:**
1. It is the policy of Tri-City Medical Center that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. **RESPONSIBILITIES:**
1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration in conjunction with the medical staff, will determine the criteria for timely, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor to ensure that medical records meet the requirements for completeness as set in this policy.

D. **PROCEDURE:**
1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports will be transcribed into the Medical Records transcription system. Upon transcription the report will be saved and sent electronically to the Cerner electronic medical record (EMR).
   d. Paper-based documents will be scanned to the EMR and will be assigned by HIM for signature when required.
   e. Physicians will utilize the Cerner Message Center to authenticate transcribed and in progress documents in a timely manner.
   f. Electronic signature of transcribed and scanned reports by the practitioner will update the medical records/health information profile system to eliminate the signature deficiency assigned by the department.
   g. The Message Center feature supports the following actions to be taken by the physician:

i. Sign/Review
   1) Physician reviews the document and selects the OK button that updates the status of the report to "Authenticated
   2) Only the responsible physician is eligible to sign a transcribed report.
      a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
      b) Resident reports will be signed by the supervising physician.
      c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician within 48 hours but prior to patient discharge in the acute care setting

ii. Modify/Sign
   1) Physician may modify the document PRIOR to signature to correct/clarify any elements of the report.
   2) Addendums are to follow the structure of new information being bolded and deleted information noted as a strike-through
   3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse
   1) Physician may refuse and redirect a document to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician via Cerner message center.

2. Written Signatures
   a. It is expected that members of the medical staff and allied health will utilize acceptable written signatures, including credentials for all paper-based documents being authenticated.
      i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, same-day surgery, observation, and inpatient documentation.
   b. Acceptable written signatures are as follows:
      i. Legible full signature
      ii. Legible first initial and last name
      iii. Illegible signature over a typed or printed name
      iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
         1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
      v. Initials over a typed or printed name
      vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
   c. Unacceptable written signatures are as follows:
      i. Signature stamps alone are not acceptable.
      ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
      iii. Unsigned typed note with provider's typed name
      iv. Unsigned typed note without provider's typed/printed name
      v. Unsigned handwritten note, the only entry on the page
3. The following criteria must be met before a chart is considered complete:
   a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
      i. Identification data
      ii. Legal status if mental health patient;

iii. Emergency care given prior to arrival if any;
iv. Findings of assessment;
v. Conclusions or impressions from history and physical;
vi. Diagnosis or diagnostic impression;
vii. Reasons for admission or treatment;
viii. Goals of treatment and treatment plan;
ix. Known advance directives;
x. Informed consent for procedures and treatment;
xi. Diagnostic and therapeutic procedures and tests and their results;
xii. Operative and other invasive procedures performed;
xiii. Progress notes;
xiv. Reassessments if needed;
xv. Clinical observations;
xvi. Response to care;
xvii. Consultation reports;
xviii. Every medication ordered; every dose administered and any adverse reaction;
xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
xx. All relevant diagnoses established during care;
xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the practitioner responsible for providing or evaluating the service provided.
   a. All documentation is to be without the use of Do Not Use Abbreviations.
      i. A reference of Do Not Use Abbreviations is referenced on the TCMC intranet.
5. History and Physical
   a. A complete history and physical examination shall be present in the medical record no more than 30 days before or within twenty-four (24) hours of admission.
      i. Handwritten history and physicals are not acceptable and an electronic or printed H&P must be provided.
      ii. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
      iii. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
      iv. For patients with H&P's not more than 30 days old (in lieu of a new H&P), an examination of the patient, including any changes in the patient's condition, must be present in the medical record within 24 hours of admission.
      v. A history and physical completed more than 30 days prior to admission is not valid and must be completed.
      vi. A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.
   b. The history and physical shall include the following elements:
      i. Chief complaint;
      ii. Personal, past medical and surgical history;
      iii. Allergy history;
      iv. Current medications;
      v. Family history;
      vi. History of present illness;
      vii. All-important findings resulting from a review of systems;
      viii. Physical examination;
      ix. Diagnosis or diagnostic impression;
      x. Plan of treatment.
   c. Surgeries or procedures requiring anesthesia services must have a history and physical present in the medical record, no older than 30 days.

i. ~~Physician Pre-Procedure Documentation including~~**An updated examination of the patient, including any changes in the patient's condition, must be completed and** an update to the H&P must be recorded on the patient's medical record on the ~~same~~ day **of surgery/procedure**, prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.

ii. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
   1) H&P was completed
   2) H&P was reviewed
   3) The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.

iii. When the required history and physical examination is not present before the time stated for the operation, the operation shall be postponed until the history and physical is present in the medical record or the physician has documented that such a delay would constitute a hazard to the patient.

d. History and physical for hospital outpatient procedures:
   i. Ambulatory surgery patients undergoing invasive procedures with anesthesia, procedural sedation, or procedures that could compromise the circulatory or respiratory status as determined by the practitioner, shall have a complete H&P as defined above prior to surgery.
   ii. Hospital outpatients undergoing invasive procedures without a significant level of risk shall have at least a limited history and physical.
   iii. A limited history and physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.

6. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.
   a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
   b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.
      i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.

7. Medication reconciliation:
   a. Admission
      i. The admitting physician is required to review, complete and reconcile admission medication reconciliation information in Cerner collected upon admission of the patient within 24 hours.
      ii. If new information is later obtained, the clinician may update the medication by history list in Cerner.
   b. Transfer
      i. All medications will be reviewed and revised as appropriate when patient is being transferred to another level of care.
         1) Electronic Orders

a) The physician will access the transfer medication reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.

c. Discharge
  i. All medications will be reviewed against HOME medications in Cerner.
    1) Electronic Orders
      a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
      b) Prescriptions to be completed
        i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
        ii) Printed on the unit and handed to the patient
        iii) Handwritten on personal (physician's) prescription pad
    2) Written Orders
      a) Physician handwrites prescriptions on personal (physician's) prescription pad.
      b) Physician updates physician medication changes on the electronic medication list through the medication reconciliation tool.

8. Daily progress notes must be documented and reflect medical care and visitation of the patient by the attending member on all patients in the hospital.
  a. All practitioners will document progress notes in any of the following methods:
    i. Hand-written progress notes are not acceptable;
    ii. An electronic note may be a progress note typed by the physician or a progress note generated using a voice recognition software application (e.g. Dragon).
  b. Progress notes recorded by mid-level providers are required to be co-signed by the supervising physician member within 48 hours but prior to patient discharge.
9. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
  a. The informed consent documented will include the following:
    i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
    ii. The likelihood of the patient achieving his or her goals.
    iii. Any potential problems that might occur during recuperation.
    iv. Reasonable alternatives including side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.
    v. Name of the practitioner who will perform the proposed care, treatment, and services.
10. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.
11. A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.
12. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient and shall include:
  a. Respiratory function including rate, airway patency and oxygenation saturation;

b. Cardiovascular function, including pulse rate and blood pressure;
c. Mental status;
d. Temperature;
e. Pain;
f. Nausea and vomiting;
g. Anesthesia complications;
h. Post-operative hydration; and
i. Additional types of monitoring and assessment as may be necessary.

13. Operative or other high risk procedure reports shall be completed electronically or dictated immediately after surgery and shall include:
    a. Pre-operative diagnosis;
    b. Post-operative diagnosis;
    c. Date of procedure
        i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
        ii. Name of procedure;
    d. Anesthesia type;
    e. A detailed account of the procedure including approach and technique used;
    f. Estimated blood loss if any;
    g. Specimen removed if any;
    h. Name of the primary surgeon and any assistants;
    i. Complications;
    j. Patient status;
14. A post-operative/procedure note shall be completed immediately following surgery or other high-risk procedures when the operative/procedure report is dictated pending transcription. An operative note is not required if the operative/procedure report is completed electronically and immediately available in the medical record. Use of the electronic post-operative procedure note is necessary to document all required elements.
    a. Name of Procedure;
    b. Pre-Operative diagnosis
    c. Post-Operative diagnosis
    d. Patient status
    e. Name of primary surgeon and any assistants
    f. Anesthesia type
    g. Complications
    h. Findings
15. When the operative note is dictated, the electronic post-operative note must be completed by the surgeon prior to the patient being discharged or transferred from recovery.
16. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
    a. Name and hospital ID number of the patient
    b. Name of anesthesiologist who administered the anesthesia
    c. Vital signs reflecting patient status just prior to induction
    d. Name, dosage, route, and time of administration of drugs and anesthesia agents
    e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
    f. Names and amounts of IV fluids, including blood or blood products
    g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
    h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.
17. All orders, including verbal orders, must be dated, timed, and authenticated.
    a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for

medication orders and fourteen (14) days post-discharge for all other orders.

b. Physician co-signature is required within 48 hours, and/or prior to patient discharge, of and Allied Health Professional's order excluding those covered under an already approved standardized procedure.

18. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.
19. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
    a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders electronically into Cerner.
    b. All orders for treatment shall be entered electronically to the medical record. An order for treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
    c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
        i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
        ii. Vaccines
        iii. Intravenous fluids
        iv. Medication doses that if weight based would equal or exceed normal adult doses.
20. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
    a. Electronic Orders
        i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
        ii. Complete the Transfer Medication Reconciliation function
        iii. The physician is not required to re-enter orders when a patient is undergoing one of the following minor procedures and returns to the same level of care:
            1) Heart Catheterization
            2) Interventional procedures including PICC line placement
            3) Endoscopy including bronchoscopies
            4) Inpatient dialysis
            5) Pain management
21. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.
22. Discharge/Depart Process
    a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
    b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
        i. Nursing will enter into the Depart Process application
        ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)
23. A Discharge Summary shall be completed for all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
    a. Discharge Diagnosis

b. Reason for hospitalization
c. Significant findings
d. Procedures performed and treatment given
e. Condition on discharge
f. Instructions given to the patient or patient representative
    i. Follow-up instructions
    ii. Diet instructions
    iii. Discharge medications
g. A discharge note is acceptable for all patients with a length-of-stay less than forty-eight (48) hours, to include normal obstetrical deliveries, and normal newborn infants.
    i. Requirements of the note include:
        1) Discharge diagnosis
        2) Instructions given to the patient or patient representative:
            a) Follow-up instructions
            b) Diet instructions
            c) Discharge medications
        3) Physicians who have not completed a discharge summary at the time of discharge will be notified by Medical Records/HIM via the Message Center in Cerner and call to their office.

24. Physicians will be notified of all pending dictations and/or signatures via their Cerner Message Center and call to their office.
    a. Physicians will be suspended if the chart is not completed within 14 days of discharge per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).
25. Late entries, addendums or corrections to the medical record
    a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry, addendum, or correction will be made with the following required elements documented:
        i. A late entry, addendum or correction to the medical record, bears the current date of the entry and is signed by the person making the change or addition to the medical record.
        ii. A late entry supplies additional information that was omitted from the original entry. A late entry bears the current date and is added as soon as possible after the original entry was entered.
        iii. An addendum is used to provide information that was not made at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.
        iv. When making a correction to the medical record, the original entry must remain viewable. Documentation of the correct information should contain the current date and time and reference back to the original entry.
    b. It is not permitted to have entries "backdated" or "predated".
    c. The chart shall be completed within fourteen (14) days of discharge; it is expected no late entries will appear after this time period.

E. <u>FORM(S):</u>

1. Electronic Signature Certification Statement - Sample

SAMPLE

Tri-City Medical Center

ELECTRONIC SIGNATURE CERTIFICATION STATEMENT

The purpose of this form is to certify that each physician identifier is kept confidential. This form also certifies that Tri-City Medical Center is committed to maintaining the confidentiality of the physician identifiers. If it is determined that an assigned identifier has been misused, the authorized hospital official will terminate a physician's use of his or her identifier.

The term 'misused' is defined to mean that the physician has allowed another person or persons to use his or her personally assigned identifier. Any proof of misuse must be documented by the authorized hospital official and actions to terminate the use of the physician identifier must be initiated immediately, including written notice to the physician involved.

PHYSICIAN CERTIFICATION:
I certify I will not disclose the identifier assigned to me to any other person or permit another person to use it.

_____ _____
Physician Signature Date

_____
Physician Name (Printed)

TRI-CITY MEDICAL CENTER CERTIFICATION
I certify that the identifiers assigned to physicians for purposes of the Compass Physician Inbox electronic signature process will be kept confidential and that I will terminate the use of a physician's identifier in the event that he or she misuses it.

_____ _____
TCMC Authorized Representative Date

Tri-City Medical Center
Oceanside, California

DELETE from NICU P&P. Replaced by Staff Development/Education Plan

WOMEN & NEWBORN SERVI
NEONATAL INTENSIVE CARE UN

ISSUE DATE: 08/12

SUBJECT: Education Plan, NICU

REVISION DATE(S): 03/18, 03/18

Women & Newborn Department Approval:	~~04/18~~10/20
Perinatal Collaborative Practice Approval:	~~11/18~~08/21
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~12/18~~10/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

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

~~1. To determine educational needs of NICU staff members and to develop an education plan based on the identified needs.~~

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

~~1. Educational Needs Assessment Survey: A survey to determine staff areas of interest and needs in learning and preferred methods to meet new learning needs.~~

~~2. Education Plan: A formal written description of the education goals derived from the needs identified in the survey and the yearly plan for meeting those objectives.~~

~~3. Education Calendar: A schedule that contains the educational activities planned for the calendar year.~~

~~C. **SCOPE AND RESPONSIBILITY:**~~

~~1. Scope: this policy applies to the Neonatal Intensive Care Unit of Tri-City Medical Center.~~

~~2. Responsibility: it is the responsibility of the Clinical Nurse Specialist and NICU Leadership, to implement the process of development, review, revision, approval and communication of the education plan as identified.~~

~~D. **POLICY:**~~

~~1. Either an educational needs assessment survey or a skills proficiency self-assessment tool will be developed and conducted annually.~~

~~2. These tools, combined with leadership assessment of visualized unit based care, incident event reports and chart audits, will be used in developing an education plan for NICU nursing staff.~~

~~E. **PROCEDURE:**~~

~~1. The CNS will develop a yearly staff educational needs assessment survey or RN skills proficiency self assessment.~~

~~2. The results of the educational needs assessment survey, leadership assessment of incident event reports, and chart audit reviews will be used in developing an education plan for NICU nursing staff.~~

~~3. The CNS in conjunction with NICU leadership will develop an education plan to address the staff learning needs.~~

~~4. The educational calendar will be posted in the NICU to assure accessibility for staff.~~

~~5. In house hospital educational offerings and applicable external educational opportunities will be posted and available to NICU staff.~~

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

1. ~~CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25 30 33. (1999)~~

Tri-City Medical Center	Women and Newborn Services Neonatal Intens
PROCEDURE:	**PATIENT ASSIGNMENT NICU**
Purpose:	To provide safe nursing care for all NICU patients based on patient needs and staff competency. To communicate and document patient assignments using consistent guidelines.

DELETE POLICY

A. **POLICY**

1. The Assistant Nurse Manager (ANM) or designee, who is a professional registered nurse, is responsible for patient care assignments at the beginning of each shift. A patient classification system is utilized. Nurse/patient ratios will be maintained to meet patient needs and Title XXII Regulations. The NICU Manager, ANMs or designee are responsible for monitoring appropriate patient assignments.
2. The NICU Nurse Manager has accountability for staffing and work schedules.

B. **PROCEDURE:**

1. The ANM or designee determines the number of registered nurses for the NICU based upon the information obtained utilizing the Cerner acuity tool. This includes appropriate personnel to staff for the patient population. Reference Policy: Patient Classification in the NICU.
2. The ANM or designee develops the patient assignment utilizing the following criteria:
   a. The complexity of the patient's condition and the required nursing care.
   b. The knowledge and the skill of the nursing staff member to effectively assess and care for the patient.
   c. The type of technology employed in providing nursing care with consideration given to the knowledge and skill required to effectively use the technology.
   d. The degree of supervision required by each nursing staff member based on his/her previous assessed level and current level of competence in relation to the nursing care needs of the patient.
   e. Relevant infection control and safety issues.
   f. The patient's geographical location within the NICU.
   g. Continuity of care by reassigning staff to patients for whom they previously provided care, including designated primary and associate nurses.
3. The assignment sheets include:
   a. Date and shift
   b. Location
   c. Manager
   d. ANM, or Designee
   e. Licensed personnel
   f. Unlicensed personnel used as support staff
   g. Preceptees/Orientees
   h. Agency/Float personnel
4. Document the Following on the assignment sheet:
   a. Each patient assigned to an RN. The following positions may be utilized to assist the RN assigned to the patient and should be indicated on the assignment sheet:
      i. An RN with a partial assignment
      ii. Assignment/Break Nurse
      iii. Charge Nurse
      iv. ANM
   b. Indicate the name of the TCMC NICU nurse assigned as a resource nurse/preceptor as appropriate.

Department Review	Perinatal Collaborative Practice	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/14	06/14, 02/18, 08/21	n/a	n/a	10/21	10/14, 03/18, n/a	09/10, 08/12, 11/14, 03/18

c. Document break/ meal times and when necessary, in-service/meeting times on the break/meal log form per current labor laws and TCMC policy. All employees working a shift of six hours or more will receive an unpaid meal period of 30 minutes. Meal period breaks are extended over enough hours to minimize the number of nurses out of the unit requiring coverage.
d. Document the name of the RN providing relief.
e. Orientees are not utilized as direct care providers without supervision by TCMC NICU RN staff.
f. Update the assignment sheet as patients are admitted or discharged, when a patient's acuity changes, and as personnel and/or assignments change.
g. The assignment sheets are archived by the TCMC NICU Nurse manager or designee. The archived sheets will be retained for the period of time as prescribed by the regulatory agencies.

5. Staffing for Periods of High Census
a. The NICU will maintain a staffing strategy in order to accommodate staffing needs when census is high.
b. The manager and designee (e.g. assistant nurse manager (ANM)/relief charge nurse) will make all attempts to use NICU core staff in an effort to provide consistency of care. Only nurses who are NRP certified can float to NICU. RNs that are floated to the NICU will only take care of CCS defined continuing care patients that do not require higher levels of care or competencies, (i.e., ventilator support, NCPAP, central lines or impending invasive procedures). Competencies of care will be documented for patient assignment.
c. An RN who floats to NICU shall be assigned a resource nurse who may or may not be the ANM/relief charge nurse. On occasions when treatment modalities that the float RN does not feel competent performing arise unexpectedly, the resource nurse will perform the tasks for the float RN or the ANM/relief charge nurse will reassign the patient to ensure safe care.
d. NICU will typically only take floats when there are appropriate acuity patients that can be assigned to them. Pre-booking through registry can be done during times that normally require a higher number of staff.
e. Travelers are required to have the same competencies as the core staff in NICU. Attending high-risk deliveries is optional, especially for those who are only committed for a short time. Travelers may be given the opportunity to orient to high-risk deliveries, if requested.

C. **REFERENCE(S):**

1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.
1. California Children's Service Manual of Procedures, Section 3.25.2.A2C
2.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Appointment of Representative Form**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To provide a mechanism for appealing a claim denial on behalf of the patient who received services in the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. The OPBHS staff will routinely explain and request the patient's signature on the Appointment of Representation Form (HCFA-1696-U4) on the patient's admission day. This form authorizes the Tri-City Healthcare District (TCHD) to represent the patient in a Medicare Appeal process in the event of denial of services Patients will be admitted regardless of their willingness to execute this form; it is not a condition of admission.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS clinical or administrative staff
   a. The OPBHS will maintain an adequate supply of Appointment of Representative Forms.
   b. On the day of admission to OPBHS, the staff responsible for completion of the admission paperwork will accurately complete the Appointment of Representation Form.
      i. Name (Claimant) (Print or type)
      ii. Social Security Number
      iii. Wage Earner (If Different)
      iv. Signature (Claimant)
      v. Address
      vi. Telephone Number (with Area Code)
      vii. Date
2. At this time the staff member will explain the rationale for this form to the patient, assure that the patient understands the content of the form and request the patient to execute (sign) the form in the appropriate signature space. The patient's consent will be voluntary and not required as a condition of admission. Do not sign as the "authorized official." This will be signed by the Medical Director or person responsible for all appeals.
3. The designated copy of the Appointment of Representative Form will be filed with appeals submitted to the Fiscal Intermediary.

D. **FORM(S):**
1. Appointment of Representation Form (HCFA-1696-U4) - Sample

Appointment of Representation Form (HCFA-1696-U4) - Sample

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I **CLAIMANT'S APPOINTMENT OF REPRESENTATIVE**

I appoint this individual, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice, give or draw out evidence or information, get information, and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

_____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part II **REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT**

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part III **FEE ARRANGEMENT**

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Form SSA-1696-U4 (07-2014) ef (07-2014)
Use Prior Editions Until Exhausted

FILE COPY

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Daily Schedule**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE**

1. To organize and outline the various groups and activities offered in Outpatient Behavioral Health Services (OPBHS) and assist patients in achieving their treatment goals.

B. **POLICY**

1. All groups and activities are arranged to therapeutically meet the needs of the patients.

C. **PROCEDURE**

1. Who may perform/responsible: Operations Manager, Clinical Coordinator or designee and Clinical Staff
2. The group schedule is posted throughout the OPBHS. ~~and is given to each patient.~~
3. The schedule is revised as needed to meet the patient's individual needs.
4. Any change within the daily schedule is announced ~~during the Community Meeting~~**to patients and staff.**
5. Therapists are to speak to each of their patients individually when there is a change in the patient's schedule.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Department Safety**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To provide general guidelines for maintaining a safe environment.

B. **POLICY:**
1. All program staff are responsible for the maintenance of a safe environment for patients, staff and visitors.

C. **PROCEDURE**
1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) Staff.
2. Program grounds are maintained in a manner that is designed to provide safe access to and a safe environment for patients, staff and visitors.
3. Emergency services are readily identifiable and easily accessible. Evacuation plans are posted throughout the facility.
4. Policies pertaining to safety issues are reviewed during orientation and annually with the program staff.
5. Any flammable, poisonous, sharp or potentially dangerous items are stored in a locked cabinet.
6. The nurse's station is closed when it is left unattended.
7. All exterior doors are to remain unlocked during program hours.
8. All corridors are to remain clear of furniture and equipment.
9. All building contents, including furniture, appliances and program materials must be kept in good condition.
10. All safety hazards are reported to the Operations Manager and are documented on an incident report if appropriate.
11. The Operations Manager or designee is responsible for the regular monthly visual safety inspection of the OPBHS.
12. The Operations Manager, Safety Representative, or designee will be responsible for completion of the Environment of Care/Patient Safety Rounds at least quarterly.
13. Safety Check List:
    a. Cords under desk - out of walk paths.
    b. All windows and doors locked at the end of the day.
    c. Corridor doors are not to be propped open.
    d. All lights out at the end of the day.
    e. Nurses' station and chart cabinet locked at the end of the day.
    f. All appropriate appliances/machines turned off at the end of the day.
    g. No water left running;
    h. All furniture and equipment placed out of walkway;

i. First Aid Kit remains fully stocked at all times.
j. Fire extinguishers are checked monthly and serviced annually.
k. Fire and evacuation drills are conducted quarterly.
l. Smoke detectors are checked monthly.
m. Emergency equipment checklist is completed monthly.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Downtime Procedures**

ISSUE DATE: **08/11**
REVISION DATE~~(S)~~: 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To provide guidelines and procedures for responding to Downtime.

B. **POLICY**
1. Outpatient Behavioral Health Services (OPBHS) staff will follow Downtime procedures by taking adequate steps to ensure continued operations.

C. **PROCEDURES:**
1. Who may perform/responsible: Tri-City Healthcare District (TCHD) Administrative and Clinical Staff.
2. Secretary and Service Coordinator Responsibilities:
   a. Notify IT by calling the help desk and notifying the manager.
   b. Request emergency cell phones from IT.
   c. Request IT help in using wireless network and connecting program and MDs.
   d. Check main voicemail and individual voicemails several times daily.
   e. Pull up progress notes for all patients for staff to document using downtime forms.
3. Manager or Designee Responsibilities:
   a. Notify CNE ~~and Safety Officer~~
   b. Change main voicemail to indicate phone problems and to direct callers to an alternate number.
   c. Review of downtime procedure with staff to ensure completion of each task.
4. Clinical Coordinator or designee responsibilities:
   a. Notify vital departments~~, such as PTE and BHU~~.
   b. Notify patients daily ~~in the patient community meetings.~~.
   c. Support staff in follow through with downtime procedure.
   d. Ongoing back up of daily roster and treatment team roster to ensure that we have a back up patient schedule.
5. Nursing Responsibilities:
   a. Send an automated fax or message to vital offices, such as quality care pharmacy to inform them of our alternate fax numbers and alternate phone line.
   b. Pull up ~~MD~~ **downtime forms**~~notes for physicians~~ to document. ~~using downtime forms~~.
6. All Staff:
   a. Change individual messages to indicate downtime and check voicemail several times per day.
   b. Document using downtime forms for any work that needs to be completed for that day.

c. If necessary, staff can go to the main campus to print sign in sheets, patient roster, etc.
d. Ideally, sign in sheets, patient roster, and schedules should be printed the day before.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Emergency Evacuation**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. Provide safe evacuation from the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY**
1. In the case of an emergency, the program staff will evacuate all patients and visitors in a safe and orderly manner.

C. **PROCEDURE**
1. Who may perform/responsible: OPBHS Staff
2. The evacuation plan for the Program is prominently posted throughout the facility.
3. When a patient is admitted to the Program, the patient will be given a tour of the facility. This tour includes the location of all exits. The evacuation plan will be reviewed as part of the orientation process.
4. A quarterly fire/emergency evacuation drill shall be conducted with the patients in accordance with the hospital evacuation plan. All patients, visitors and staff are to be evacuated to a designated place. The Operations Manager, or designee, will conduct a count of all patients, visitors and staff (see Environment of Care: Fire Plan – Code Red Policy).

D. **RELATED DOCUMENT(S):**
1. Environment of Care: Fire Plan – Code Red Policy

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Exchange and Replacement of Medication**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To provide an effective method for the exchange and replacement of expired or dispensed medications.

B. **POLICY:**
1. The Pharmacist and Registered Nurse (RN) are responsible for inspecting the medication storage cabinet monthly to determine completeness of stock and expired medications.

C. **PROCEDURE:**
1. Who may perform/responsible: Pharmacist and RN.
2. The pharmacist and RN inspects the contents of the medication storage cabinet monthly, for completeness of stock and expired medications.
3. The Pharmacist is responsible for returning expired medications to the pharmacy for proper disposal. The medication is then replaced and locked in the medication storage cabinet.
4. The results of the pharmacist inspection are documented by hospital Pharmacist.
5. There's a psychiatric emergency box that contains medications, for emergencies only. This box is stored in the nurses' office with two secure locks. Any medications given by the RN from the emergency box must be done with a physician's order.
6. When an emergency stock medication is used, the RN enters into the Stock Medication Log, the name of the patient taking the medication, the date of administration and the dosage. Nursing will document effectiveness in a nursing note in the medical record. When the medication is depleted or out of date it is replaced by the hospital pharmacy.

D. **FORM(S):**
1. Stock Medication Log

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Financial Assessment**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To accurately document the patient's financial records and screen for secondary insurance prior to patient's admission to the program.

B. **POLICY**
1. It is the responsibility of the hospital to pursue collection from all primary and secondary payors for services rendered by the Outpatient Behavioral Health Services (OPBHS). Consequently, all OPBHS staff members are expected to adhere to Tri-City Healthcare District's (TCHD) Collection Policies and Procedures.
2. TCHD must pursue collection of all deductibles and coinsurance obligations, and has in place policies and procedures that independently assess patients' ability to pay. In these instances, the Community Liaison Coordinator's (CLC) responsibility is to assist in gathering all financial information needed by TCHD to make such a determination.

C. **PROCEDURE:**
1. Who may perform/responsible: CLC, or designated Clinical Staff
2. CLC Responsibilities:
   a. Gathers all pertinent patient information and supporting documentation at the time of admission, or shortly thereafter, to assist TCHD in ensuring appropriate reimbursement from third party payors.
   b. Awareness of TCHD policies pertaining to Charity Care, such as Administrative: Charity Care, Uncompensated Care, Community Service Policy # 285.
   c. Obtains initial insurance authorization on all admissions to OPBHS.
   d. Informs patients of any co-pays, deductibles, etc.
   e. Informs patients of Charity Care Process if applicable.
   f. Assists the patients in completing the Patient Financial Assessment Form and forwards the forms to Patient Financial Services.
3. CLC and Therapist Documentation:
   a. Documents all verbal and telephone discussions with outside sources regarding each patient's financial status.
   b. Documents all insurance authorization
   c. When there is a co-pay present, the CLC will discuss the implications of this with the potential patient.
4. Ongoing Treatment Authorization:
   a. The program therapist or designee is responsible for keeping track of ongoing treatment authorizations for patients on their caseload.

b. The therapist will obtain concurrent authorizations by contacting the insurance reviewer prior to completion of authorized visits.
c. The therapist is then responsible for updating the Insurance Authorization log and with providing the program Service Coordinator with a copy of the updated log.
d. The Service Coordinator will input any authorization into the ~~Affinity~~ **the EMR** System.
e. The Service Coordinator will ~~also~~ **coordinates with patient accounting monthly** ~~obtain~~ insurance verification on patients **and** as requested by the CLC or manager.

5. Ability to pay should be independently determined by TCHD in the most pragmatic manner possible. In absolutely no instance can the CLC waive any patient's financial obligations or guarantee that the patient will not receive bills. When asked by the patient whether he/she shall be billed for deductibles and/or coinsurance, the most prudent answer is that which states that it is upon the discretion of TCHD to determine the ability to pay based upon the completed financial screen and supporting documentation. The patient must be referred back to their insurance company for verification of coverage, co-payments, etc. Furthermore, the patient must be advised that bills will be sent out by TCHD if either the patient is deemed able to pay or the patient's financial declarations cannot be verified.

D. **FORM(S):**
1. Insurance Authorization Log
2. Patient Financial Assessment Form

E. **RELATED DOCUMENT(S):**
1. Administrative: Charity Care, Uncompensated Care, Community Service Policy # 285

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Fire Safety**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To identify specific guidelines for fire safety in Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. Patient and staff safety is the most important consideration. Everyone must be removed quickly and safely from the facility. The fire drill plan will be implemented at least quarterly. Documentation of the fire drills will be completed on the "Fire Drill Record". Any problems identified corrective action taken, and staff participation will also be documented.

C. **PROCEDURE**
1. Who may perform/responsible: OPBHS Staff
2. In Case of Fire:
   a. Utilize "R.A.C.E."
      i. The Procedure for Code Red is "R.A.C.E."
         1) "R" Rescue people in immediate danger.
         2) "A" Activate the fire notification process and report the fire and the exact location.
         3) "C" Contain the fire by closing all doors.
         4) "E" Extinguish the fire with the fire extinguisher, using the P.A.S.S. method (Pull pin, Aim hose, Squeeze handle, Sweep from side to side at base of fire). Evacuate if necessary.
   b. The Operations Manager or designee will designate an area to which everyone in the facility will evacuate.
   c. The Operations Manager or designee will assign staff the following tasks:
      i. Announce Code Red
      ii. Evacuate patients
      iii. Call 911
      iv. Call 66 to notify main hospital
      v. Attempt to extinguish
      vi. Close Doors to contain fire
      vii. Notify hospital safety officer
      viii. Secure medical records
      ix. Sweep the building
      x. Take head count once everyone is evacuated
   d. The designated staff will conduct a count of patients, visitors and staff by means of verifying patient sign-in sheets, visitor sign-in sheets.
   e. Remain at the designated evacuation area until an "All Clear" is announced, which indicates that it is safe to return to the building.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Food Service Procedures

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. The program is to provide only fresh and heart healthy food for patients.

B. **POLICY**
1. Food service for the Program will be provided by Tri-City Healthcare District's (TCHD) Food and Nutrition Department or an outside vendor approved by the TCHD Food and Nutrition Director.
2. When food is provided by an outside food service, all applicable requirements set forth in section 70273 Dietetic Service General requirement shall be adhered to.
3. The Operations Manager or designee will oversee the serving procedures to insure all necessary precautions are taken to avoid food contamination, i.e., proper hand washing techniques both before and after food handling, and the wearing of food service gloves. Designated staff members, and volunteer patients will be responsible for the clean-up following lunch.

C. **PROCEDURE:**
1. Who may perform/responsible: TCHD Staff or Volunteers.
2. Serving containers and serving utensils will be sanitized daily after use. In general, disposable knives, forks, spoons, plates, bowls and cups will be used for meal service.
3. Counters, shelves and equipment shall be kept clean and maintained in good repair.
4. All food, paper and equipment supplies will be stored separately from cleaning and sanitation chemicals and/or equipment.
5. To assure maintenance of proper storage temperatures, thermometers are kept in patient refrigerator used for food. Refrigerator temperatures will be checked daily and recorded. Temperatures outside of the established range will be re-checked in one hour. If temperatures remain higher than 40 degrees F, a work order will be placed with Engineering to fix the issue prior to use of the refrigerator.
6. Refuse Disposal:
    a. Paper, cans, non-food trash and garbage which is to be disposed of will be placed in leak-proof trash cans lined with heavy leak-proof plastic trash liners
        i. Garbage ready for removal will be securely tied and disposed of in the outdoor trash receptacles daily.
        ii. Trash containers will be routinely cleaned.
    b. To avoid injuries, broken glass, sharp objects and other hazards needing disposal will be placed in a separate, marked disposal container.

D. **REFERENCE(S):**
1. Dietetic Service General Requirements, Cal. Title 22 §70273

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Inclement Weather and Critical Incident Policy

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To establish minimum standards and expectations regarding Outpatient Behavioral Health Services (OPBHS) operations during periods of inclement weather. In addition, this policy sets forth the processes and approvals necessary prior to closing OPBHS due to severe weather conditions.

B. **POLICY:**

1. Throughout the year there are numerous situations where a decision must be made to close the OPBHS site due to inclement weather.
   a. Examples of inclement weather include, but are not limited to, fire, floods, or earthquake.
2. This policy is designed to provide overall guidance to the Operations Manager in making the decision whether to transport patients to the OPBHS site and/or close the OPBHS. It is the responsibility of the Operations Manager to make a reasonable decision by balancing the safety needs of the patients with a rational and objective decision to not close the OPBHS prematurely.
3. The following are some guidelines and minimum expectations related to a specific inclement weather policy for the OPBHS.

C. **PROCEDURE**

1. Who may perform/responsible: Director of Behavioral Health or designee
2. OPBHS site closure must be consistent with other community responses; e.g., when immediate area schools, governmental agencies and Tri-City Healthcare District (TCHD) are closed.
3. OPBHS site closure is prudent in the event of road closures or other serious road conditions in the immediate vicinity. Road closure is defined as those publicly announced by the proper civil authorities.
4. Staff will make every reasonable effort to arrive timely at the OPBHS. In those cases where the OPBHS will be closed for patients, staff can make phone contact to ensure that engagement with patients continues. Charting will be completed in accordance with OPBHS policy related to these phone contacts.
5. Weather conditions will be assessed throughout the day and if conditions improve sufficiently for the OPBHS to reopen, then the OPBHS will be reopened even if only a portion of the patients can be safely transported and only part of the OPBHS schedule can be completed.
6. Local cab services will be established by contract, as needed, for back up in the event that our usual means of transportation is not an option. Other public transportation back up systems will also be established, as needed.
7. The Director of Behavioral Health or CNE, and Safety Office will be contacted and consulted with, and must approve the final decision to close or reopen the OPBHS.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Orientation of New Patients**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To identify the process of patient orientation.

B. **POLICY:**
1. Each patient receives an orientation to the Outpatient Behavioral Health Services (OPBHS) by the patient's Therapist or designee. The orientation will be presented in a manner that maximizes patient understanding and the information will be reviewed as needed.

C. **PROCEDURE**
1. Who may perform/responsible: OPBHS Staff
2. The patient will sign a copy of the OPBHS rules. If applicable, Dual Recovery patients sign the dual recovery program guidelines.
3. The orientation checklist is reviewed with the patient by the therapist or designee. The checklist guides the staff in orienting patients to the program. It includes information regarding rules and regulations, tour of facility, introduction to staff members, transportation procedures, sign in procedures, program schedule, evacuation procedure, procedure for calling in sick, procedure for obtaining staff assistance, lunch procedure, complaints or grievance procedure, and disclosure regarding qualifications of staff and therapists.
4. Patients will be informed of their rights and responsibilities and sign the multiple consent form, which addresses limits to confidentiality.
5. The patient will be introduced to other staff and clients during a tour of the OPBHS.
6. Another patient (buddy) may be assigned to the new patient to assist with the orientation and acclimating to program.
7. When appropriate, the family will also receive an orientation to the OPBHS (typically facilitated by the Community Liaison Coordinator (CLC) prior to admission).
8. Orientation will include the items on the Orientation Checklist and patient orientation will be noted in the medical record.

D. **RELATED DOCUMENT(S):**
1. Orientation Checklist
2. Outpatient Behavioral Health Services Rules

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Pastoral Care**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/033, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To define availability of pastoral care, religious, and spiritual consultation to patients.

B. **POLICY:**
1. Recognizing that spiritual values and issues may affect patient response to treatment, patients will have access to a list of local clergy who have agreed to provide consultation on an as needed basis.

C. **PROCEDURE:**
1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) clinical and administrative staff.
2. All patients' spiritual needs are assessed in the Biopsychosocial assessment.
3. When a patient requests pastoral assistance or consultation, the OPBHS staff will provide that patient with a multi-denominational list of local clergy or the name of Tri-City Healthcare District's (TCHD) chaplain who may be available for them.
4. If assistance in contacting community clergy is necessary the OPBHS staff will provide the patient with a telephone or assist in making the necessary arrangements.
5. If clergy is requested to come to the OPBHS, private office space will be provided for consultation.
6. Staff will maintain a supportive but unbiased relationship with patients regarding religious issues and patient's personal secular needs may be referred to community supports.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Practicum Student Placement**

ISSUE DATE: **03/05**
REVISION DATE(S): 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To define guidelines for Practicum student placements (working toward a Master's Degree in Counseling or Social Work) in the Outpatient Behavioral Services (OPBHS).

B. **POLICY:**

1. OPBHS will accept student placements from local colleges and universities who are working toward a Master's Degree in Counseling or Social Work. The Program will provide direct supervision by a qualified, licensed clinician.

C. **PROCEDURE:**

1. Who may perform/responsible: Licensed Clinical staff
2. A contract between the school and Tri-City Healthcare District (TCHD) must be signed prior to the student placement.
3. Practicum students must be cleared by the Medical Center's Education Department to begin their practicum and must complete all hospital requirements to begin their internship.
4. Practicum students are directly supervised by a licensed clinician and obtain weekly individual supervision.
5. Practicum students will be assigned one to three patients to follow as their Primary Therapist and will provide group and individual therapy under the direct supervision of the Clinical Supervisor.
6. Practicum students will obtain group supervision by attending Treatment Team meetings facilitated by the Medical Director along with licensed clinicians.
7. Practicum students will present patient cases assigned to them and review the patient's treatment plan monthly in Treatment Team meetings under the supervision of the Medical Director and Clinical Supervisor.
8. Practicum students have access to a Clinical Supervisor in person or by telephone during the time they are providing services.
9. Practicum students communicate concerns regarding patients to their clinical supervisor.
10. Practicum students are aware of reporting requirements for child abuse, elder abuse, and domestic violence and keep their Clinical Supervisor informed of any possibility of abuse.
11. Practicum students are aware of steps that need to be taken when dealing with suicidal, homicidal, and gravely disabled patients and keep their clinical supervisor informed of their findings.
12. Practicum students are not able to bill for services unless services are performed along with a licensed clinician but they must document any services provided.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Staff Meetings**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/055, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To establish guidelines for the Outpatient Behavioral Health Services (OPBHS) staff meetings.

B. **POLICY:**
1. The OPBHS will have staff meetings and clinical problem solving meetings on a **bi**-monthly basis.

C. **PROCEDURE:**
1. Who may perform/responsible: Operations Manager or designee
2. General Staff Meetings are conducted by the Operations Manager and are held monthly. All scheduled staff ~~are~~**is** expected to attend.
   a. The purpose of general staff meetings are:
      i. To give staff the opportunity to discuss OPBHS administrative issues and day to day operations;
      ii. To encourage staff to participate in decision making;
      iii. To keep communication lines open between the staff and administration;
      iv. To discuss ongoing quality, performance improvement, and safety issues.
   b. Staff is encouraged to submit agenda items prior to the meeting.
   c. Minutes are taken and circulated to staff that are unable to attend. Past minutes are kept on file, in a binder, in the Operations Manager's office.
3. Clinical Problem Solving Meetings are held weekly concurrent with Treatment Planning meetings for all clinical OPBHS staff. The meetings are facilitated by the Operations Manager or the Clinical Coordinator and Medical Director.
   a. The purpose of the Clinical Problem Solving Meeting is to:
      i. Provide the staff the opportunity to discuss challenging cases, individual patient issues and clinical concerns with the Medical Director;
      ii. To discuss and resolve milieu issues; and
      iii. To revise and plan changes in the patient's treatment schedule.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Staffing Levels**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	~~**07/17**~~ **n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. To insure adequate staffing ratios for a low risk and therapeutic program.

B. **POLICY:**
1. Staffing levels are determined each day based on the number of patients scheduled.

C. **PROCEDURE:**
1. Who may perform/responsible: Director of Behavioral Health, Operations Manager or designee and Clinical Staff.
2. The staffing guidelines are used to determine staffing levels. Staffing levels are based on an average daily census.
3. Considerations for modifying staffing levels are:
   a. Orientation of new staff;
   b. Unusual programming needs, i.e., holiday programs, projected increase or decrease in census and an unusually high number of admissions or discharges; and
   c. The acuity of the patient population.

D. **STAFFING LEVELS:**
1. For Intensive Outpatient Program (IOP), each therapist working a forty (40) hour week will be responsible for providing an average weekly total of ~~eighteen to twenty~~ **sixteen** patient cases, ten groups per week, and admissions. Part-time staff carrying a caseload will be pro-rated accordingly.
2. When appropriate qualified professional staff members are not available or are not needed on a full time basis, arrangements are made to obtain these services on a per diem or part time basis.

Tri-City Medical Center
Oceanside, California

~~Unit Specific Policy Manual~~ PULMONARY REHABILITATION SERVICES

SUBJECT: Six Minute Walking Test Monitoring Policy **~~POLICY NUMBER: (Optional)~~**

ISSUE DATE: 08/08
REVISION DATE~~(S)~~: 11/11, 12/12, ~~8~~10/13

Department Approval ~~Date(s)~~:	**05/18**
Division of Pulmonary Approval ~~Date(s)~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**09/21**
Administration Approval:	**10/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**10/13**

A. **DEFINITIONS:**
1. To establish guidelines to perform a 6-minute walking test for pulmonary rehabilitation program patients.
2. Establish a standard of care for performing and assessing distance and oximetry levels of pulmonary rehabilitation patients.

B. **PROCEUDRE:**
1. Explain test to patient; they are going to walk as far as possible for 6 minutes. Instruct they are permitted to slow down, to stop and to rest as necessary.
2. Take patients resting blood pressure, SpO2 level, note FiO2 and heart rate. Enter on 6-minute walking test form.
3. If patient requires a walker, or wheel chair to push, provide one. If they brought their own, allow them to use theirs.
4. Position the patient at the starting mark.
5. When they begin walking, start timer.
6. Walk behind patient so you don't pace their walk, holding the SpO2 monitor. If the patient appears unstable, walk next to them.
7. Walk to either the 200 ft. mark or the 400 ft. mark, depending on patients walking ability.
8. On the form note the following:
   a. Distance the patient walked.
   b. SpO2 levels, note FiO2.
   c. Heart rate.
   d. Number of stops.
   e. With each stop how long did they rest.
9. If the patient SpO2 level drops below 88%, place them on oxygen or increase their oxygen liter flow.
10. At the completion of the six minutes. Have the patient stop, note final SpO2 level and heart rate.
11. Have patient rate shortness of breath and fatigue, using the borg scale.
12. Note if patient is using accessory muscles, diaphragm breathing, pursed lip breathing.
13. Have patient sit down.
14. Re-take blood pressure.

C. **REFERENCE LIST**
1. AACVPR Guidelines for Pulmonary Rehabilitation Programs 4th Edition

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILIATION SERVICES

SUBJECT: **Supplemental Oxygen ~~&~~ and Oximetry Monitoring**

ISSUE DATE: 08/08
REVISION DATE~~(S)~~: 11/11, 12/12, ~~8~~10/13

Department Approval ~~Date(s)~~:	**~~05/18~~02/20**
Division of Pulmonary Approval ~~Date(s)~~:	**n/a**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**09/21**
Administration Approval:	**10/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**10/13**

A. **PURPOSE:**
1. To establish guidelines for the use of supplemental oxygen during the pulmonary rehabilitation program.
2. To establish guidelines for the use of supplemental oxygen during the pulmonary rehabilitation maintenance program.

B. **POLICY:**
1. The need for and quantity of supplemental oxygen during exercise is either pre-determined by the physician, during the evaluation process, or during the program.
2. A program oxygen source will be provided for those who use oxygen during the exercise class.
3. All participants involved in the early outpatient pulmonary rehabilitation program will have oxygen saturation monitored pre exercise. It will also be monitored during exercise to ensure adequate oxygenation and to prevent complications.
4. Participants in the maintenance program will have oxygen saturation monitored pre exercise and during one exercise station per session.
5. Oxygen saturation shall remain $\geq$ 90% pre and during exercise.
6. The participant will remain at the facility for supervision until the SaO2 returns to normal limits.

C. **PROCEDURE:**
1. The pulmonary rehabilitation employee will be responsible for making sure saturation is obtained and recorded prior to warm-up.
   a. Oxygen saturation must be > 90% prior to warm-up unless otherwise noted by the referring physician or medical director.
   b. If the oxygen saturation is below normal limits prior to exercise, the etiology must be identified, i.e., oxygen flow rate too low, respiratory complications, and corrected.
2. The pulmonary rehab team is responsible for titrating the flow rate of his/her oxygen up during the exercise session per guidelines set during the exercise test.
3. Oxygen flow may be further titrated by the pulmonary rehabilitation team.
4. During exercise, oxygen saturation will be monitored during one activity station. Frequency of monitoring may be increased if a participant is demonstrating difficulty maintaining saturations $\geq$ 90%.
5. For saturations between 85% - 90%:
   a. Visually confirm that the oxygen source is set on the appropriate flow rate for activity.
   b. Reinforce and remind the participant of the importance of proper breathing techniques, i.e., pursed lip breathing and diaphragmatic breathing.

c. Decrease exercise intensity by decreasing resistance, speed and/or grade on treadmill.
d. Have the participant note his/her obvious and subtle signs of a low saturation. This assists the participant to be better able to recognize decreasing oxygen saturation at home.

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

1. Guidelines for Pulmonary Rehabilitation Programs 4th Edition
2. Pulmonary Health, Rehabilitation and Exercise Testing Policy and Procedure Guideline Manual 2nd Edition

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

September 30, 2021 – 3:00 o'clock p.m.
Meeting Held via Teleconference

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:00 p.m. on September 30, 2021.

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

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Adela Sanchez
Director Tracy M. Younger

Absent were Directors Nina Chaya, M.D. and Gigi Gleason

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Jennifer Paroly, Foundation President
Anna Aguilar, Vice President, Human Resources
Jeremy Raimo, SVP, Business Development
Susan Bond, General Counsel
Dr. Jamie Johnson, Chief of Staff
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky J. Chavez, called the meeting to order at 3:00 p.m. with attendance as listed above.

   Chairperson Chavez stated Directors Chaya and Gleason are not in attendance today. At Director Chaya's request, Chairperson Chavez provided information on Dr. Chaya's personal experience with COVID-19 and she implored everyone to take the pandemic seriously and encouraged everyone to get their boosters when available.

2. Approval of Agenda

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

3. Pledge of Allegiance

Director Chavez led the Pledge of Allegiance.

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

Chairperson Chavez made an oral announcement of the item listed on the September 30, 2021 Regular Board of Directors Meeting agenda to be discussed during Closed Session which included one Report Involving Trade Secrets.

5. Motion to go into Closed Session

It was moved by Director Younger and seconded by Director Coulter to go into Closed Session at 3:06 p.m. The motion passed (5-0-0-2) with Directors Chaya and Gleason absent.

6. Report from Chairperson on any action taken in Closed Session.

Chairperson Chavez reported the Board in Closed Session heard a Report on Trade Secrets and took no action.

Chairperson Chavez shared some thoughts on recent developments in our community related to Vista Community Clinic's decision to no longer participate in Tri-City's 24/7 community physician call coverage and delivery service after October 16th. He stated that "while decisions made by other agencies may impact the number of babies born in the short term, it doesn't change the fact that we are committed to our community and providing quality care."

7. Public Comments – Announcement

Chairperson Chavez read the Public Comments section listed on the September 30, 2021 Regular Board of Directors Meeting Agenda.

Dr. Donald Miller requested to speak under Public Comments.

9. Open Session

10. Special Announcement – Director Leigh Anne Grass Board Service Continuance

Chairperson Chavez reported Director Grass has rescinded her resignation and will continue to serve on the Board.

11. New Business

a) Fiscal 2021 Financial Statement Audit – Moss Adams

Ms. Stacy Stelzriede, Engagement Partner with Moss Adams and Kyle Rogers, Manager on the Audit presented the results of the year-ended June 30, 2021 Fiscal Year Financial Statement Audit. Ms. Stelzriede reported the Auditors will issue an unmodified opinion which reflects the Financial Statements are presented fairly and in accordance with US Generally Accepted Accounting Principles. Mr. Stelzriede also reported there were no material weaknesses or proposed adjustments.

The presentation included information on the following:

- Auditor Opinions & Reports
  - Scope of Services
  - Auditor Report on the Financial Statements
- Communications with Those Charge with Governance
  - Our Responsibility
  - Planned Scope & Timing of the Audit
  - Significant Accounting Policies & Unusual Transaction
  - Management Judgments & Accounting Estimates
  - Significant Audit Areas
  - Areas of Audit Emphasis: Revenue Recognition and Valuation of Patient Receivables
- Snapshot of Financial Information

Ms. Stelzriede noted there is also a Single Audit required by our HUD loan.

Ms. Stelzriede reviewed the Significant Audit Areas as follows:

- Patient Revenue and Receivables
- Cost Report Settlements and Supplemental Funding
- Self-Insured Liabilities
- Line of Credit and Long Term Debt
- MOB Legal Proceedings
- CARES Act Grant Funding (Revenue Recognition and Single Audit)
- Compliance with Federal Laws and Regulations

Lastly, Ms. Stelzriede reviewed the Financial Ratios & Metrics as follows:

- Cash on Hand Days - 95
- Current Ratio – 1.58 – the goal is to better than 1.
- Debt to Capitalization – 52%
- Days in Accounts Receivable – 59 – elevated due to the Cerner conversion however within normal hospital range and expected to continue to go down
- Excess/Deficiency of Revenue over Expenses (EROE) plus Depreciation and Interest as a % of Operating Income – 6.0% which includes provider relief grant funds of $4.6 million in 2021

Ms. Stelzriede stated there were no adjustments that were proposed or uncorrected adjustments identified which is extremely important. In addition, there were no material weaknesses or significant deficiencies, no difficulties encountered in performing the audit and no matters came to the attention of the auditors related to fraud.

Ms. Stelzriede congratulated management on a clean audit with an unmodified opinion.

There were no questions from Board members.

It was moved by Director Younger that the Tri-City Healthcare District Board of Directors accept the Fiscal 2021 Financial Statement Audit as presented. Director Sanchez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Chaya, Gleason**

b) August, 2021 Financial Statements – Ray Rivas, Chief Financial Officer

Mr. Rivas reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $55,291
- Operating Expense - $58,681
- EBITDA - $266
- EROE ($1,911)

Mr. Rivas reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 145
- Adjusted Patient Days – 17,831
- Surgery Cases – 1,121
- ED Visits – 8,691

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

- Net Operating Revenue – $27,549
- Operating Expense - $29,277
- EBITDA - $76
- EROE ($1,011)

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

- Average Daily Census – 151
- Adjusted Patient Days – 9,231
- Surgery Cases – 539
- ED Visits – 4,408

- Net Patient Accounts Receivable - $51.3
- Days in A/R – 63.6

c) Consideration to approve Resolution No. 803, a Resolution of the Board of Directors of the Tri-City Healthcare District Authorizing Remote Teleconference Meetings During Periods of Declared Emergencies in Accordance with the Ralph M. Brown Act.

Board Counsel Jeff Scott reported beginning in March 2020, amid rising concerns surrounding the COVID-19 pandemic, Governor Newsom issued a series of Executive Orders modifying certain Brown Act requirements to allow more flexibility for conducting remote meetings while still complying with the intent and purposes of the Brown Act. The Resolution presented today for the Board's consideration

will allow meetings to continue to be held remotely during a Governor proclaimed state of emergency.

It was moved by Director Younger that the Tri-City Healthcare District Board of Directors approve Resolution No. 803, a Resolution of the Board of Directors of the Tri-City Healthcare District Authorizing Remote Teleconference Meetings During Periods of Declared Emergencies in Accordance with the Ralph M. Brown Act. Director Sanchez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Chaya, Gleason**

d) Tri-City Hospital Foundation Update – Foundation President

Jennifer Paroly, Foundation President provided an exciting report on the overwhelming financial support we have received from the Conrad Prebys Foundation and the Copley Foundation and how their contributions are supporting the Emergency Department remodel which has been a priority of Tri-City for many years. Ms. Paroly stated naming opportunities were discussed with the Conrad Prebys Foundation and they are honored to be part of the Tri-City story and anticipate working alongside the Foundation in the future.

Ms. Paroly reported the Foundation Gala will be held on October 23rd and all proceeds will benefit the Emergency Department remodel as well.

It was moved by Director Younger that the Tri-City Healthcare District Board of Directors award the naming rights to the Emergency Department Main Waiting Room to the Conrad Prebys Foundation. Director Grass seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Chaya, Gleason**

12. Old Business – None

13. Chief of Staff

a) Consideration of the September 2021 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on September 27, 2021.

Dr. Jamie Johnson, Chief of Staff presented for the Board's consideration nine Initial Appointments, 11 Reappointments, one request for Extension of Proctoring Requirement, one Automatic Relinquishment of Privileges, one Change of Status and nine Proctoring Recommendations.

It was moved by Director Younger to approve the September, 2021 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on September 27, 2021. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Chaya, Gleason**

14. Consideration of Consent Calendar

It was moved by Director Younger to approve the Consent Calendar as presented. Director Sanchez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Chaya, Gleason**

15. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

16. Comments by Members of the Public

Chairperson Chavez recognized Dr. Donald Miller.

Dr. Miller commented on Vista Community Clinic's decision to no longer participate in Tri-City's 24/7 community physician call coverage and delivery service after October 16th. He stated as a child advocate and member of the Medical Staff for 25 years he was disappointed with the negative press related to this issue and stated it is not reflective of his own experience. Dr. Miller also stated there is great support for our Labor & Delivery Department and our Neonatal Unit. Dr. Miller stated he is encouraged by comments made by Chairman Chavez today at today's meeting and the cohesiveness of the Board he is witnessing today.

17. Comments by Chief Executive Officer

Mr. Dietlin, CEO thanked Dr. Miller for his comments and commitment to our community.

Mr. Dietlin provided a brief report on COVID-19 and the Delta variant. He stated we are seeing the numbers come down however the pandemic is still present. Currently Tri-City has 16 COVID positive inpatients. Mr. Dietlin stated we continue to vaccinate and those who are approved for a booster can register on "My Turn". He commented on the exemplary Tri-City team's response to the pandemic.

Mr. Dietlin commented on the audit from a financial statement perspective. He stated the "clean" audit is a testament to the financial team and it gives the Board confidence in the monthly financials that are presented. Mr. Dietlin complimented the entire finance team on the audit.

Mr. Dietlin commented on Ms. Paroly's Foundation report. He stated the Foundation has reached levels never seen here at Tri-City and he looks forward to the future collaboration between the Foundation, the Board and the District.

Mr. Dietlin stated during the pandemic staff had to be extremely flexible. Employees flexed their time and executives flexed their time while still working to help the financials in the most challenging time in a century. He expressed his appreciation to everyone for participating in that effort to keep Tri-City sustainable. Mr. Dietlin commented on the workforce challenges which are more severe county and statewide than at the height of the pandemic.

Mr. Dietlin reported today, September 30th is the vaccine mandate deadline. Prior to today's meeting Tri-City was 98% compliant which includes those that have been vaccinated or have a medical or religious exemption. The goal is to reach 100% by midnight tonight!

Lastly Mr. Dietlin commented on the successful IT conversion that was implemented during the pandemic.

18. Board Communications

Director Sanchez expressed her appreciation to everyone who cared for her father while in the ICU. She stated the great care gave her another reason to love her Tri-City family.

Director Sanchez encouraged Labor & Delivery staff to stay positive and reiterated that the Board is committed to serving our community needs.

Lastly, Director Sanchez thanked the executive team for supporting the managers and employees and the dedicated team on the Foundation,

Director Coulter stated all the comments made today touched his heart. He thanked Mr. Dietlin for his diligence and Ms. Paroly for her efforts in the Foundation. Director Coulter also commented on the Board's cohesive relationship.

Director Younger thanked Dr. Miller for his thoughtful comments and his 25 years of service to Tri-City. She also recognized Jennifer Paroly for her efforts in the Foundation.

Lastly, Director Younger urged everyone to get both the COVID-19 and flu vaccines to protect not only themselves but their family and community as well.

Director Grass thanked Dr. Miller for his comments and Director Sanchez for her diligence. She also commented on Jennifer Paroly's Foundation report today and the wonderful job the Foundation is doing.

19. Report from Chairperson

Chairperson Chavez thanked staff members for communicating their concerns.

Chairperson Chavez also thanked Director Sanchez for her dedication.

20. Move to adjourn

It was moved by Director Younger and seconded by Director Coulter to adjourn the meeting. The motion passed (5-0-0-2) with Directors Chaya and Gleason absent.

21. There being no further business Chairperson Chavez adjourned the meeting at 4:05 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Tracy M. Younger, Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY22	63.3	63.8	64.7										63.9	48-52
FY21	51.1	50.9	52.7	50.7	50.9	50.7	55.4	54.6	50.9	53.0	62.4	60.9	51.6	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY22	102.6	96.5	99.7										99.6	75-100
FY21	107.1	103.1	101.1	99.6	99.6	92.7	93.9	94.6	94.0	100.5	103.5	98.1	103.8	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	($900)	($1,011)	($733)										($2,644)	($3,805)
FY21	($1,489)	($923)	($930)	$508	($175)	($881)	$1,109	($245)	$210	($554)	$4,682	$4,774	($3,343)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	-3.24%	-3.67%	-2.55%										-3.15%	-4.68%
FY21	-6.12%	-3.74%	-3.60%	1.78%	-0.64%	-3.12%	4.13%	-0.92%	0.73%	-1.89%	14.69%	15.52%	-4.47%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	$190	$76	$340										$607	$ (313)
FY21	($191)	$291	$302	$1,738	$879	$332	$2,344	$935	$1,383	$422	$5,782	$5,855	$402	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	0.69%	0.28%	1.19%										0.72%	-0.38%
FY21	-0.78%	1.18%	1.17%	6.09%	3.22%	1.18%	8.73%	3.50%	4.79%	1.44%	18.14%	19.03%	0.53%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	5.73	5.35	4.97										5.34	5.64
FY21	5.38	5.66	5.40	5.87	5.25	5.75	5.10	5.61	6.18	6.33	5.64	5.83	5.48	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY22	$81.4	$76.9	$71.5										
FY21	$59.5	$57.4	$83.5	$76.9	$71.3	$68.5	$71.4	$75.4	$83.2	$67.3	$59.6	$86.8	

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Building Operating Leases
Month Ending September 30, 2021

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	48,472.27	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	Approx 10,218	$2.58	(a)	34,350.62	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)	20,197.50	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
CreekView Orhopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	20,304.29	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.15	(a)	7,169.67	04/01/20	03/31/22	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	12,314.58	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	39,237.00	10/01/12	10/01/22	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	14,026.32	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#83685	Approx 1,444	$2.59	(a)	3,754.00	02/01/20	09/30/21	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**199,826.25**				

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

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Education & Travel Expense
Month Ending September 2021

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6186	ONS CHEMO RENE	90921	103.00	77804	ENGELHART, DEBBIE
7400	PERINATAL ORIENTATION EDUCATION	2083	2,475.00	77316	1 EDUCATOR SEAT, 20 PARTICIPANT SEATS
7400	FETAL HEART	92121 EDU	251.10	81264	KENNEDY,CARMENCITA
7400	RNC RE CERT	91021 EDU	100.00	81329	ERICKSON, WENDEE
8740	AWHONN	92421 EDU	200.00	82430	BETZ, DENA
8740	ACLS	91721 ACLS	200.00	14289	BYRD, JILL R.
8740	ACLS	91721 EDU	200.00	79284	FRENCH, JENESSA
8740	CCRN	90221 EDU	199.00	80655	SETTLE, CHRISTA
8740	OB RNC NCC CES	90221 EDU	115.00	82528	BRENDA BENEDETTI
8740	ONS ONCC	91721 EDU	103.00	82702	ORENCIA, RIZALINA
8750	NAHQ	91421 CONFRENCE	349.00	82501	MANTA MED-JOHNSON

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.