TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
August 29, 2024 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	2 min.	Chair
3	Roll Call / Pledge of Allegiance		
4	Approval of Agenda	2 min	Standard
5	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
6	July 2024 Financial Statement Results	10 min.	CEO
7	New Business – a) Consideration to approve the amended Conflict of Interest Code	5 min.	Board Counsel
8	Old Business – None		

Note: This certifies that a copy of this agenda was posted in the entrance to the Tri-City Medical Center at 4002 Vista Way, Oceanside, CA 92056 at least 72 hours in advance of the meeting. Any writings or documents provided to the Board members of Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Department located at the Tri-City Medical Center 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	Chief of Staff – Information Only a) August 2024 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on August 21, 2024 and approved by Board Chairperson Younger on behalf of the Board on August 22, 2024 due to time constraints.	5 min.	COS
10	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee Director Younger, Committee Chair** 1) Approval of the First Amendment Lease Renewal with Cardiff Investments, for an additional two (2) year term beginning September 1, 2024 and ending August 31, 2026. This proposal remains within fair market value rental rate of $3.11 per square foot, plus monthly CAM fees of $0.57 for a monthly expense of $37,586.91 year 1, and $38,540.25 year 2, for a total expense for the two (2) year term of $903,525.92. 2) Approval of the agreement with ARUP Laboratories, Inc. for reference laboratory testing for a term of 36 months, beginning, November 1, 2024 and ending October 31, 2027, for an annual cost of $300,000 and a total cost for the term of $900,000. 3) Approval of Recruitment Agreement with Dr. Pava Reddy for a term of 24 months, beginning October 1, 2024 and ending September 30, 2026, not to exceed a total amount for relocation assistance of $10,000 and a sign-on bonus of $50,000. 4) Approval of the renewal of a consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2024, and ending August 31, 2025 for an annual and total term cost not to exceed $118,800. 5) Approval of the renewal of an agreement with Mohammad Jamshidi-Nezhad, D.O. as the CVHI Vascular Surgery Medical Director for a term of 12 months, beginning September 1, 2024 and ending August 31, 2025, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 and a total term cost of $30,240. 6) Approval of the renewal of an agreement with Yuan Hwang Lin, M.D. as the CVHI Medical Director for Cardiothoracic Surgery, for a term of 12 months, beginning September 1, 2024 and ending August 31, 2025, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 and a total term cost of $30,240. 7) Approval of the renewal of an agreement with Donald Ponec, M.D. as the CVHI Medical Director for a term of 12 months, beginning September 1, 2024 and ending August 31, 2025, not to exceed an average of eight (8) hours per month or 96 hours annually, at an hourly rate of $210 and a total term cost of $20,260	10 min.	Chair

	Agenda Item	Time Allotted	Requestor
	8) Approval of the renewal of an agreement with Aaron Yung, M.D. as the CVHI Invasive Cardiology Medical Director for a term of 12 month, beginning September 1, 2024 and ending August 31, 2025, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 and total term cost of $30,240. 9) Approval of the renewal of an agreement with Yuan Hwang Lin, M.D. and Darrell Wu, M.D. as the ED On -Call Coverage Panel for Cardiothoracic Surgery for a term of 24 months, beginning September 1, 2024 and ending August 31, 2026, for an annual cost of $365,000 and a shared total term cost of $730,000. 10) Approval of the agreement with Yuan Hwang Lin, M.D. and Darrell Wu, M.D., for second surgical assist services for registered TCMC hospital patients for cardiovascular bypass procedures for a term of 24 months, beginning, September 1, 2024, and ending August 31, 2026, for a total term cost not to exceed $547,000. 11) Approval of an agreement with Donald Ponec, M.D. as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning September 1, 2024 and ending on August 31, 2025, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040. 12) Approval of an agreement with Aaron Yung, M.D., as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning September 1, 2024 and ending on August 31, 2025, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040. 13) Approval of an agreement with Andrew Deemer, M.D. as a Cardiovascular Health Institute – Quality Committee Member for a term of as months, beginning September 1, 2024 and ending August 31, 2025, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040. 14) Approval of an agreement with Yuan Lin, M.D. as Cardiovascular Health Institute Operations Committee member for a term of 12 months, beginning September 1, 2024 and ending August 31, 2025, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040. 15) Approval of an agreement with Hanh Bui, M.D. as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning September 1, 2024 and ending August 31, 2025, not to exceed two hours per month at a hourly rate of $210 for an annual and term cost of $5,040. 16) Approval of an agreement with Jamshidi-Nezhad, M.D., as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning September 1, 2024 and ending on August 31, 2025, not to exceed two hours per month at an hourly rate of $210, for an annual cost of $5,040. 17) Approval of an agreement with Megan E. Novo, M.D., to the existing Emergency Department on call coverage panel for Gastroenterology General & ERCP services, for a term of 12 months,		

	Agenda Item	Time Allotted	Requestor
	beginning September 1, 2024 and ending August 31, 2025, as part of the existing coverall panel, resulting in no increase in cost for the shared total term amount. (2) **Administrative Policies & Procedures** **A. Patient Care Services** 1) Administration of vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure (RETIRE) 2) Blood Glucose Newborn Monitoring Standardized Procedure (RETIRE) 3) Chemotherapy Administration Procedure 4) Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents Procedure 5) Code Pink Resuscitation Standardized Procedure 6) Code Triage Alert, Emergency Department Procedure (RETIRE) 7) Determination of Brain Death 8) Eclampsia Management in the Antepartum, Intrapartum or Postpartum Period Standardized Procedure (RETIRE) 9) Epicardial Pacing Wires Procedure 10) HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure (RETIRE) 11) Medical Screening Exam to Rule out Labor Standardized Procedure 12) MRSA Screening of Elective Surgery Patients Pre-Operative Education Standardized Procedure 13) Percutaneous Tracheostomy Assist Procedure 14) Rapid Response Team and Condition Help Policy 15) Spontaneous Awakening Trials/Spontaneous Breathing Trials 16) Transporting Ventilator Patients Procedure **B. Allied Health Professional** 1) Standards for Allied Health Professional RNFA **C. Emergency Department** 1) ED Scope of Practice Definition Policy **D. Outpatient Behavioral Health** 1) Aggressive or Potentially Violent Behavior 2) Appointment of Representative Form Policy 3) Daily Schedule 4) Downtime Procedures 5) Family Involvement 6) Financial Assistant 7) Food Service Procedures 8) Inclement Weather and Critical Incident Policy 9) Orientation of New Patients 10) Practicum Student Placement 11) Staff Meetings 12) Staffing Levels **E. Pulmonary** 1) Procedural Triage 2) Respiratory Care Students in the Patient Care Areas **F. Rehabilitation** 1) Fire Plan for OP Rehab Services at 2124 El Camino Real – 1511 (RETIRE) 2) Pre-Op Teaching		

	Agenda Item	Time Allotted	Requestor
	G. Rehabilitation Center 1) Rehabilitation Leadership Structure **H. Surgical Services** 1) PACU On Call Coverage Policy (3) Minutes a) Special Meeting – June 21, 2024 b) Regular Meeting – June 21, 2024 b) Special Meeting – July 19, 2024 (4) Reports – (Discussion by exception only) a) Building Lease Report – July, 2024) b) Reimbursement Disclosure Report – (July, 2024)		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications	18 min.	Standard
15	Total Time Budgeted for Open Session	1 hour	
16	Adjournment		

LAW OFFICES

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Of Counsel
JAMES R. DODSON

Date: August 22, 2024

To: Board of Directors – Tri-City Healthcare District
Gene Ma, M.D., FACEP, CEO

From: Jeffrey G. Scott, General Counsel

Re: **Biennial Conflict of Interest Code Update 2024**

State law and FPPC regulations require that in every even number year the District's Conflict of Interest Code needs to be reviewed and updated as necessary. The District adheres to the State Model Conflict of Interest Code as provided in Title 2 of the California Code of Regulations.

This year's code has been reviewed and attached in redline and clean versions are the changes from the 2022 code. The changes relate to Designated Employees designation and the gift ceiling amount has increased from $520 to $590. Approval by the Board to the updated code is requested.

APPENDIX

CONFLICT OF INTEREST CODE
OF THE
TRI-CITY HEALTHCARE DISTRICT

AUGUST 29, 2024

EXHIBIT "A"

OFFICIALS WHO MANAGE PUBLIC INVESTMENTS

District Officials who manage public investments, as defined by California Code of Regulations, title 2, section 18700.3, subdivision (b), are not subject to the District's Code, but are subject to the disclosure requirements of the Act. (Gov. Code § 87200 *et seq.)* These positions are listed here for informational purposes only, and are required to file a statement of economic interest with the Executive Secretary to the Board of the District. Upon receipt of Statements of Economic Interests from Members of the Board of Directors and the President/Chief Executive Officer, the Executive Secretary shall make and retain a copy and forward the original to the County of San Diego Clerk of the Board of Supervisors.

It has been determined that the positions listed below are officials who manage public investments[1]:

Members of the Board of Directors
President/Chief Executive Officer

DESIGNATED POSITIONS
GOVERNED BY THE CONFLICT OF INTEREST CODE

Designated employees listed below and the Chief Financial Officer[1] shall file Statements of Economic Interests with the Executive Secretary who will retain the originals and make the statements available for public inspection and copying.

DESIGNATED EMPLOYEES' TITLE OR FUNCTION	DISCLOSURE CATEGORIES ASSIGNED
Chief Compliance Officer	All
Director of Facilities	5
Chief Information Officer	All

[1] Individuals holding one of the above-listed positions may contact the FPPC for assistance or written advice regarding their filing obligations if they believe that their position has been categorized incorrectly. The FPPC makes the final determination whether a position is covered by Government Code section 87200.

Director of Materials Management	5
Chief Operating Officer	All
Facilities Manager	6
General Counsel	All
Board Counsel	All
Purchasing Manager	5
Purchasing Clerk	5
Vice President of Human Resources	6
Chief Nurse Executive	5
Chief Medical Officer	5
Director of Total Rewards and HRIS	5
Senior Director of Nursing	5, 6
Directors and Senior Directors (ALL others not specified)	6
President of Foundation	All
Consultant[2]	

EXHIBIT "B"

DISCLOSURE CATEGORIES

The disclosure categories listed below identify the types of investments, business entities, sources of income, including gifts, loans and travel payments, or real property which the Designated Employee must disclose for each disclosure category to which he or she is assigned.

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[2] Consultants shall be included in the list of Designated Employees and shall disclose pursuant to the broadest disclosure category in this Code subject to the following limitation:

The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that are limited in scope and thus is not required to fully comply with the disclosure requirements described in this Section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this Conflict of Interest Code.

Category 1: All investments and business positions in business entities, and sources of income that are located in, do business in or own real property within the jurisdiction of the District.

Category 2: All interests in real property which is located in whole or in part within, or not more than two (2) miles outside, the jurisdiction of the District.

Category 3: All investments and business positions in, and sources of income from, business entities that are engaged in land development, construction or the acquisition or sale of real property within the jurisdiction of the District.

Category 4: All investments and business positions in, and sources of income from, business entities that are banking, savings and loan, or other financial institutions.

Category 5: All investments and business positions in, and sources of income from, business entities that provide services, supplies, materials, machinery, vehicles or equipment of a type purchased or leased by the District.

Category 6: All investments and business positions in, and sources of income from, business entities that provide services, supplies, materials, machinery, vehicles or equipment of a type purchased or leased by the Designated Employee's Department.

Category 7: All financial interests in investment advisors and managers; financial services providers, actuaries, and those providing fiduciary services (including record-keeping) to retirement plans.

Regulations of the Fair Political Practices Commission,

Title 2, Division 6, California Code of Regulations

§ 18730 Provisions of Conflict of Interest Codes

(a) Incorporation by reference of the terms of this regulation along with the designation of employees and the formulation of disclosure categories in the Appendix referred to below constitute the adoption and promulgation of a conflict of interest code within the meaning of Section 87300 or the amendment of a conflict of interest code within the meaning of Section 87306 if the terms of this regulation are substituted for terms of a conflict of interest code already in effect. A code so amended or adopted and promulgated requires the reporting of reportable items in a manner substantially equivalent to the requirements of Article 2 of Chapter 7 of the Political Reform Act, Sections 81000, et seq. The requirements of a conflict of interest code are in addition to other requirements of the Political Reform Act, such as the general prohibition against conflicts of interest contained in Section 87100, and to other state or local laws pertaining to conflicts of interest.

(b) The terms of a conflict of interest code amended or adopted and promulgated pursuant to this regulation are as follows:

(1) Definitions.

The definitions contained in the Political Reform Act of 1974, regulations of the Fair Political Practices Commission (Regulations, §§ 18110, et seq.), and any amendments to the Act or regulations, are incorporated by reference into this conflict of interest code.

(2) Designated Employees.

The persons holding positions listed in the Appendix are designated employees. It has been determined that these persons make or participate in the making of decisions which may foreseeably have a material effect on economic interests.

(3) Disclosure Categories.

This code does not establish any disclosure obligation for those designated employees who are also specified in Section 87200 if they are designated in this code in that same capacity or if the geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction in which those persons must report their economic interests pursuant to article 2 of chapter 7 of the Political Reform Act, Sections 87200, et seq.

In addition, this code does not establish any disclosure obligation for any designated employees who are designated in a conflict of interest code for another agency, if all of the following apply:

(A) The geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction of the other agency;

(B) The disclosure assigned in the code of the other agency is the same as that required under article 2 of chapter 7 of the Political Reform Act, Section 87200; and

(C) The filing officer is the same for both agencies.[1]

Such persons are covered by this code for disqualification purposes only. With respect to all other designated employees, the disclosure categories set forth in the Appendix specify which kinds of economic interests are reportable. Such a designated employee shall disclose in his or her statement of economic interests those economic interests he or she has which are of the kind described in the disclosure categories to which he or she is assigned in the Appendix. It has been determined that the economic interests set forth in a designated employee's disclosure categories are the kinds of economic interests which he or she foreseeably can affect materially through the conduct of his or her office.

(4) Statements of Economic Interests: Place of Filing.

The code reviewing body shall instruct all designated employees within its code to file statements of economic interests with the agency or with the code reviewing body, as provided by the code reviewing body in the agency's conflict of interest code.[2]

(5) Statements of Economic Interests: Time of Filing.

(A) Initial Statements. All designated employees employed by the agency on the effective date of this code, as originally adopted, promulgated and approved by the code reviewing body, shall file statements within 30 days after the effective date of this code. Thereafter, each person already in a position when it is designated by an amendment to this code shall file an initial statement within 30 days after the effective date of the amendment.

(B) Assuming Office Statements. All persons assuming designated positions after the effective date of this code shall file statements within 30 days after assuming the designated positions, or if subject to State Senate confirmation, 30 days after being nominated or appointed.

(C) Annual Statements. All designated employees shall file statements no later than April 1. If a person reports for military service as defined in the Servicemember's Civil Relief Act, the deadline for the annual statement of economic interests is 30 days following his or her return to office, provided the person, or someone authorized to represent the person's interests, notifies the filing officer in writing prior to the applicable filing deadline that he or she is subject to that federal statute and is unable to meet the applicable deadline, and provides the filing officer verification of his or her military status.

(D) Leaving Office Statements. All persons who leave designated positions shall file statements within 30 days after leaving office.

(5.5) Statements for Persons Who Resign Prior to Assuming Office.

Any person who resigns within 12 months of initial appointment, or within 30 days of the date of notice provided by the filing officer to file an assuming office statement, is not deemed to have assumed office or left office, provided he or she did not make or participate in the making of, or use his or her position to influence any decision and did not receive or become entitled to receive any form of payment as a result of his or her appointment. Such persons shall not file either an assuming or leaving office statement.

(A) Any person who resigns a position within 30 days of the date of a notice from the filing officer shall do both of the following:

(1) File a written resignation with the appointing power; and

(2) File a written statement with the filing officer declaring under penalty of perjury that during the period between appointment and resignation he or she did not make, participate in the making, or use the position to influence any decision of the agency or receive, or become

entitled to receive, any form of payment by virtue of being appointed to the position.

(6) Contents of and Period Covered by Statements of Economic Interests.

(A) Contents of Initial Statements. Initial statements shall disclose any reportable investments, interests in real property and business positions held on the effective date of the code and income received during the 12 months prior to the effective date of the code.

(B) Contents of Assuming Office Statements. Assuming office statements shall disclose any reportable investments, interests in real property and business positions held on the date of assuming office or, if subject to State Senate confirmation or appointment, on the date of nomination, and income received during the 12 months prior to the date of assuming office or the date of being appointed or nominated, respectively.

(C) Contents of Annual Statements. Annual statements shall disclose any reportable investments, interests in real property, income and business positions held or received during the previous calendar year provided, however, that the period covered by an employee's first annual statement shall begin on the effective date of the code or the date of assuming office whichever is later, or for a board or commission member subject to Section 87302.6, the day after the closing date of the most recent statement filed by the member pursuant to Regulation 18754.

(D) Contents of Leaving Office Statements. Leaving office statements shall disclose reportable investments, interests in real property, income and business positions held or received during the period between the closing date of the last statement filed and the date of leaving office.

(7) Manner of Reporting.

Statements of economic interests shall be made on forms prescribed by the Fair Political Practices Commission and supplied by the agency, and shall contain the following information:

(A) Investment and Real Property Disclosure. When an investment or an interest in real property[3] is required to be reported,[4] the statement shall contain the following:

1. A statement of the nature of the investment or interest;

2. The name of the business entity in which each investment is held, and a general description of the business activity in which the business entity is engaged;

3. The address or other precise location of the real property;

4. A statement whether the fair market value of the investment or interest in real property equals or exceeds $2,000, exceeds $10,000, exceeds $100,000, or exceeds $1,000,000.

(B) Personal Income Disclosure. When personal income is required to be reported,[5] the statement shall contain:

1. The name and address of each source of income aggregating $520 or more in value, or $50 or more in value if the income was a gift, and a general description of the business activity, if any, of each source;

2. A statement whether the aggregate value of income from each source, or in the case of a loan, the highest amount owed to each source, was $1,000 or less, greater than $1,000, greater than $10,000, or greater than $100,000;

3. A description of the consideration, if any, for which the income was received;

4. In the case of a gift, the name, address and business activity of the donor and any intermediary through which the gift was made; a description of the gift; the amount or value of the gift; and the date on which the gift was received;

5. In the case of a loan, the annual interest rate and the security, if any, given for the loan and the term of the loan.

(C) Business Entity Income Disclosure. When income of a business entity, including income of a sole proprietorship, is required to be reported,[6] the statement shall contain:

1. The name, address, and a general description of the business activity of the business entity;

2. The name of every person from whom the business entity received payments if the filer's pro rata share of gross receipts from such person was equal to or greater than $10,000.

(D) Business Position Disclosure. When business positions are required to be reported, a designated employee shall list the name and address of each business entity in which he or she is a director, officer, partner, trustee, employee, or in which he or she holds any position of management, a description of the business activity in which the business entity is engaged, and the designated employee's position with the business entity.

(E) Acquisition or Disposal During Reporting Period. In the case of an annual or leaving office statement, if an investment or an interest in real property was partially or wholly acquired or disposed of during the period

covered by the statement, the statement shall contain the date of acquisition or disposal.

(8) Prohibition on Receipt of Honoraria

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept any honorarium from any source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests.

(B) This section shall not apply to any part-time member of the governing board of any public institution of higher education, unless the member is also an elected official.

(C) Subdivisions (a), (b), and (c) of Section 89501 shall apply to the prohibitions in this section.

(D) This section shall not limit or prohibit payments, advances, or reimbursements for travel and related lodging and subsistence authorized by Section 89506.

(8.1) Prohibition on Receipt of Gifts in Excess of $590.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept gifts with a total value of more than $590 in a calendar year from any single source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests.

(B) This section shall not apply to any part-time member of the governing board of any public institution of higher education, unless the member is also an elected official.

(C) Subdivisions (e), (f), and (g) of Section 89503 shall apply to the prohibitions in this section.

(8.2) Section 8.2. Loans to Public Officials.

(A) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the elected officer holds office or over which the elected officer's agency has direction and control.

(B) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the public official holds office or over which the public official's agency

has direction and control. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(C) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status.

(D) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(E) This section shall not apply to the following:

1. Loans made to the campaign committee of an elected officer or candidate for elective office.

2. Loans made by a public official's spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such persons, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.

3. Loans from a person which, in the aggregate, do not exceed $590 at any given time.

4. Loans made, or offered in writing, before January 1, 1998.

(8.3) Loan Terms.

(A) Except as set forth in subdivision (B), no elected officer of a state or local government agency shall, from the date of his or her election to office through the date he or she vacates office, receive a personal loan of $520 or more, except when the loan is in writing and clearly states the terms of the loan,

including the parties to the loan agreement, date of the loan, amount of the loan, term of the loan, date or dates when payments shall be due on the loan and the amount of the payments, and the rate of interest paid on the loan.

(B) This section shall not apply to the following types of loans

1. Loans made to the campaign committee of the elected officer.

2. Loans made to the elected officer by his or her spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.

3. Loans made, or offered in writing, before January 1, 1998.

(C) Nothing in this section shall exempt any person from any other provision of Title 9 of the Government Code.

(8.4) Personal Loans.

(A) Except as set forth in subdivision (B), a personal loan received by any designated employee shall become a gift to the designated employee for the purposes of this section in the following circumstances:

1. If the loan has a defined date or dates for repayment, when the statute of limitations for filing an action for default has expired.

2. If the loan has no defined date or dates for repayment, when one year has elapsed from the later of the following:

a. The date the loan was made.

b. The date the last payment of $100 or more was made on the loan.

c. The date upon which the debtor has made payments on the loan aggregating to less than $250 during the previous 12 months.

(B) This section shall not apply to the following types of loans:

1. A loan made to the campaign committee of an elected officer or a candidate for elective office.

2. A loan that would otherwise not be a gift as defined in this title.

3. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor has taken reasonable action to collect the balance due.

4. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor, based on reasonable business

considerations, has not undertaken collection action. Except in a criminal action, a creditor who claims that a loan is not a gift on the basis of this paragraph has the burden of proving that the decision for not taking collection action was based on reasonable business considerations.

5. A loan made to a debtor who has filed for bankruptcy and the loan is ultimately discharged in bankruptcy.

(C) Nothing in this section shall exempt any person from any other provisions of Title 9 of the Government Code.

(9) Disqualification.

No designated employee shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any governmental decision which he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the official or a member of his or her immediate family or on:

(A) Any business entity in which the designated employee has a direct or indirect investment worth $2,000 or more;

(B) Any real property in which the designated employee has a direct or indirect interest worth $2,000 or more;

(C) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating $590 or more in value provided to, received by or promised to the designated employee within 12 months prior to the time when the decision is made;

(D) Any business entity in which the designated employee is a director, officer, partner, trustee, employee, or holds any position of management; or

(E) Any donor of, or any intermediary or agent for a donor of, a gift or gifts aggregating $590 or more provided to, received by, or promised to the designated employee within 12 months prior to the time when the decision is made.

(9.3) Legally Required Participation.

No designated employee shall be prevented from making or participating in the making of any decision to the extent his or her participation is legally required for the decision to be made. The fact that the vote of a designated employee who is on a voting body is needed to break a tie does not make his or her participation legally required for purposes of this section.

(9.5) Disqualification of State Officers and Employees.

In addition to the general disqualification provisions of section 9, no state administrative official shall make, participate in making, or use his or her official position to influence any governmental decision directly relating to any contract where the state administrative official knows or has reason to know that any party to the contract is a person with whom the state administrative official, or any member of his or her immediate family has, within 12 months prior to the time when the official action is to be taken:

(A) Engaged in a business transaction or transactions on terms not available to members of the public, regarding any investment or interest in real property; or,

(B) Engaged in a business transaction or transactions on terms not available to members of the public regarding the rendering of goods or services totaling in value $1,000 or more.

(10) Disclosure of Disqualifying Interest.

When a designated employee determines that he or she should not make a governmental decision because he or she has a disqualifying interest in it, the determination not to act may be accompanied by disclosure of the disqualifying interest.

(11) Assistance of the Commission and Counsel.

Any designated employee who is unsure of his or her duties under this code may request assistance from the Fair Political Practices Commission pursuant to Section 83114 and Regulations 18329 and 18329.5 or from the attorney for his or her agency, provided that nothing in this section requires the attorney for the agency to issue any formal or informal opinion.

(12) Violations.

This code has the force and effect of law. Designated employees violating any provision of this code are subject to the administrative, criminal and civil sanctions provided in the Political Reform Act, Sections 81000-91014. In addition, a decision in relation to which a violation of the disqualification provisions of this code or of Section 87100 or 87450 has occurred may be set aside as void pursuant to Section 91003.

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(1) Designated employees who are required to file statements of economic interests under any other agency's conflict of interest code, or under article 2 for a different jurisdiction, may expand their statement of economic interests to cover reportable interests in both jurisdictions, and file copies of this expanded statement with both entities in lieu of filing separate and distinct statements, provided that each copy of such expanded statement filed in place of an original is signed and verified by the designated employee as if it were an original. See Government Code Section 81004.

(2) See Section 81010 and Regulation 18115 for the duties of filing officers and persons in agencies who make and retain copies of statements and forward the originals to the filing officer.

(3) For the purpose of disclosure only (not disqualification), an interest in real property does not include the principal residence of the filer.

(4) Investments and interests in real property which have a fair market value of less than $2,000 are not investments and interests in real property within the meaning of the Political Reform Act. However, investments or interests in real property of an individual include those held by the individual's spouse and dependent children as well as a pro rata share of any investment or interest in real property of any business entity or trust in which the individual, spouse and dependent children own, in the aggregate, a direct, indirect or beneficial interest of 10 percent or greater.

(5) A designated employee's income includes his or her community property interest in the income of his or her spouse but does not include salary or reimbursement for expenses received from a state, local or federal government agency.

(6) Income of a business entity is reportable if the direct, indirect or beneficial interest of the filer and the filer's spouse in the business entity aggregates a 10 percent or greater interest. In addition, the disclosure of persons who are clients or customers of a business entity is required only if the clients or customers are within one of the disclosure categories of the filer.

APPENDIX

CONFLICT OF INTEREST CODE
OF THE
TRI-CITY HEALTHCARE DISTRICT

~~**(September 2022)**~~

PROPOSED (AUGUST 29, 2024)

EXHIBIT "A"

OFFICIALS WHO MANAGE PUBLIC INVESTMENTS

District Officials who manage public investments, as defined by California Code of Regulations, title 2, section 18700.3, subdivision (b), are not subject to the District's Code, but are subject to the disclosure requirements of the Act. (Gov. Code § 87200 *et seq.)* These positions are listed here for informational purposes only, and are required to file a statement of economic interest with the Executive Secretary to the Board of the District. Upon receipt of Statements of Economic Interests from Members of the Board of Directors and the President/Chief Executive Officer, the Executive Secretary shall make and retain a copy and forward the original to the County of San Diego Clerk of the Board of Supervisors.

It has been determined that the positions listed below are officials who manage public investments[1]:

Members of the Board of Directors
President/Chief Executive Officer

DESIGNATED POSITIONS
GOVERNED BY THE CONFLICT OF INTEREST CODE

Designated employees listed below and the Chief Financial Officer[1] shall file Statements of Economic Interests with the Executive Secretary who will retain the originals and make the statements available for public inspection and copying.

DESIGNATED EMPLOYEES' TITLE OR FUNCTION	DISCLOSURE CATEGORIES ASSIGNED
Chief Compliance Officer	All
~~Chief Government & External Affairs Officer~~	~~All~~

[1] Individuals holding one of the above-listed positions may contact the FPPC for assistance or written advice regarding their filing obligations if they believe that their position has been categorized incorrectly. The FPPC makes the final determination whether a position is covered by Government Code section 87200.

Director of Facilities	5
~~Vice President of Information Technology~~	1, 5
Chief Information Officer	1,5
Director of Materials Management	5
~~Executive Vice President and~~ Chief Operating Officer	All
Facilities Manager	6
General Counsel	All
Board Counsel	All
Purchasing Manager	5
Purchasing Clerk	5
~~Senior Director of Business Development~~	~~1, 2, 5~~
Vice President of Human Resources	6
Chief Nurse Executive	5
Chief Medical Officer	5
~~Chief of Patient Care Services~~	~~5~~
Director of Total Rewards and HRIS	5
Senior Director of Nursing	5, 6
Directors and Senior Directors (ALL others not specified)	6
President of Foundation	All
Consultant[2]	

[2] Consultants shall be included in the list of Designated Employees and shall disclose pursuant to the broadest disclosure category in this Code subject to the following limitation:

> The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that are limited in scope and thus is not required to fully comply with the disclosure requirements described in this Section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this Conflict of Interest Code.

EXHIBIT "B"

DISCLOSURE CATEGORIES

The disclosure categories listed below identify the types of investments, business entities, sources of income, including gifts, loans and travel payments, or real property which the Designated Employee must disclose for each disclosure category to which he or she is assigned.

Category 1: All investments and business positions in business entities, and sources of income that are located in, do business in or own real property within the jurisdiction of the District.

Category 2: All interests in real property which is located in whole or in part within, or not more than two (2) miles outside, the jurisdiction of the District.

Category 3: All investments and business positions in, and sources of income from, business entities that are engaged in land development, construction or the acquisition or sale of real property within the jurisdiction of the District.

Category 4: All investments and business positions in, and sources of income from, business entities that are banking, savings and loan, or other financial institutions.

Category 5: All investments and business positions in, and sources of income from, business entities that provide services, supplies, materials, machinery, vehicles or equipment of a type purchased or leased by the District.

Category 6: All investments and business positions in, and sources of income from, business entities that provide services, supplies, materials, machinery, vehicles or equipment of a type purchased or leased by the Designated Employee's Department.

Category 7: All financial interests in investment advisors and managers; financial services providers, actuaries, and those providing fiduciary services (including record-keeping) to retirement plans.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
August 19, 2024

Attachment A

Initial Appointments

Any items of concern will be "red" flagged in this report. Verification of education, training, experience, current competence, health status, current licensure, liability coverage, claims history and the National Practitioner Data Bank, the following practitioners are recommended for a 2-year appointment with delineated clinical privileges, to the Provisional Staff or Allied Health Professional Staff with customary monitoring.

Medical Staff:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term	Comments
BURTON, Elijah MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	Open case from 8/2022 – Reviewed by chairman, no care concerns found
FIFE, William MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	
GIUDICI, Mario MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	Open case from 12/2021 – Reviewed by chairman, no care concerns found
GUPTA, Neil MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	Open case from 8/2015 – Reviewed by chairman, no care concerns found
LONG, Matthew MD	Medicine / Internal Medicine	Provisional	8/23/2024 – 8/23/2026	
MITSUNAGA, Myles MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	
NAKHAIMA, Selasi MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	
OLSEN, Erik MD	Radiology / Teleradiology	Provisional	8/23/2024 – 8/23/2026	
REDDY, Pavan MD	Medicine / Interventional Cardiology	Provisional	8/23/2024 – 8/23/2026	
TRINH, Brian MD	Radiology	Provisional	8/23/2024 – 8/23/2026	
VERA, Juan Carlos MD	Radiology	Provisional	8/23/2024 – 8/23/2026	

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 21, 2024

Members Present	Director Tracy Younger, Director Nina Chaya, Director Adela Sanchez, Dr. Mohammad Jamshidi-Nezhad, Dr. Henry Showah
Non-Voting Members	Dr. Gene Ma, CEO; Janice Gurley, CFO; Jeremy Raimo, COO; Donald Dawkins, CNE; Roger Cortez, CCO; Mark Albright, CIO; Susan Bond, General Counsel
Others Present	Eva England, Miava Sullivan
Members Absent:	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Younger called the meeting to order at 3:02 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Director Chaya, and seconded by Dr. Jamshidi-Nezhad to approve the agenda of August 21, 2024.** **Members:** **AYES: Younger, Showah, Chaya, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Younger read the paragraph regarding comments from members of the public.	No comments	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of May 22, 2024	Minutes were ratified.	**MOTION** **It was moved by Dr. Jamshidi-Nezhad and seconded by Dr. Showah to approve the minutes of May 22, 2024.** **Members:** **AYES: Younger, Chaya, Showah, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Chair
5. Old Business	None		
6. New Business	None		Chair
7. Consideration of Consent Calendar:		**MOTION** **It was moved by Director Chaya to approve the Consent Calendar and seconded by Dr. Jamshidi-Nezhad.** **Members:** **AYES: Younger, Showah, Chaya, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Chair
a) First Amendment - Lease Renewal Proposal -3905 Waring Rd., Oceanside - OSNC • Cardiff Investments		**Approved via Consent Calendar**	Jeremy Raimo
b) Reference Laboratory Testing Proposal • ARUP Laboratories, Inc.		**Approved via Consent Calendar**	Eva England
c) Physician Recruitment Agreement • Pavan Reddy, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
d) Consulting Agreement –		**Approved via Consent Calendar**	Dr. Gene Ma

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Governmental Affairs • Robert E. Hertzka, M.D.			
e) Physician Agreement – CVHI Vascular Surgery Medical Director • Mohammad Jamshidi -Nezhad, D.O.		**Approved via Consent Calendar**	Eva England
f) Physician Agreement – CVHI Cardiothoracic Surgery Medical Director • Yuan Hwang Lin, M.D.		**Approved via Consent Calendar**	Eva England
g) Physician Agreement – CVHI Medical Director • Dr. Donald Ponec		**Approved via Consent Calendar**	Eva England
h) Physician Agreement – CVHI Invasive Cardiology Medical Director • Aaron Yung, M.D.		**Approved via Consent Calendar**	Eva England
i) Physician Agreement – ED On-Call Coverage: Cardio-Thoracic Surgery • Yuan Hwang Lin & Darrell Wu, M.D.		**Approved via Consent Calendar**	Eva England
j) Physician Agreement – ED On-Call Coverage: Cardiovascular Surgery Assist Services • Yuan Hwang Lin & Darrell Wu, M.D.		**Approved via Consent Calendar**	Eva England
k) Physician Agreement – Cardiovascular Health Institute – Quality Committee • Donald Ponec, M.D.		**Approved via Consent Calendar**	Eva England
m) Physician Agreement – Cardiovascular Health Institute – Quality		**Approved via Consent Calendar**	Eva England

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Committee • Andrew Deemer, M.D.			
n) Physician Agreement – Operations Committee CVHI • Yuan Lin, M.D.		**Approved via Consent Calendar**	Eva England
o) Physician Agreement – Operations Committee CVHI • Hanh Bui, M.D.		**Approved via Consent Calendar**	Eva England
p) Physician Agreement – Operations Committee CVHI • Mohammad Jamshidi-Nezhad, D.O.		**Approved via Consent Calendar**	Eva England
q) Physician Agreement – ED On-Call Coverage – Gastroenterology – General and ERCP • Megan E. Novo, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
8. Financials	Janice Gurley presented the financials ending July 31, 2024 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 25,700 Operating Expense $ 26,789 EBITDA $ 1,519 EROE $ (18) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 117 Adjusted Patient Days 6,552 Surgery Cases 399 ED Visits 4,002 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 25,700 Operating Expense $ 26,789 EBITDA $ 1,519		Janice Gurley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EROE $ (18) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 117 Adjusted Patient Days 6,552 Surgery Cases 399 ED Visits 4,002 **Graphs:** • TCHD-EBITDA and EROE • TCHD Financial Summary • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Emergency Department Visits • TCMC-Acute Average Length of Stay • TCMC-Adjusted Patient Days • TCMC-Paid Full Time Equivalents-13 Month Trend		
a. Dashboard	No discussion	Information Only	Janice Gurley
9. Comments by Committee Members	None		Chair
10. Date of next meeting	September 18, 2024		Chair
11. Adjournment	Meeting adjourned 3:57 pm		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
First Amendment - Lease Renewal Proposal – 3905 Waring Rd., Oceanside - OSNC

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

Vendor's Name: Cardiff Investments, LLC

Premises: 3905 Waring Rd., Oceanside, CA 92056 (10,218 sq. ft.)
Orthopaedic Specialist of North County – Oceanside location (TCMC 1206b practice)

Term of Agreement: 2 year, Beginning, September 1, 2024 – Ending, August 31, 2026

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:		**Monthly Expense**
Rental Rate of $3.11 per square foot, per month	Year 1	$31,777.98
$10,000 rent abatement credit in month 2		($10,000)
-3% rent increase each year	Year 2	$32,731.32
(10,218 sq. ft.)		
Common Area Maintenance Fees – $0.57 SF per mo.		$5,808.93
Total 2 Yr. Term Expense Amount:		**$903,525.92**

Document Submitted to Legal for Review: 8/7/24 (Negotiations with Colliers Int'l.)	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:

I move that the Finance, Operations & Planning Committee authorize the First Amendment Lease Renewal with Cardiff Investments, for an additional Two (2) year term beginning September 1, 2024, ending August 31, 2026. This proposal remains within fair market value rental rate of $3.11 per square foot, plus monthly CAM fees of $0.57 for a monthly expense of $37,586.91 year 1, and $38,540.25 year 2, for a total expense for the Two (2) year term of $903,525.92.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: AUGUST 21, 2024
REFERENCE LABORATORY TESTING PROPOSAL

Type of Agreement		Medical Director		Panel	X	Other: Lab Testing Agreement
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Vendor's Name: ARUP Laboratories, Inc.

Area of Service: Laboratory – Reference Laboratory Testing

Term of Agreement: 36 months, Beginning, November 1, 2024 – Ending, October 31, 2027

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$25,000	$300,000	$900,000

Description of Services/Supplies:

- ARUP Laboratories is our reference laboratory of choice for referral laboratory testing services. ARUP performs laboratory testing on our patient samples that we do not perform in our laboratory. We have a long-standing relationship with the reference laboratory dating back more than 10 years.
- ARUP Laboratories is interfaced directly to Cerner to ensure ease of ordering, specimen processing, and result review in a timely manner. Their commitment to quality mirrors the quality patient care focus and initiatives at TCMC.
- ARUP pricing is negotiated through a Group Purchasing Organization (GPO), Vizient, which provides volume-based tiered discounts based upon utilization. We have maximized available discounts with Vizient.

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

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with ARUP Laboratories, Inc. for reference laboratory testing for a term of 36 months, beginning, November 1, 2024 and ending, October 31, 2027 for an annual cost of $300,000 and a total cost for the term of $900,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN RECRUITMENT AGREEMENT

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

Physician's Name: Pavan Reddy, M.D.

Area of Service: Interventional Cardiology

Term of Agreement: 24 months, Beginning, October 1, 2024 – Ending, September 30, 2026

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

Terms of the Agreement:	Proposal Costs:
Relocation Allowance	$10,000
Sign-on Advance	$50,000
Income Guarantee, NTE	$0 (no income guarantee)
Total Loan Amount Request, NTE	**$60,000**

Position Responsibilities:

- Physician will practice with Dr. Dimitri Sherev at Sherev Heart & Vascular Clinic, Vista, CA, and will receive assistance under a physician recruitment agreement in the form of a loan to be forgiven over a two-year (24 month) period, for relocation assistance and sign-on bonus as long as physician remains practicing in the TCHD service area full time.

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

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize a Physician Recruitment Agreement for Dr. Pavan Reddy for a term of 24 months beginning October 1, 2024 and ending September 30, 2026. Not to exceed a total amount for relocation assistance of $10,000, and a sign-on bonus of $50,000, for a total expenditure of $60,000 in the form of a loan forgiven over a 24-month period.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
CONSULTING AGREEMENT – GOVERNMENTAL AFFAIRS

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

Vendor's Name: Robert E. Hertzka, M.D.

Area of Service: Governmental Affairs

Term of Agreement: 12 months, Beginning September 1, 2024 – Ending August 31, 2025

Maximum Totals:

Hourly Rate	Hours/Month	Monthly Cost (NTE)	Total Term Cost (NTE)
$450/hr.	NTE 22 hrs./mo.	$9,900	$118,800

Description of Services/Supplies:

- Consulting services in the pursuit of legislative, regulatory, or financing objectives that support the interests of Tri-City Healthcare District
- Collaborate in close partnership with administration and Board of Directors to develop a strategic roadmap for governmental and legislative priorities
- Provide guidance and recommendations with respect to legislative advocacy on behalf of the District
- Be available as a resource to the Board and Hospital with respect to governmental affairs

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2024, and ending August 31, 2025, for an annual and total term cost not to exceed of $118,800.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT – CVHI VASCULAR SURGERY MEDICAL DIRECTOR

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

Physician's Name: Mohammad Jamshidi-Nezhad, D.O. – CVHI Vascular Surgery Medical Director

Area of Service: Cardiovascular Health Institute (CVHI)

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Term Cost
$210	12	144	$2,520	$30,240

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Mohammad Jamshidi-Nezhad, D.O. as the CVHI Vascular Surgery Medical Director for term of 12 months, beginning, September 1, 2024 and ending, August 31, 2025. Not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT – CVHI CARDIOTHORACIC SURGERY MEDICAL DIRECTOR

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

Physician's Name: Yuan Hwang Lin, M.D. – CVHI Cardiothoracic Surgery Medical Director

Area of Service: Cardiovascular Health Institute (CVHI)

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Term Cost
$210	12	144	$2,520	$30,240

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Yuan Hwang Lin, M.D. as the CVHI Medical Director for Cardiothoracic Surgery for term of 12 months, beginning, September 1, 2024 and ending, August 31, 2025. Not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING August 21, 2024
PHYSICIAN AGREEMENT – CVHI MEDICAL DIRECTOR

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

Physician's Name: Donald Ponec, M.D. - Cardiovascular Health Institute Medical Director

Area of Service: Cardiovascular Health Institute (CVHI)

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Term Cost
$210	8	96	$1,680	$20,160

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Donald Ponec, M.D. as the CVHI Medical Director for term of 12 months, beginning, September 1, 2024 and ending, August 31, 2025, not to exceed an average 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT – CVHI INVASIVE CARDIOLOGY MEDICAL DIRECTOR

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

Physician's Name: Aaron Yung M.D. – CVHI Invasive Cardiology Medical Director

Area of Service: Cardiovascular Health Institute (CVHI)

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Term Cost
$210	12	144	$2,520	$30,240

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommends that the TCHD Board of Directors authorize Aaron Yung M.D. as the CVHI Invasive Cardiology Medical Director for term of 12 months, beginning, September 1, 2024 and ending, August 31, 2025, not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: CARDIO-THORACIC SURGERY

Type of Agreement		Medical Directors		Panel	X	Other: On-Call Coverage
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Name: Yuan Hwang Lin, M.D. & Darrell Wu, M.D.

Area of Service: Emergency Department On-Call: Cardio-Thoracic Surgery

Term of Agreement: 24 months, Beginning, September 1, 2024 – Ending, August 31, 2026

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

Rate/Day	Panel Annual Cost	Panel Total Term Cost
$1,000	$365,000	$730,000

Position Responsibilities:

- Provide 24/7 patient coverage for all Cardio-Thoracic 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: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Yuan Hwang Lin, M.D. and Darrell Wu, M.D., as the ED On-Call Coverage Panel for Cardiothoracic Surgery for a term of 24 months, beginning, September 1, 2024 and ending, August 31, 2026, for an annual cost of $365,000 and a shared total term cost of $730,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
ED ON-CALL COVERAGE - CARDIOVASCULAR SURGERY ASSIST SERVICES

Type of Agreement		Medical Directors		Panel	X	Other: On-Call Coverage
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physicians Name: Yuan Hwang Lin, M.D. and Dr. Darrell Wu, M.D.

Area of Service: Emergency Department On-Call: CVT Surgery Assist

Term of Agreement: 24 months, Beginning, September 1, 2024 – Ending, August 31, 2026

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

Rate/Day	Days per Year	Annual Cost	Total Term Cost Not to Exceed
$750	Year 1: 365 days	$273,750	$547,500
	Year 2: 365 days	$273,750	

Position Responsibilities:

- Provide 24/7 patient coverage for CVT Surgery Assist services to the primary CVT surgeon taking call 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: Eva England, Sr. Director-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Yuan Hwang Lin, M.D. and Darrell Wu, M.D. for second surgical assist services for registered TCMC hospital patients for cardiovascular bypass procedures for a term of 24 months beginning, September 1, 2024 and ending, August 31, 2026, for a total term cost not to exceed $547,500.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
Physician Agreement for Cardiovascular Health Institute – Quality Committee

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

Physician's Name: Donald Ponec, M.D.

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 months (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Senior Director

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Donald Ponec, M.D., as Cardiovascular Health Institute – Quality Committee members for a term of 12 months, beginning September 1, 2024 – ending August 31, 2025, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
Physician Agreement for Cardiovascular Health Institute – Quality Committee

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

Physician's Name: Aaron Yung, M.D.

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 months (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Senior Director

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Aaron Yung, M.D., as Cardiovascular Health Institute – Quality Committee members for a term of 12 months, beginning September 1, 2024 – ending August 31, 2025, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
Physician Agreement for Cardiovascular Health Institute – Quality Committee

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

Physician's Name: Andrew Deemer, M.D.

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 months (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Senior Director

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Andrew Deemer, M.D., as Cardiovascular Health Institute – Quality Committee members for a term of 12 months beginning, September 1, 2024 – ending August 31, 2025, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT Operations Committee CVHI

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

Physician's Name: Yuan Hwang Lin, M.D.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 month (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Senior Director

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Yuan Hwang Lin, M.D. as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning, September 1, 2024 – ending, August 31, 2025, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT Operations Committee CVHI

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

Physician's Name: Hanh Bui, M.D.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 months (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Senior Director

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Hanh Bui, M.D. as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning September 1, 2024 – ending August 31, 2025, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT Operations Committee CVHI

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

Physician's Name: Mohammad Jamshidi-Nezhad, D.O.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, September 1, 2024 – Ending, August 31, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 month (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Senior Director

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Mohammad Jamshidi-Nezhad, D.O. as Cardiovascular Health Institute – Operations Committee members for a term of 12 months, beginning September 1, 2024 – ending August 31, 2025, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2024
PHYSICIAN AGREEMENT FOR ED ON-CALL COVERAGE – GASTROENTEROLOGY-GENERAL & ERCP

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

Vendor's Name: Megan E. Novo, M.D.

Area of Service: Emergency Department On-Call: Gastroenterology - General and ERCP

Term of Agreement: 12 months, Beginning, September 1, 2024 - Ending, August 31, 2025

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call Agreement with Entire ED call panel for Gastroenterology - General & ERCP

Service	Rate/Day	Term	Total Term Cost
Gastroenterology	$1,050	FY2025	$383,250
ERCP	$700	FY2025	$255,500
	Total Term Cost:		**$638,750**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all Gastroenterology-General and ERCP 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:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer / Bert Lawson, Director-Emergency Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement to add Megan E. Novo, M.D., to the Emergency Department on-call coverage panel for Gastroenterology - General & ERCP services for a term of 12 months, beginning September 1, 2024 and ending, August 31, 2025, as part of the existing coverage panel, resulting in no increase in cost for the shared total term amount.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
August 19, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure	RETIRE	Forward to BOD for Approval
2. Blood Glucose Newborn Monitoring Standardized Procedure	RETIRE	Forward to BOD for Approval
3. Chemotherapy Administration Procedure	3 year review, practice change	Forward to BOD for Approval
4. Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents Procedure	3 year review, practice change	Forward to BOD for Approval
5. Code Pink Resuscitation Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
6. Code Triage Alert, Emergency Department Procedure	RETIRE	Forward to BOD for Approval
7. Determination of Brain Death	3 year review, practice change	Forward to BOD for Approval
8. Eclampsia Management in the Antepartum, Intrapartum or Postpartum Period Standardized Procedure	RETIRE	Forward to BOD for Approval
9. Epicardial Pacing Wires Procedure	3 year review, practice change	Forward to BOD for Approval
10. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure	RETIRE	Forward to BOD for Approval
11. Medical Screening Exam to Rule out Labor Standardized Procedure	RETIRE	Forward to BOD for Approval
12. MRSA Screening of Elective Surgery Patients Pre-Operative Education Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
13. Percutaneous Tracheostomy Assist Procedure	3 year review, practice change	Forward to BOD for Approval
14. Rapid Response Team and Condition Help Policy	3 year review, practice change	Forward to BOD for Approval
15. Spontaneous Awakening Trials/Spontaneous Breathing Trials	3 year review	Forward to BOD for Approval
16. Transporting Ventilator Patients Procedure	3 year review, practice change	Forward to BOD for Approval
Allied Health Professional		
1. Standards for Allied Health Professional RNFA	2 year review	Forward to BOD for Approval
Emergency Department		
1. ED Scope of Practice Definition Policy	3 year review, practice change	Forward to BOD for Approval
Outpatient Behavioral Health		
1. Aggressive or Potentially Violent Behavior	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
August 19, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
2. Appointment of Representative Form Policy	3 year review	Forward to BOD for Approval
3. Daily Schedule	3 year review	Forward to BOD for Approval
4. Downtime Procedures	3 year review	Forward to BOD for Approval
5. Family Involvement	3 year review	Forward to BOD for Approval
6. Financial Assessment	3 year review	Forward to BOD for Approval
7. Food Service Procedures	3 year review	Forward to BOD for Approval
8. Inclement Weather and Critical Incident Policy	3 year review	Forward to BOD for Approval
9. Orientation of New Patients	3 year review	Forward to BOD for Approval
10. Practicum Student Placement	3 year review	Forward to BOD for Approval
11. Staff Meetings	3 year review	Forward to BOD for Approval
12. Staffing Levels	3 year review	Forward to BOD for Approval
Pulmonary		
1. Procedural Triage	3 year review, practice change	Forward to BOD for Approval
2. Respiratory Care Students in the Patient Care Areas	3 year review, practice change	Forward to BOD for Approval
Rehabilitation		
1. Fire Plan for OP Rehab Services at 2124 El Camino Real - 1511	RETIRE	Forward to BOD for Approval
2. Pre-OP Teaching	3 year review	Forward to BOD for Approval
Rehabilitation Center		
1. Rehabilitation Leadership Structure	3 year review	Forward to BOD for Approval
Surgical Services		
1. PACU On Call Coverage Policy	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

RETIRE – no longer needed with suspension of Women and Newborn Services

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ADMINISTRATION OF VITAMIN K INJECTION AND ERYTHROMYCIN OPHTHALMIC OINTMENT TO NEWBORNS

~~I. POLICY:~~

~~A. Function: To provide guidelines for Women and Newborn Services (WNS) nurses administering Vitamin K and Erythromycin Ophthalmic Ointment to newborns.~~

~~B. Circumstances:~~

~~1. Setting: **Emergency Department**WNS~~

~~C. Consent:~~

~~1. The **registered nurse** (RN) shall obtain verbal parental consent prior to administration of the Vitamin K injection and the Erythromycin Ophthalmic Ointment to the newborn.~~

~~i. If the parent or legal guardian declines the Vitamin K injection and Erythromycin Ophthalmic Ointment refer to documentation guidelines. In the Medication Administration Record (MAR) this will be documented as "refusal".~~

~~D. Administration/Documentation:~~

~~1. The newborn's patient record~~

~~i. Refer to Tri-City Medical Center Patient Care Services (PCS) policy Medication Administration.~~

~~ii. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.~~

~~a. Not required if a screening process triggers the order~~

~~iii. Document given or "refused" in the MAR~~

~~a. If refused, complete Refusal of Newborn Eye Prophylaxis and/or Refusal of Vitamin K form(s), original to be kept with the patient chart and one copy to be given to the parent or legal guardian and notify **Emergency physician**Pediatrician of refusal(s).~~

~~II. PROCEDURE:~~

~~A. The RN will administer Vitamin K 1 mg IM and Erythromycin Ophthalmic Ointment to the newborn within two hours of birth.~~

~~III. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:~~

~~A. Current unencumbered California RN license and working in WNS~~

~~B. Initial Evaluation: Orientation~~

~~C. Ongoing Evaluation: Annually~~

~~IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:~~

~~A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.~~

~~B. Review: Every two (2) years.~~

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Department of Pediatrics	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/05, 6/07, 9/09, 5/11, 07/13, 06/18, 10/20, **11/23**	6/07, 9/09, 07/13, 04/15, 07/18, 10/20, **01/24**	8/07, 11/09, 7/13, 4/15, 07/18, 12/20, **02/24**	05/15, 08/18, n/a	7/07, 12/09, 9/13, 05/15, 09/18, 05/21, **04/24**	8/07, 12/09, 09/13, 09/15, 10/18, 10/21	8/07, 2/10, 10/13, 09/15, 11/18, 01/22, **07/24**	01/19, 02/22, **08/24**	10/15, n/a	12/05, 8/07, 2/10; 6/11,10/15, 01/19, 02/22

~~V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:~~

~~A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure~~

~~VI. RELATED DOCUMENT(S):~~

~~A. Patient Care Services Policy: Medication Administration~~
~~B. Refusal of Vitamin K Form 6385-1012 English - Sample~~
~~C. Refusal of Vitamin K Form 6385-1014 Spanish - Sample~~
~~D. Refusal of Newborn Eye Prophylaxis Form 6385-1011 English - Sample~~
~~E. Refusal of Newborn Eye Prophylaxis Form 6385-1013 Spanish - Sample~~

SAMPLE

I, _____, have been advised and my physician, Dr. _____ (physician's name, printed) has recommended that my newborn receive a single intramuscular injection of .5-1.0 milligrams of vitamin K (phytonadione) within two hours of birth for prevention of vitamin K deficiency bleeding (Hemorrhagic Disease of the Newborn).

Hemorrhagic Disease of the Newborn usually occurs in the first week of life, but can occur up to 3 months of age. Early warning signs of this disease include but are not limited to:

- skin bruising
- blood seepage from any body opening

Upon observing any such symptoms, a physician should be notified immediately.

Very minimal correlations between childhood leukemia and the use of vitamin K in infants have been reported. If the treatment is not provided, the following injuries could occur:

- onset of vitamin K deficiency bleeding (Hemorrhagic Disease of the Newborn)
- intracranial hemorrhage
- seizure
- death

I have read and I understand the ... medical treatment, the risks, benefits, and alternatives thereof, ...tment. All my questions have been answered. Despite this infor... the hospital to administer a vitamin K injection to my infant. I ... **male infant who has not received the vitamin K injection**

RETIRE

I accept full responsibility for any ... ual, and on behalf of my infant child, hereby release, indemnify a... employees, including but not limited to anyone involved in my c... any injury resulting from my refusal to allow treatment. I have ... knowledge of the harm that may result to my child as a result ...

I understand that the physician na... ot employees, servants or agents of the hospital but indepen...

_____	_____	___/___/___	___:___ AM/PM
Name: Patient/Representative	**Signature:** Patient/Representative	**Date**	**Time**

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

_____	_____	___/___/___	___:___ AM/PM
Witness – TCHD Representative (print name)	**Signature** • *Firma*	**Date** • *Fecha*	**Time** • *Hora*

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI
☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

_____	_____	___/___/___	___:___ AM/PM
Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

Affix Patient Label

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

6385-1012
(Rev. 3/17)

REFUSAL OF VITAMIN K FORM

White - Medical Record Canary - Patient

SAMPLE

Fecha: _____,

Nombre de la madre: _____.

Yo, _____, **he sido aconsejada y mi médico, el Dr./la Dra.**
(imprima/escriba en letra de molde el nombre del médico): _____
ha recomendado que mi recién nacido reciba una sola inyección intramuscular de entre 0.5 a 1.0 miligramos de vitamina K (fitonadiona) dentro de la primera hora de haber nacido para la prevención del sangrado por causa de la deficiencia de vitamina K (Enfermedad Hemorrágica del Recién Nacido). Hay una forma oral disponible de la vitamina K, pero no ha mostrado ser tan efectiva y pone a la criatura en riesgo de tener un sangrado tardío.

La Enfermedad Hemorrágica del Recién Nacido usualmente ocurre en la primera semana de vida, pero puede ocurrir hasta los 3 meses de edad. Las señales de alerta o advertencia temprana de esta enfermedad incluyen pero no se limitan a:

- **moretones en la piel**
- **sangre que filtra (sale) de cualquier**

Al observar cualquiera de estos síntomas, s

Ha sido mínima la correlación que se ha rep **ién nacidos. Si no se proporciona el tratamiento, las siguiente**

- **inicio de sangrado por deficiencia d**
- **hemorragia intracraneal**
- **convulsiones**
- **muerte**

RETIRE

He leído y comprendo el material/informació **este tratamiento médico, los riesgos, los beneficios y las alte** **cias de recibir y de rehusar este tratamiento. Todas mis preg** **ecomendación de mi médico, rehúso permitir al hospital admir** **emás, que no circuncisión se realizará en ningún recié**

Acepto completa y total responsabilidad por cualquier efecto perjudicial que mi rehúso pudiera tener en mi criatura. Yo, como individuo, y en nombre de mi criatura, por la presente libero, indemnizo, y exonero a Tri-City Medical Center, a sus agentes, servidores y empleados, incluyendo pero no limitándose a cualquier persona involucrada en mi atención médica, y en el parto y atención de mi criatura, de cualquier y toda responsabilidad por cualquier lesión/daño que resulte de mi rehúso a permitir el tratamiento. He tomado esta decisión por mi propia voluntad y con la completa comprensión y conocimiento del daño a mi criatura que podría resultar como consecuencia de mi decisión de no permitir que mi criatura reciba una inyección de vitamina K.

Comprendo que el médico mencionado anteriormente y otros médicos que me proporcionan servicios son contratistas independientes y no son empleados, servidores (dependientes) o agentes del hospital.

Firma: _____ **Fecha:** _____ **Hora:** _____ **AM / PM**
(Madre o Padre)

Si se firma por alguien más que no sea la madre o el padre del paciente, imprima su nombre en letra de molde e indique la relación con el paciente:

Nombre: _____ **Relación:** _____.

Testigo: _____ **Fecha:** _____ **Hora:** _____ **AM / PM**

Affix Patient Label

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

6385-1014
(Rev. 01/14)

REFUSAL OF VITAMIN K
REHÚSO A LA VITAMINA K

White - Hospital Yellow - Patient

SAMPLE

I, _____, have been informed by my physician, Dr. _____ (physician's name, printed) that California State law[1] requires both of my newborn infant's eyes to be treated with efficient prophylaxis treatment approved by the California Department of Public Health. Erythromycin is the medication provided at Tri-City Medical Center.

The hospital intends to comply with California State law by administering an approved prophylactic agent to the newborn's eye within two hours after the infant's birth in order to prevent ophthalmia neonatorum and gonorrheal ophthalmia, which most commonly result from Sexually Transmitted Infections. Neither agent stings or otherwise irritates the eyes. If any other symptoms are observed, a physician should be notified immediately.

The most common side effects can last up to 24 hours and include:

- blurred vision
- swelling, redness and/or puffiness to the eyelids

If the treatment is not provided, the following injuries could occur:

- severe eye infection up to and including
- other systemic infection with significant

I have read and I understand the above materia ment, the risks, benefits, and alternatives thereof, and the prob questions have been answered. Despite this information, I refu nt's eyes.

I accept full responsibility for any detrimental effec orn infant, hereby release, indemnify and hold harmless Tri-City Mec d to anyone involved in my care and the delivery and care of m allow treatment.

I understand that by signing this document I am e full responsibility for the consequences for any civi allow my infant child to undergo prophylactic-efficient treatmen

I understand that the doctor named above and nts or agents of the hospital but independent contractors.

RETIRE

Name: Patient/Representative	Signature: Patient/Representative	Date	Time
			: AM/PM

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

Witness – TCHD Representative (print name)	Signature • *Firma*	Date • *Fecha*	Time • *Hora*
		/ /	: AM/PM

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI
☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time
		/ /	: AM/PM

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

[1]The Business and Professions Code Section 551 requires the infant's eye be treated within two hours after birth with a prophylactic-efficient treatment to prevent ophthalmia neonatorum and gonorrheal ophthalmia.

Affix Patient Label

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

6385-1011
(Rev 5/17)

REFUSAL OF NEWBORN EYE PROPHYLAXIS FORM

White - Medical Record Canary- Patient

SAMPLE

Fecha: _____

Nombre de la madre: _____

Yo, _____, he sido informada por mi médico, el Dr./la Dra. _____ (nombre del médico en letra de molde) que la Ley Estatal de California[1] requiere que ambos ojos de mi recién nacido sean tratados con tratamiento profiláctico-eficiente aprobado por el Departamento de Salud Pública de California. Los agentes profilácticos aprobados por el Departamento de Salud Pública de California, incluyen (1) uno porciento de nitrato de plata en ampolletas de cera administradas sin irrigación con solución salina; o (2) pomadas oftálmicas o gotas conteniendo tetraciclina o eritromicina.

El hospital se propone cumplir con la Ley Estatal de California, administrándole un agente profiláctico aprobado a los ojos del recién nacido a menos de dos horas de haber nacido la criatura con el fin de prevenir la oftalmia neonatorum y la gonorrea oftálmica, los que más comúnmente resultan de las Infecciones Sexualmente Transmitidas. Ninguno de los agentes causan ardor o irritan de ninguna manera a los ojos. Si se observa cualquier otro síntoma, se debería notificar inmediatamente a un médico.

Los más comunes efectos secundarios pueden durar hasta 24 horas e incluyen:

- visión borrosa
- inflamación, enrojecimiento y o/hinchazón en los párpados

Si no se provee el tratamiento, los si
- infección severa de los ojos
- otras infecciones sistémicas

ra

He leído y comprendo el material an
aturaleza de este tratamiento médico, los riegos, los beneficios, las
cibir y de rehusar este tratamiento. Todas mis preguntas ha
mitir que el hospital administre un agente profiláctico a lo

RETIRE

Acepto completa responsabilidad po
eda causar en mi criatura. Yo, en mi nombre y en nombre de mi
ro de toda responsabilidad a Tri-City Medical Center, a sus agen
ualquier persona involucrada en mi cuidado y en el acto de lar a lu
ad y obligación por cualquier daño resultante de mi rehúso a perm

Comprendo que, al firmar este docur
y asumo total responsabilidad de las consecuencias de cualquier a
ón de no permitir que mi criatura se someta al tratamiento profiláctico-eficiente.

Comprendo que el médico nombrado anteriormente y otros médicos que a mi me proveen servicios no son empleados, servidores o agentes del hospital, sino contratistas independientes.

_____

Firma del padre (madre/padre) Fecha / Hora

Si ha sido firmado por otra persona que no sea la madre o el padre del paciente, escriba el nombre en letra de molde e indique la relación o el parentesco con el paciente:

_____ _____

Nombre en letra de molde **Relación con el paciente**

Testigo: _____

Representante del Hospital Fecha / Hora

[1]La Sección 551 del Código de Negocios y Profesiones de California requiere que el ojo de la criatura sea tratado en menos de dos horas de haber nacido con un tratamiento profiláctico-eficiente para prevenir la oftalmia neonatorum y la gonorrea oftálmica.

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

6385-1013
(Rev 12/13)

REFUSAL OF NEWBORN EYE PROPHYLAXIS FORM
REHÚSO A LA PROFILAXIS OCULAR EN RECIÉN NACIDO

White - Medical Record Canary - Patient

Tri-City Medical Center
Oceanside, California

RETIRE – no longer needed with suspension of Women and Newborn Services

PATIENT CARE SERVICES

~~STANDARDIZED PROCEDURE: BLOOD GLUCOSE NEWBORN MONITORING~~

~~I. POLICY:~~

~~A. Function: To screen blood glucose (BG) levels in infants of diabetic mothers, late-preterm, small for gestational age, large for gestational age, and term symptomatic infants in order to correct or manage neonatal hypoglycemia.~~

~~B. Circumstances: Infants 36 0/7-36 6/7 weeks up to term, infants at risk, or symptomatic term infants with no risk factors.~~

~~1. Setting: Women and Newborn Services (WNS)~~

~~C. Background: Neonatal glucose concentrations decrease after birth, to as low as 30mg/dL during the first 1 to 2 hours after birth, and then increase to higher concentrations, generally above 45mg/dL by 12 hours after birth.~~

~~D. See Patient Care Services (PCS) Glucose Point of Care (POC) Testing using the Nova Stat Strip Blood Glucose Meter Procedure for step by step instructions for blood glucose machine.~~

~~II. PROCEDURE:~~

~~A. Identify infants at risk and implement monitoring as appropriate.~~

~~a. POC BG is performed for the following infants classified as at risk:~~

~~b. Infants of diabetic mothers (IDM)~~

~~c. Large for gestational age (LGA) infants (greater than or equal to 4 kilogram [kg] or 8 pounds [lbs] 13 ounces [oz])~~

~~d. Small for gestational age (SGA) infants (less than or equal to 2.5kg or 5lbs 9oz)~~

~~e. Late Preterm (LPT) infants – (36 0/7 to 36 6/7 weeks gestation)~~

~~f. Post term infants – (greater than 42 weeks gestation)~~

~~g. Intrauterine Growth Restriction (IUGR) infants~~

~~h. Infants with signs and symptoms of hypoglycemia: (irritability, tremors, jitteriness, exaggerated Moro reflex, a high-pitched cry, seizures, lethargy, floppiness, cyanosis, apnea and poor feeding)~~

~~i. Monitoring and treatment is based on hours of age, risk factors, and symptoms.~~

~~2. Feed at risk infants by 1 hour of age. If unable to feed in the first hour, notify provider immediately.~~

~~3. Utilize breastfeeding or expressed breastmilk first. Supplement with formula if medically indicated per physician/Allied Health Professional (AHP) order.~~

~~B. Perform initial POC BG screen 30 minutes after the first feed by performing a heel stick per PCS Collection of Blood Specimen by Skin Puncture procedure.~~

~~C. From birth to 4 hours of age~~

~~1. If infant is symptomatic with a POC BG less than 40mg/dL, call provider for assessment or NICU consult.~~

~~2. If infant is asymptomatic, but falls into one of the risk factor categories above:~~

~~a. If POC BG is greater than or equal to 40mg/dL continue feeds every 2-3 hours screening the glucose prior to each feed~~

~~b. If initial screen is less than or equal to 39mg/dL, re-feed immediately, and re-check POC BG 1 hour after feed ends.~~

Patient Care Services Content Expert	Clinical Policies & Procedures Comm.	Nursinge Leadership ~~Executive Comm.~~	Perinatal Collab.	Dept. of Pediatrics	Pharmacy & Therapeutics Comm.	Inter-disciplinary Comm.	Medical Executive Comm.	Admin.	Professional Affairs Comm.	Board of Directors
12/14, 09/16, 06/18, 11/23	03/15, 10/16, 07/18, **01/24**	04/15, 10/16, 07/18, **02/24**	05/15, 01/17, 09/18, n/a	05/15, 02/17, 11/18, n/a	03/17, 03/19, **04/24**	09/15, 04/17, 04/19, 07/24	09/15, 04/17, 07/19 **07/24**	08/19, **08/24**	10/15, 05/17, n/a	10/15, 05/17, 08/19

i. If follow-up POC BG is less than 25mg/dL, call provider for assessment or NICU consult.
ii. If follow up POC BG is 25-39mg/dL, re-feed immediately, and re-check POC BG 1 hour after feed ends.
iii. If at any time the POC BG falls below 40mg/dL, re-feed immediately, and re-check POC BG 1 hour after feed ends and continue to follow the steps above based on the POC BG result.
iv. If follow up POC BG is greater than or equal to 40mg/dL, continue feeds every 2-3 hours and screen POC BG prior to each feed until 3 consecutive values greater or equal to 45mg/dL are achieved not counting the initial POC BG.

D. From 4 hours to 24 hours of age:
1. If pre-prandial screen is greater than or equal to 45mg/dL, continue to check POC BG prior to each feed until 3 consecutive values greater than or equal to 45mg/dL are achieved not counting the initial POC BG
2. If pre-prandial screen is less than or equal to 44mg/dL, re-feed immediately, and re-check POC BG 1 hour after feed ends.
a. If follow-up POC BG is less than 35mg/dL, 1 hour after feed ends, then call provider for assessment or NICU consult.
b. If pre prandial screen is 35-44mg/dL, re-feed immediately and re-check POC BG 1 hour after feed ends.
c. If follow up POC BS is greater than or equal to 45mg/dL, continue to monitor POC BG prior to each feed until 3 consecutive values greater than or equal to 45mg/dL are achieved, not counting the initial POC BG.

III. DOCUMENTATION:

A. Blood glucose results in the electronic health record (EHR)
B. Patient assessment and response to feeding or interventions
C. Any complications or adverse side effects
D. Provider notification and follow-up orders for any critical lab value.
E. When implementing orders from a standardized procedure the nurse shall enter the orders electronically.

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Education: Current unencumbered California License
B. Initial Evaluation: New Hire Orientation
C. Ongoing Evaluation: Annually

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All healthcare providers in who have successfully completed requirements as outlined above are authorized to direct and perform.

VII. RELATED DOCUMENT(S):

A. Patient Care Services Procedure: Collection of a Blood Specimen by Skin Puncture
B. Patient Care Services Procedure: Glucose Point of Care Testing using the Nova Stat Strip Blood Glucose Meter
C. Postnatal Glucose Homeostasis Flowchart

VIII. REFERENCE(S):

A. American Academy of Pediatrics. (2011). Postnatal Glucose Homeostasis in Late Preterm and Term Infants. Pediatrics. 127(3): 575-579. Retrieved online from pediatrics.aapublications.org.
B. Guidelines for Perinatal Care 8th Ed., (2017). American Academy of Pediatrics and American College of Obstetricians and Gynecologists.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CHEMOTHERAPY ADMINISTRATION**
Purpose:	To outline the chemotherapy competent nurse's responsibility when administering a chemotherapeutic agent: 1. Notification of a Chemotherapy Order 2. Safe Handling 3. Requirements Prior to Administering a Chemotherapeutic Agent 4. Patient Preparation 5. Documentation 6. Administrating Intravenous and Intramuscular Chemotherapy a. IV Push b. IV Continuous or Intermittent c. Intramuscular and Subcutaneous 7. Administering Oral Chemotherapy
Supportive Data:	See References
Equipment:	See Equipment Lists for specific administration methods

A. **NOTIFICATION OF A CHEMOTHERAPY ORDER:**

1. All inpatient units must notify the oncology unit's Charge Nurse or designee when a chemotherapy order has been written for a patient on a unit other than the oncology unit. Notification must be done as soon as the order is written and no later than a 12-hour notice. The oncology unit must be notified so staffing can be adjusted appropriately for patient safety.
2. Nursing must notify Pharmacy via phone and by scanning the chemotherapy orders as soon as possible when a chemotherapy order is received.

B. **SAFE HANDLING:**

1. Many drugs used in the treatment of cancer (i.e., chemotherapy) are considered to be hazardous to health care workers. The term hazardous refers to drugs/chemicals that require special handling because of potential health risks. Therefore, it is imperative that those who work with chemotherapy drugs adhere to this procedure, the pharmaceutical companies' recommendations, the Safety Data Sheet (SDS) that pertains to the particular hazardous agent and Tri-City Healthcare District (TCHD) policies including but not limited to:
   a. Patient Care Services (PCS) Procedure: Chemotherapy Exposure, Spills and Handling of **Linens** Contaminated ~~Linen~~ with Chemotherapeutic agents and Bodily Fluids
   b. PCS Procedure: Disposal of Chemotherapy Waste
2. Transporting Chemotherapy Agents:
   a. Transport syringes containing chemotherapy in a sealed container, with the luer lock end syringe capped.
   b. All chemotherapy agents will be placed in a leak proof sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" before agent can be transported.
   c. **TCHD personnel**~~The nurse~~ transporting a chemotherapy agent will carry a spill kit at all times in case of a potential chemotherapy spill.
   d. In case of an accidental spill or exposure please see PCS Procedure: Chemotherapy Exposure, Spills and Handling of **Linens** Contaminated ~~Linen~~ with Chemotherapeutic ~~a~~**A**gents ~~and Bodily Fluids procedure~~ as well as the PCS Procedure: Disposal of Chemotherapy Waste.
3. Transporting patients receiving intravenous chemotherapy:

Patient Care Services Content Review	Clinical Policies and Procedures	Nurse Executive Committee	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09,8/09,8/10,11/13, 5/16, 10/19, **07/23**	6/16, 10/19, 01/20, 03/20, **02/24**	07/16, 10/19, 04/20, **03/24**	07/16, 09/20, **06/24**	6/16, 05/20, **04/24**	08/16, 10/20 **07/24**	12/20, **08/24**	09/16, n/a	1/07, 08/09, 8/10;7/13, 09/16, 12/20

a. Transporting a patient receiving intravenous chemotherapy should be avoided if at all possible due to potential risk of a chemotherapy spill, extravasation at the IV site and physiological complications associated with chemotherapy administration.

b. If a patient must be transported to another department the nurse must carry a chemotherapy spill kit at all times. The nurse must ensure the IV site, IV bag(s) and IV lines that are connected to the chemotherapy and the patient are visible and secure to prevent extravasation and spillage of the chemotherapy agent during transport.

4. **Gloves used when handling chemotherapy agents should be chemotherapy rated.**

C. **REQUIREMENTS PRIOR TO ADMINISTERING A CHEMOTHERAPEUTIC AGENT:**

1. At the Outpatient Infusion Center a physician must be on the premises at all times when chemotherapy is being infused into a patient(s).
2. Process for verifying chemotherapy
   a. IV, IM and SQ
      i. First verification requires Chemotherapy Competent RN/Chemotherapy Competent RN or Chemotherapy Competent RN/ Pharmacist
      ii. Second verification Chemotherapy Competent RN/ Chemotherapy Competent RN or TCHD RN
      iii. Exception ED IM Methotrexate Administration – ED RN/ED RN
   b. Oral Chemotherapy
      i. First dose of medication new to the patient requires a Chemotherapy Competent RN /TCHD RN
      ii. Doses the patient has taken previously may be checked by two TCHD RNs
3. Non-PO Chemotherapy may only be administered by a Chemotherapy Competent Registered Nurse (RN) with the exception of IM methotrexate administration for ectopic pregnancy in the Emergency Department which may be administered by any ED Nurse.
~~3.~~**4.** -A Chemotherapy Competent RN is defined by the following requirements:
   a. Has taken and passed an Oncology Nursing Society approved chemotherapy course.
   b. Has completed Chemotherapy Administration competency validation by a TCHD chemotherapy competent nurse (see example Acute Care Services (ACS) 2 P Advanced Oncology- Chemotherapy Addendum Nursing Skills Checklist or Outpatient Infusion Center Skills Checklist).
   c. Completes Chemotherapy Administration competency annually
~~4.~~**5.** -A TCHD approved consent form for chemotherapy administration must be signed by the patient or designee prior to the administration of the chemotherapy regimen for all non-PO and first dose new PO chemotherapy.
~~5.~~**6.** For chemotherapy orders see PCS Policy: Chemotherapy Prescribing, Processing and Preparations.

D. **PATIENT PREPARATION:**

1. Set up continuous pulse oximetry for all patients receiving monoclonal antibodies.
2. Explain to the patient and family/caregivers who will administer the chemotherapy, the route, and the planned sequence of events.

E. **DOCUMENTATION:**

1. The administering Chemotherapy Competent RN will document the chemotherapy verification in the electronic health record (EHR) on every non-PO chemotherapy agent administered.
2. All chemotherapy agents require a second electronic signature by a Chemotherapy Competent RN verifying accuracy of the chemotherapy agent and order (Verification #1) and the electronic Medication Administration Record (eMAR) by using their EHR password (Verification #2).
   a. Off unit non-PO chemotherapy Verification #1 can be witnessed by the floor pharmacist if a second Chemotherapy Competent RN is not available.

F. **ADMINISTERING INTRAVENOUS (IV), INTRAMUSCULAR (IM) AND SUBCUTANEOUS (SQ) CHEMOTHERAPY**

1. IV, IM and SQ chemotherapy orders and agents will be verified twice for accuracy before administration.
2. **VERIFICATION #**
   a. Verification for accuracy will be completed by two Chemotherapy Competent RNs when the chemotherapy agent arrives on the unit and documented in the EHR.
      i. A floor Pharmacist/ Chemotherapy Competent RN can do the #1 verification if two Chemotherapy Competent RNs are not available on the off unit areas.
      ii. Exception ED IM Methotrexate Administration – ED RN/ED RN
   b. Verification #1 will be determined by verifying:
      i. Date /Time of Administration
      ii. Patient Name
      iii. Chemotherapy Agent
      iv. Dose
      v. Diluent/Volume (if applicable)
      vi. Rate of administration (if applicable)
      vii. Route
      viii. Patient's height and weight
      ix. Patient's body surface area (BSA) (if applicable)
      x. Area under the curve (AUC) (if applicable)
3. **VERIFICATION #2**
   a. At the patient's bedside a second verification for accuracy will be completed and documented on the electronic medication administration record (EMAR)
   b. Verification #2 will be determined by verifying the following per the PCS Policy: Medication Administration:
      i. Verify correct:
         1) Patient
         2) Dose
         3) Time
         4) Medication
         5) Route/Rate (if applicable)
         6) Documentation
         7) Reason
4. All intravenous **Vesicant** Chemotherapy will only be administered via a Central Venous Catheter and should never be administered peripherally.
   a. Exception- Paclitaxel may be administered via peripheral IV if the IV site is visually assessed every 15 minutes for signs and symptoms of extravasation (Inpatient ratio would be 2:1).
5. All intravenous chemotherapy will be administered through an Alaris IV pump using the oncology profile and specific ~~guardrail~~**Guardrails®** for the chemotherapy agent if available.
6. Peripheral **Non-Vesicant** Chemotherapy Administration:
   a. Start a new peripheral IV if site is more than 24 hours old.
   b. Avoid flexion joint sites.
   c. -Preferably select a large vein between wrist and elbow.
   d. Avoid veins in the hand, wrist and antecubital fossa, if possible.
7. Extravasation Prevention
   a. Blood return must be checked prior to administration of any chemotherapy agent.
      i. Vesicants: Verify blood return and IV patency prior to, during and post administration of a vesicant.
   b. Inspect IV site for signs and symptoms of the following before administration:
      i. Peripheral
         1) Redness

2) Inflammation
3) Infiltration
4) Patient comfort level at IV site

ii. Central Venous Catheters (CVC)
1) Erythema
2) Swelling
3) Drainage
4) Leakage

8. Verify that the patient has signed a TCHD approved consent form for chemotherapy administration for all non-PO chemotherapy administration and first dose new PO chemotherapy.

9. Don personal protective equipment (PPE) in the following order before spiking a pre-filled chemotherapy IV bag or when manipulating a syringe that contains a chemotherapy agent:
a. Surgical mask
~~a.~~**b.** Face shield or splash goggles
~~b.~~**c.** ~~surgical mask~~
~~c.~~**d.** First pair of chemo gloves
~~d.~~**e.** Chemo gown with the cuffs over the first pair of gloves
~~e.~~**f.** Second pair of chemo gloves over the cuffs of the gown

10. **Procedure:**
a. **IV Push**
i. Don two pair of chemotherapy safe gloves.
1) Examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.
ii. Complete Verification #1.
iii. Assemble equipment.
1) Extravasation Kit
2) PPE (**surgical mask,** face shield or splash goggles, ~~surgical mask,~~ chemotherapy gown, 2 pairs of chemotherapy gloves). It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
3) Chemotherapy puncture- proof waste disposal container
4) Leak-proof bag marked "Chemotherapy Waste"
5) Plastic –backed absorbent pad
6) Sterile gauze
7) Alcohol Prep Pads
iv. Review all manufacturer recommendations pertaining to the administration, pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow PCS Procedure: Chemotherapy Extravasation.
vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent–, chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
1) Extravasation
a) Burning
b) Pain
c) Heat
d) Ulceration
e) Swelling
2) Signs and symptoms of hypersensitivity and anaphylaxis
a) Uneasiness
b) Tightness of the chest

c) Shortness of breath-with or without wheezing
d) Hives or rash
e) Local or generalized itching
f) Periorbital or facial edema
g) Lightheadedness or dizziness

vii. IV Chemotherapy shall be administered with no other IV medications or IV fluids running except for the mainline compatible IV fluid used during the IV push chemotherapy administration.

viii. Label the IV pump and the IV push chemotherapy syringe with a TCHD approved "Chemotherapy" identification sticker before administration.

ix. Inspect IV site and check patient's IV for blood return.

x. Don PPE in the following order before administration:
1) Surgical mask
~~1)~~**2)** Face shield or splash goggles
~~2) surgical mask~~
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

xi. Place plastic –backed absorbent pad under the patient's arm to prevent drug contact with patient's skin.

xii. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
1) Outpatient Infusion Center will complete the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.

xiii. Complete Verification #2 and complete the witness section on the medication barcode scanning device.
1) Outpatient Infusion Center will document on the EMAR.

xiv. Using the alcohol prep pads, clean the patient's IV access port three times

xv. Wrap sterile gauze around IV ports during IV push to reduce the potential for spraying

xvi. Inject drug into distal port of IV with free flowing solution at the prescribed rate (minimum of 100mL/hour). Verify blood return every 2-3 mL of drug administration.

xvii. Flush line with 10-20mL of IV solution between administration of drugs or prior to discontinuing IV.
1) Prevents incompatibility reaction and avoids exposure to anti-neoplastic agents.

xviii. Dispose of syringes in the puncture proof container labeled "Chemotherapy Waste".

xix. Recheck IV lines to be sure lines are leading to patient and are connected to the correct IV port.

xx. Remove PPE in the following order and place in a chemotherapy waste bag and seal:
1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) Surgical mask
5) Final pair of gloves

xxi. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials.

b. **IV Continuous or Intermittent**

i. Donning two pair of chemotherapy gloves, examine the Chemotherapy pre-filled IV bag and tubing for leakage or damage in the medication room before administration.
ii. Complete Verification #1.
iii. Assemble equipment for use during administration.
    1) Extravasation Kit
    2) Personal Protective Equipment (PPE) (**surgical mask,** Face shield or goggles, ~~surgical mask,~~ chemotherapy disposable gown, two pairs of chemotherapy gloves).
    3) Chemotherapy puncture proof waste disposal container
    4) Leak-proof bag marked "Chemotherapy Waste"
    5) "Chemotherapy" identification stickers
    6) Disposable plastic –backed absorbent liner
    7) Plastic tape
    8) 3 Alcohol Prep Pads
iv. Review all manufacturer's recommendations pertaining to the administration (located in the TCHD Drug Formulary or package insert), pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCHD's Chemotherapy Extravasation Procedure.
vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent, chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
    1) Extravasation
        a) Burning
        b) Pain
        c) Heat
        d) Ulceration
        e) Swelling
    2) Signs and symptoms of hypersensitivity and anaphylaxis
        a) Uneasiness
        b) Tightness of the chest
        c) Shortness of breath-with or without wheezing
        d) Hives or rash
        e) Local or generalized itching
        f) Periorbital or facial edema
        g) Lightheadedness or dizziness
vii. IV Chemotherapy shall be administered on a single Alaris IV pump with no other IV medications or IV fluids running except for the mainline compatible flush bag for the IV chemotherapy agent.
viii. Don PPE in the following order before administration:
    1) Surgical mask
    ~~1)~~**2)** Face shield or splash goggles
    ~~2) surgical mask~~
    3) First pair of chemo gloves
    4) Chemo gown with the cuffs over the first pair of gloves
    5) Second pair of chemo gloves over the cuffs of the gown
ix. Prime all IV tubing with a compatible IV fluid before administering the chemotherapy intravenously if not already done by pharmacy.
x. At the patient's bedside, program the Alaris pump using the appropriate chemotherapy drug ~~guardrail~~**Guardrails®** profile with the witnessing second Chemotherapy Competent RN (preferred) or TCHD RN.

1) Power on the Alaris IV pump and select New Patient.
2) Select the Oncology Profile.
3) Enter the patient's medical record number.
4) Select Channel letter that will be used.
5) Select ~~Guardrail~~**Guardrails®** -Drugs.
6) Select the appropriate chemotherapy agent to be administered from the Alaris Oncology Drug ~~Guardrail~~**Guardrails®** List.
7) Verify and confirm correct dosing program.
8) Review Clinical Advisory Warning on the Alaris IV pump and Confirm when read.
9) Input the Drug Amount, Diluent Volume, BSA (if applicable). Verify dose and select Next.
10) Input Rate and Volume to be infused (VTBI).

xi. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy IV bag per the PCS Policy: Medication Administration.
1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physician order.

xii. Complete Verification #2 including verification of the Alaris infusion ~~guardrail~~**Guardrails®** set up and rate as well as the chemotherapy agent for accuracy at the patient's bedside and complete the witness section on the medication barcode scanning device (see verification #2).
1) Outpatient Infusion Center will document on the EMAR.

xiii. Label the IV pump and the IV chemotherapy bag with a TCHD approved "Chemotherapy" identification sticker before administration.
xiv. Inspect IV site and check patient's IV for blood return.
xv. Use disposable plastic –backed absorbent liner under the IV
xvi. Using the alcohol prep pads, clean the patient's IV access port three times.
xvii. Securely attach the IV tubing to the patient's venous access device or, if using a secondary set, to the primary tubing
xviii. Tape the two IV connections together
xix. Review dose and then select Start to begin infusion on the Alaris pump.
xx. When infusion is complete, don PPE as instructed.
xxi. Dispose of contaminated IV tubing and IV bags in a sealed chemotherapy waste bag and place in a puncture- proof chemotherapy waste container
xxii. Remove PPE in the following order and place in a chemotherapy waste bag and seal:
1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) Surgical mask
5) Final pair of gloves

xxiii. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials

c. **<u>Intramuscular (IM) and Subcutaneous (SQ)</u>**

i. Donning two pair of chemotherapy gloves, examine the chemotherapy pre-filled syringe for leakage or damage in the medication room before administration.
ii. Compete Verification #1
iii. Assemble equipment for use during administration.
1) PPE (**Surgical mask,** ~~F~~face shield or goggles, ~~surgical mask,~~ chemotherapy disposable gown, two pairs of chemotherapy gloves).
2) Chemotherapy puncture- proof sharps waste container
3) Leak-proof bag marked "Chemotherapy Waste"

4) "Chemotherapy" identification sticker
5) Appropriate size sterile needle (Use smallest needle possible)
6) 2x2 gauze pads
7) Alcohol Prep Pads
8) Band-Aid

iv. Review all manufacture's recommendations pertaining to the administration (located in the TCHD Drug Formulary or package insert), pre-medication, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.

v. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent, chemo safety for body fluids and when to notify the nurse for ~~signs and symptoms of~~:
1) Signs and symptoms of hypersensitivity and anaphylaxis
a) Uneasiness
b) Tightness of the chest
c) Shortness of breath-with or without wheezing
d) Hives or rash
e) Local or generalized itching
f) Periorbital or facial edema
g) Lightheadedness or dizziness

vi. Label chemotherapy syringe with a TCHD approved "Chemotherapy" identification sticker before administration.

vii. Don PPE in the following order before administration:
1) Surgical mask
~~1~~**2)** Face mask or Splash Goggles
~~2) Surgical mask~~
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

viii. Remove cap and connect sterile needle of the appropriate size for administering the drug.

ix. Do not expel air from the syringe or prime the needle.

x. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.

xi. Complete Verification #2 and complete the witness section on the medication scanning device.
1) Outpatient Infusion Center will document on the EMAR.

xii. Review the manufacturers injection site recommendation

xiii. Cleanse injection site with alcohol prep pads

xiv. After administering the drug, do not re-cap and do not ~~message~~ **massage the** injection site.

xv. Place the syringe with the needle attached directly into the puncture- proof chemotherapy waste container.

xvi. Remove PPE in the following order and place in a chemotherapy waste bag and seal
1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) -Surgical mask
5) Final pair of gloves

xvii. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials
xviii. Monitor injection site post injection for signs and symptoms of infection and bleeding.
xix. Educate patients going home after injection to assess the injection site after return home for bleeding and signs and symptoms of infection.

G. **ADMINISTERING ORAL CHEMOTHERAPY**

1. Oral Chemotherapy may not be crushed, scored or capsules opened on the nursing units. All oral chemotherapy agents that need to be altered in this manner must only be done by the pharmacy in a controlled environment. If patient is unable to take the chemotherapy agent orally in a whole form and an alternative route (Nasogastric tube, gastric tube etc.) is available, notify the pharmacy as soon as possible (ASAP) so alterations can be made to the original medication form so the agent can be administered safely.
2. **Procedure**
   a. **Oral Chemotherapy**
      i. Complete Verification #1
         1) Oral chemotherapy that the patient has not taken previously must be initially checked for accuracy on the first dose by a Chemotherapy Competent RN and a TCHD RN.
         2) All oral chemotherapy that the patient has taken previously may be checked by two TCHD RNs. A Chemotherapy Competent RN may be requested for additional education for any new PO chemotherapy orders that the patient has not been on previously.
      ii. Assemble disposal equipment for use during administration
         1) Personal Protective Equipment (PPE)
         2) Two pairs of chemotherapy gloves.
         3) If administering an oral chemotherapeutic agent that is in a liquid or powder form, a **surgical mask,** face shield or goggles, ~~surgical mask~~, and chemotherapy disposable gown is recommended. It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
         4) Leak-proof bag marked "Chemotherapy Waste"
      iii. Review all manufactures recommendations pertaining to the administration, pre-medication, labs and potential side effects (located in the TCHD Drug Formulary or package insert), of the specific chemotherapeutic agent before agent is administered.
      iv. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent, chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
         1) Hypersensitivity and anaphylaxis
            a) Uneasiness
            b) Tightness of the chest
            c) Shortness of breath-with or without wheezing
            d) Hives or rash
            e) Local or generalized itching
            f) Periorbital or facial edema
            g) Lightheadedness or dizziness
      v. Assess patient's ability to swallow prior to administration
      vi. Don two chemotherapy gloves before handling the oral chemotherapy agent and during administration.
      vii. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.

1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physician's order).

viii. Complete Verification #2 and complete the witness section on the medication barcode scanning device.
1) Outpatient Infusion Center will document on the EMAR.

ix. Dispose of all materials that came into contact with the chemotherapeutic agent (i.e. medication cup, manufacturer's container or packaging) in a leak-proof chemotherapy waste bag and seal
1) See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated material.

H. **RELATED DOCUMENTS:**

1. PCS Policy: Chemotherapy Prescribing, Processing and Preparations
2. PCS Policy: Medication Administration
3. PCS Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids
4. PCS Procedure: Chemotherapy Extravasation
5. PCS Procedure: Disposal of Chemotherapy Waste

I. **REFERENCES**

1. Mafrica, Leonard. Safe Handling of Hazardous Drugs. Oncology Nursing Society. (2003)
2. National Institute for Occupational Safety and Health, (2004). Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Retrieved from the NIOSH website at http://www.cdc.gov/niosh/docs/2004-165/#c
3. Oncology Nursing Forum: Vol.39, No.1 (Jan 2012) Revisions to the 2009 American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards: Expanding the Scope to Include Inpatient Settings
4. Oncology Nursing Society, (2019). Chemotherapy and Immunotherapy.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXPOSURE, SPILLS, AND HANDLING OF LINENS CONTAMINATED WITH CHEMOTHERAPEUTIC AGENTS AND BODY FLUIDS, ACCIDENTAL EXPOSURE TO RADIOACTIVE BODY FLUIDS**
Purpose:	To outline staff responsibility and management of chemotherapy spills, radioactive body fluid exposures, and handling of contaminated linens.
Supportive Data:	To prevent staff exposure to chemotherapy and radiopharmaceuticals
Equipment:	Chemotherapy Spill Kit

A. **POLICY:**

1. Many drugs used in the treatment of cancer are considered to be hazardous to health care workers.
   a. The term hazardous refers to drugs/chemicals requiring special handling because of potential health risks.
2. Staff working with chemotherapy drugs and the body fluids of patients that have received chemotherapy shall adhere to this procedure and reference Patient Care Services Disposal of Chemotherapy Waste procedure.
   a. Body fluid including but not limited to sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.
3. Do not use chemical inactivators due to the potential for dangerous by-products.
   a. Exception: Sodium thiosulfate is used to inactivate nitrogen mustard.
4. **Contact the Environmental Services (EVS) supervisor at 760-644-6973 for assistance with spills.**
5. **Don personal protective equipment in the following order:**
   a. N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
   b. Splash goggles or face shield
   c. First pair of chemotherapy gloves
   d. Protective Shoe covers
   e. Chemotherapy gown with the cuffs over the first pair of gloves
   f. Second pair of chemotherapy gloves over the cuffs of the gown
6. **Remove personal protective equipment in the following order.**
   a. Outer pair of gloves
   b. Chemotherapy gown
   c. Splash goggles or face shield
   d. N95 mask
   e. Protective Shoe covers
   ~~a.~~f. Final pair of gloves

B. **PROCEDURE FOR SPILL MANAGEMENT:**

1. For chemotherapy spills greater than 400 mL in any department:
   a. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in kit).
   b. Remove personnel and patients from the immediate area.
      i. Immediate area is approximately 20-foot perimeter.
   c. If spill occurs in a patient's room, evacuate patient(s) from the room and close door.
   d. Nursing to contact Environmental Services (EVS) supervisor ~~at 760-644-6973~~.
      i. EVS to contact EOC Safety Officer regarding the chemotherapy spill ~~at 760-590-0352.~~
2. For chemotherapy spills less than 400 mL:
   a. Non-Oncology Nursing Units Responsibilities for spills on hard surfaces estimated at less than 400 mL

Department Review	Clinical Policies & Procedures	Nursing Executive Council Committee	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admin stration	Professional Affairs Committee	Board of Directors
3/00, 10/06, 5/09, 2/12, 9/15, 09/19, **02/24**	4/12, 8/15, 6/16, 10/19, **02/24**	4/12, 09/15, 7/16, 10/19, **03/24**	4/12, 09/15, 07/16, 03/20, **06/24**	09/15, 6/16, 11/19, **04/24**	5/12. 10/15, 08/16, 04/20, **07/24**	05/20, **08/24**	6/12, 11/15, 09/16, n/a	6/12, 12/15, 09/16, 05/20

i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Contact EVS Supervisor of the chemotherapy spill 760-644-6973.

b. EVS Responsibilities for spills on hard surfaces estimated at 400 mL or less:
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Don personal protective equipment ~~in the following order:~~
~~1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)~~
~~2) First pair of chemotherapy gloves~~
~~3) Chemotherapy gown with the cuffs over the first pair of gloves~~
~~4) Second pair of chemotherapy gloves over the cuffs of the gown~~
~~5) Splash goggles or face shield~~
~~6) Protective Shoe covers~~
iii. Place spill pillows from spill kit in a "V" position on outer perimeter of spill to prevent spreading of fluid.
iv. Place one towel from the spill kit over spill to absorb fluid.
v. Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
vi. Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
vii. Use the DIMENSION 3 procedure of the EVS guidelines to complete the cleaning.
viii. After DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
ix. Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
x. Remove personal protective equipment ~~in the following order.~~
~~1) Outer pair of gloves~~
~~2) Chemotherapy gown~~
~~3) N95 mask~~
~~4) Splash goggles or face shield~~
~~5) Protective Shoe covers~~
~~6) Final pair of gloves~~
xi. Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
xii. Place sealed bag in the designated chemotherapy waste area on the unit.
xiii. Complete the Hazardous Drug Exposure Report and give to the supervisor of the EVS department.
xiv. The EVS supervisor shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the EOC Officer.

c. Oncology Unit/Outpatient Infusion Center/Pharmacy responsibilities for spills on hard surfaces estimated between 200 mL and 400 mL:
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Delegate to a co-worker to contact EVS Supervisor of the chemotherapy spill and/or EOC Safety Officer regarding the chemotherapy spill. EVS is responsible for spills on the oncology and pharmacy units that are between 200 mL and 400 mL.
~~1) 760-644-6972 (Day Shift) or pager 760-926-0841~~
~~2) 760-644-6973 (Evening Shift) or pager 760-926-0832~~
~~3) 760-644-6974 (Night Shift) or pager 760-926-0834~~
~~4) 760-590-0352 (EOC Officer)~~

d. Oncology Unit/Outpatient Infusion Center/Pharmacy responsibilities for spills on hard surfaces estimated at less than 200 mL:

i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).

ii. Contact or delegate a co-worker to contact Environmental Services (EVS) Supervisor of the chemotherapy spill.

~~1) 760-644-6972 (Day Shift) or pager 760-926-0841~~
~~2) 760-644-6973 (Evening Shift) or pager 760-926-0832~~
~~3) 760-644-6974 (Night Shift) or pager 760-926-0834~~

iii. Don personal protective equipment ~~in the following order:~~

~~1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)~~
~~2) First pair of chemotherapy gloves~~
~~3) Chemotherapy gown with the cuffs over the first pair of gloves~~
~~4) Second pair of chemotherapy gloves over the cuffs of the gown~~
~~5) Splash goggles or face shield~~
~~6) Protective Shoe covers~~

iv. To clean up a spill from a hard surface estimated as less than 200 mL:

1) Place spill pillows in a "V" position on outer perimeter of spill to prevent spreading of fluid.
2) Place one towel from the spill kit over spill to absorb fluid.
3) Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
4) Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
5) EVS must use the DIMENSION 3 procedure of their EVS guidelines to complete the cleaning.
6) After EVS has completed the DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
7) Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
8) Remove personal protective equipment ~~in the following order:~~
   ~~a) Outer pair of gloves~~
   ~~b) Chemotherapy gown~~
   ~~c) N95 mask~~
   ~~d) Splash goggles or face shield~~
   ~~e) Protective Shoe covers~~
   ~~f) Final pair of gloves~~
9) Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
10) Place sealed bag in the designated chemotherapy waste area on the unit.
11) Complete the Hazardous Drug Exposure Report and give to the clinical manager on the nursing unit.
12) The clinical manager shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the Environment of Care (EOC) Safety Officer.

C. **PROCEDURE -- EXPOSURE AND PREVENTION RELATED TO CHEMOTHERAPY AGENTS AND BODY FLUIDS:**

1. In the event of skin exposure to chemotherapeutic agent; remove any contaminated garment and immediately wash contaminated skin with soap and water.

2. In case of eye exposure, immediately flush the eye with saline solution or water for at least five minutes.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Contact EVS when chemo waste linen bag is 2/3 full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.
5. Place any disposable cytoxic contaminated materials into a sealed, leak proof chemo waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items and/or items that are saturated with body fluids. See Patient Care Services: Disposal of Chemotherapy Waste Procedure.
6. All containers will be clearly labeled citing the hazardous nature of the contents-Chemotherapy.
7. Report any cytotoxic exposures or spills to your supervisor.
8. Report any employee exposure to employee health services and/or emergency department.
   a. Fill out Illness/Injury Investigation Report
9. Report any patient exposure to the patient's healthcare provider and per institution policy.

D. **PROCEDURE - PRECAUTIONS WHEN HANDLING BODY FLUIDS OF A PATIENT RECEIVING CHEMOTHERAPY (Precautions need to be taken during and 48 hours after last Chemotherapy Dose):**

1. Wear appropriate personal protective equipment (PPE) which may include the following:
   a. N-95 mask
   b. Double chemotherapy gloves
   c. Chemotherapy gown
   d. Splash goggles or face shield
   e. Protective shoe covers
2. Disposing of body fluid
   a. Dispose of body fluids in the toilet.
   b. DO NOT USE THE TOILET SPRAYER. Rinse containers with a cup of water to prevent splashing
   c. Before flushing toilet, cover open toilet with chux. (New chux to be used with each flush).
   d. Flush toilet twice
   e. Place personal protective equipment and chux in chemotherapy waste bag.
   f. Non-Oncology contact EVS to dispose of chemo waste bag when they become ¾ of the way full.
   g. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Skin care of incontinent adult receiving chemotherapy
   a. Clean patients skin well after voiding or having a bowel movement
   b. Apply protective barrier ointment or cream before diapering
5. All disposable equipment (i.e. **urinary**~~foley~~ catheter, bedpan, graduated cylinder, and diapers) used in caring for chemotherapy patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

E. **PROCEDURE - RADIOACTIVE BODY FLUIDS, EXPOSURE RELATED TO:**

1. In the event of exposure from the body fluid, immediately remove any contaminated garment or shoes being careful to avoid contact with substance.

2. Place contaminated articles in red radioactive marked containers in room.
3. Place as much distance from contaminated articles and self as possible.
4. Immediately wash contaminated skin with soap and water.
5. Alert Radiation Safety Officer and manager via in room phone or call light, of radiation exposure.
6. Do not leave room unless cleared by Radiation Safety Officer.
7. Report any employee exposure to employee health department or emergency department.
   a. Fill out appropriate injury form
8. Report any patient exposure to the patient's healthcare provider and per institution policy.

F. **RELATED DOCUMENTS:**

1. PCS Disposal of Chemotherapy Waste Procedure

G. **REFERENCES**

1. ONS Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, 2014, Fourth Edition
2. Center for Disease Control and Prevention. Occupational Exposure to Antineoplastic Agents and Other Hazardous Drugs. http://www.cdc.gov/niosh/topics/antineoplastic/December 12, 2014
3. Medical Waste Management Act January 2015 California Health and Safety Code Sections 117600 – 118360
4. "Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings." National Institute for Occupational Safety and Health (NIOSH), 2014. http://www//cdc/gov/niosh/docs/2004-165/#c. "Kendall Chemobloc Procedure." Tyco Healthcare. 2006 www.tycohealthcare.com
5. Oncology Nursing Society. Manual for Radiation Oncology Nursing Practice and Education, 4th Edition, 2012. Print

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CODE PINK RESUSCITATION

I. **POLICY:**

A. Function: Management of impending or actual cardiopulmonary arrest in the pediatric patient greater than ~~30~~ days of age through 13 years.

~~1. A Code Caleb will be activated for the resuscitation and stabilization needs of the high-risk neonate/ infant up to 30 days old. Please see Patient Care Services: Code Caleb Team Mobilization Policy.~~

B. Circumstances:

1. Setting: Tri-City Healthcare District (TCHD).
2. Supervision: None required. However, upon arrival of a physician the Code Pink team will follow physician orders instead of the Standardized Procedure.
3. Patient contraindications: Patients with a written "No Code Order."

II. **PROCEDURE ~~(CHILDREN GREATER THAN 30 DAYS OLD THROUGH 13 YEARS)~~ :**

A. Data Base:

1. Subjective: None
2. Objective: Significant acute change in neurologic status, status epilepticus unresponsive, absent respirations status asthmaticus and/or rhythm disturbances (monitored patient) absent pulse, acutely hypotensive or absent blood pressure.
3. Diagnosis: Impending/Actual Cardiopulmonary arrest
4. Plan:
   a. Initiate Standardized Procedure as appropriate and initiate Code Pink (dial 66 on the telephone).
   b. Assessment: Patient will be reassessed after each intervention.
   c. Record Keeping: Events are to be recorded on the Cardiopulmonary Arrest Record.

B. Respiratory Distress/Arrest:

1. Establish patent airway.
2. Administer oxygen to maintain O_2 saturation greater than 95%.
3. Begin Positive Pressure Ventilation (PPV) with 100% oxygen as necessary, monitoring adequate rise and fall of chest, breath sounds, color, and work of breathing.
4. Assist with intubation as appropriate.
5. Have adequate suction readily available.
6. Obtain STAT Arterial Blood Gas (ABG) and chest X-ray as needed.

C. Heart Rate less than 60 **beats per minute** (bpm) (Bradycardia):

1. Initiate chest compressions.
2. Begin PPV with 100% oxygen.
3. Obtain Intravenous (IV) access:
   a. Establish IV access with Normal Saline (NS) at to keep open (TKO) rate (may be used for resuscitation medications or fluid bolusing as needed).
   b. Get Intraosseous (IO) device ready for placement by physician if IV access is unobtainable (must be placed by a physician or supervised by a physician).
   c. Give fluid bolus for hypotension systolic blood pressure **(SBP)** less than (70 + [age in years times 2]) NS 20 mL/kg. Can repeat times 2 if lungs remain clear.

Patent Care Service Content Expert ~~Department Review~~	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Council~~	Department of Pediatrics	Department of Emergency Medicine	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Admini Stration	Board of Directors
03/00, 08/07, 02/10, 06/11, 09/14, 05/17, 11/23	01/11, 09/13, 09/14, 06/17, 12/23	03/11, 09/13, 10/14, 08/17, 01/24	11/14, 02/18, n/a	04/24	06/11,09/13, 09/14, 07/17, 04/24	06/11, 02/14, 03/15, 04/18, 07/24	06/11,02/14, 03/15, 05/18, 08/24	05/15, 06/18, n/a		06/11, 02/14, 05/15, 06/18

4. Medications for Bradycardia:
   a. Epinephrine:
      i. Indicated when heart rate remains less than 60 **bpm** and patient is hypotensive.
      ii. Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.
      iii. IV/IO DOSING: 0.01 mg/kg (0.1 mL/kg of 0.1 mg/mL solution) Maximum single dose 1 mg. Administer every 3-5 minutes as needed.
      iv. ET DOSING: 0.1 mg/kg (0.1 mL/kg of 1 mg/mL solution). Maximum single dose 2.5 mg. Administer every 3- 5 minutes as needed until IV/IO access is established.
      v. Rate of administration is rapid.

D. Symptomatic Hypoglycemia:
   1. Obtain a capillary blood glucose value. If glucose level is less than 60 mg/dL then treat with D10W 5 mL/kg via slow IVP

E. Hypotension:
   1. IV/IO bolus for hypotension (SBP less than 70 + [age in years times 2]). Administer NS 20 mL/kg. May repeat times 2 if lungs remain clear.

F. Cardiac Rhythm Disturbances/Shock:
   1. Follow American Heart Association (AHA) ~~2015~~ **2020** Pediatric Advance Life Support (PALS) guidelines:
      a. BLS for healthcare providers
      b. Pediatric Bradycardia with a pulse Algorithm
      c. Pediatric Tachycardia with Pulses and Poor Perfusion Algorithm
      d. Pediatric Pulseless Arrest Algorithm
      e. Septic Shock Algorithm
      f. Treatment of Shock Algorithm

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Registered Nurse (RN) with current California license and working in the Emergency Department.

B. Education: Pediatric Advanced Life Support (PALS), or Emergency Nurse Pediatric Course (ENPC).

C. Initial Evaluation: Before an RN may initiate the Code Pink Standardized Procedure, the RN must be observed in the management of a pediatric resuscitative effort and demonstrate successful skills in PALS or the ENPC course.

D. Ongoing Evaluation: Annually.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Emergency Department Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Code Pink Resuscitation Standardized Procedure.

~~VI. RELATED DOCUMENT(S):~~

~~A. Patient Care Services: Code Caleb Team Mobilization Policy~~

~~VII.~~VI. REFERENCES:

A. American Heart Association: ~~2015~~ **2020** Pediatric Advance Life Support

Tri-City Medical Center	Patient Care S

RETIRE – follow Patient Care Services Policy: Code Surge: Patient Capacity Management

PROCEDURE:	CODE TRIAGE ALERT, EMERGENCY DEPARTMENT
Purpose:	To ensure patients have access to appropriate care when patient care demands exceed resources. To provide care at safe and consistent levels regardless of census overall.

A. **DEFINITIONS:**

1. Code Triage: The Emergency Department (ED) is experiencing capacity and/or is unable to accommodate incoming patients due to flow of patients through the hospital continuum.
2. Code Triage – Yellow: The status assumed when the availability of inpatient beds and/or staffing is limited, and the ED is experiencing delays in admissions of greater than (> 2) hours and is boarding patients.
3. Code Triage – Red: The status assumed when there is no availability of inpatient beds and/or staffing, and house wide resources are limited. The ED is experiencing inability to obtain inpatient beds and flow is restricted in the ED due to multiple boarded patients.
4. Boarder: delay in admission greater than 2 hours

B. **PROCEDURE:**

1. Bed census information is communicated to the ED Leadership /Charge RN, by the Administrative Supervisor (AS) when the hospital is experiencing limited availability of staffing and/or beds.
2. Communication will occur 24/7 with updates at least every 2 hours, unless otherwise determined. Communication will be conducted via the daily Administrative Supervisor Report process for each shift, through phone conversations between the ED and the Administrative Supervisor, during the throughput huddle and emergency bed meetings as appropriate.
   a. During Code Triage – RED, the ED Charge RN shall communicate with the AS for all diversions, critical patients, and codes.
      i. ED Leadership shall communicate with the ED Charge RN every 2 hours from 0500-2200.
3. The ED Leadership, and the Senior Administrator/Clinical Operations Manager on call will determine when a hospital response (Code Triage – Yellow or Code Triage – Red) is necessary and notify the AS and PBX.
4. Code Triage Response
   a. Code Triage – Yellow:
      i. AS will communicate the emergency at the morning throughput huddle meeting and afternoon routine bed meeting. Attendees will include:
         1) All inpatient representatives (Leadership/designee)
         2) Surgery representative (Leadership/designee)
         3) Administrative Supervisor
         4) Case Management representative
         5) Staffing Office representative
      ii. Recommended actions include:
         1) Assess all unit censuses and potential discharges.
         2) Case Management to contact attending physicians to obtain discharges and plan early rounds as appropriate. Initiate active discharge planning to include disposition, education, and transportation.
         3) Call in extra staff as needed and/or adjust existing staff to accommodate patients. Consider increasing to 1:5 ratio in Med/Surg unit as appropriate. Utilize premium or incentive pay for staff and agencies.
         4) Remove barriers to flow including charge nurse to charge nurse report.

Review/Revision Date	Clinical Policies & Procedures	Nursing Executive Committee	Department of Emergency Medicine	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
9/07;5.14; 02/20, 01/24	11/07, 1/10, 6/10;5/14, 03/20, 04/24	12/07, 1/10, 7/10; 6/14, 04/20, 06/24	7/14, 06/20, 06/24	1/08, 07/10; 8/14, 07/20, 07/24	08/20, 08/24	2/08, 08/10;10/14, n/a	2/08, 08/10;11/14, 08/20

5) Consider sending inpatient staff to ED to "pull" patients and receive face to face report.

b. Code Triage – Red:

i. AS will initiate emergency bed meeting STAT in the French Room, or via conference call. Attendees will including but not limited to:

1) All inpatient representatives (Leadership/designee)
2) Surgery representative (Leadership/designee)
3) Administrative Supervisor
4) Case Management representative
5) Staffing Office representative
6) Administrator or Clinical Operations Manager on call
7) Environmental Services (EVS) Leadership/designee
8) Nutrition Services
9) Supply Chain Management
10) Pharmacy as appropriate if opening overflow areas

ii. Recommended Actions include:

1) All Code Triage to include Yellow actions.
2) ED to consider additional staffing for "Provider in Triage" or additional Fast Track/Hallway beds.
3) ED to aggregate inpatient holds and request nursing support for staffing.
4) Facilitate Skilled Nursing Facility transfers.
5) Case Management to contact all physicians of potential discharges to seek early discharge.
6) Call in additional EVS staff as necessary. Provide STAT clean of all beds within 10 minutes of request.
7) Evaluate elective procedures for Radiology and Surgery schedule. Consider rescheduling as appropriate.
8) Evaluate availability of supplies and equipment (IV pumps and channels, monitors, ED gurneys, inpatients beds).
9) Inpatient units to aggressively seek to "pull" patients from the ED and receive face to face report.
10) Move patients within 20 minutes of bed ready regardless of shift change or recent admissions to the same unit.
11) Consider opening an overflow unit.
12) Consider alternative holding areas for ED "boarders" –Phase II Area or Post Anesthesia Care Unit (PACU).

C. **RELATED DOCUMENTS**

1. Code Triage Census Zones

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:- 04/17	**SUBJECT: Determination of Brain Death**
REVISION DATE: 08/20	

Patient Care Services Content Expert Approval:	~~11/19~~04/24
Clinical Policies & Procedures Committee Approval:	~~12/19~~04/24
Nursinge Leadership~~Executive Committee~~ Approval:	~~02/20~~06/24
Critical Care Committee Approval Date(s):	~~06/20~~06/24
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval:	~~07/20~~07/24
Administration Approval:	~~08/20~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**
1. To establish guidelines for brain death determination in adult patients (15 years and older) as a means of standardization of:
   a. Criteria for the diagnosis of brain death
   b. Medical decision making
   c. Health record documentation.

B. **DEFINITIONS:**
1. Brain death: An irreversible cessation of all functions of the entire brain, including the brain stem (Health and Safety Code§ 7180). A physician may determine an individual has suffered brain death (as defined by statute). Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code§7181). Patient time of death is recorded at the time the second physician confirms brain death. These physicians:
   a. May not participate in procedures for removing or transplanting part(s)
   b. Must document in the health record procedures used to determine the death and factual basis for determination of death.
   c. Must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.

C. **POLICY:**
1. Determination of Death: Based on current medical standards (California Code, Health and Safety Code §7180 of The Uniform Determination of Death Act), an individual who has sustained either of the following is dead:
   a. Irreversible cessation of circulatory and respiratory functions or
   b. Irreversible cessation of all functions of the entire brain, including those of the brain stem.
2. A determination of brain death must be made in accordance with accepted medical standards, at this time considered to be those standards outlined in the American Academy of Neurology Guidelines.
3. The declaration of brain death should not be given as a choice for families.
   a. Testing should be performed when clinical signs and symptoms suggest brain death has occurred.
   b. Appropriate efforts should be made to discuss the patient's medical condition and the process of determining death with family or surrogate decision-makers prior to evaluating whether or not the patient is dead.
      i. Family/surrogate must be provided with the policy if requested.

c. Determination of death should be accomplished as early as practical in the patient's clinical course, for the benefit of both family/surrogate decision makers and staff.

4. Declaration of brain death by neurological criteria is outlined in the 2010 American Academy of Neurology (AAN) Guidelines, reaffirmed on April 30, 2014, and is reflected in *Declaration of Brain Death, Physician Progress Note* which should be used for documentation. Brain death by neurologic criteria requires the following evaluations:
   a. Clinical reflexes
   b. Apnea testing
   c. If one of the evaluations cannot be completed, ancillary testing should be considered.
5. Two licensed physicians must independently confirm the diagnosis of brain death, (California Health and Safety code, § 7181).
   a. Each physician must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.
   b. One physician should be an active member of the patient's care team.
   c. One physician must actively participate in the clinical evaluation of any patient where declaration of brain death is determined. This participation must include an appropriate clinical exam performed by the physician to include being present during the apnea test if performed to observe for respiratory movement, and documenting the results of the exam in the patient's health record.
   d. The time of brain death must be recorded as the time the second physician confirms brain death diagnosis.
   e. A physician involved in the declaration of death must NOT participate in the procedure for organ/tissue procurement or transplantation.
6. The Care Team will follow California Health and Safety Code §1254.4 requiring that a reasonably brief period of accommodation be provided for family or next-of-kin to gather at the bedside after the determination of death has been made through the discontinuation of cardio pulmonary support.
   a. The period of reasonable accommodation is generally not greater than 24 hours after brain death has been declared.
   b. Reasonable accommodation also may include the hospital's consideration of the needs of other patients and prospective patients in urgent need of care.
   c. The care team shall make reasonable efforts to accommodate the religious/cultural practices and concerns of the family.
7. Required Notification to provide for option of Donation of Organ and Tissue.
   a. If imminent death criteria are present and/or brain death is being considered, validate that the Organ Procurement Organization (OPO) has been notified. The OPO will be responsible for the evaluation of potential organ and tissue donation options.
   b. The OPO is responsible for verifying death in any patient where organ donation is being considered or is authorized. The OPO will review the brain death documentation to validate that it meets the requirements set forth in the 2010 AAN Guidelines; this may include a physical assessment of the organ donor patient as well as a review of the brain death declaration documentation.
   c. The OPO will evaluate the declaration of brain death as an element of medical suitability for organ donation. The OPO may ask the hospital for clarification or additional testing if the declaration does not include elements in brain death by neurologic criteria outlined in the AAN Guidelines. The OPO will not participate in the actual brain death declaration process.

~~D. **FORM(S):**~~
~~1. Declaration of Brain Death Physician Progress Note – Sample~~

~~E.~~D. **RELATED DOCUMENT(S)**:
1. Patient Care Services Policy: Code Status/Do not Resuscitate (DNR)/ Withholding or Withdrawing Life Sustaining Treatment.
2. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes.

~~F.~~E. REFERENCES:

1. California Health and Safety Code §7150.65(c), §7180-83, §1254.4
2. Wijdicks, E. F., Varelas, P. N., Gronseth, G. S., and Greer, D. M. Evidence-Based Guideline Update: Determining Brain Death in Adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology (June 8, 2010). *Neurology* (74)23, 1911-1918.
3. Scintigraphic Confirmation of Brain DeathPartha Sinha, MD, and Gary R. Conrad, MD Semin Partha, S., and Conrad, G. R. (2012). Scintigraphic Confirmation of Brain Death. *Seminars in Nuclear Medicine* (42), 27-32.

Declaration of Brain Death Physician Progress Note – Sample

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Prerequisite	**Yes**	**No**
Evidence of acute CNS catastrophe compatible with brain death		
Exclusions:		
1. Presence of CNS depressant drug effect by history, drug screen*		
2. Recent administration or continued presence of neuromuscular blocking agent		
3. Electrolyte imbalances, acid-base imbalances or endocrine disturbances		
4. Conditions such as severe facial trauma, preexisting pupillary abnormalities, pulmonary disease resulting in CO_2 retention		
5. Core body temperature less than 32°C (90°F)		

**Calculate drug clearance using 5 times the drug half-life*

Clinical Exam – ***Do not proceed with Apnea test if any 1-6 in Clinical Exam PRESENT***	**Yes**	**No**
1. Motor response to pain in extremities (nail-bed pressure; supraorbital pressure; temporomandibular joint compression)		
2. Pupillary response to light		
3. Doll's Eyes movement (oculocephalic reflex) present		
4. Eye movement to ice water calorics (oculovestibular reflex)		
5. Eyelid movement to corneal swab/touch (corneal reflex)		
6. Cough or gag to deep endotracheal suctioning		

Apnea Exam Pre Conditions, Guidance for Testing Inclusion Criteria	**Verified**
1. Normotensive (may require vasopressors, MAP greater than or equal to 60-65mmHg)	
2. Normothermic: (core temp greater than or equal to 36°C)	
3. Normal pCO_2 (35 – 45 mmHg) or at patients documented pCO_2 baseline	
4. pO_2 greater than or equal to 200 mm Hg or ability to pre oxygenate to 200mmHg	
If unable to complete Apnea Exam, proceed with Ancillary Testing	
Apnea Exam:	**Completed**
1. Increase FiO_2 to 100% and PEEP of 5mmHg	
2. Draw baseline ABG	
3. Disconnect patient ventilator	
4. Provide O_2 via cannula at level of carina at 6 L/min (or 1-piece with CPAP at 10 cm H_20)	
5. Observe closely for respiratory movements for approximately 8-10 minutes	
6. Repeat ABG in approximately 8-10 min	
7. Reconnect ventilator	

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Apnea Exam Results						
If pCO_2 is greater than or equal to 60mmHg OR pCO_2 increase is greater than or equal to 20 mmHg over baseline normal pCO_2 WITHOUT respiratory movement noted — patient is apneic and apnea testing is consistent with diagnosis of Brain Death. If respiratory movements are observed, the apnea test result does not support the clinical diagnosis of brain death.						
Test 1—Adult	**pH**	**pO_2**	**pCO_2**	**BP**	**SpO_2**	**Apnea Time**
Baseline Blood Gas						
Apneic Blood Gas						

Ancillary Testing		**Verified**
Cerebral Angiography	Flow absent in all major intracranial vessels consistent with death	
CBF Isotopic Scan	Cerebral perfusion is absent in cortex and brain stem, consistent with death.	
Other		

PHYSICIAN COMPLETING ABOVE DOCUMENTATION:

I have examined the patient, together with the health record and laboratory results and was present and observed the apnea test if performed. I declare that the patient is dead on the basis of this evaluation.

Signed: _____ **Date:** / / **Time:** _____

Print: _____

BRAIN DEATH DECLARATION

Attestation: Physician 2

I have examined the patient _____ **together with the health record and laboratory results. This included conducting or reviewing the results of the apnea test and or/any ancillary tests. The patient is declared dead on the basis of this evaluation.**

Signed: _____ **Date:** / / **Time:** _____

Print: _____

This form is a composite drawn from a number of sources, reflecting best practice — and amended in the context of the 2010 AAN Adult and 2011 SPA/SCCM Pediatric guidelines.

Tri-City Medical Center
Oceanside, California

RETIRE – follow physicians orders

STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: ECLAMPSIA MANAGEMENT IN THE ANTEPARTUM, INTRAPARTUM OR POSTPARTUM PERIOD

I. **POLICY:**

A. Eclampsia is defined by new-onset tonic-clonic, focal or multifocal seizures in the absence of other causative conditions such as epilepsy, cerebral arterial ischemia and infarction, intracranial hemorrhage, or drug use). It can occur without warning during the antepartum, intrapartum, or postpartum period. It is the most severe hypertensive syndrome related to pregnancy and the postpartum period and the diagnosis of preeclampsia is usually present ("ACOG Practice", 202019).

B. The Eclamptic patient is at risk for severe maternal hypoxia, trauma, and aspiration pneumonia.

C. During eclamptic seizures, there are usually prolonged fetal heart rate deceleration, even fetal bradycardia, and sometimes an increase in uterine contractility and baseline tone. After a seizure, because of maternal hypoxia and hypercarbia, the fetal heart rate tracing may show recurrent decelerations, tachycardia, and reduced variability ("AGOG Practice", 2020).

1. The best treatment for the fetus is maternal stabilization with oxygen, and antiseizure drugs and treating hypertension if present, with continuous fetal monitoring, as indicated.
2. Mode of delivery is dependent upon clinical circumstances surrounding the pregnancy and determined by the Obstetrician.

D. For postpartum patients and/or females reporting to the Emergency Department who have a history of delivering a baby within the last **eight**six weeks, early recognition is critical.

1. Signs and symptoms can include elevated blood pressure, headache, visual complaints, altered mental status, cerebral vascular accident, seizure, right upper quadrant abdominal pain, epigastric pain, persistent nausea and vomiting, shortness of breath, clonus, brisk deep tendon reflexes, and pulmonary edema.
2. "Of note, a significant proportion of women (20–38%) do not demonstrate the classic signs of preeclampsia (hypertension or proteinuria) before the seizure episode" ("ACOG Practice", 2020).

II. **PROCEDURE:**

A. Initial Management:

1. Call for help. May initiate the Rapid Response Team as needed.
2. Position the patient on her side (preferably left lateral position) and protect from injury.
3. Establish open airway and maintain breathing.
4. Check blood pressure and pulse every 5 minutes, with continuous pulse oxygen saturation.
5. Obtain intravenous (IV) access, with a minimum of one large bore IV catheter (minimum 18 gauge).
6. Draw preeclampsia labs: CBC, AST, ALT, urine dip for protein, LDH, Uric Acid, Creatinine.
7. Prepare to administer medications
8. **W**Apply fetal monitor when possible **check fetal heart tones with a handheld doppler or ultrasound**

B. Initial Medication Management:

Patient Care Services Content Review	Clinical Policies & Procedures	Nursing Leadership	Department of OB/GYN	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/15, 12/19, **11/23**	1/15, 01/20, 03/20, **02/24**	2/15, 04/20, **03/24**	06/15, 06/21, n/a	09/15, 07/21, **04/24**	01/16, 10/21, **07/24**	01/16, 01/22 **07/24**	03/22, **08/24**	02/16, n/a	02/16, 03/22

1. Administer Magnesium Sulfate 6 gram IV loading dose over 20 minutes, followed by a 2 gram/hour maintenance dose if patient's renal function is normal.
   a. If patient is already on Magnesium Sulfate, give patient 2 gram bolus over 5 minutes
2. May give a 2gram bolus over 5 minutes for a second seizure event.
3. May give two doses of 5 gram IM, if no IV access.
4. Observe for magnesium sulfate toxicity and follow assessment guidelines per Patient Care Services, Magnesium Sulfate Administration Procedure.

C. Medication Management for recurrent seizure activity nNot resolved with magnesium:
1. Give Midazolam (Versed) 1 mg Intravenous Push (IVP). (May repeat dose in 5- 10 minutes).Monitor respiration and BP, ECG and signs of magnesium toxicity.
2. If seizure activity continues after Magnesium and Versed are administered call provider for further orders.

D. Following Seizure:
1. Suction patient's mouth
2. Give oxygen at 10 liters per minute via non-rebreather mask.
3. Contact Respiratory Therapist (if not already present) to provide ventilatory support as needed.
4. Assess blood pressure, pulse and respirations every 5 minutes until stable.
5. Assess oxygen saturation and level of consciousness every 15 minutes until stable for a minimum of one hour.
6. If pregnant, monitor fetal heart rate and uterine activity **per physician orders**continuously if viable fetus is present, per Fetal Heart Rate Surveillance/Monitoring Procedure
   a. Delivery decision to be evaluated and determined by Obstetrician.
7. Assess for any signs of neurological injury/focal deficit.
   a. Head imaging shall be considered if neurologic injury is suspected.
8. Insert urinary catheter with a urometer.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current unencumbered California RN license working in Women and Newborns Services, **the** Emergency Department **or**, and Intensive Care Unit.s
B. Education: Registered Nurse and completion of the Magnesium Sulfate Administration Net Learning Module
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed the requirements as outlined above are authorized to direct and perform Eclampsia Management in the Antepartum Intrapartum and Postpartum Period Standardized Procedure

VI. RELATED DOCUMENTS

A. Patient Care Services Procedure: Magnesium Sulfate, Administration in Obstetrics Procedure
B. Women and Newborn Services Procedure: Fetal Heart Rate Surveillance/Monitoring Procedure
C. Women and Newborn Services Procedure: **Hypertension in Pregnancy Guidelines**Preeclampsia Care Guidelines Procedure

VII. REFERENCES:

A. American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin No. 222. (2020). *Obstetrics & Gynecology*, 135(6). doi: 10.1097/aog.0000000000003018

B. Eclampsia Checklist. (2019). *The American College of Obstetricians and Gynecologists*, 1. Retrieved from https://www.acog.org/-/media/Districts/District-II/Public/SMI/v2/19sm02a170703EclampsiaCheck1.pdf?dmc=1&ts=20191216T0623500370

C. Troiano, N. H., Witcher, P. M., & Baird, S. M. M. (2019). *High-risk & critical care obstetrics.* Philadelphia, PA: Wolters Kluwer.

D. California Maternal Quality Care Collaborative. (2014) *Improving Health Care Response to Preeclampsia: A California Toolkit to Transform Maternity Care.* Retrieved from https://www.cmqcc.org/resource/cmqcc-preeclampsia-toolkit-errata-51314

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**EPICARDIAL PACING WIRES**
Purpose:	To outline the nursing responsibilities for: 1. Dressing epicardial pacing wires sites 2. Attaching epicardial pacing wires to A-V sequential pulse generator 3. Assisting with removal of epicardial pacing wires 4. Performing an atrial electrogram
Supportive Data:	Epicardial pacing wires are attached to the epicardium during cardiac surgery. Two Teflon-coated, stainless steel wires may be implemented on the right atrium and brought out through the chest wall at the right subcostal area. Two wires are re-implanted on the right ventricle and brought out on the left subcostal area. Only trained staff are allowed to dress epicardial pacing wires and attach epicardial pacing wires to a pulse generator. Only physicians are allowed to remove epicardial wires. Licensed staff may assist with removal.
Equipment:	See sections below.

A. **DRESSING EPICARDIAL PACING WIRES SITES:**

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

B. **ATTACHING EPICARDIAL PACING WIRES TO A-V SEQUENTIAL PULSE GENERATOR AND SINGLE CHAMBER GENERATOR:**

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

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
06/93, 12/10, 04/11, 03/20, **04/24**	01/11, 04/20, **04/24**	05/20, **06/24**	06/20, **06/24**	n/a	11/05, 04/08, 07/20 **07/24**	08/20, **08/24**	01/06, 06/08, n/a	06/93, 07/03, 01/06, 06/08, 05/11, 08/20

C. **ASSISTING WITH REMOVAL OF EPICARDIAL PACING WIRES:**

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

A. **PERFORMING AN ATRIAL ELECTROGRAM:**

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

D. **DOCUMENTATION:**

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

E. **REFERENCE(S):**

1. Weingard, D. L. (2017). AACN procedure manual for high acuity, progressive, and critical care (7th ed.). St. Louis, MO: Elsevier
2. Perry, A.G. & Potter, P.A. (2013). ~~(eds)~~. *Clinical nursing skills and techniques, .*
3. *(8th ed.).* Urden, L.D., Stacy, K.M., and Loguh, M.E. (2013). ~~(2006)~~. *Thelan's critical care nursing: diagnosis and Management (7th ed.).* St. Louis, MO: Mosby

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

1. Online Skills: Pacing: Temporary Transvenous and Epicardial
2. Online Skills: Atrial Electrogram

Tri-City Medical Center
Oceanside, California

RETIRE – no longer required with suspension of Women and Newborn Services

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING, IDENTIFICATION/TREATMENT FOR THE PREVENTION OF PERINATAL TRANSMISSION

~~I. POLICY:~~
~~A. Function:~~
~~1. To provide guidelines for the RN to identify and provide treatment for obstetric HIV infected patients admitted to Tri-City Medical Center.~~
~~2. To identify pregnant patients with positive HIV results and reduce the risk of maternal to child transmission to the newborn.~~
~~a. Allows intrapartum treatment for pregnant patient and fetus.~~
~~b. Allows ongoing treatment for the pregnant patient and exposed newborn during the postpartum period.~~
~~3. To identify community resources for pregnant patients who are HIV positive~~
~~a. University of California San Diego (UCSD) Mother and Adolescent HIV Program Hotline: (619) 543-8089.~~
~~b. National Prenatal HIV Consultation and Referral Service: (888-448-8765)~~
~~4. To comply with Health codes as outlined in State and Federal laws – January 2008~~
~~a. The state of California requires that all pregnant women are offered HIV screening throughout the pregnancy and at the time of hospital admission~~
~~B. Circumstances for Screening~~
~~1. Setting: Tri-City Medical Center~~
~~2. Supervision: None~~
~~3. Exclusions: Emergency Department (ED)~~

~~II. PROCEDURE FOR INPATIENT AREAS, OTHER THAN WOMEN AND NEWBORN SERVICES (WNS), WHO ARE TREATING PREGNANT PATIENTS:~~
~~A. During the patient history data collection, the RN shall complete an HIV risk screening to determine if the patient should be offered HIV testing~~
~~1. Each pregnant patient shall receive information about the importance of having an HIV test and documentation of providing this information is noted in the medical record.~~
~~2. If patient declines, the refusal shall be documented in the medical record.~~
~~3. If patient agrees to HIV testing, place an order for HIV testing.~~
~~a. Expect results from the chemistry lab (ext 7909) within two hours once test is drawn.~~
~~B. The admitting physician will review the results and discuss the findings and antiretroviral prophylaxis with the patient in a confidential manner as indicated.~~
~~1. The admitting physician shall refer the patient with positive results to her obstetrician and/or the maternal child adolescent HIV program as soon as possible to review therapy, method of delivery, infant care, and follow-up.~~

~~III. PROCEDURE FOR LABOR AND DELIVERY (WNS) ONLY:~~
~~A. During the patient history/prenatal lab data collection, RN shall:~~
~~1. Perform careful screening of the patient's prenatal care or lack of prenatal care~~

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/18, **11/23**	8/12, 1/15, 04/18, **12/23**	8/12, 02/15, 04/18, 10/21, **01/24**	03/15, 05/18, 11/21, **01/24**	9/12, 04/15, n/a	11/12, 05/15, 07/18, 01/22, **04/24**	11/12, 06/15, 08/18, 04/22,**07/24**	09/18, 05/22, **08/24**	07/15, n/a	12/12, 07/15, 09/18, 05/22

2. Review the patient's prenatal form for results of the prenatal HIV test. If documented test results are negative or are positive with the woman being currently treated, document results in the medical record.
   a. Refer to the WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission for patients in labor with positive results.
3. If no test results are available:
   a. Contact the provider's office and obtain the HIV test results if the prenatal indicates the test was done, but results not on the chart.
   b. Assess patient's risk factors and offer HIV testing for the following indications:
      i. Pregnant patients who have unknown HIV results
      ii. Pregnant patients who declined HIV testing in a prenatal setting, and have risk factors associated HIV exposure
      iii. Pregnant patients who are at high risk for becoming infected and have negative HIV results in the clinic setting may be offered a second HIV test in the third 3rd trimester
   c. For patient's meeting the indications listed for the Rapid HIV screen discuss the following in a confidential setting:
      i. The purpose and rationale for the test
      ii. The risk and benefits of the test
      iii. Her ability to decline the test
4. Provide the patient with a copy of the Protecting Yourself and Your Baby information form provided by the California Department of Health Services and the Office of AIDS.
5. Obtain consent. Only verbal consent is required for running the test.
6. Document any refusal of the HIV test in the medical record and note the reason why if possible.
7. After obtaining verbal consent for the HIV test, draw the tubes of blood (small red and purple top tubes) for prenatal labs (RN or lab)
   a. Place an order for HIV testing
   b. A rapid HIV test shall be run STAT by the chemistry lab when labeled tubes are received and accompanied with the completed requisition
   c. Results will be called to the attending provider by the chemistry lab. Expect the results in about 2 hours (Chemistry lab, ext. 7909).
8. The attending provider will provide test results to the patient. The lab will automatically run a confirmatory HIV test with results available with 7-10 days.
   a. If the result is negative, no further treatment is necessary.
   b. If the result is positive and the woman is not in labor:
      i. Physician will review treatment options, and discuss antiretroviral prophylaxis with the mother in a confidential manner.
      ii. The patient will be referred to the UCSD maternal child adolescent HIV program as soon as possible to review therapy/method of delivery, infant care, and follow-up.
   c. If the results are positive and the woman is in labor, obtain order for antiretroviral therapy
      i. Refer to WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission, and PPO: "HIV Intrapartum Treatment"
9. Contact the Women and Newborn Services Social Work/designee and submit a consult order for crisis intervention or postpartum counseling using the key words "Rapid Test Response." This wording alerts the Social Work staff that the patient is a newly screened HIV patient who may need referral to the appropriate community resources, i.e., WE CARE, County Social Services, etc.

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annually

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All healthcare providers who have successfully completed the requirements as outlined above are authorized to direct and perform HIV Identification and Screening, Prevention of Perinatal Transmission Standardized Procedure.

VII. RELATED DOCUMENT(S):

A. Protecting Yourself and Your Baby - Sample (available via external link: http://www.sbcounty.gov/uploads/dph/publichealth/documents/mcah_cpsp_hiv_testing_information.pdf)
B. WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission

VIII. REFERENCE(S):

A. American Academy of Pediatrics on Fetus and Newborn and American College of Obstetricians and Gynecologists Committee on Obstetric Practice Guidelines for Perinatal Care, 8th Edition, 2017. *Guidelines for Perinatal Care Sixth Edition.* Washington, DC
B. AAP Policy Statement, Committee on Pediatric AIDS 120(6) e1547. Diagnosis of HIV-1 Infection in children younger than 18 months in the United States. Washington, DC
C. 682 Assembly Bill –CHAPTERED
D. ACOG Committee Opinion # 635, Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations. Obstetrics & Gynecology: June 2015 – Volume 125 – Issue 6 – p 1544 - 1547
E. ACOG Committee Opinion #389, Human Immunodeficiency Virus*, December, 2007
F. California Law: Assembly Bill No. 1676
G. California Perinatal Quality Care Collaborative, 2008 Standards of Care for the Prevention of Perinatal Transmission (HIV Toolkit)
H. AAP Redbook 30th Edition 2015
I. Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States, May 30, 2018. https://aidsinfo.nih.gov/guidelines/html/3/perinatal/508/maternal-hiv-testing-and-identification-of-perinatal-hiv-exposure
J. Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings. MMWR Recommendations and Reports, September 22, 2006/55 (RR14); 1-17.Revised CDPH Perinatal Policy (2008)
K. National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1-888-448-8765
L. UCSD Medical Center, Woman's and Infant's Department Policy/Procedure: "HUMAN IMMUNODEFICIENCY VIRUS PREVENTION OF PERINATAL TRANSMISSION" (8/15/09).
M. ACOG Committee Opinion #595, Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus. May 2014.
N. ACOG Committee Opinion # 635, Prenatal and Perinatal Human Immodeficiency Virus Testing: Expanded Recommendations Obsterics & Gynecology: June 2015 – Volume 125 – Issue 6 – p 1544 - 1547

~~O. Simpson, K. R., & Creehan, P.A. Perinatal Nursing 4th edition 2014, pp. 679-680 Association of Women's Health Obstetric and Neonatal Nurses~~
~~P. "Aids info" from Department of Health and Human Services: aidsinfo.nih.gov~~

SAMPLE

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

Protecting Yourself and Your Baby

If you are pregnant or think you may be pregnant, you need to know about HIV, the virus that causes AIDS.

Pregnancy is a time to take care of yourself and get regular medical checkups for your health and your baby's health. Your health care provider will ask you questions and check you for conditions so that you and your baby can be as healthy as possible. As part of your routine prenatal care or when you are in labor and delivery, you will be tested for HIV unless you decline. HIV testing during pregnancy is the best choice for you and your baby.

What is HIV?
Human Immunodeficiency Virus (HIV) is a disease that weakens the immune system, making it hard for the body to fight infections.

How is HIV transmitted?
HIV is primarily spread by having unprotected sex or sharing needles with an HIV-infected person. Most women in the US have been infected with HIV through sex with men.

A pregnant woman who is HIV infected or who has AIDS can pass HIV to her baby during pregnancy, delivery, and while breastfeeding.

How will an HIV test help my baby?
An HIV test will help you and your baby by alerting you to the need for treatment if your HIV test is positive. Treatment during pregnancy, labor and delivery can help decrease the risk of transmitting HIV to your baby.

Doctors have learned that if you are infected with HIV, treatment with appropriate medication can greatly reduce your chances of giving HIV to your baby.

What if I test HIV positive?
If you are HIV positive, you will want to discuss treatment options with your health care provider. They will likely recommend medication that is considered safe in pregnancy. You may be encouraged to continue the medication after delivery for your own health, depending on a number of factors.

You can protect yourself from HIV by:
- Using a latex/polyurethane condom (male or female) when you have sex even if you are pregnant. Use only water-based lubricants. Oil-based lubricants will weaken condoms and make them less effective.
- Not sharing needles for injecting drugs, steroids, vitamins, tattooing, or piercing.

Other resources for help:
Call the California HIV/AIDS Hotline at 1-800-367-2437 (AIDS) for HIV referral and consultation resources including experts of prenatal HIV treatment in your local area.

Tri-City Medical Cent
Oceanside, California

RETIRE – follow Physician Order in Emergency Department

STANDARDIZED PROCEDURES MANUAL

~~STANDARDIZED PROCEDURE: MEDICAL SCREENING EXAM TO RULE OUT LABOR~~

~~I. **POLICY:**~~

~~A. Function: Performance of a medical screening exam on pregnant patients who complain of "contractions" who have had prenatal care. All unassigned patients (those with no prior prenatal care) will be seen by the obstetrician on "unassigned call".~~

~~B. Circumstances:~~

~~1. Setting: Tri-City Medical Center, Labor and Delivery unit.~~

~~2. Supervision: None required.~~

~~3. Patient condition: Pregnant and complaining of "contractions or rule out labor concerns".~~

~~II. **DEFINITION:**~~

~~A. Medical Screening Exam (MSE): An assessment of the patient consisting of specific subjective and objective symptom evaluation and prenatal history review performed by the labor and delivery nurse for patients who present to labor and delivery with "contractions or rule out labor concerns."~~

~~B. Emergency Medical Treatment and Labor Act (EMTALA): requires Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status.~~

~~1. A woman in labor is considered unstable from the latent phase through delivery of the placenta. If there is inadequate time to safely transfer her to another hospital before delivery, or if that transfer may pose a threat to her or her fetus's health or safety, she is thereby deemed to have an emergency condition.~~

~~2. The Medical Screening Exam allows the nurse, certified nurse midwife, nurse practitioner, physician assistant, or physician to collect data to determine if the patient is in active labor. Triage is followed by the complete evaluation of the woman and the fetus by a health care provider with skills and training appropriate to evaluate the issues identified during triage.~~

~~III. **PROCEDURE:**~~

~~A. Obtain the following information by reviewing patient's prenatal record as available or interviewing the patient:~~

~~1. Pregnancy Summary~~

~~a. Estimated due date~~

~~b. Prior pregnancy history~~

~~2. Past medical and surgical history~~

~~3. Allergies~~

~~4. Current Medications~~

~~5. Significant risk factors identified or health problems during this pregnancy~~

~~B. **Subjective Data**~~

~~1. Brief history of current condition/reason for exam~~

~~2. Report of fetal movement~~

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Department of OB/GYN	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
8/03, 5/06, 10/09, 3/10;6/13, 01/20, **11/23**	03/10;6/13, 01/20, **01/24**	04/10;6/13, 02/20, **02/24**	06/21, n/a	08/10;7/13, 07/21, **04/24**	08/10;10/13, 10/21, **07/24**	08/10; 10/13, 01/22,**07/24**	02/22, **08/24**	n/a	8/03, 2/08, 8/10;10/13, 02/22

3. Uterine contractions
   a. Time contractions started
   b. Frequency
4. Leaking of fluid
   a. Date and time when leaking started
   b. Color of fluid
5. Vaginal bleeding
   a. Bleeding amount
6. Pre-Eclampsia/Hypertension Symptoms

C. **Objective Data**
1. Obtain Vital Signs
   a. Pulse
   b. Respiratory rate
   c. Blood pressure
   d. Temperature
   e. Current numerical pain level
      i. Target numerical pain level
      ii. Location of pain
      iii. Quality of pain
      iv. Pattern of pain
2. Signs of acute respiratory or cardiac distress.
3. Collect a clean catch urine sample, if patient is able to void, for a urine dip stick screening
4. Assess fetal heart rate (FHR) and uterine contractions for a minimum of 20 minutes, per Fetal Heart Rate (FHR) Surveillance/Monitoring Procedure.
   a. If patient is less than 24 weeks gestation, may obtain and document FHR via Doppler. Continuous contraction monitoring with toco placement is needed to rule out premature contractions/preterm labor.
   b. Notify the provider if patient is less than 34 weeks gestation and having more than six contractions in an hour or if contraction pattern noted to be less than ten minutes apart.
5. If the patient reports no vaginal bleeding or leakage of fluids and is greater than 34 weeks gestation, perform a vaginal exam (VE). Note at a minimum: Cervical dilation, effacement, station, and presenting part.
   a. For gestational age <34 weeks, DO NOT complete a VE, unless ordered by the provider. VE can interfere with some premature labor screening tools.
6. For vaginal bleeding, more than bloody show, or placenta previa notify the provider. DO NOT PERFORM a vaginal exam.

D. **Provider Notification for:**
1. FHR tracing that are a Category II or Category III immediately.
2. Initial assessment data, and one-hour re-assessment data findings.
3. Obtain additional orders/instructions as appropriate.

E. **Admission**
1. Notify the provider and start the admission process for the patient presenting with:
   a. Positive rupture of membrane status
   b. Greater than 34 weeks EGA, regular contractions with cervical exam of 4 cm or greater.

F. **Discharge**
1. Patients of term gestation will have the following documented prior to discharge:
   a. Category I FHR
   b. Absence of active labor.
   c. Provider order for discharge.

G. **Patient instructions/education:**
1. Review discharge instructions with the patient and support person (if present), provide a copy of the discharge follow-up instructions and appropriate educational material.

IV. DOCUMENTATION:

A. Document discharge instructions ordered by the provider on the OB Patient Triage and add appropriate educational material during the depart process. Topics for consideration can include: Labor Precautions, Fetal Movement Counts

B. Document patient disposition (admission to labor and delivery, discharge, transfer) on the OB Patient Triage .

V. REQUIREMENTS FOR RN:

A. Current unencumbered California RN license

B. Education and training: At least six (6) months experience as a full time labor and delivery RN.

C. Experience: If less than six (6) months full time experience as L&D RN, nurse must consult with L&D shift charge nurse or designee prior to conversation with the provider and prior to the discharge of patient. Documentation shall be reviewed by the consulting RN.

VI. RNs AUTHORIZED TO DIRECT AND PERFORM MEDICAL SCREENING EXAM TO "RULE OUT LABOR"

A. Designated registered nurses who have been trained and maintain the annual requirements.

VII. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: Developed and approved by authorized representative of administration, nursing, medicine, and quality resource services.

B. Review: every two years.

VIII. REFERENCES:

1. AAP, C. O. F. A. N., & ACOG, C. O. O. P. (2017). *Guidelines for perinatal care*. Retrieved from https://ebookcentral-proquest-com.ezproxy.liberty.edu
2. EMTALA Fact Sheet. (2019). Retrieved November 12, 2019, from https://www.acep.org/life-as-a-physician/ethics---legal/emtala/emtala-fact-sheet/
3. Martin, E.J. (2009) Intrapartum Management Modules (3rd Ed.) Lippincott Williams and Wilkins
4. Tucker, S.M., Miller, L.A., Miller, D.A. (2009). Fetal Monitoring and Assessment (5th ed.), Mosby: Elsevier.
5. Lyndon, A. & Ali, L. (2009) AWHONN Fetal Heart Monitoring Principles and Practices (4th ed), Kendall Hunt Professional.
6. Committee Opinion No. 667: Hospital-Based Triage of Obstetric Patients. (2016). *Obstetrics & Gynecology*, 128(1). doi: 10.1097/aog.0000000000001524
7. Troiano, N. H., Witcher, P. M., & Baird, S. M. M. (2019). *High-risk & critical care obstetrics* (4th ed.). Philadelphia, PA: Wolters Kluwer. **(Rev 9/15/23)**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: MRSA SCREENING OF ELECTIVE SURGERY PATIENTS IN PRE-OPERATIVE EDUCATION

I. **POLICY:**

A. To prevent and control the spread of Methicillin Resistant Staphylococcus Aureus (MRSA), an Infection Control MRSA Screening Protocol has been established. Antimicrobial resistant pathogens, such as MRSA, have become a common hospital and community problem. Identified antibiotic resistance is one of the key microbial threats to health in the United States, and decreasing the inappropriate use of anti-microbial agents is a primary solution to address this threat. The initiation of a screening and surveillance program is one of the Center for Disease Control and Prevention (CDC's) top priorities to eradicate MRSA.

B. Tri-City Healthcare District (TCHD) has developed a MRSA protocol based on evidence-based practice to prevent anti-microbial resistance in the community as well as the health care setting based on CDC guidelines, recommendations, and other scientific research. It is the goal of TCHD to:

1. Perform active surveillance testing by screening all patients scheduled for the following elective procedures at their pre-operative education appointment:
   a. Total hip arthroplasty
   b. Total knee arthroplasty
   c. Total shoulder arthroplasty (primary and reverse)
   d. Instrumented spine procedures
2. Educate the applicable patients and their families about MRSA and its precautions.
3. See Infection Control Policy: Management of Patients with Multi-Drug Resistant Organism (MDRO) and/or C. Difficile Infection for additional information.

II. **PURPOSE:**

A. To ensure that patients who are known or suspected to be at risk for infection, or have demonstrated colonization with MRSA are appropriately managed based on approved protocol to reduce post-operative surgical site infections (SSIs).

B. To decrease the incidence of post-operative SSIs by identifying patients colonized with MRSA and decolonizing the patient prior to surgery.

III. **DEFINITION(S):**

A. Carrier - a person who is colonized with MRSA. The organism may be present in the nares (nose), sputum, urine, an open wound, the stool, or on the skin, without clinical manifestations of the disease. A carrier may transmit the organism to another person through direct contact, usually via contact with the hands.

B. Colonization - Presence of MRSA on tissue without the presence of symptoms or clinical manifestations of illness or infection. A carrier is colonized with MRSA.

C. Decolonization - Elimination of MRSA carrier state through the use of infection control measures and/or antibiotics. This decreases the risk of transmission to high-risk individuals (immune-compromised or otherwise highly susceptible persons) or to others in an outbreak situation.

D. Eradication - Elimination of infections and/or colonization of MRSA in a facility through implementation of infection control and hygiene measures and/or antibiotics.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Operating Room Committee	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
12/13, 08/17, **04/23**	0/14, 04/16, 03/18, 11/18, 03/20, **05/23**	01/14, 04/16, 03/18, 04/20, **06/23**	11/16, 09/17, 07/18, 04/20, **02/24**	01/14, 02/17, 07/20, **04/24**	05/14, 04/17, 01/21,**07/24**	05/14, 04/17, 07/21,**07/24**	08/21, **08/24**	05/17 , n/a	05/14, 05/17, 08/21

E. Infection - Invasion and multiplication of MRSA in tissue with the manifestation of clinical symptoms of infection such as white blood cell counts, fever, lesions, furuncles, drainage from a break in skin integrity, and erythema. Infection warrants treatment.
F. Invasive Disease - Clinical manifestation of symptoms caused by MRSA such as furuncles, cellulitis, pneumonia, carbuncles, septicemia, osteomyelitis or vascular line infection.
G. MRSA - A gram-positive bacteria that grows in cluster formation, like grapes; growth of MRSA is not inhibited by methicillin or oxacillin, and many other antibiotics.
H. Screen - A nasal swab collected at the pre-operative education appointment to determine whether a patient is colonized with MRSA.
I. Culture - A specimen that can be collected from various sites on a patient's body (i.e.: nose, perineum, groin, wound, sputum, anus, etc.), though usually from the nose/nostrils to determine the presence of MRSA organisms.
J. SSI - infection of superficial surgical incision involving skin or subcutaneous tissue, deep incision involving fascia and/or muscular layers, and organs. TCHD follows the most current version of the CDC/National Healthcare Safety Network (NHSN) definitions of infection.
K. Surveillance - Monitoring of patient data to determine incidence and prevalence of infections and distribution in a facility.

IV. PROCEDURE:

A. To the extent possible, patients included in the criteria shall be screened via nasal swab during the pre-operative education appointment.
   1. Total hip arthroplasty
   2. Total knee arthroplasty
   3. Total shoulder arthroplasty (Primary and Reverse)
   4. Instrumented spine procedures
B. The Registered Nurse (RN) conducting the patient's pre-operative education appointment shall obtain nares culture and enter the order for nasal swab in the electronic health record.
   1. Patients who are screened for MRSA shall receive education on MRSA decolonization in the event the culture is positive (see MRSA Screening and Decolonization Patient Education).
C. An RN in pre-op education shall communicate positive results to the patient's provider.
   1. The physician/Allied Health Professional's (AHP) office will notify the patient of positive results and provide necessary prescriptions and additional patient education.

V. PROCEDURE FOR NARES CULTURES:

A. Swab both nares with attention to swabbing the anterior portion of the nares.
   1. Use one (1) culturette swab for both nares.
B. Swab nose using same swab to both nostrils being careful not to touch outside of nose.
C. Insert swab ½ – 1 inch into nares gently rotating swab in a clockwise then counter clockwise two (2) – five (5) times pressing gently into the nasal septum.
D. Return swab into transport medium being careful not to touch sides of container.
E. Label the culture in accordance with Patient Care Services Procedure: Specimen-Handling and include "rule out MRSA," to alert the lab to screen for only this organism.

VI. SURVEILLANCE OF SURGICAL SITE INFECTIONS:

A. Surgical site infection surveillance is done as required by the California Department of Public Health (CDPH) using the most recent Center for Disease Control and Prevention (CDC)/ **National Healthcare Safety Network** (NHSN) protocols. Data is entered into the CDC/NHSN database and is published annually by CDPH. Data reports can be provided by Infection Prevention and Control to departments or committees upon request.

VII. REQUIREMENTS FOR CLINICANS INITIATING STANDARDIZED PROCEDURE:

A. Current unencumbered California RN

B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annually.

VIII. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. This procedure has been developed by Surgical Services with approval from the Nursing Leadership and the Operating Room (OR) Committee.

IX. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDZIED PROCEDURE:**

A. Unencumbered RN's in the Pre-Operative Education Department.

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

A. Infection Control Policy: Management of Patients with Multi-Drug Resistant Organism (MDRO) and/or C. Difficile Infection for additional information.
B. MRSA Fact Sheet Screening and Treatment
C. Patient Care Services: Specimen-Handling Procedure

XI. **REFERENCE(S):**

A. Anderson,P.A., Savage, J.W., Vaccaro, A.R., Radcliff, K., Arnold, P.M., Lawrence, B.D., Shamji, M.F. (2017) Prevention of Surgical Site Infection in Spine Surgery. Neurosurgery. 2017 Mar 1;80(3S):S114-S123. **(Reviewed 4/2023).**
B. Bebko, S.P., Green, D.M., Awad, S.S. (2015) Effect of a Preoperative Decontamination Protocol on Surgical Site Infections in Patients Undergoing Elective Orthopedic Surgery with Hardware Implantation. *JAMA Surg, 150(5)*, 390-395 doi:10.1001/jamasurg.2014.3480 http://jamanetwork.com/journals/jamasurgery/fullarticle/2173311 **(Reviewed 4/2023).**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PERCUTANEOUS TRACHEOSTOMY ASSIST**
Purpose:	Percutaneous Dilational Tracheostomy (PDT), also referred to as bedside tracheostomy, is the placement of a tracheostomy tube without direct surgical visualization of the trachea. It is a procedure that can be performed in the Intensive Care Unit at the patient's bedside with continuous monitoring of patient's vital signs. The procedure may be performed under local anesthesia.
Supportive Data:	A. Advantages of Percutaneous Dilational Tracheostomy: 1. Time required for performing bedside PDT is considerably shorter than that for an open tracheostomy. 2. Eliminates complications that can occur during transport to or from the OR such as accidental extubation or intravascular catheter decannulation. 3. Elimination of the need to use an operating room and anesthesiology team 4. A smaller operative scar 5. Less bleeding and tracheal erosion 6. Reduced likelihood of infection. B. Indications: 1. The need for prolonged artificial airway. 2. The patient that is unable to cough effectively requiring assistance in the removal of bronchial secretions. 3. The need for positive pressure ventilation when using a cuffed tracheostomy\tube. 4. To prevent aspiration of gastric secretions or contents in the unconscious (or paralyzed) patient by the use of a cuffed tracheostomy tube that will not allow those fluids to communicate with the trachea.

A. **POLICY:**

1. The procedure should be scheduled in advance to ensure the availability of the Video bronchoscope. The Pulmonary lead should be called to schedule: 760-802-1974.
2. The bedside nurse and respiratory therapists will be responsible for monitoring the patient and providing the Physician with the necessary equipment for the bedside tracheostomy procedure.
3. One respiratory therapist is responsible for ventilator adjustments and tube manipulations. The physician is responsible for manipulating the bronchoscope.

B. **PROCEDURE (NURSING):**

1. Ensure that all the necessary supplies are available – obtain Percutaneous Tracheostomy Cart
2. Provide education to the patient about the procedure.
3. Ensure that the procedural consent is signed.
4. Place patient in a supine position with the head midline and the neck extended with chin pointing toward the ceiling.
5. Assist physician with sterile draping and site preparation
6. Ensure Time Out is performed per Patient Care Services (PCS) **Policy:** Universal Protocol Procedure
7. Document Time Out in the medical record.
8. Support and reassure the patient during the procedure.
9. Administer sedation as ordered by physician per PCS **Procedure: Procedural Sedation**~~/Analgesia Used During Therapeutic or Diagnostic Procedures~~ **as indicated**.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Critical Care Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/13, 12/16, 03/20, **01/24**	03/13,0 1/17, 05/20, **01/24**	03/13, 02/17, 06/20, **02/24**	03/17, 06/20, **04/24**	n/a	08/13, 04/17, 07/20, **07/24**	08/20, **08/24**	10/13, 05/17, n/a	10/13, 05/17, 08/20

10. Assist the physician with the procedure and equipment as needed. Open sterile supplies as directed by physician.
11. Monitor and document patient's vital signs every 5 minutes during procedure. Vital Signs include but are not limited to:
    a. Heart rate,
    b. Respiratory rate,
    c. Blood pressure,
    d. Pulse oximetry,
    e. End-tidal CO_2 and Color.
12. Assist with post procedural tube securement and dressing.

C. **PROCEDURE (RESPIRATORY):**

1. Make sure protective equipment is being worn, such as gown, gloves, mask and eye protection.
2. Assist with monitoring vital signs as noted above.
3. Monitor end-tidal CO_2 measurements (if applicable)
4. Place patient on 100% FiO_2 in preparation for the procedure and increase peak pressure limit to allow adequate V_T delivery during procedure.
5. Suction patient (both orally and down endotracheal [ET] tube) if necessary.
6. Attach syringe to pilot balloon for cuff inflation and deflation.
7. Have videoscope/bronchoscope ready to insert down ET tube and follow physician instructions.
8. Deflate the cuff upon physician request and slowly withdraw the ET tube to a level just above the vocal cords—physician will guide the RCP during the process.
9. The RCP may need to adjust the V_T and rate on the ventilator to compensate for the air leak created when the ET tube cuff is deflated. Another option is the RCP may gently re-inflate cuff only until V_T is achieved.
10. Observe insertion of needle, dilators and tracheostomy tube by the physician.
11. Inflate cuff on tracheostomy tube and attach ventilator tubing.
12. Check end-tidal CO_2.
13. Assess breath sounds.
14. Remove the scope.
15. Remove ET tube after proper placement is confirmed.
16. Secure tracheostomy tube.
17. Return ventilator to the ordered settings.
18. Tape obturator at the head of bed to assist in emergent replacement in case of decannulation.
19. Keep appropriate sized back up tracheostomy at bedside.
20. Clean scope appropriately per Patient Care Services **Policy**: **Point of Use Pre-Cleaning of Reusable Instruments**~~High Level Disinfection Procedure~~.

D. **RELATIVE CONTRAINDICATIONS TO PERCUTANEOUS TRACHEOSTOMY:**

1. Children younger than 12 years of age
2. Emergency Airway Access
3. Hemodynamic instability
4. Anatomic abnormality of the trachea
5. Palpable blood vessel over the tracheostomy site
    a. For example malposition of the brachiocephalic or innominate artery
6. FiO_2 > 60%
7. PEEP >15 cmH_2O
8. Coagulopathies
9. Limited ability to extend the cervical spine

E. **COMPLICATIONS THAT CAN OCCUR WITH PERCUTANEOUS TRACHEOSTOMY:**

1. Bleeding
2. Infection
3. Accidental extubation

4. Para-tracheal insertion
5. Esophageal perforation
6. Subcutaneous emphysema
7. Pneumothorax
8. Tracheal stenosis.
9. Airway obstruction as evidenced by:
   a. Restlessness
   b. Tachycardia
   c. Tachypnea, wheezing, stridor
   d. Decreased SpO_2 levels, cyanosis, pallor
10. Injury to thyroid or laryngeal nerve.

F. **DOCUMENTATION:**
1. Document in the electronic health record.
2. Respiratory to chart new tracheostomy insertion under Artificial Airway

G. **RELATED DOCUMENT(S):**
1. Patient Care Services **Policy**: **Point of Use Pre-Cleaning of Reusable Instruments**~~High Level Disinfection~~
2. Patient Care Services **Procedure**: **Procedural** Sedation~~/Analgesia Used During Therapeutic or Diagnostic Procedures~~
3. Patient Care Services **Policy**: Universal Protocol Procedure

H. **REFRENCES:**
1. Hashimoto, M.D., D. A., Axtell, M.D., A. L., & Auchincloss, M.D, H. G. (2020). Percutaneous Tracheostomy. *New England Journal of Medicine, N Engl J Med 2020*, 383:e112
~~1.~~**2.** Cianchi G, Bonizzoli M, Batacchi S, Cammelli R, Biondi S, Spina R, Peris A. A Comparison between single step and balloon dilatational tracheostomy in intensive care unit; a single centre, randomized controlled study. Br J Anaesth. 2010 Jun: 104 (6): 728-732. Epub 2010 April 2010.
~~2.~~**3.** Marchese S,Corrado A, Scala R, Corrao S, Ambrosino N; Intensive Care Study Group, Italian Association of Hospital Pulmonologists (AIPO) Tracheostomy in patients with long-term mechanical ventilation: a survey.Respir Med. 2010 May; 104 (5) 749-753. Epu2010 Feb 1.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/06

SUBJECT: Rapid Response Team Activation and Condition Help (H)

REVISION DATE: 03/07, 10/07, 09/08, 06/11, 06/12 03/17, 08/20

Patient Care Services Content Expert Approval:	~~11/19~~04/24
Clinical Policies & Procedures Committee Approval:	~~12/19~~04/24
Nursing Executive Council Approval:	~~02/20~~06/24
Critical Care Committee Approval:	~~06/20~~06/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~07/20~~07/24
Administration Approval:	~~08/20~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **DEFINITIONS:**

1. Bipap (**nasal intermittent positive pressure ventilation** [NIPPV]): A type of mechanical ventilation which provides inspiratory and/or expiratory positive pressure ventilation via nasal, full face or total face mask in order to improve hypoxemia, reduce ventilatory muscle fatigue, and to support ventilation.
2. Condition Help (H): A program that enables patients and family members to call for immediate help if they feel the patient is not receiving adequate medical attention.
3. Multidisciplinary Medical Team: A team consisting of multiple members with varying medical education backgrounds such as an Intensive Care Unit (ICU) Nurse, a Respiratory Care Practitioner (RCP), Patient's Primary Nurse and the Administrative Supervisor if duties/time permits. For Condition H, a social worker and a chaplain also **may**~~will~~ respond.
4. Rapid Response Team (RRT): A multidisciplinary team that responds to urgent patient situations throughout the hospital.

B. **PURPOSE:**

1. To provide, within minutes a multidisciplinary medical team approach using a formalized process, to assess and treat a patient, whose condition is deteriorating or when nursing staff on the floors has concerns related to patient's condition.
2. To provide support when a patient/family recognizes a noticeable medical change in condition and feels they are not receiving the appropriate response from the healthcare team.
3. Tri-City Medical Center (TCMC) will plan for, support, and coordinate a systematic approach to complex patients such as the implementation of the RRT to respond to deterioration in patient status outside the critical care setting.
4. The role of the RRT is to:
   a. Assess
   b. Stabilize
   c. Assist with communication
   d. Educate and support
   e. Assist with transfer to a higher level of care if necessary

C. **POLICY:**

1. The goal of the team is to provide early and rapid intervention in order to promote better outcomes such as:
   a. Reduced cardiac and/or respiratory arrests in the hospital;

b. Reduced or more timely transfers to the ICU or a higher level of care;
c. Reduced patient intubations; and
d. Reduced number of hospital deaths.

2. The RRT Nurse provides clinical expertise, advanced assessment skills and support for the patient's primary nurse, patient and patient's family, as well as facilitates a more timely transfer to a higher level of care when needed.
3. The Primary Nurse is a critical member of the team who shall provide report, remain in room to collaborate with the RRT Nurse, and assist in the care of the patient.
4. The Respiratory Care Practitioner (RCP) provides advanced respiratory assessment, immediate oxygen therapy, delivery of aerosolized medications, and assistance in delivering mechanical ventilation, through Non-Invasive Positive Pressure Ventilation (NIPPV) if required.

D. **PROCEDURE:**

1. When a nurse is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will:
   a. Contact the operator by dialing "66." The operator will announce "Rapid Response Team to Room -----", three times overhead.
      i. Once notified, the RRT members will simultaneously respond to that room/location within 5 minutes.
   b. Call RRT cell phone.
2. When a caregiver/family member is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will contact the operator by dialing "66." The operator will announce "Condition H" and the RRT members will respond.
3. Criteria to call the Rapid Response Team:
   a. Staff member is concerned/worried about the patient
   b. Acute change in:
      i. Heart rate (less than 50 or greater than 130 beats per minute)
      ii. Systolic blood pressure (less than 90 mm/Hg or greater than 180 mm/Hg)
      iii. Respiratory rate (less than 8 or greater than 28 breaths per minute) or threatened airway
      iv. Oxygen saturation, which reflects the percentage of red blood cells, saturated with oxygen (level is less than 92% despite oxygen therapy)
      v. Level of consciousness, sudden unexplained agitation and confusion.
      vi. Urine output (less than 50 mL in 4 hours)
   c. New onset unilateral motor weakness, sensory loss, and/or aphasia or other neurological changes suggestive of stroke.
   d. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS)
   e. Acute significant bleed
   f. New, repeated, or prolonged seizures
   g. Failure to respond to treatment for an acute problem/symptom
   h. Change in skin tone (pale, dusky, gray or blue)
   i. The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.
4. Criteria to Call a Condition H Rapid Response:
   a. A caregiver or family member is worried about the patient's condition and feels it is not receiving appropriate response from the healthcare team.
   b. Noticeable medical changes:
      i. Shortness of breath or barely breathing
      ii. Severe pain not resolved after treatment
      iii. Feels as though heart is beating too fast
      iv. Difficulty speaking or moving arms or legs
      v. Confusion, agitation, or other mental changes
      vi. Difficulty waking up when aroused
      vii. Using the bathroom less or more frequently

5. RRT Nurse Responsibilities:
   a. Takes emergency cart to room.
   b. Speak with the primary nurse to get the situation, background, assessment and recommend (SBAR) of the patient.
   c. Assist with further assessment of the patient.
   d. Speak with the physician/family/patient about the situation.
   e. Assist with/facilitate transfer to higher level of care if indicated.
   f. Provides necessary treatment and obtains pertinent diagnostic tests per Rapid Response Standardized Procedure.
   g. In emergency situations implements current standards of care by following Advanced Cardiac Life Support (ACLS) protocols.
   h. Functions as role model.
   i. Provides education pertinent to event and general clinical education as time allows.
   j. Follows up on patients maintained on the floor
   k. Completes a RRT Cart check at least daily and documents the following on the RRT Cart Checklist located inside the RRT Cart:
      i. Verifies presence of:
         1) RRT cellular telephone and charging cable.
         2) Cart keys
         3) Manual blood pressure cuff
         4) Emergency supplies, including
            a) Three sets of gel defibrillation pads
            b) Three sets of multifunction defibrillator pads
            c) Resuscitation bag (Ambu).
            d) Restock any missing supplies
      ii. Verifies contents of Respiratory bag and tool box
         1) Restock any missing supplies
      iii. Checks expiration dates of all supplies completed on the first day of each month
         1) Replace any expired supplies
      iv. Checks for proper functioning of defibrillator, per Patient Care Services Procedure: Defibrillator Checks, every shift that an RN is assigned to the RRT role:
      v. Signs name in the signature box of the Cart Checklist
6. Respiratory Care Practitioner Responsibilities:
   a. Assesses and provides treatment.
   b. Assists in managing airway and providing ventilatory support.
   c. Assists with and provides treatment as necessary to facilitate transfer to higher level of care.
   d. Functions as role model.
7. Primary Care Nurse Responsibilities:
   a. Briefs the team on patient history, current assessment, and identified concerns.
   b. Ensures patient's chart, all labs and diagnostic test results are available for the team.
   c. Remains with patient as a vital member of the team, repeats vital signs and other assessments as needed.
   d. Contacts physician if asked by RRT Nurse and give information as needed, using SBAR communication.
   e. Follows through with determined plan of action and ongoing patient assessment.
8. Administrative Supervisor Responsibilities:
   a. Responds and assists as needed if duties/time permits.
   b. Provides necessary resources.
   c. Facilitates efficiency of the team.
   d. Recognizes and utilizes the chain of command to obtain appropriate medical care when necessary to ensure patient's well-being.
   e. Facilitates transfer and bed assignment if a higher level of care is indicated.
   f. Responds to Condition H on nights, weekends, and holidays in place of social worker to address patient/family non-medical concerns.

9. Social Worker Responsibilities:
   a. Responds to Condition H to address patient/family non-medical concerns.
10. Chaplain:
   a. Responds to Condition H to provide spiritual and emotional support to patient/family.
11. In the event the ICU is unable to provide a RRT RN (such as in times of unanticipated low staffing), the following steps will occur:
   a. The ICU Charge Nurse will notify the Administrative Supervisor (AS) when there is no RRT; the ICU Charge Nurse will notify the AS when the RRT becomes available.
   b. The AS will notify each unit's Management Team/designee that the RRT has been pulled to patient care.
      i. Each unit's ANM/Charge Nurse will ensure their immediate staff is aware of the lack of RRT coverage.
      ii. Each unit's ANM/Charge Nurse will be available to all immediate staff to address patient concerns prior to calling a Rapid Response event.
   c. The ICU Charge Nurse (or other designated ICU RN) will be available for telephone consults.
      ~~i. Call forwarding from the RRT phone to the Charge Nurse phone *may* be done to avoid carrying more than one cell phone (optional).~~
         ~~1) Dial *72 760 802 1939 and press *CALL* from the RRT phone to forward calls to the charge nurse phone (you will hear 3 beeps when the task is complete).~~
         ~~2) Dial *720 and press *CALL* from the RRT phone to cancel call forwarding (you will hear 3 beeps when the task is complete).~~
   d. The ICU Charge Nurse ~~(~~or other designated ICU RN~~)~~ will respond to overhead RRT pages and/or provide bedside support to floor nurses when necessary.
      ~~i. If a designated ICU RN other than the Charge Nurse will respond to a Rapid Response call, the Charge Nurse will ensure adequate coverage of that RN's patient assignment.~~

E. **DOCUMENTATION:**
1. The **EHR**~~Emergency Event Record~~ will be used to document the RRT and Condition H activation and interventions performed.

F. **RELATED DOCUMENTS:**
1. Patient Care Services Procedure: Defibrillator Checks
2. Patient Care Services Standardized Procedure: Rapid Response

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SPONTANEOUS AWAKENING TRIALS/SPONTANEOUS BREATHING TRIALS**
Purpose:	To provide guidelines to determine the readiness for removal of mechanical ventilator support on adult patients. These guidelines (approved by the Pulmonary physicians) are intended to guide the ICU team in providing the most efficient and effective care plan that will result in reducing the number of days a patient is on mechanical ventilation.

A. **POLICY:**

1. Patients who are mechanically ventilated should be assessed daily for their readiness to breathe spontaneously and afforded the opportunity to do so.
2. A physician's order is not needed for the Spontaneous Awakening Trial (SAT).
3. A Physician's order is required to perform the Spontaneous Breathing Trial (SBT)
4. This order must be placed in the electronic health record (EHR) before being initiated.
5. The procedure must be performed in collaboration between respiratory and nursing to ensure patient safety.
6. Eligibility for SAT and SBT should be determined by nursing and respiratory using the worksheet (see Spontaneous Awakening and Spontaneous Breathing Trials Algorithm).

B. **PROCEDURE - SAT:**

1. The RN will assess and screen all mechanically ventilated adult patients on a daily basis to determine eligibility for SAT. Exclusion criteria for SAT include the presence of one or more of the following:
   a. Patient on airway pressure release ventilation (PRV)/Bilevel ventilation
   b. PEEP greater than or equal to 8cmH_2O
   c. Active seizures
   d. Receiving a sedative infusion for active seizures or alcohol withdrawal
   e. Unstable angina/myocardial ischemia in the prior 24 hours
   f. Hemodynamic instability and or receiving moderate doses of vasopressor(s)
   g. ICP greater than15mmHg
   h. Systolic blood pressure (SBP) greater than 170 or less than 90mmHg
   i. RASS greater than 2 and/or receiving escalating doses of a sedative for agitation
   j. Receiving neuromuscular blockers
2. If the patient is not eligible for SAT, the RN will document "Does not meet criteria for SAT" in the EHR. DO NOT PROCEED.
3. If no exclusion criteria is present, turn sedation off completely and monitor the following parameters:
   a. Richmond Agitation Sedation Scale (RASS) (1 to 0)
   b. Respiratory rate (less than 35 per minute for at least 5 minutes)
   c. SpO_2 (greater than or equal to 92% for at least 5 minutes)
   d. FiO_2 (less than or equal to 45%)
   e. Cardiac rhythm (stable, no acute dysrhythmias)
   f. Respiratory effort (no increase work of breathing, use of accessory muscles, dyspnea, or abdominal paradox)?
4. If the patient does not stay within the acceptable levels specified above, the RN will restart the sedation at half the previous dose and rescreen in 24 hours. Nursing to document "Failed SAT" in the EHR.
5. If parameters are maintained at the acceptable levels, the RN will keep sedation off in preparation for the weaning process. RN should contact the RCP to perform a ventilator weaning safety screen.

Patient Care Services Content Expert	Clinical Policies and Procedures Committee	Nursing Leadership	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/20, 04/24	01/15, 07/20, 04/24	02/15, 10/20, 06/24	04/17, 12/20, O6/24	n/a	05/17, 03/21,07/24	04/21, 08/24	06/17, n/a	06/17, 04/21

C. **PROCEDURE - VENTILATOR WEANING SAFETY SCREEN:**

1. Exclusion criteria for SBT include ~~is~~ the presence of one or more of the following:
   a. SpO_2 less than 92%
   b. FiO_2 greater than 45%
   c. PEEP greater than 8cmH_2O
2. No spontaneous inspiratory effort in a 5-minute periodIf the patient passes the safety screen for weaning, the RCP may perform the Rapid Shallow Breathing Index (RSBI). (The RSBI = rate divided by tidal volume: f/VT [Liters]).

D. **PROCEDURE – RESPIRATORY SPONTANEOUS BREATHING INDEX (RSBI):**

1. When a patient passes the safety screen for the SBT, the RCP will perform the RSBI by placing the patient on tube compensation. Patients are placed on SBT and their treatment plans are driven by the RSBI measurement.
2. If RSBI is greater than or equal to 100: The RCP will place the patient back on the previous ventilator settings. The RCP may repeat the RSBI in 4-6 hours if the patient's condition seems more conducive to weaning.
3. RSBI is less than100: The RCP will initiate the SBT.

E. **PROCEDURE – SBT:**

1. RCP places the patient on Spontaneous mode with the same $Fi0_2$ and a CPAP of +5 and Pressure Support of 6-10 cmH_2O. Continue spontaneous mode for a minimum of 30 minutes and a maximum of 2 hours. Perform an ABG at the end of the trial. Physician will be contacted for extubation orders.
2. The patient must be evaluated during the SBT/CPAP trial. This trial is not successful and should be stopped if any of the following occur within 2 hours:
   a. Respiratory rate is greater than 35 or less than 8 for a duration greater than or equal to (≥) five minutes.
   b. Respiratory distress, as manifested by SpO_2 less than 90% with visibly increased work of breathing, tachycardia, bradycardia, abdominal paradox, or marked dyspnea
   c. There is a change in heart rate (HR) of 20% or more; or HR is greater than or equal to (≥) 130 bpm
   d. Acute cardiac arrhythmia
   e. -Abrupt change in mental status
   f. Agitation, panic, diaphoresis
   g. Acidemia (acute drop in pH to less than 7.33 associated with an increasing $PaCO_2$)
3. If the trial is successful, the RCP will contact the physician to request an order for extubation or extending the trials.

F. **DOCUMENTATION:**

1. The RCP and RN will document the SAT, SBT and all related monitoring parameters in the EHR.

G. **REFERENCE(S):**

1. Coordinated Spontaneous Awakening and Breathing Trials Protocol. Content last reviewed January 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/hai/tools/mvp/modules/technical/sat-sbt-protocol.html
2. Ely EW, Baker AM, Dunagan DP et al. Effect on the duration of mechanical ventilation of identifying patients capable of breathing spontaneously. N Engl J Med 1996; 335 (25): 1864-1869. DOI: 10.1056/N EJ M 199612193352502.
3. McConville, John F, Kress, John P. Weaning Patients from the Ventilator. Dec 6,2012. The New England Journal of Medicine, 367.23
4. SAT and SBT Protocol Definitions for CUSP for VAP, EVAP. 2013. John Hopkins University; Armstrong Institute for Patient Safety and Quality.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**TRANSPORTING PATIENTS ON A VENTILATOR**
Purpose:	Establish a standard of care for transporting ventilator patients.
Equipment:	1. Manual resuscitator bag with reservoir 2. ~~m~~Mask and **positive end-expiratory pressure** (PEEP) attachment (if needed) 3. ~~p~~Pulse oximeter 4. ETCO2 monitoring and cardiac monitor depending on patient's condition 5. Full oxygen cylinder 6. ~~g~~Gas source in the area to which patient is being transported 7. Suction source in the area to which patient is being transported 8. Transport vent, if applicable.

A. **PROCEDURE:**

1. Registered Nurses (RNs) and Respiratory Care Practitioners (RCPs) competent to care for ventilated patients are authorized to perform this procedure.
2. Two people are required to transport a patient on a ventilator; one being a qualified RN and the other must be a RCP / anesthesiologist.
3. The responsibilities of the RCP/**Anesthesiologist** shall include:
   a. Ensure a resuscitator bag and mask is available.
   b. Ensure adequate oxygen in cylinder for transport.
   c. Attach a PEEP valve to the resuscitator bag or the transport vent if greater than 5 cmH20 PEEP is required.
   d. Attach resuscitation bag or transport ventilator to the patient, ventilating patient at previously noted rate and minute volume.
      ~~d.~~i. Ensure oxygen is connected and flowing appropriately
   e. Maintain airway security and patency during transport.
   f. Connect ventilator to oxygen and air gases (as applicable) and plug into electrical ~~P~~power source at destination and upon returning to unit~~.~~. ~~-~~All vents should be plugged into red emergency power outlets unless none available.~~-~~
   g. Ensure ventilator is functioning properly and patient is being adequately ventilated.
   h. Provide the RN with RCP - cell phone number.
   i. Document ~~-~~both the transport and the ventilator check in the electronic health record (EHR).
   ~~i.~~j. Document in the medical record the time the patient was removed from the transport ventilator.
4. The responsibilities of the RN shall include:
   a. Coordinate~~or~~ ~~Oversee~~ the transport~~,~~ **by ensuring the following:**
      i. RCP is contacted
      ii. ~~Verbally verify with~~ RCP/Anesthesiology visualize and verify patient is properly connected to portable ventilator and oxygen source
      ~~a.~~iii. Ensure resuscitator bag and mask ~~ambu~~ is transported with patient
   b. Ensure cardiac monitoring, pulse oximetry monitoring**, respiratory rate,** and ETCO2 monitoring (as applicable) during the transport to ensure patient safety.
   c. Stay with the patient throughout the procedure unless a qualified RN is present (i.e.~~,~~, Interventional Radiology, Cardiac Cath Lab).
   d. Monitor patient safety at all times.
   e. Document the **following in the medical record:**
      i. Time the patient left the unit / department.
      ~~i.~~ii. ~~transport~~Time the patient returned to the unit / department.

Patient Care Services Content Expert	Clinical Policies & Procedures Committees	Nursinge Leadership ~~Executive Committee~~	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/88,7/97,7/03, 4/04, 4/06, 6/09, 12/14, 03/19, **08/23**	08/11, 12/14, 03/19, **02/24**	08/11, 12/14, 03/19, **03/24**	08/15, 03/20, **06/24**	n/a	10/11, 09/15, 04/20, **07/24**	05/20, **08/24**	11/11, 10/15, n/a	12/11, 10/15, 05/20

~~ii.~~**iii. Any change in patient's status during transport or procedure** ~~and all applicable vital signs in the EHR~~.

B. **REFERENCE(S):**

1. Warren, J., Fromm Jr. R., Orr, R., Rotello, L., and Horst, M. A, American College of Critical Care Medicine. 32(1). P 256 – 262.

~~1.~~**2.** AARC Clinical Practice Guideline (RespirCare 2002), Intra-hospital transport of Critically Ill ventilated patients; 2005 Nov

~~2.~~**3.** Egan's Fundamentals of Respiratory Care, 2017, 11th edition, pages 1013-1014.

~~3.~~**4.** Respiratory Care, -Blakeman, TC; Inter-and Intra- Hospital transport of the Critically Ill, June 2013 pgs. 1008-1023~~.~~.

Tri-City Medical Center
Allied Health Professional

Registered Nurse First Assist (RNFA)
Standardized Procedures

Approvals

Operating Room (Signature):	~~April 22, 2021~~March 14, 2024
Pharmacy & Therapeutics Committee (Date):	April 25, 2024
Interdisciplinary Practice Committee (Date):	~~October 18, 2021~~July 15, 2024
Medical Executive Committee (Date):	~~February 22, 2022~~,July 17, 2024
Administration (Date):	~~March 21, 2022~~August 19,2024
Professional Affairs Committee (Date):	n/a
Board of Directors (Date):	March 31, 2022

Standards for Allied Health Professionals

Registered Nurse First Assist (RNFA)

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Standards for Allied Health Professionals

Registered Nurse First Assist (RNFA)

A. Scope of Service

1. The Registered Nurse First Assist (RNFA) renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation and formal instruction.
2. The RNFA is authorized to perform in an expanded role and may assist on procedures which specify that a first assistant and second assistant is required. The safety and welfare of the patient should be given primary consideration in the selection of a first assistant in surgery
3. The RNFA may assist the surgeon during a surgical procedure with specified technical functions. These specific technical functions are:
    a. Intraoperative retraction - Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.
        i. Provide retraction by:
            a. Closely observing the operative field at all times.
            b. Demonstrating stamina for sustained retraction.
            c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
            d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
            e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
    b. Intraoperative hemostasis - Provide hemostasis by:
            a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
            b. Sponging and utilizing pressure as necessary.
            c. Utilizing suctioning techniques.
            d. Applying clamps on superficial vessels and the tying off, electrocoagulation of them as directed by the surgeon.
            e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
            f. Placing hemoclips on bleeders as directed by the surgeon.
    c. Intraoperative tissue manipulation
    d. Intraoperative wound closure:
        i. Perform knot tying by:
            a. Having knowledge of the basic techniques.
            b. Tying knots firmly to avoid slipping.
            c. Avoiding undue friction to prevent fraying of suture.
            d. Carrying knot down to the tissue with the tip of the index finger and laying the strands flat.
            e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
        ii. Provide closure of layers by:
            a. Correctly approximating the layers under the direction of the surgeon.
            b. Demonstrating knowledge of different types of closure.
            c. Correctly approximating skin edges when utilizing skin staples.

    e. Assist the surgeon at the completion of the procedure by:
            a. Affixing and stabilizing all drains.
            b. Cleaning the wound and applying the dressing.
            c. Assist with applying casts or plaster splints.

f. The RNFA will assist the surgeon with setting up and removing the patient from cardiopulmonary bypass.

4. The RNFA practices under the direct supervision of the surgeon during the surgical intervention.
5. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nursing Practice Act of the State of California.

NOTE: The above specifications are general guidelines and do not reflect all duties in all specialty areas. Therefore, they should not preclude the performance of other duties, which, in the judgment of the surgeon, can be successfully accomplished by the RN First Assistant. However, the RN First Assistant must know his/her limitations and may refuse to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

B. **Qualifications**
1. Refer to the Medical Staff, "Allied Health Professionals" policy.
2. Sponsorship by a Department of Surgery medical staff member who is in good standing of the TCMC Medical Staff.

C. **Scope of Practice**
1. Refer to RNFA Standardized Procedures.

D. **Skills**
1. Refer to RNFA Standardized Procedures.

E. **Supervision**
1. The RNFA shall be supervised by his/her Medical Staff Sponsor.

F. **Proctoring**
1. The RNFA shall be proctored for a minimum of his/her first ten (10) cases using the "Skills Inventory Checklist".
2. The written evaluations (Skills Inventory Checklists) must be completed and returned to the Medical Staff Services Office within 30 days of the procedure.

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA)

I. **POLICY:**

A. Function: To provide guidelines for the RNFA assisting a surgeon in the first or second assistant role.

B. Circumstances:

1. Setting: Open Operating Room at Tri-City Medical Center.
2. Supervision: Requires the direct supervision of the primary surgeon.
3. The RNFA must perform only as first assistant and not concurrently as the scrub nurse.
4. Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.
5. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**

A. The RNFA will assist the surgeon by providing intraoperative retraction giving exposure and optimum visualization of the surgical site without subsequent tissue/organ compromise as directed by the surgeon.

1. Retracting tissues or organs by use of the hand.
2. Placing or holding surgical retractors.
3. Packing sponges into body cavities to hold tissues or organs out of the operative field.
4. Managing all instruments in the operative field to prevent obstruction of the surgeons view.

B. The RNFA will assist the surgeon by providing intraoperative hemostasis promoting adequate visual assessment and access to the surgical site as directed by the surgeon.

1. Aspiration of blood and other fluids from the operative site.
2. Sponging the wound or other area of dissection.
3. Using hemostats or other surgical instruments to clamp bleeding tissue or vessels.
4. Using suture to tie off clamped blood vessels or other bleeding tissue.
5. Using electrocautery to cauterize tissue or surgical instruments clamped to tissue or blood vessels.
6. Place hemoclips or ligating suture on vessels or tissue.

C. The RNFA will use surgical instruments and surgical materials to manipulate tissue as directed by the surgeon.

1. Expose and retract tissue.
2. Clamp and sever tissue.
3. Grasp and fixate tissue with screws or staples.
4. Cauterize and approximate tissue.

D. The RNFA will suture tissue to insure hemostasis and wound alignment by using suture material or instruments as directed by the surgeon.

1. Correctly approximate tissue layers.
2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
3. Tying knots firmly to avoid slipping.
4. Using suture, staples, clips or other devices to approximate tissue.

E. Assist the surgeon at the completion of the procedure by:

1. Affixing and stabilizing all drains.
2. Cleaning the wound and applying the dressing.
3. Assist with applying casts or plaster splints.

F. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the responsibility of the RNFA is to:

1. Assist the 1st Assistant Surgeon if one is present, in taking over the case.
2. Maintain hemostasis, according to the approved standardized procedure.
3. Keep the surgical site moistened, as necessary, according to the type of surgery.
4. Maintain the integrity of the sterile field.
5. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).

a. Remain at the field while a replacement 1st Assistant is being located.
b. The RN Circulator will initiate the procedure for obtaining a surgeon in an emergency.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license.

B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).

C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.

D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist Standardized Procedure.

STANDARDIZED PROCEDURE: Cardiac Surgery Registered Nurse First Assistant (RNFA)

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in placing and removing a patient on and off cardiopulmonary bypass.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**
- A. Placement of patient on cardiopulmonary bypass
  1. The RNFA shall:
     a. Provide retraction and suction during sternotomy and cannulation, and assist with pericardial retraction sutures.
     b. Prepare pump circuit tubing, cardiotomy, and cardioplegia delivery system lines.
     c. Apply and secure arterial and venous purse string tourniquets.
     d. Alert surgeon in heparin dose administration has not been initiated.
     e. Hold cannulae in place while surgeon tightens tourniquets.
     f. Visually inspect arterial line for the presence of air, and alert the surgeon if observed.
  2. Proper placement and removal of is vital to ensure proper cardiopulmonary bypass.
- B. Removal of the patient from cardiopulmonary bypass
  1. The RNFA shall:
     a. Cut suture securing arterial line to sterile field after heparin reversal.
     b. Hold cannulae in place while surgeon loosens purse string tourniquets.
     c. Tie arteriotomy suture while the surgeon remove cannulae.
     d. Visually inspect cannulation sites for hemostasis.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Cardiac Surgery Registered Nurse First Assist Standardized Procedure.

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) - Surgical Assistant During Surgeon Incapacitation or Emergency Surgical Site Evacuation by Physician

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing surgical assistance in the event the surgeon becomes incapacitated or needs to leave for an emergency during surgery.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: None required.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. **PROCEDURE:**
- A. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to and emergency, the RNFA shall:
  1. Maintain hemostasis according to the approved standardized procedure.
  2. Keep the surgical site moistened, as necessary, according to the type of surgery.
  3. Maintain the integrity of the sterile field.
  4. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).
  5. Remain at the field while the RN circulator locates a replacement surgeon.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist - Surgical Assistant During Surgeon Incapacitation or Emergency Surgical Site Evacuation Standardized Procedure.

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Hemostasis

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing hemostasis of the surgical field to minimize blood loss during surgery.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Effective hemostasis is essential to carry out surgery in a time-efficient manner and to prevent excessive blood loss. Providing a dry operative field promotes adequate visual assessment and access to the surgical site.

II. **PROCEDURE:**
- A. The RNFA shall assist the surgeon by providing intraoperative hemostasis using the following measures:
  1. Aspiration of blood and other fluids from the operative site, as directed by the surgeon.
  2. Sponging the wound or other area of dissection, as directed by the surgeon.
  3. Using hemostasis or other surgical instruments to clamp bleeding tissue, as directed by the surgeon.
  4. Using sutures to tie off clamped blood vessels or other tissue, as directed by the surgeon.
  5. Using electrocautery or other surgical device to cauterize tissue, or surgical instruments clamped to tissue.
  6. Place hemoclip, or other ligating devices on vessels or tissue, as directed by the surgeon.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Hemostasis Standardized Procedure.

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Retracting

I. **POLICY:**
- A. Function: To provide guidelines for the RNFA in providing retraction of the surgical field to allow adequate surgical exposure without subsequent tissue/organ compromise.
- B. Circumstances:
  1. Setting: Open Operating Room at Tri-City Medical Center.
  2. Supervision: Requires the direct supervision of the primary surgeon.
  3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Selection and placement of and appropriate retraction instrument will assist the surgeon by providing exposure and optimum visualization of the surgical site.

II. **PROCEDURE:**
- A. The RNFA shall assist the surgeon by providing intraoperative retraction using the following measures:
  1. Retracting tissues or organs by the use of the hand.
  2. Placing and holding surgical retractors.
  3. Packing sponges or laporotomy pads into body cavities to hold tissues and organs out of the operative field.
  4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Retraction Standardized Procedure.

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Wound Closure

I. **POLICY:**
   A. Function: To provide guidelines for the RNFA in providing proper suturing of tissue during a surgical procedure, so that tissue heals without complications from the suturing process.
   B. Circumstances:
      1. Setting: Open Operating Room at Tri-City Medical Center.
      2. Supervision: Requires the direct supervision of the primary surgeon.
      3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
   C. Proper suturing is vital to ensure hemostasis, wound alignment, and tissue healing.

II. **PROCEDURE:**
   A. The RNFA shall suture tissue using instruments and suture material as directed by the surgeon by:
      1. Correctly approximating tissue layers.
      2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
      3. Tying knots firmly to avoid slipping.
      4. Using staples, clips, or other devices to approximate tissue.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
   A. Current California RN license.
   B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
   C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
   D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
   A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
   B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
   A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Wound Closure Standardized Procedure.

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**07/05**	**SUBJECT:**	**ED Scope of Practice/Definition of Emergency Department**
REVISION DATE:	**07/05, 02/11, 10/11, 08/14, 08/22**	**POLICY NUMBER:**	**7010-001**

Emergency Department Approval:	**~~02/20~~06/24**
Department of Emergency Medicine Approval:	**~~04/22~~06/24**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **DEFINITIONS:**

1. To delineate the scope of services provided throughout the various areas of the Emergency Department **(ED)** ~~**and Obstetrics Emergency Department (OB ED)**~~.

B. **SCOPE OF SERVICES:**

~~B.~~**1. ED**

~~1.~~**a.** This is a basic ~~Emergency Department (ED)~~**/ED/**Paramedic Base Station. It is a non-bedded (episodic) department with a total of **4** treatment areas and two (2) Triage stations. It is located on the first floor of the southwest side of the medical center. The ED includes ~~.~~**4** areas for care and treatment with a Triage station for patient sorting. A **Director,** Clinical Operations Manager, ~~Assistant Nurse Managers (ANM)~~**supervisors, charge Registered Nurses (RN)** and a Hospital Base Station Coordinator lead and manage the services and staff 24 hours/7 days per week. **TeamHealth**~~Tri-City Emergency Medical Group (TCEMG)~~ provides medical management and leadership.

~~a.~~**i.** Treatment Area Scope:

~~i.~~**1)** Triage is staffed 24 hours/7 days per week with an RN. During peak hours there is an additional RN and EMT. The area is not equipped with monitors, but can accommodate portable monitoring equipment.

~~ii.~~**2)** Stations A, B, C and D have a total of 41 treatment bays and are the primary acute areas. They are equipped to accommodate all ages and types of illnesses and injuries for this level of emergency services, 24/7. It is staffed at all times with at least one physician who is board-certified or board-eligible in emergency medicine, along with an RN at a ratio of at least 1:4 and a supporting staff comprised of EMTs ~~and ACTs/PSTs~~.

~~iii.~~**3)** **Team Triage**~~Fast Track~~ has six (6) minor treatment bays. It is non-monitored, designed to accommodate lower acuity illnesses and injuries than those seen in stations A-D. The hours of service are variable and are subject to change in volume. It is staffed with an RN, LVN, EMT and a Physician who is board-certified or board-eligible in emergency medicine. **TeamHealth**~~TCEMG~~ may alternatively designate a Physician Assistant (PA) experienced in emergency medicine in lieu of a Physician.

~~b.~~**ii.** Community Relationships:

~~i.~~**1)** Guidelines for the relationship between pre-hospital providers and Tri-City Medical Center (TCMC) may be found in the Base Station Administrative Committee Bylaws.

~~ii.~~**2)** Participating agreements for disaster drills and planning are referenced in the TCMC Disaster Manual Guidelines.

~~iii.~~**3)** Trauma transfer facilities are the following:

~~1)~~**a)** Sharp Memorial Hospital.

~~2)~~**b)** Scripps Memorial Hospital, La Jolla.

~~3)~~**c)** Scripps Mercy Hospital and Medical Center.

~~4)~~**d)** Palomar Medical Center.

~~5)~~**e)** Rady Children's Hospital, San Diego.

~~6)~~**f)** UCSD Medical Center, Hillcrest.

~~c.~~**iii.** Staffing:

~~i.~~**1)** The ED is staffed with variable FTEs based on patient volume which includes a Clinical Nurse Educator/CNS, Case Manager, ~~Assistant Nurse Manager (ANM)~~**supervisor** or Charge RN, Registered Nurses (RN), EMTs, LVNs, ~~ACTs/PSTs~~ and Unit Secretaries (US).

~~2.~~**iv.** Staffing Considerations will take into account the following variables:

~~a.~~**v.** *Patients:* Patient characteristics and the number of patients for whom care is being provided.

~~b.~~**vi.** *Complexity of Care:* Individual patient complexity, across the department complexity, variability of care and volume.

~~c.~~**vii.** *Context:* Architecture and physical limitations of the facility; technology and variability of equipment; clustering of patients within geographic locations.

~~d.~~**viii.** *Expertise:* Learning curve for individuals and groups of nurses; staff consistency; continuity and cohesion; cross training;; control of practice; involvement in quality improvement activities; professional expectations, preparation and experience.

~~e.~~**ix.** *~~ANMs and~~ Charge RNs:* The ~~ANM and/or~~ Charge RN for the day is responsible for making assignments. The ~~ANM and/or~~ Charge RN is accountable for maintaining the appropriate skill mix required for comprehensive, holistic care. The ~~ANM and/or~~ Charge RN has the authority to increase staff levels when census and patient stability deem it necessary. They may make adjustments to the staffing plan as needed in order to provide the best staffing options for optimum patient outcomes while considering regulatory and budgetary issues. The authority to decrease staff will rest with the ~~ANM and/or~~ Charge RN.

~~3.~~**b.** Environment of Care:

~~a.~~**i.** One (1) airborne precaution room (#C26) provides negative pressure ventilation for patients requiring airborne precautions.

~~4.~~**c.** Methods Used to Assess Patient's Needs:

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

~~**OB ED**~~

~~a. **The OB ED is located on the 2nd floor of Vista North Tower next to Labor & Delivery. It consists of 2 triage beds staffed 24 hours/7 days a week by a labor & delivery RN. It is staffed by at least one physician who is board certified in obstetrics.**~~

C. **QUALIFICATIONS OF STAFF:**

1. Registered Nurses in the ED are required to be certified in basic life support (BLS) and advanced care life support (ACLS) upon hiring, within six (6) months Pediatric Advanced Life Support (PALS) and/or Emergency Nursing Pediatric Course (ENPC) and within three (3) months Non-Violence Crisis Intervention (NVCI) certified. Triage education is required and

offered to staff after eighteen (18) months of ED experience. RNs are required to attend at least one (1) clinical education event per year, complete orientation materials, initial and annual competencies and complete all educational tools and activities given to them by the Clinical Nurse Educator/CNS.

a. A minimum of eighteen (18) months of ED experience is required to be an MICN or Triage RN. Additionally, in order to become an MICN or Triage RN, nurses must complete training and pass an examination specific to those roles.

b. In order to respond to Code Pinks, an ED RN must have a certificate in Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC).

~~b. RNs in the OB ED are required to be certified in BLS, ACLS, Neonatal Resuscitation (NRP), and fetal monitoring (intermediate or advanced) upon hire. Triage education is required and offered to staff after 12 months of labor experience.~~

2. EMTs are unlicensed personnel in the ED. They are required to be certified in basis life support (BLS) and perform patient care activities delegated to them by an RN, PA or Physician. All EMTs and ~~ACTs/PSTs~~ are required to complete orientation materials, initial and annual competencies, educational tools and activities given to them by the Clinical Nurse Educator/CNS. Per the Board of Registered Nursing, EMTs in the ED are **NOT ALLOWED** to perform those functions that require a substantial amount of scientific knowledge and technical skills, including but not limited to the following:
   a. Venipuncture or IV therapy.
   b. Parental or tube feedings.
   c. NG tube, catheter insertions and/or removal and tracheal suctioning.
   d. Assessment of patient condition.
   e. Patient and family education for care or post discharge care.
   f. Moderate complex lab testing.
3. LVN's are licensed vocational nurses that work under the direct supervision of physicians, PAs and RNs to provide patient care. LVNs are required to complete orientation materials, initial and annual competencies, educational tools and activities given to them by the Clinical Nurse Educator/CNS.
   a. LVN scope of practice
      1) Perform basic assessments e.g. data collection (shift, reassessment and focus assessments)
      2) Document the basic assessments in the medical record.
      3) Document significant changes in patient's behavior and health status in the medical record.
      4) Documents tasks completed in the medical record
      5) Participates in planning, executes interventions in accordance with the plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.
         a) LVN/s may not initiate interdisciplinary plans of care (IPOCs) or add new outcomes or interventions.
      6) Administer medications by any route except intravenous and intrathecal.
      7) Document patient response to medications (this includes medications administered by the RN).
      8) Apply restraints and remove restraints per physician order or as directed by an RN.
      9) May accept orders to apply and remove restraints
      10) Must inform RN prior to calling physicians for an order to apply restraints
      11) Passage of nasogastric tubes and discontinue NG tubes
      12) Administration of enteral feedings
      13) Simple dressing changes.
      14) Insert and discontinue urethral urinary catheters
      15) Administer enemas.
      16) Perform blood glucose testing using a glucometer

17) Reapply oxygen devices per order or as directed by an RN.
18) Post and analyze EKG strips after completing a basic EKG course.
19) Vital signs.
20) Ambulate patients.
21) Assist ACTs/PSTs to perform tasks for their patient assignments
22) Assist triage RN with monitoring patients.
23) Assist with transporting stable patients
24) Monitor intake and output.
25) Call physicians and accept physician orders for tasks within their scope of practice. May inform PA.
26) May sign off physician orders within LVN's scope of practice.
27) Perform orders (written or entered in the computer).
28) Perform orders (written or entered in the computer) by PA.
29) May not accept verbal orders
30) Report significant changes to both an RN and physician.
31) Discharge patients (RN must review the discharge documentation.
32) Review/reinforce education provided by RN.
33) Perform tasks for patients assigned to an RN that are within the LVN's scope of practice.
34) Contributes to the development and implementation of a teaching plan related to self-care for the patient.
35) Document teaching provided in the medical record.
36) LVN's that have completed an intravenous course approved by the Board as outlined in 16 CCR may perform the following:
    a) Start and discontinue peripheral IV's
    b) Flush peripheral IVs (no PICC, centrally inserted lines, midlines)
    c) Hang IV solutions with vitamins, electrolytes, and 20 mEq or less of KCL.
    d) Administer blood products
    e) Document all of the actions for administering IV solutions and blood products in the medical record.

4. Individuals and multidisciplinary groups provide in-services. The Clinical Nurse Educator/CNS and Leadership arrange for vendor in-services, self-study modules, case study presentations, department-based competencies as well as peer mentoring with experienced ED team members. The education needs are identified through chart reviews, patient complaints, and direct communication relating to the educational needs of the ED, surveys, audits and peer review activities.
5. The nursing service abides by regulations by California Title XXII, JCAHO, HCFA and BRN.

D. **COMMUNICATION, COLLABORATION AND FUNCTIONAL RELATIONSHIP:**

1. Communication is shared through monthly department meetings, staff mailboxes, e-mails, mailing to staff members homes, communication books and communication/educational boards located throughout the ED. Practicing the TCMC Mission and Values is an expectation, as is teamwork, professionalism and a positive attitude.

E. **DEPARTMENTS LEVEL OF CARE/SERVICE:**

1. The level of care provided by the Emergency Department meets the needs of outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with services of other disciplines.

F. **PERFORMANCE IMPROVEMENT:**

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

G. **MISSION OF THE EMERGENCY DEPARTMENT:**

1. The Mission of the Emergency Department is to deliver exceptional care and service to all patients and their families by providing timely service, individualized care and excellent customer service.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT:** Aggressive or Potentially Violent Behavior

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~08/20~~05/24
Division of Psychiatry Approval:	~~03/22~~06/24
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~04/22~~07/24
Administration Approval:	~~05/22~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/22

A. **PURPOSE**

1. To protect the safety of patients, staff, and visitors.

B. **POLICY**

1. All aggressive and/or potentially violent behavior will be dealt with immediately to prevent any harm to patients, staff and visitors.

C. **PROCEDURE**

1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) Staff
2. To maintain safety, any signs of escalation, increased psychiatric symptoms, or increased agitation need to be addressed immediately and if possible identified in the morning patient review meeting.
3. Staff is to contact 911 using the black emergency phone if there are any signs of danger, and risk to patients and staff members.
4. Staff is to attempt to remove the agitated patient away from other patients by calmly walking him/her away from other patients and toward a safe area where the patient and the therapist can escape easily.
5. If the patient refuses to leave group, staff is to instruct other patients to leave the group room.
6. Staff member is to request help from other available staff by sending a patient for assistance. ~~or using the whistle/walkie-talkie or phones to alert staff of danger~~.
7. If the patient is in a Telehealth group, staff may remove an aggressive patient from the group, if necessary and must follow up with a phone call to assess for safety.
8. ~~The use of the whistle/walkie-talkie is a last resort to obtain help and only after failed attempts to de-escalate the patient or remove him/her from the group. Premature use of the whistle can further escalate an agitated or angry patient.~~
9. ~~8.~~ Staff, along with the operations manager or clinical coordinator will gather all information regarding the threatening behavior and assess the patient's mental status.
10. ~~9.~~ Implement the most appropriate response, which may be a time out, verbal de-escalation techniques, suspension, 911 call, or inpatient hospitalization.
11. ~~10.~~ If inpatient admission is required, follow the procedure outlined in the Patient Care Services: Admission Psychiatric Patients Policy and contact the program psychiatrist.
12. ~~11.~~ Physical restraint is not used as a clinical intervention. If a patient becomes violent 911 must be called immediately and the patient must be allowed to escape.
13. ~~12.~~ To help de-escalate the agitated or angry patient, staff is to calmly communicate the intent to help the patient, convey empathy, and attempt to remove the patient from group or milieu.

~~14.~~**13.** Staff must take safety precautions by sitting close to an exit, ensuring that they have an escape, and not placing self at risk by meeting with an agitated patient alone, walking in front of a patient that is agitated, or blocking the patient from escape.

~~15.~~**14.** The Operations Manager or designee will meet with all staff and patients involved to process the incident and address safety concerns. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.

~~16.~~**15.** Staff is to complete the on-line Quality Review forms, when necessary, and report any safety issues or violent behavior to the CNE and Risk Management department.

~~17.~~**16.** Staff is to document the incident and staff response in the patient's medical record.

~~18.~~**17.** Staff will discuss the incident in the treatment team meeting with the physician to determine the best course of action and to assess whether the patient is appropriate in the intensive outpatient program.

~~19.~~**18.** Patients that are unable to control anger and pose a risk to other patients or staff are not appropriate for Outpatient Level of Care and must be referred to a more appropriate setting.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Appointment of Representative Form**

ISSUE DATE: **08/96**
REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17,10/21

Department Approval:	**~~08/20~~07/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

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

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Daily Schedule**

ISSUE DATE: **08/96**
REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17,10/21

Department Approval:	~~08/20~~07/24
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/21~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

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.
3. The schedule is revised as needed to meet the patient's individual needs.
4. Any change within the daily schedule is announced 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

ISSUE DATE: 08/11 **SUBJECT:** Downtime Procedures

REVISION DATE: 04/13, 07/17, 10/21

Department Approval:	~~08/20~~07/24
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/21~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

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 IT help in using wireless network and connecting program and MDs.
   c. Check main voicemail and individual voicemails several times daily.
   d. Pull up progress notes for all patients for staff to document using downtime forms.
3. Manager or Designee Responsibilities:
   a. Notify CNE and obtain approval to initiate downtime procedure.
   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.
   b. Notify patients daily.
   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 downtime forms to document.
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

ISSUE DATE: 08/96 **SUBJECT:** Family Involvement

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~08/20~~07/24
Division of Psychiatry Approval:	~~03/22~~,06/24
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~04/22~~,07/24
Administration Approval:	~~05/22~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/22

A. **PURPOSE**
1. To identify the role of the family in the patient's treatment.

B. **POLICY**
1. When appropriate, the patient's family and or significant others will be involved in the patient's treatment.

C. **PROCEDURE**
1. Who may perform/responsible: Clinical staff
2. At the time of screening, the Community Liaison Coordinator (CLC) will discuss the opportunity for family participation in treatment with the potential patient and the family when appropriate.
3. With the patient's consent, family members will be encouraged to participate in the treatment process by participating in family therapy sessions as ordered by the attending physician.
4. With the patient's consent, the family will also be involved in the discharge planning process.
5. A Release of Information must be signed by the patient before any interaction is initiated with the family or significant other, or before any information is provided to them.

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Patient and Family Education

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Financial Assessment**

ISSUE DATE: **08/96**
REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17,10/21

Department Approval:	**~~08/20~~07/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

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 EMR System.
e. The Service Coordinator will coordinate with patient accounting monthly 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: **Food Service Procedures**

ISSUE DATE: **08/96**
REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17,10/21

Department Approval:	**~~08/20~~07/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

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: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**~~08/20~~07/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

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 backup systems will also be established, as needed.
7. The Chief Nurse Executive, and Safety Officer 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: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	**~~08/20~~07/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

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: **Practicum Student Placement**

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

Department Approval:	~~08/20~~07/24
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/21~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

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: 05/98, 08/00, 10/01, 02/02, 02/03, 01/055, 06/07, 06/10, 04/13, 07/17

Department Approval:	**~~10/21~~07/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

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 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: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	~~08/20~~07/24
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/21~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

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 managing an average weekly total of thirteen to sixteen patient cases, and will facilitate eight to ten groups per week. Part-time staff's 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

PULMONARY SERVICES

ISSUE DATE: 05/13 **SUBJECT: Procedural Triage**

REVISION DATE(S): 07/17

Department Approval:	~~03/20~~01/24
Division of Pulmonary Approval:	~~12/20~~06/24
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/21~~07/24
Administration Approval:	~~04/21~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/21

A. **PURPOSE:**

1. To outline the process for the triaging of procedures administered and performed by the Pulmonary Services clinical staff in the event of unanticipated staffing changes or increases in physician ordered procedures.

B. **POLICY:**

1. The department of Pulmonary Services will have a standardized approach for the activation of the department specific procedural triage plan.

C. **PROCEDURE:**

1. The decision for the activation of the triage plan will be at the discretion of the Respiratory Care Practitioner (RCP Charge, in consultation with the RCP Manager, based on their assessment of:
   - **a.** Total house-wide respiratory care procedural volumes.
   - ~~a.~~**b. Sufficient number of house-wide respiratory care practitioners.**
   - ~~b.~~**c.** House-wide patient census.
   - ~~c.~~**d.** Unit specific census in the adult and neonatal intensive care units.
   - ~~d.~~**e.** Patient acuity.
2. Verbal communication of the decision to activate the triage plan will be made to each staff member by the RCP charge assigned to that shift in order to clarify or answer any unit specific questions that staff members may have related to triage plan activation.
3. At no time will an individual clinical staff member make the decision to activate the department procedural triage plan.
4. Clinical staff will communicate directly with the patient's assigned nurse which may be affected by the team's triage prioritization plans.
5. Re-evaluation of the need to continue with the activation of the department procedural triage plan will be every two to four hours or sooner based on the RCP Charge's assessment and communications with clinical staff.
6. The decision to discontinue the triage plan will be at the discretion of the RCP Charge assigned to that shift, based on their assignment of total house-wide respiratory care procedural volumes, house-wide patient census, unit specific census in the adult and neonatal intensive care units, patient acuity, and clinical staff skill mix.
7. The Pulmonary manager will be kept apprised of the situation throughout the shift whenever procedural triage is initiated, re-evaluated and/or discontinued.

D. **PROCEDURAL TRIAGE PRIORITY MATRIX :**

1. In order of importance from the care that is not triaged to the least important that may be triaged:
    a. Any patients on continuous mechanical ventilation or non-invasive ventilation systems in adult intensive care or neonatal intensive care or emergency department units. If necessary, the patient assessment checks may be extended to every 4-6 hours.
    b. Any patients on heated high flow systems or with ordered titrations.
    c. Any inhaled medication therapy or blood draw ordered STAT, NOW, or ASAP.
    d. Any patients ordered inhaled medications every four hours or more frequently.
    e. Non-interventional bronchoscopy procedures.
    f. Chest physiotherapy, including Positive Expiratory pressure (PEP) therapy.
    g. Incentive spirometer therapy.
    h. Patients scheduled for discharge that day.

E. **REFERENCES:**

1. California Code of Regulations Title 22 for Staffing and Triage.

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES
POLICY

ISSUE DATE: 07/03

SUBJECT: **Respiratory Care Students in the Patient Care Areas**

REVISION DATE(S): 04/08, 01/10, 05/12, 07/17

Department Approval:	~~02/20~~01/24
Division of Pulmonary Approval:	~~09/20~~06/24
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/20~~07/24
Administration Approval:	~~12/20~~08/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/20

A. **AUTHORIZED TO PERFORM:**
1. All respiratory therapy students under supervision of a licensed Tri-City Healthcare District (TCHD) Respiratory Care Practitioner (RCPs).

B. **DEFINITION:**
1. Respiratory therapy students attending the residency program through an accredited college for Respiratory Care are sent to TCHD for clinical rotation experience. It is a requirement that each school have a current contract on file in order for TCHD to allow their students on site.
   a. A list of which level of rotation the students are on and written clinical objectives are sent to the pulmonary services department from the college prior to the student's arrival at the hospital.
      i. Example: observation only, general care, critical care, pulmonary function, pulmonary rehabilitation.
   b. Authorization to perform: different levels of rotation and what students are authorized to complete.
      i. Observation Only: able to follow licensed RCPs throughout the hospital in different settings to observe situations and/or procedures. No therapy may be given by the student.
      ii. General Care: floor care, (floor care is all general respiratory care, non-critical). Examples: aerosol therapy, hyperinflation therapy, bronchial hygiene therapy, and oxygen therapy.
      iii. Critical Care: floor care and critical care procedures: ventilators, Non-Invasive ventilation, intubation assist with physician and in presence of licensed RCP, ~~observation of~~ **perform** ABG's **under observation of licensed RCP** .
      iv. Bronchoscopy/PFT: may observe and/or assist the licensed RCP in completing these procedures (PFTs, bronchoscopy, Oximetry studies, Bedside Spirometry testing, and patient education)
      v. NICU: respiratory students may only observe patients in this setting.
   c. All care provided to patients by respiratory students must be supervised by a licensed respiratory care practitioner. The licensed RCP will enter all charting in the hospital computer charting system.

Tri-City Medical Cent
Oceanside, California

REHABILITATION SERVICES POLIC
~~TRI-CITY MEDICAL CENTER~~
~~4002 Vista Way, Oceanside, Cali~~

REITRE - This Location was closed as of 09/01/2019. Impacted Staff have been consolidated to Main Hospital and Wellness Location since then.

~~REHABILITATION SERVICES POLICY MANUAL~~

~~**ISSUE DATE: 7/91**~~	~~**SUBJECT:**~~ **FIRE PLAN FOR OP REHAB SERVICES & WOUND CARE CENTER at 161 Thunder Drive, Vista**
~~**REVISION DATE: 2/94, 8/97, 10/99, 11/02, 2/03, 1/06, 5/08, 1/09**~~	~~**STANDARD NUMBER: 1509**~~
~~**REVIEW DATE: 5/12**~~	~~**CROSS REFERENCE:**~~ ~~**APPROVAL:**~~

REVISION DATE(S): 2/94, 8/97, 10/99, 11/02, 2/03, 1/06, 5/08, 1/09, 6/15
Department Approval Date(s): 07/24
Department of Medicine Approval Date(s): n/a
Pharmacy and Therapeutics Approval Date(s): n/a
Medical Executive Committee Approval Date(s): n/a
Administration Approval: 08/24
Professional Affairs Committee Approval Date(s): n/a
Board of Directors Approval Date(s):

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

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☐~~

SUBJECT: Fire Plan for- Outpatient Rehabilitation Services~~**2124 El Camino Real,** Suite 100, Oceanside, CA~~

~~☐ 6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To remove patients from danger area in the event of a fire.~~

~~B. POLICY~~

~~1. Staff members are divided into 2 teams that are responsible for removing patients from designated areas within the clinic. Areas/teams will be updated on an annual basis or as needed (team assignment is on Page 2 of this policy).~~

~~2. Team Areas:~~

~~A – Front lobby, OT room, chart room, lobby restroom, Medical Director and Wound Care Center Director offices, Wound Care Center treatment rooms 1-4, hyperbaric chamber room, hall restroom~~

~~B – Rehab gym, rooms 5-9, staff restroom, lunch room, staff office~~

~~**RESCUE:**~~

~~**POLICY:**~~

~~3. **Rescue:** The individual who sees the fire will remove anyone in immediate danger from the area. **Refer to Rehabilitation Services evacuation plan.**~~

~~a. **Alarm:** Front office staff will notify the emergency medical system by dialing 911, giving the exact location of the building, the fire, and, if possible, the severity of the fire.~~

~~4. **ALARM:** Code Red, with the location, will be announced 3 times over the loudspeaker.~~

~~**CONTAIN, EXTINGUISH:** Staff members in the vicinity of the fire will contain the fire, close~~**Contain, Extinguish: Close** ~~all doors and, windows, place a wet towel at the base of door, and, if possible, use a~~**and use** ~~fire extinguisher to confine the area of the fire~~**, if appropriate,** ~~until help arrives.~~

~~a. To operate the extinguisher, twist out the safety pin, direct the horn at the base of the fire, and then press the valve lever.~~

~~**REHAB SERVICES**~~
~~**161 THUNDER DRIVE FIRE PLAN**~~

~~**TEAM AREAS:**~~

~~**TEAM A:** Front lobby, OT room, chart room, lobby restroom, Medical Director and Wound Care Center Director offices, Wound Care Center treatment rooms 1-4, hyperbaric chamber room~~

~~*Consists of:* Office staff, Hand Therapy staff, Wound Care nurses, medical assistants and hyperbaric technicians, Wound Care Center Physician, Program Director~~

~~**TEAM B:** Rehab gym, rooms 1-5, staff restroom, lunchroom, staff office~~

~~*Consists of:* OT/PT staff, Rehab Aides~~

~~**RESPONSIBLITIES:**~~

1. ~~**RESCUE:** The individual who sees fire will remove anyone in immediate danger from the area.~~

a. ~~Front office staff will notify the emergency medical system by dialing 911, giving the exact location of the building, the fire, and if possible the severity of the fire.~~

2. ~~**ALARM:** "Code Red", with the location, will be announced 3 times over the loudspeaker.~~

3. ~~**CONTAIN, EXTINGUISH:** Staff members in the vicinity of the fire will contain the fire, close all doors, place a wet towel at the base of the door, and, if possible, use a fire extinguisher to confine the area of the fire until help arrives.~~

4. ~~All staff members evacuate patients with whom they are in immediate contact.~~

5. ~~Team A exits with patients through front exit door. Team B members exit through the back door in the gym.~~ **~~Close doors and flip tags in assigned areas before exiting.~~** ~~All staff and patients congregate to the back parking lot of the facility.~~

~~**Do not use water pressure extinguisher or fire hose on any electrical apparatus, oil or grease fire. CO_2 extinguishers are provided in areas where this type of fire is likely to occur.**~~

~~**Use wet blankets or spreads, if necessary, to help control the blaze.**~~

~~**Remove all valuable records if possible.**~~

~~**Responsibility for reporting a fire:**~~

a. ~~**During business hours, the Director of Rehabilitation Services should report any fire and fill out a Quality Review report.**~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

SUBJECT: **Pre-Op Teaching**

ISSUE DATE: **06/93**
REVISION DATE(S): 02/94, 01/97, 06/97, 01/06, 01/09, 05/12, 03/16

Rehabilitation Department Approval:	**~~05/18~~10/23**
Department of Medicine Chiefs Approval:	**~~10/19~~ 06/24**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~07/24**
Administration Approval:	**~~11/19~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **PURPOSE:**

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

B. **PROCEDURE:**

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

Tri-City Medical Center
Oceanside, California

REHABILITATION CENTER

SUBJECT: Rehabilitation Leadership Structure

ISSUE DATE: 02/20
REVISION DATE(S):

Rehabilitation Department Approval:	**~~05/18~~10/23**
Department of Medicine Chiefs Approval:	**~~10/19~~,06/24**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/20~~07/24**
Administration Approval:	**~~02/20~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/20**

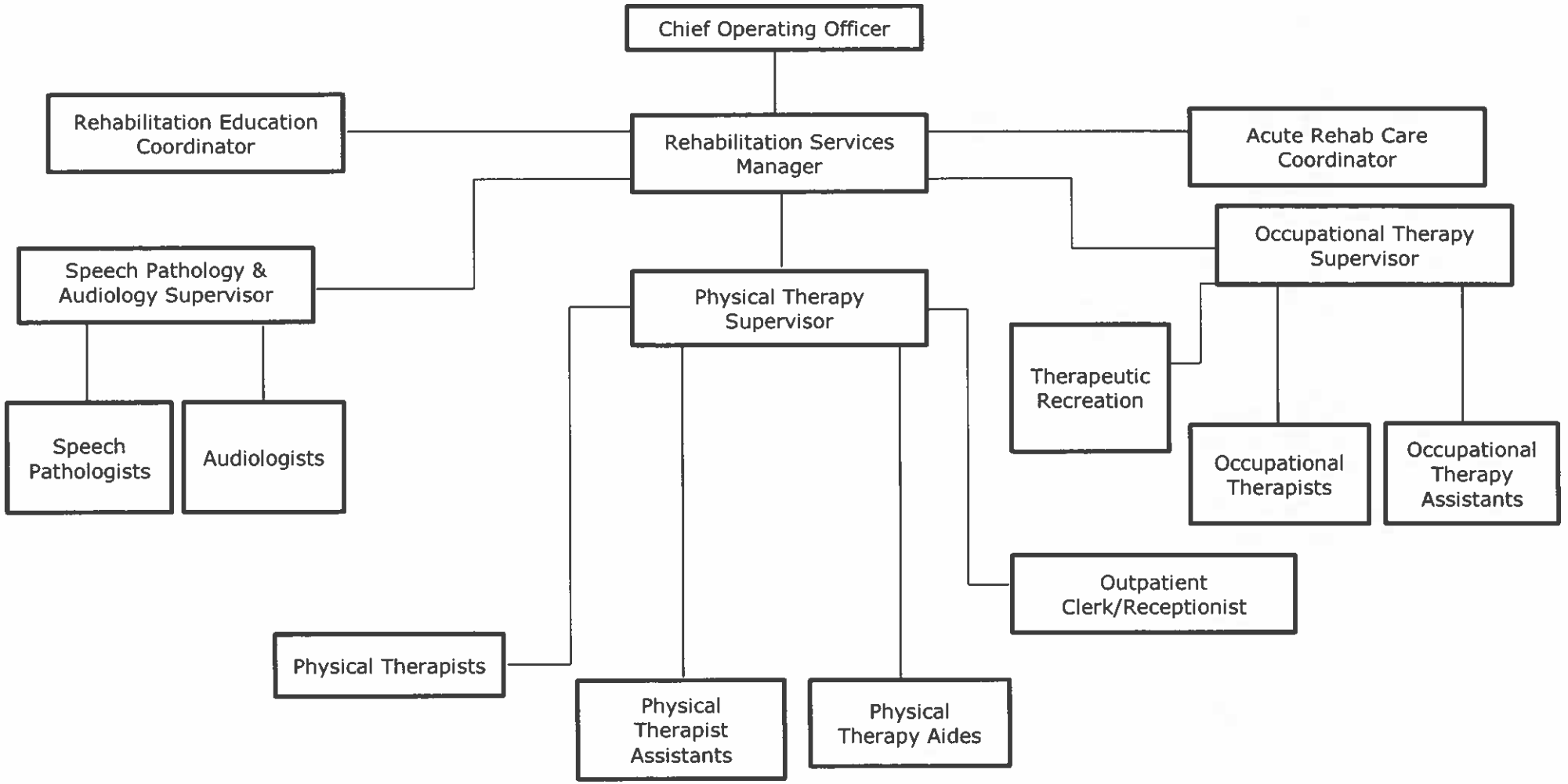
A. **POLICY:**

1. The Tri-City Rehabilitation Center will follow the below outlined Leadership Structure.
2. Any mention of the Rehabilitation Center Leadership Structure shall refer to the below outlined Leadership Structure
3. Any changes in the Rehabilitation Center Leadership Structure will be reflected accurately and updated within a timely manner

Tri-City Medical Center
Oceanside, California

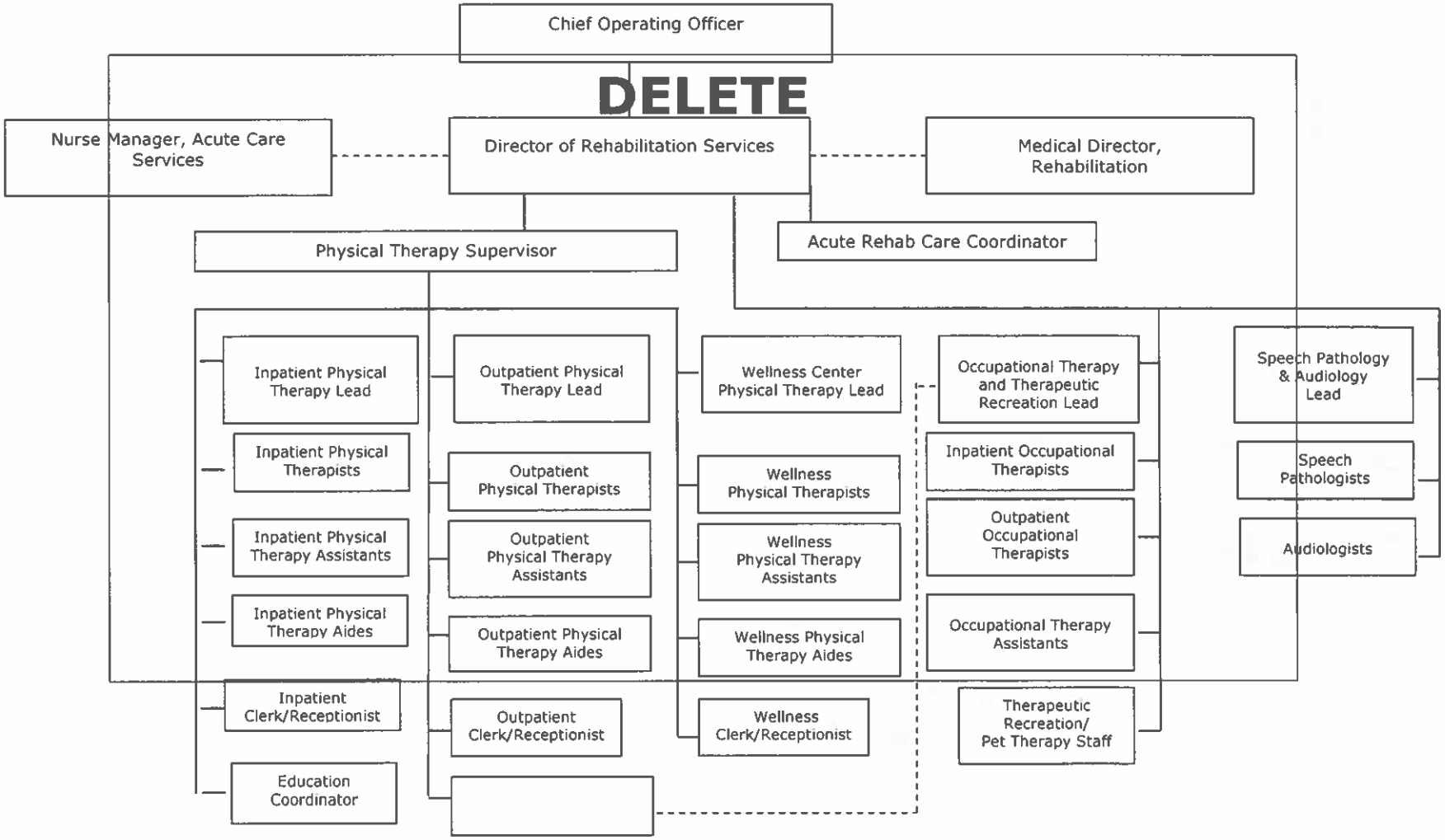
REHABILITATION CENTER

REHABILITATION CENTER



Tri-City Medical Center
Oceanside, California

REHABILITATION CENTER



Revised 11/17, 02/20

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
PERI-ANESTHESIA NURSING SERVICES

ISSUE DATE: **SUBJECT:** **PACU On Call Coverage**

REVISION DATE(S): **01/13, 04/20**

Department Approval:	**05/24**
Department of Anesthesiology Approval:	**~~03/20~~ n/a**
Operating Room Committee Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval: N/A	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**~~04/20~~08/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**
1. To establish a system for providing staffing after hours for urgent/emergent surgical cases and procedures requiring sedation.

B. **WEEKDAY CALL COVERAGE:**
1. Monday – Friday ~~2300 – 0700~~ **2130-0700** hours
   a. 2 PACU RNS (on call)

C. **WEEKEND COVERAGE:**
1. Saturday and Sunday -0700 – 1900 hours:
   a. 1 PACU RN (in-house professional)
   b. 1 PACU RN (second call)
   c. 1 PACU RN (third call)

~~2. Saturday and Sunday 0900-1800 hours:~~
~~a. 1 ACT/Aide (on call)~~

~~3.~~**2.** Saturday and Sunday 1900 – 0700 hours:
   a. 1 PACU RN (first call)
   b. 1 PACU RN (second call)

D. **HOLIDAY COVERAGE:**
1. 0700 – 1900 hours
   a. 1 PACU RN (in-house or first call)
   b. 1 PACU RN (second call)
   c. 1 PACU RN (third call)
   ~~d. 1 ACT/Aide (on call)~~
2. 1900 – 0700 hours:
   a. 1 PACU RN (first call)
   b. 1 PACU RN (second call)

E. **ON CALL REQUIREMENTS:**
1. Benefited and non-benefited staff shall take two weekday calls and one weekend call as follows:
   a. **Staff are required to take two weekday call shifts** every 4 weeks, depending on staffing levels **and staff will be in PACU to accept patients within 30 minutes**.
   ~~b. Staff will be in the PACU to accept patients within 30 minutes.~~

b. Staff are required to take two weekend call shifts during a 10-week period.

c. On call shift requirements for non-benefited (per diem) staff:

i. Scheduled shifts do not include call shifts. Call shifts are assigned in addition to scheduled shifts.

d. In the event that PACU staffing levels decrease, due to open positions, PTO, or staff on leave, the amount of call required may increase from the stated above.

e. Holidays are divided into major and minor holidays.

f. Major holidays consist of July 4th, Thanksgiving Day, Christmas Day and New Year's Day.

g. Minor holidays consist of President's Day, Memorial Day, and Labor Day (all holidays are three day weekends.)

h. The weekend professional is responsible for all ~~minor~~ holiday call **that falls on a weekend, unless PTO request approved by Supervisor or Department Manager. The weekend professional is not expected to take weeknight call, but may volunteer to do so**~~and is not required to take major holiday call~~.

F. **CALL ASSINGMENT**:

1. WEEKDAY CALL (Monday – Friday 2300 – 0700)

a. A rotation list for the next schedule will be available ~~on the second Friday of the current~~ **by the Friday after the** schedule **is posted**. The first person on the list will be first to choose their shift; the second person will have second choice, etc. The person at the top of the list will be placed at the bottom of the list on the next schedule. The number of nights each person chooses will vary depending upon the number of staff in the rotation.

2. WEEKEND CALL

a. A weekend availability list will be posted 2-4 weeks prior to the beginning of the next weekend rotation schedule. The schedule will cover the same number of weekends as the number of staff. Each staff member is required to indicate availability for a minimum number of weekends, currently four (4). Management will assign weekends according to the choices indicated on the availability list. Each staff member will be assigned **two** weekends **in a 10-week period**.

3. HOLIDAY CALL

~~a. The holiday drawing will take place in October. Management will draw for those who are not present.~~

~~b. Each staff member will pull one holiday shift.~~

~~c. The Department will be divided into equal groups of holiday shifts. If there are more personnel in a group than there are holiday shifts to work, blank slips will be added to the pot. The personnel with a blank slip will move into a shift that has been left uncovered due to changes in staffing. The slips will be numbered consecutively and this is the order in which empty shifts will be filled.~~

~~d.~~**a.** Major holidays will rotate annually for each employee. For example, if an employee was assigned Thanksgiving the previous year, he/she would rotate to Christmas this year, then New Years the following year.

i. When new personnel are added to the call schedule they would be placed in **any**~~the~~ holiday slot that ~~was~~**remains** vacant and ~~would begin their rotation~~ **will be scheduled for holiday shifts based on need/availability of the unit according to the** ~~within that holiday shift based on~~ terms of **their** employment.

~~e.~~**b.** Minor holidays will also rotate annually for each employee. For example, if an employee was assigned President's Day weekend the previous year, he/she would rotate to Memorial Day this year, then July 4th the following year.

~~f.~~**c.** If the holiday falls in the middle of the week, including Thanksgiving Day, the holiday personnel are not required to cover the weekend. If the holiday falls on the weekend they are responsible for the entire weekend.

~~g.~~**d.** Those personnel covering a holiday weekend will count this as a part of their weekend rotation. Those personnel covering a holiday night during the week will count this as a part of their weekday rotation.

~~h.~~**e.** If individuals wish to trade their holidays they must submit the trade in writing to Management

~~i.~~**f.** The PANS holiday call applies to benefited and non-benefited staff, equally.

G. **CALL COVERAGE PROCEDURE:**

1. If arrangements have been made with a coworker to cover any part of the call time, it is the responsibility of the primary nurse to communicate this to Management and submit a change of shift form. The call sheet shall be updated by Management.
2. In the event a call position is left unfilled due to illness, the Charge Nurse or Management will attempt to secure coverage of the shift by another nurse. If this cannot be done, the coverage will be as follows:
   a. First Call 0700-1900 hours (Saturday/Sunday):
      i. The second call person will move up to first Call
      ii. The third call person will move up to second call 0700-1900.
      iii. Attempts will be made to find a third call 0700 - 1900.
   b. First Call 1900-0700 hours (Saturday/Sunday):
      i. Attempts will be made to find a backup for 1900-0700.
      ii. If attempts to find a replacement for an uncovered shift are unsuccessful, the Charge Nurse or Management will use a lottery system to assign the call. Staff with approved PTO will not be in the lottery.
3. If a staff member cannot fulfill an assigned call shift; he/she is expected ~~-~~to repay the staff member who covered his/her call shift.

H. **PROCEDURE FOR CALLING IN THE "ON CALL" NURSES:**

1. The Operating Room (OR) will call the ~~entire~~ on-call team~~, including PACU RNs~~ at the time the case is booked.
2. Two PACU RNs will be called in ~~for all cases.~~**30-minutes prior to the finish of the OR case.**
3. Both PACU RNs will be present in PACU before the patient's arrival and through discharge/transfer from PACU.
4. Additional PACU RNs may be called in to cover departmental needs.

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

June 21, 2024 – 2:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on June 21, 2024.

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

Director Rocky J. Chavez
Director Nina Chaya
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel (via teleconference)
Teri Donnellan, Executive Assistant

1. The Chairperson, Director Tracy M. Younger, called the meeting to order at 2:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Chavez to approve the agenda as presented. The motion passed unanimously (7-0).

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

   Chairperson Younger made an oral announcement of the items listed on the June 21, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation and Reports Involving Trade Secrets.

6. Motion to go into Closed Session

   It was moved by Director Chavez and seconded by Director Gleason to go into Closed Session at 2:02 p.m. The motion passed unanimously (7-0).

7. At 3:25 p.m. the Board returned to Open Session with attendance as previously noted.

8. Report from Chairperson Younger on any action taken in Closed Session.

   Chairperson Younger stated the report out from closed session will be given at the beginning of today's Regular Board meeting at 3:30 p.m.

9. Open Session

a) Consideration to authorize the Professional and General Liability Insurance Agreements with various carriers as reflected on the accompanying Executive Summary through McGriff Insurance Services, LLC, for a term of 12 months, beginning July 1, 2024 and ending on June 30, 2025, for a total term cost of $2,428,630.

General Counsel Susan Bond reviewed the Executive Summary with the Board. There were no comments or questions.

It was moved by Director Coulter to authorize the Professional and General Liability Insurance Agreements with various carriers as reflected on the accompanying Executive Summary through McGriff Insurance Services, LLC, for a term of 12 months, beginning July 1, 2024 and ending on June 30, 2025, for a total term cost of $2,428,630. Director Gleason seconded the motion.

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

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

10. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:30 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
June 21, 2024 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on June 21, 2024.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez

Absent: Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Janice Gurley, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. In Board Chairperson's absence, Vice Chairperson Chaya called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Report from Closed Session

   General Counsel Susan Bond reported the Board in Closed Session discussed reports involving Trade Secrets and took no action. The Board also discussed a Potential Litigation matter and directed staff and counsel to take appropriate action.

3. Pledge of Allegiance

   Director Gleason led the Pledge of Allegiance.

4. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Chavez to approve the agenda as presented. The motion passed (6-0-0-1) with Director Younger absent.

5. Public Comments – Announcement

Vice Chairperson Chaya read the Public Comments section listed on the June 21, 2024 Regular Board of Directors Meeting Agenda.

6. May, 2024 Financial Statements – Janice Gurley, Chief Financial Officer

Janice Gurley, Chief Financial Officer reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $269,063
- Operating Expense – $303,223
- EBITDA – ($6,776)
- EROE – ($23,701)

Janice reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 115
- Adjusted Patient Days – 74,470
- Surgery Cases – 4,606
- ED Visits – 40,615

Janice reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $26,349
- Operating Expense – $27,389
- EBITDA – $1,794
- EROE – $218

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 115
- Adjusted Patient Days – 7,103
- Surgery Cases – 511
- ED Visits – 3,992

Janice also presented graphs that reflects trending of EBITDA and EROE, Average Daily Census, Paid Full Time Equivalents, 3 Month Trend per Adjusted Occupied Bed, Acute Average Length of Stay and Emergency Department Visits.

Janice noted this is the fifth consecutive positive month.

7. New Business –

a) Review, discussion and action regarding the Operating and Capital Budgets for FY2025.

Janice Gurley, CFO presented the FY2025 Operating and Capital Budgets for the board's consideration. She provided an overview of the Operating budget and gave a brief summary of Key Indicators, Financial Statements as well as the Capital Budget.

Janice reported the FY 2025 budget forecasts Expenses over Revenue of ($2.0 million) and EBITDA is projected at $16.1 million. This projected EROE improvement

of $19.0 million over the projected FY2024 is expected to be realized through a combination of revenue increases from newly negotiated health plan contracts, service line strategic initiatives, and continued expense management and workforce control. The budget anticipates capital acquisition and renovation investment of approximately $12.0 million. Janice noted projected FY2024 was negatively impacted in November and December due to the cyber incident.

There were no additional comments or questions.

It was moved by Director Chavez to approve the Operating and Capital Budgets for FY2025. Director Gleason seconded the motion.

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

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

b) Consideration to extend the MidCap Financial Services Capital Management and Credit Agreement for an additional two years.

Janice Gurley explained we are extending the agreement with MidCap for an additional two years which will provide extra capital through a revolving line of credit.

It was moved by Director Chavez to extend the MidCap Financial Services Capital Management and Credit Agreement for an additional two years. Director Mizell seconded the motion.

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

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

8. Old Business - None

9. Chief of Staff –

Dr. Henry Showah, Chief of Staff explained the June Credentialing Actions and Reappointments Involving the Medical Staff are presented for the Board's approval pending approval by the Medical Executive Committee on June 25, 2024.

It was moved by Director Sanchez to approve the June 2024 Credentialing Actions and Reappointments Involving the Medical Staff pending approval by the Medical Executive Committee on June 25, 2024. Director Gleason seconded the motion.

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

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

10. Consideration of Consent Calendar

It was moved by Director Sanchez to approve the Consent Agenda as presented. Director Gleason seconded the motion.

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

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

11. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

12. Comments by Members of the Public

There were no comments from members of the public.

13. Comments by Chief Executive Officer

Dr. Ma stated he is optimistic about the FY2025 budget and the outlook for the organization. He recognized a number of individuals with heartfelt thanks for their efforts and hard work, including but not limited to Finance, Patient Accounting, Pharmacy, Foundation, Auxiliary and C-Suite, to name a few.

14. Board Communications

Vice Chairperson Chaya thanked Dr. Ma for his heartfelt messages to the staff. Director Chaya stated the Board is dark in July, however there will be a Special Board meeting held on Friday, July 19, 2024.

15. Adjournment

There being no further business, Vice Chairperson Chaya adjourned the meeting at 4:15 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

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

July 19, 2024 – 2:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on July 21, 2024.

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

Director Rocky J. Chavez
Director Nina Chaya
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Janice Gurley, Chief Financial Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Chairperson, Director Tracy M. Younger. called the meeting to order at 2:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Coulter to approve the agenda as presented. The motion passed unanimously (7-0).

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

   Chairperson Younger made an oral announcement of the items listed on the July 19, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Potential Litigation and Reports Involving Trade Secrets.

6. Motion to go into Closed Session

   It was moved by Director Sanchez and seconded by Director Gleason to go into Closed Session at 2:02 p.m. The motion passed unanimously (7-0).

7. At 3:25 p.m. the Board returned to Open Session with all board members present with the exception of Director Sanchez.

8. Report from Legal Counsel on any action taken in Closed Session.

Board Counsel Scott reported the Board heard a report on Trade Secrets pursuant to Health & Safety Code Section 32106 and took no action. The Board also received a report involving Potential Litigation pursuant to Government Code 54956(d4) and took no action.

9. Open Session

Roll Call/Pledge of Allegiance

Director Chavez led the Pledge of Allegiance

12. Public Comments Announcement

Board Chairperson Younger read the Public Comments section listed on the July 19, 2024 Special Board of Directors Meeting Agenda.

13. New Business

a) Discussion and consideration of possible action related to the Affiliation with UC San Diego Health

Dr. Ma provided an update on the status of the affiliation agreement between Tri-City Healthcare District and UC San Diego Health. The original proposal, presented in October 2023, included immediate transitions such as Tri-City employees becoming UC San Diego Health employees, UC San Diego Health assuming full financial responsibility, and immediate assumption of district liabilities. However, the current proposal has significantly changed, delaying these transitions by up to five years, which raises concerns about financial risk and the role of the district board.

Key changes include:

1. **Employee Transition**: Initially, Tri-City employees were to transition to UC San Diego Health immediately at closing; this has now been delayed for up to five years.
2. **Financial Responsibility**: UC San Diego Health initially agreed to assume full financial responsibility immediately at closing; now, they will not fully assume this risk for the first five years.
3. **District Liabilities**: The initial proposal included UC San Diego Health taking on all district liabilities at closing; this has also been delayed by up to five years.
4. **Medical Office Building (MOB)**: The commitment to building a robust Cancer Center as part of the MOB is now subject to further due diligence and not guaranteed in the current proposal.
5. **Labor & Delivery Services**: The reopening of Women's & Newborn Services, a key factor in choosing UC San Diego Health, is now uncertain and unlikely to occur within the first two years.
6. **Core Services Commitment**: The commitment to maintaining core services for 15 years remains, but there is uncertainty about what happens after that period.
7. **Operating Authority**: UC San Diego Health will have full operating authority, but the district board's reserved rights are not clearly defined, creating potential governance issues.
8. **Financial and Operational Risks**: The delay in assuming financial responsibility and liabilities puts Tri-City Healthcare District at potential financial risk if projections are not met.

Board Counsel Scott reiterated comments made by Dr. Ma and also stated that our lender HUD raises significant concerns about the viability of a proposal like this. He opined that the proposal is unworkable at this point.

Director Chavez exited the meeting at 3:45 p.m.

Dr. Ma emphasized that despite claims that Tri-City's financial situation has worsened, the district's financials have actually improved, with positive EBITDA and EROE in recent months. The executive team is seeking guidance from the Board on whether to accept the revised proposal from UC San Diego Health or explore other partnership options while considering a revised proposal from UC San Diego Health.

Chairperson Younger reiterated that while we are not closing the door on UC San Diego Health, we are open to exploring other options if significant changes are not made to the current proposal

It was moved by Director Mizell to explore other partnership options without closing the door on UC San Diego Health. Director Chaya seconded the motion.

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

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

b) Consideration to approve the Emergency Department On-Call agreements for General Cardiology, STEMI and EKG Panel services with Karim EL-Sherief, M.D., Aaron Yung, M.D., Dimitri Sherev, M.D., Mihir Barvalia, M.D. Jesse Naghi, M.D., Mohammed Pashmfourosh, M.D., PhD, and Genaro F. Fernandez, M.D. for a term of 36 months, beginning August 1, 2024 and ending July 31, 2027, with an annual cost of $690,820 and total term cost of $2,072,460.

Jeremy Raimo provided feedback on the diligent process the district followed in evaluating proposals from a highly qualified group of cardiologists. He expressed gratitude to both groups for their proposals to deliver comprehensive services. Although it was a challenging decision, one group clearly demonstrated their capability to meet the district's needs with a full array of providers.

Jeremy explained that during the May 30th board meeting, the board instructed the Administration to extend the proposal submission period, which was kept open until June 14th. The district received two proposals, and the administrative team carefully reviewed each, assessing their ability to cover all three cardiology panels: general, STEMI, and EKG/Invasive cardiology. After an exhaustive search to bring one group together, the administrative team is recommending that the board now consider approval of the selected group.

It was moved by Vice Chairperson Chaya to approve the Emergency Department On-Call agreements for General Cardiology, STEMI and EKG Panel services with Karim EL-Sherief, M.D., Aaron Yung, M.D., Dimitri Sherev, M.D., Mihir Barvalia, M.D. Jesse Naghi, M.D., Mohammed Pashmfourosh, M.D., PhD, and Genaro F.

Fernandez, M.D. for a term of 36 months, beginning August 1, 2024 and ending July 31, 2027, with an annual cost of $690,820 and total term cost of $2,072,460. Director Gleason seconded the motion.

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

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

14. Consent Calendar

It was moved by Director Gleason to approve the Consent Calendar. Director Coulter seconded the motion.

The vote on the motion was as follows:

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

10. Adjournment

There being no further business, Vice Chairperson Chaya adjourned the meeting at 5:00 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending July 31, 2024

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)	54,257.88	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)	38,547.79	07/01/17	08/31/24	**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)	20,594.69	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	20,499.89	10/01/22	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 2,460	$2.21	(a)	12,515.76	04/01/23	03/31/25	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Appox 4,508	$1.75	(a)	10,051.41	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	23,977.58	09/01/21	08/31/33	**PCP Clinic Calrsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	13,621.27	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)	31,749.00	10/01/22	09/30/25	**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)	14,880.52	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 3,262	$2.21	(a)	19,606.78	05/01/23	06/30/25	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**260,302.57**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 2024

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	Charge	70124 EDU	129.90	84157	ROBERTS STACIA
8740	Charge	72424 EDU	100.00	84396	NGUYEN JUDY
8740	Charge	70124 EDU	200.00	38603	KOVAK, GRETAL
8740	Charge	70124 EDU	200.00	80011	CHAPPELL, DIANE

**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.