TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING **REVISED**
June 26, 2025 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

Director Brown will attend via Teleconferencing pursuant to Government Code 54953(b) at 92-1185 Aliinui Drive, Kapolei, Hawaii 967707

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	Special Recognition – a) Henry F. Showah, M.D., Chief of Staff – 2022-2025	5 min,	Chair
7	Introduction a) Mohammad Jamshidi-Nazhad, DO – Incoming Chief of Staff	5 min.	COS
8	May 2024 Financial Statement Results	10 min.	CFO
9	New Business – a) Review, discussion and action regarding the Operating and Capital Budgets for FY2026 b) Consideration to approve the addition of Bayan Aghdasi, M.D., as a provider to Tri-City Healthcare District's 1206(b) clinic through Addendum Two to the existing Professional Services Agreement	 15 min. 5 min.	 CFO COO

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
	between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, Inc.		
10	Old Business – None		
11	Chief of Staff - a) Consideration of June 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals, **pending** recommendation from the Medical Executive Committee on June 23, 2025 b) Clinical Privilege Request Form – PA – Wound Care Center c) PA (Wound Care) Proctoring Form	5 min.	COS
12	Consent Calendar 1) Consideration to approve Resolution No. 828, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2025 and ending June 30, 2026, in Accordance with Article XIII B of the Constitution of the State of California; Code of the State of California 2) Board Committee **a. Finance, Operations & Planning Committee Director Younger, Committee Chair** 1) Approval of the renewal of the comprehensive hospital-based interventional radiology services agreement with North County Radiology Medical Group for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an annual cost of $951,000 for a total term cost of $1,902,000. 2) Approval of the renewal of the agreement with Senior Medical Associates for the co-medical directorship of the Outpatient Behavioral Health-Morning and Afternoon Program with Dr. Tavakoli, for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an hourly rate of $165, an annual cost of $55,440, and a total cost for the term of $110,880. 3) Approval of the Medical Staff Leadership Agreement for Chief of Staff, Mohammad Jamshidi-Nezhad, DO, for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an annual cost not to exceed $72,000 and a total term cost of $149,000. 4) Approval of the renewal of an agreement with Cary Mells, M.D. as the Chair of the Physician Well-Being Committee at a cost of $3,000 a month, for a term of 24 months, beginning August 1, 2025 and ending July 31, 2027, at an annual cost of $36,000 and a total term cost of $72,000. 5) Approval of the renewal of the Medical Directorship agreement for Structural Heart Disease in Cardiology with	10 min.	Chair

	Agenda Item	Time Allotted	Requestor
	Aaron Yung, M.D. for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an annual cost not to exceed $30,240 and a total term cost not to exceed $60,480. 6) Approval of the renewal of the Medical Directorship agreement for Invasive Cardiology Services with Aaron Yung, M.D., for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. 7) Approval of the renewal of the Medical Directorship agreement for Cardiothoracic Surgery with Darrel Wu, M.D., beginning July 1, 2025 and ending June 30, 2026, 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. 8) Approval of the renewal of the Medical Directorship agreement for Cardiac Rehabilitation Services, with Karim El-Sherief, M.D., for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $150, for an annual cost of $79,200 and a total term cost not to exceed $158,400. 9) Approval of the renewal of an agreement for the Medical Directorship for Vascular Surgery, with Mohammad Jamshidi-Nezhad, M.D., for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. 10) Approval of the renewal of an agreement for Medical Directorship for the Cardiovascular Health Institute with Donald Ponec, M.D. for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, not to exceed an average of eight (8) hours per month or 96 hours annually, at an hourly rate of $210, for an annual and total term cost of $20,160. 11) Approval of the renewal of an agreement with Andrew Deemer, M.D. as a Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, not to exceed two (2) hours per month at an hourly rate of $210 for an annual and term cost of $5,040. 12) Approval of the renewal of an agreement with Aaron Yung, M.D., as a Cardiovascular Health Institute – Quality Committee member, for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, not to exceed two (2) hours per month at an hourly rate of $210, for an annual and term cost of $5,040. 13) Approval of the renewal of an agreement with Donald		

	Agenda Item	Time Allotted	Requestor
	Ponec, M.D., as a Cardiovascular Health Institute – Quality Committee member, for a term of 12 months, beginning July 1, 2025, and ending June 30, 2026, not to exceed (two (2) hours per month at an hourly rate of $210, for an annual and term cost of $5,040. 14) Approval of an agreement with Darrell Wu, M.D., as a Cardiovascular Health Institute – Operations Committee member, for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, 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 the renewal of the Emergency Department On-Call coverage panel for Urology to include Aaron G. Boonjindasup, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., Caroline J. Vilchis, M.D., and Robert Shapiro, M.D., for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, at a shared panel total term cost not to exceed $620,500. 16) Approval of the renewal of the Emergency Department On-Call coverage panel for Spine surgery to include Payam Moazzaz, M.D., Kevin Yoo, M.D., Sunil Jeswani, M.D. and Braden McKnight, M.D. for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, with an annual cost of $173,375, and a total term cost of $346,750. 17) Approval of the renewal of the Emergency Department On-Call coverage panel for ENT/Otolaryngology with Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Ashish Wadhwa, M.D. Sarah Carroll, M.D., Richard Liu, M.D., and Amit Date, M.D., for a term of 24 months, beginning July 1, 2025, and ending June 30, 2027, with a shared total term cost of $501,875. 18) Approval of the renewal of the Emergency Department On-Call coverage panel for Oral-Maxillofacial Surgery with Brian Mudd, D.D.S., for a term of 24 months, beginning July 1, 2025, and ending June 30, 2027, for an annual cost of $182,500 and a total term cost of $365,000. 19) Approval of the renewal of the Emergency Department On-Call coverage panel for Gastroenterology, General, and ERCP with Hellen Chiao, M.D., Christopher Devereaux, M.D., Javaid Shad, M.D., Michael Shim, M.D., and Eric Viernes, M.D., for a term of 24 months, beginning July 1, 2025, and ending June 30, 2027, for a total term cost, not to exceed $1,478,250. 20) Approval of an agreement with Jeff Raunig, M.D., for Locum Tenens coverage at Seaside Medical Group, for a term of 12 months, beginning June 16, 2025 and ending June 15, 2026, for an annual and term cost not to exceed $50,000. 21) Approval of an agreement with Greater Tri-City IPA Medical Group, Inc. for Locum Tenens Coverage at Seaside		

	Agenda Item	Time Allotted	Requestor

Medical Group for a term of 12 months, beginning June 16, 2025 and ending June 15, 2026, for an annual and term cost not to exceed $20,000.

22) Approval of an agreement with Abbott, Inc. for service and technology services for a term of 36 months, beginning June 1, 2025 and ending May 31, 2028, for a total term cost of $542,600.

23) Approval of an agreement with Iodine Software, LLC for a subscription and services agreement, for a term of 36 months, beginning July 1, 2025 and ending June 30, 2028, for a total term cost of $1,460,404.

(3) **Administrative Policies & Procedures**

A. Patient Care Services

1. Activate Clotting Time Testing by Medtronic ACT Plus Procedure
2. Amnisure Placental Alpha – 1 Microglobulin (PANGI) Test for Rupture of Fetal Membranes (ROM) Procedure
3. Collection of a Blood Specimen by Skin Puncture Procedure
4. HMS Plus Hemostasis Management System: Activated Clotting Time, Heparin Assay, Heparin Dose Response Procedure
5. Infusion Pump Syringes or PCA Module System with Guardrails Procedure
6. Newborn Screening Collection of Specimen Procedure
7. Nitrazine Test on Vaginal Fluid Procedure
8. Patient Controlled Analgesia (PCA) Procedure
9. Siemens Rapidpoint 500 Procedure
10. Urine Dipstick Analysis Manual Read Procedure
11. Urine Dipstick Using Siemens Clinitek Status+Connect Procedure
12. Urine Dipstick Using McKesson Consult 120 Urine Analyzer Procedure
13. Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure

B. Administrative

1. Medicare Hospital Readmission Billing 290
2. Lactation Accommodation Policy 402

C. Employee Health & Wellness

1. Temporary Modified Duty for Industrial Injuries Policies

D. Laboratory General

1. Laboratory Organization Quality System Essentials QSE.01

E. Pharmacy

1. Peri-operative Antimicrobials Policy
2. Local Anesthesia in Operating Room Policy
3. Registered Nurse Assisting with Peripheral Nerve Block Policy

F. Surgical Services

1. Anesthesia Type, Location and Monitoring Policy
2. Local Anesthesia in Operating Room Policy

G. Telemetry

	Agenda Item	Time Allotted	Requestor
	1. Skin and Wound Team Rounds (4) Minutes a) Special Meeting – May 29, 2025 b) Regular Meeting – May 29, 2025 (5) Reports – (Discussion by exception only) a) Building Lease Report – (May, 2025) b) Reimbursement Disclosure Report - (May, 2025)		
13	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
14	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
15	Comments by Chief Executive Officer	5 min.	Standard
16	Board Communications	18 min.	Standard
17	Total Time Budgeted for Open Session	1.5 hour	
18	Adjournment		

Tri-City Medical Center

Tri-City Healthcare District Board of Directors
DATE OF MEETING: June 26, 2025
Addendum Two to 1206(b) OSNC - Professional Services Agreement

Type of Agreement		Medical Directors		Panel	X	Other: Addendum to PSA
Status of Agreement	X	New Agreement		Renewal: New Rates		Renewal: Same Rates

Physician Name: Bayan Aghdasi, M.D.

Areas of Service: Orthopedic Surgery; Spine Surgeon

Key Terms of Agreement:

- Effective Date: September 1, 2025 through August 31, 2026
- Annual stipend amount is within Fair Market Value

Terms of the Engagement:	Proposal Costs:
Monthly Professional Stipend	$39,583.33/month ($475,000/annual)
Relocation Assistance	$10,000 (reimbursed with receipts)
Total Amount of Request:	**$485,000**

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 Tri-City Healthcare District Board of Directors approve the addition of Bayan Aghdasi, M.D. as a provider to Tri-City Healthcare District's 1206(b) clinic. This will be accomplished through an Addendum Two to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, Inc.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
June 11, 2025

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
BROTHERTON, Brian MD	Medicine/Critical Care	Provisional	6/26/2025 – 6/26/2027	
SADEGHI, Saha MD	Pathology	Provisional	6/26/2025 – 6/26/2027	
SHARMA, Abhinav MD	Medicine/Cardiology	Provisional	7/01/2025 – 7/01/2027	Insurance effective 7/01/2025.
TRAMBERT, Michael MD	Teleradiology	Provisional	6/26/2025 – 6/26/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
June 11, 2025

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Credentials Committee for consideration for reappointment to the Medical Staff or Allied Health Professional Staff, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance. Reappointment is for 2-years unless otherwise noted below.

Medical Staff

Department of Emergency Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
DEMBITSKY, Zachary Y, MD	Emergency Medicine	Active	6/26/2025-6/26/2027	
GUTIERREZ, Miguel A, MD	Emergency Medicine	Active	6/26/2025-6/26/2027	Change in staff status from Provisional to Active.
LAREAUX, Daniel, MD	Emergency Medicine	Active	6/26/2025-6/26/2027	Change in staff status from Provisional to Active.
PREGERSON, David B, MD	Emergency Medicine	Active	6/26/2025-6/26/2027	

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
ADHANOM, Teamrat A, MD	Internal Medicine	Active	6/26/2025-6/26/2027	
BAKER, David A, DO	Neurology	Active	6/26/2025-6/26/2027	Change in staff status from Provisional to Active.
COHEN, David N, MD	Cardiology	Active	6/26/2025-6/26/2027	
CORONA, Frank E, MD	Pulmonary	Active	6/26/2025-6/26/2027	
CURRAN, Perrin J, MD	Internal Medicine	Refer and Follow	6/26/2025-6/26/2027	
KASED, Norbert, MD	Radiation Oncology	Active	6/26/2025-6/26/2027	
KHARADIJIAN, Talar, MD	Nephrology	Active	6/26/2025-6/26/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
June 11, 2025

Attachment B

LI, Xiangli, MD	Internal Medicine	Refer and Follow	6/26/2025-6/26/2027	
LIU, Andrew C, MD	Nephrology	Active	6/26/2025-6/26/2027	Change in staff status from Provisional to Active.
OH, Irene, MD	Neurology	Active	6/26/2025-6/26/2027	
PEREZ, Ronald Nino M, MD	Family Medicine	Refer and Follow	6/26/2025-6/26/2027	
SHALI, Reyza, MD	Internal Medicine	Refer and Follow	6/26/2025-6/26/2027	
VILCHIS, Caroline J, MD	Urology	Active	6/26/2025-6/26/2027	

Department of Radiology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
KHOSLA, Ankaj, MD	Interventional Radiology	Active	6/26/2025-6/26/2027	

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
KUSNEZOV, Nicholas, MD	Orthopedic Surgery	Active	6/26/2025-6/26/2027	Change in staff status from Provisional to Active.
WONG, Amy A, DPM	Podiatric Surgery	Active	6/26/2025-6/26/2027	

Resignations *Medical Staff and AHP*:

Practitioner Name	Department/Specialty	Reason for Resignation
ANTOUN, David G, MD	Internal Medicine	Will not be moving forward with Reappointment, via email effective 6/31/2025.
HANRAHAN, David, MD	Telepsychiatry	Array Behavioral Care contract ended with hospital.12/30/2024
McDONALD, Corry MD	Emergency Medicine	Resignation letter received for 12/31/2024
WANG, Siyuan, DO	Emergency Medicine	Resignation document rcvd via email effective 6/30/2025.

MBOC (Medical Board of California): No new information at this time

NPDB (National Practitioner Data Bank): No new information at this time

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 2 of 3
June 11, 2025

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below.
Effective **June 26, 2025.**

Practitioner Name	Department/Specialty	Change in Privilege/s
SHEREV, Dimitri MD	Medicine/Cardiology	**Additional:** Peripheral Angiography (Extremity, Pulmonary, Thoracic); Peripheral Intervention (Angioplasty, Drug infusion, Stent graft, Stent Placement, Thrombolysis); Venography and Venous Intervention (IVC filter, Stent, tPA, Venous thrombolysis) WITH proctoring.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
June 11, 2025

Proctoring Recommendations

The following providers have successfully completed their initial FPPE (Focused Professional Practice Evaluation) and are being recommended for release of their proctoring requirements for the privilege(s) as noted below.

Practitioner Name	Department/Specialty	Privilege(s)
Batasin, Ma Lovely DO	Emergency Medicine	Moderate/Deep Sedation
Buckley, David. MD	Radiology/Teleradiology	Teleradiology privileges as delineated
Fooladian, Siyavash. MD	Anesthesiology	Regional Anesthesia
LaReaux, Daniel	Emergency	Moderate Sedation
Lizerbram, Eric. MD	Radiology/Diagnostic	Computed tomography, General diagnostic/fluoroscopy, Magnetic resonance imaging/spectroscopy, Nuclear medicine (all routine) Positron Emission Tomography (PET), Ultrasonography/hysterosonography and vascular duplex ultrasound
Novo, Megan. MD	Medicine/Gastroenterology	Admit patients, Consultation, including via telemedicine (F), Perform History and Physical, including via telemedicine (F), Colonoscopy, Esophageal dilation, Esophagogastroduodenoscopy (EGD), Flexible sigmoidoscopy, Percutaneous endoscopic gastrostomy (PEG), Snare polypectomy, Variceal hemostasis (upper and lower), Moderate sedation.
Presente, Asaf. MD	Medicine/Critical Care	Admit patients, Consultations, including via telemedicine (F) and sleep tests/polysomnography, Perform History & Physical examination, including via telemedicine (F) and General Critical Care privileges.
Quinn, Catherine, MD	Medicine/Oncology	Consultation, including via telemedicine (F) (OPIC), Perform medical history and physical examination, including via telemedicine (F)
Sherev, Dimitri, MD	Medicine/Cardiology	Transcatheter Aortic Replacement (TAVR)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE INITIALS REPORT
June 18, 2025

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.

Allied Health Professional:

Practitioner Name	Group	Specialty	Staff Status	Initial Appointment Term	Comments
ISHAK, Amy NP	TeamHealth	NP – Emergency Medicine	Allied Health Professional	6/26/2025 – 6/26/2027	
SAK, Emily PA	TCMC – OSNC	PA – Orthopedic Surgery	Allied Health Professional	6/26/2025 – 6/26/2027	

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

PA - Wound Care Center

Provider Name:

	Privilege

SITES:
The following locations have adequate resources to allow the performance of designated Wound Care privileges:
1. 6260 El Camino Real, Carlsbad, California - Wound Care and Hyperbaric Medicine Oxygen Therapy
2. 4002 Vista Way, Oceanside, California - Wound Care only

CHRONIC NON-HEALING WOUND CARE CRITERIA - Intial, Proctoring, and Reappointment criteria as outlined in Medical Staff policy 8710-523

___ Chronic non-healing wound care (Sites: 1,2)

___ Consultation

___ Perform History & Physical Exam

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

_____
Division/Department Signature

_____
Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:

As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

PA - Wound Care Center

Provider Name:

	Privilege

_____

Date

Tri-City Medical Center – Medical Staff
Physician Assistant (Wound Care) – Proctoring Form

Patient MR #_____ Date of Care:_____

Physician Assistant: _____

Procedure or Diagnosis:_____

Please place "N/A" after any standard that does NOT apply to the role in which the Physician Assistant is functioning.

	MEETS STANDARD (Each box in a column must be Checked)		
	ABOVE	**MEETS**	**BELOW** *(Comments are required)*
Technical Ability			
Preparedness for Case			
Commnication with Primary Care Physician			
Interaction with Patient/Family			
Ablity to inteact with other healthcare professionals			
Overall ability and performance (Competence/Skill)			
Clinical Documentation/Dictation of the Procedure			
Compliance with Hospital and Medical Staff Policies			

COMMENTS: _____

_____

NOTE TO PROCTOR:
Thank you very much for observing this practitioner. Your comments are of great value and will be held in strict confidence. Please return completed proctor form directly to the Medical Staff Office.

_____ _____
Proctor's Signature Date

_____
Proctor's Name (Print)

NOTE: This form should **not** be placed in the patient's medical record.

RESOLUTION NO. 828

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2025 AND ENDING JUNE 30, 2026 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA

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

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

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

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

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

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2025 and ending June 30, 2026 is not to exceed $$20,891,460.

2. In accordance with Section 2, Article XIII B of the Constitution of the State of California, any revenues received by TRI-CITY HEALTHCARE DISTRICT in excess of that

amount, which is appropriated in compliance with Article XIII B of the Constitution of the State of California, during the fiscal year shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

ADOPTED, SIGNED AND APPROVED this 26th day of June, 2025.

Tracy M. Younger, Chairperson of the
TRI-CITY HEALTHCARE DISTRICT and
of the Board of Directors thereof

ATTEST:

Adela I. Sanchez, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

STATE OF CALIFORNIA)
)
COUNTY OF SAN DIEGO)

ss.

I, Adela I. Sanchez, Secretary of TRI-CITY HEALTHCARE DISTRICT and of the Board of Directors thereof, do hereby certify that the foregoing Resolution was duly adopted by the Board of Directors of said District at a Regular Meeting of said Board held on the 26th day of June, 2025, and that it was adopted by the following vote:

AYES:	**DIRECTORS:**
NOES:	**DIRECTORS:**
ABSTAIN:	**DIRECTORS:**
ABSENT:	**DIRECTORS**:

Adela I. Sanchez, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
May 21, 2025

Members Present	Director Tracy Younger (via telephone), Director Nina Chaya (via telephone), Director Adela Sanchez, Dr. Henry Showah, Dr. Mohammad Jamshidi-Nezhad
Non-Voting Members Present:	Jeremy Raimo, COO, Donald Dawkins, CNE, Roger Cortez, CCO, Mark Albright, CIO, Anh Nguyen, Interim CFO
Others Present:	Eva England, VP Ancillary Services, Jane Dunmeyer, Miava Sullivan
Members Absent:	Dr. Gene Ma

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Adela Sanchez called the meeting to order at 3:01 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Jamshidi-Nezhad, and Adela Sanchez seconded, and it was unanimously approved to accept the agenda of June 18, 2025.**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Sanchez read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of May 21, 2025	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Jamshidi-Nezhad, Dr. Chaya seconded, that the minutes of May 21, 2025, are to be approved without any requested modifications.**	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
5. Old Business	None		
6. New Business	None		
7. Consideration of Consent Calendar:		**MOTION** **It was moved by Dr. Showah to approve the Consent Calendar and seconded by Dr. Chaya.** **Members:** **AYES: Younger, Sanchez, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT:**	Chair
a) Comprehensive Interventional Radiology Services Agreement • North County Radiology Medical Group		**Approved via Consent Calendar**	Eva England
b) Medical Staff Leadership Agreement – Chief of Staff • Mohammad Jamshidi-Nezhad, D.O.		**Approved via Consent Calendar**	Dr. Gene Ma
c) Medical Staff Leadership Agreement - Physician Well-Being Committee Chair • Cary Mells, M.D.		**Approved via Consent Calendar**	Dr. Gene Ma
d) Physician Agreement for Co-Medical Director – Outpatient Behavioral Health Services • Senior Medical Associates (Jason Keri as signer and Dr. Tavakoli as the covering physician)		**Approved via Consent Calendar**	Donald Dawkins

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
e) Physician Agreement for Cardiovascular Health Institute – Quality Committee • Andrew Deemer, M.D.		**Approved via Consent Calendar**	Eva England
f) Physician Agreement for Medical Director - Cardiac Rehab • Karim El-Sherief, M.D.		**Approved via Consent Calendar**	Eva England
g) Physician Agreement for Medical Director, Vascular Surgery • Mohammad Jamshidi-Nezhad, M.D.		**Approved via Consent Calendar**	Eva England
h) Physician Agreement for Cardiovascular Health Institute – Medical Director • Donald Ponec, M.D.		**Approved via Consent Calendar**	Eva England
i) Physician Agreement for Cardiovascular Health Institute – Quality Committee • Donald Ponec, M.D.		**Approved via Consent Calendar**	Eva England
j) Physician Agreement for Cardiovascular Health Institute – Operations Committee • Darrell Wu, M.D.		**Approved via Consent Calendar**	Eva England
k) Physician Agreement Medical Director – Cardiothoracic Surgery • Darrell Wu, M.D.		**Approved via Consent Calendar**	Eva England

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
l) Physician Agreement - for Cardiovascular Health Institute – Quality Committee • Aaron Yung, M.D.		**Approved via Consent Calendar**	Eva England
m) Physician Agreement for Invasive Cardiology Medical Director • Aaron Yung, M.D.		**Approved via Consent Calendar**	Eva England
n) Physician Agreement – Structural Heart Medical Director • Aaron Yung, M.D.		**Approved via Consent Calendar**	Eva England
o) Physician Agreement – ED On-Call Coverage – ENT/Otolaryngology • Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Ashish Wadhwa, M.D., Sarah Carroll, M.D., Richard Liu, M.D., Amit Date, M.D. Aaron Yung, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
p) Physician Agreement – ED On-Call Coverage – Spine Surgery • Payam Moazzaz, M.D., Kevin Yoo, M.D., Sunil Jeswani, M.D., Braden McKnight, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
q) Physician Agreement – ED On-Call Coverage – Urology • Aaron G. Boonjindasup, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., Caroline J.		**Approved via Consent Calendar**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Vilchis, M.D., Robert Shapiro, M.D.			
r) Physician Agreement for ED On-Call Coverage – Oral/Maxillofacial Surgery • Brian Mudd, D.D.S.		**Approved via Consent Calendar**	Jeremy Raimo
s) Physician Agreement for ED On-Call Coverage – Gastroenterology, General & ERCP • Hellen Chiao, M.D., Christopher Devereaux, M.D., Javaid Shad, M.D., Michael Shim, M.D., Matthew Viernes, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
t) Locum Tenens Coverage Agreement • Jeff Raunig, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
u) Locum Tenens Coverage Agreement • Greater Tri-City IPA		**Approved via Consent Calendar**	Jeremy Raimo
v) Service and Technology Agreement • Abbott Service and Technology Plan		**Approved via Consent Calendar**	Eva England
w) Master Subscription and Services Agreement • Iodine Software, LLC		**Approved via Consent Calendar**	Mark Albright
8. Financials	Anh Nguyen presented the financials ending May 31, 2025 (dollars in thousands) **TCHD – Financial Summary**		Anh Nguyen

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Fiscal Year to Date Operating Revenue $ 307,527 Operating Expense $ 312,726 EBITDA $ 25,002 EROE $ 8,851 **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 125 Adjusted Patient Days 74,098 Avg Acute Length of Stay 5.0 Surgery Cases 4,966 ED Visits 43,438 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 33,241 Operating Expense $ 30,155 EBITDA $ 6,224 EROE $ 4,994 **TCMC – Key Indicators** **Current Month** Avg. Daily Census 111 Adjusted Patient Days 6,119 Surgery Cases 436 ED Visits 3,791 **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		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Equivalents-13 Month Trend		
a. Dashboard	No discussion	Information Only	Anh Nguyen
7. Comments by Committee Members	None	None	Chair
8. Date of next meeting	August 20, 2025		Chair
10. Adjournment	Meeting adjourned 3:20 pm.		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
COMPREHENSIVE INTERVENTIONAL RADIOLOGY SERVICES AGREEMENT

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

Physician Group Name: North County Radiology Medical Group

Area of Service: Hospital Professional Services: Interventional Radiology

Term of Agreement: 24 months, Beginning July 1, 2025 – Ending June 30, 2027

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Renewal, no change in rates, termination of separate ED call panel

Service	Annual Cost	Total Term Cost
Comprehensive Hospital Based Interventional Radiology Services including 24/7 Stroke Center Coverage	$876,000	$1,752,000
Specialty Advanced Nurse Practitioner	$75,000	$150,000
Totals	**$951,000**	**$1,902,000**

Description of Services/Supplies:

- Comprehensive coverage of all hospital-based services for interventional radiology to support all clinical service lines
- 24/7 coverage of ED call
- 24/7 Stroke center coverage with collaborative responsibility for achieving target metrics as a Joint Commission designated Thrombectomy Capable Stroke Center
- Backup coverage for diagnostic radiology services and procedures

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-VP Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the comprehensive hospital-based interventional radiology services agreement with North County Radiology Medical Group for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an annual cost of $951,000 for a total term cost of $1,902,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT for CO-MEDICAL DIRECTOR – OUTPATIENT BEHAVIORAL HEALTH SERVICES

Type of Agreement	X	Co-Medical Directors		Panel	X	Other: Reduced Hours
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Physician's Name: Senior Medical Associates (Jason Keri as signer and Dr. Tavakoli as the covering physician)

Area of Service: Outpatient Behavioral Health-Morning and Afternoon Program

Term of Agreement: 24 months, Beginning, July 1, 2025 – Ending, June 30, 2027 (Rate increase from $144 to $165)

	Old Rate/Hour	New Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	Two Years Term Cost
Medical Director Duties	$144	$165	16	192	$2,640	$31,680	**$63,360**
Case Care Management Duties	$144	$165	8	96	$1,320	$15,840	**$31,680**
Additional Coverage	$144	$165	As needed	48 max	$660	$7,920	**$15,840**
		Total:	**28**	**336**	**$4,620**	**$55,440**	**$110,880**

Co-Medical Director Responsibilities:

- Provide medical supervision and direction to the unit, including the morning and afternoon programs
- Supervise and promote the quality of care and evaluate delivery systems.
- Oversee the development of evidence-based clinical services and provide psychiatric expertise.
- Facilitate weekly problem solving and treatment team meetings with clinical staff.
- Review all treatment plans at least monthly to determine appropriateness of problems and treatment goals.
- Evaluate and review policies and procedures and make suggestions for changes as appropriate.
- Provide education to staff and community providers

Case Care Management and other Duties:

- Take on utilization management duties and respond to insurance authorization calls for IOP and communicate clinical determination of medical necessity
- Evaluate patients at least once per month for IOP medical necessity and discharge readiness
- Evaluate whether patients are medically stable and meet inclusion/exclusion criteria for IOP on admission and monthly thereafter
- Prepare reports and records as requested by hospital and regulatory bodies
- Provide professional guidance to staff Monday through Friday and evaluate risk/protective factors and recommend whether a patient needs inpatient treatment or can be managed with safety planning. Respond to calls Mondays through Fridays, 8 am-5 pm.

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

Person responsible for oversight of agreement: Sarah Jayyousi-Operations Manager, Outpatient Behavioral Health / Donald Dawkins, Chief Nursing Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Senior Medical Associates for the co-medical directorship for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an hourly rate of $165, an annual cost of $55,440, and a total cost for the term of $110,880.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
MEDICAL STAFF LEADERSHIP AGREEMENT – CHIEF OF STAFF

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

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

Area of Service: Medical Staff Leadership: Chief of Staff

Term of Agreement: 24 months, Beginning, July 1, 2025 – Ending, June 30, 2027

Maximum Totals: Within Hourly and Annualized Fair Market Value: YES
Same rate as prior contract for position

Rate/Hr.	Hrs./Month NTE	Monthly Cost NTE (TCHD)	Annual Cost NTE (TCHD)	Education Expense for Term NTE	Total Term Cost NTE (TCHD)
$150	40 hrs.	$6,000	$72,000	$5,000	**$149,000**

Description of Services/Supplies:

- Perform the duties of the Chief of Staff as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Attend meetings of the Board of Directors and such Board Committees as per District and Medical Staff bylaws
- Liaise with hospital Administration including reporting on the status of activities of the Medical Staff

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: Jonathan Gonzalez, Director-Medical Staff Services / Dr. Gene Ma, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Dr. Mohammad Jamshidi-Nezhad for Chief of Staff for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027 for an annual cost not to exceed $72,000 and a total term cost of $149,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 26, 2025
Medical Staff Leadership Agreement - PHYSICIAN WELL-BEING COMMITTEE CHAIR, Cary Mells, MD

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

Physician's Name: Cary Mells, M.D.

Area of Service: Medical Staff Leadership: Physician Well-Being Committee Chair

Term of Agreement: 24 months, Beginning August 1, 2025 – Ending July 31, 2027

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

Rate/Month	Annual Cost	24 Month (Term) Cost
$3,000	$36,000	**$72,000**

Position Responsibilities:

- Perform the duties of Chair of the Physician Well-Being Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Be available as a resource to the Medical Staff and Hospital with respect to well-being issues
- Liaise with hospital Administration and Medical Staff on issues relating to physician well-being programs

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: Jonathan Gonzalez, Director-Medical Staff Services / Dr. Gene Ma, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the agreement with Dr. Cary Mells as the chair of the Physician Well-Being Committee at a cost of $3,000 a month for a term of 24 months, beginning August 1, 2025 and ending July 31, 2027, at an annual cost of $36,000 and a total term cost of $72,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT for Structural Heart - Cardiology 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: Aaron Yung M.D.

Area of Service: Medical Director – Structural Heart - Cardiology

Term of Agreement: 24 months, Beginning, July 1, 2025 – Ending, June 30, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 Month (Term) Cost
$210	12	144	$2,520	$30,240	**$60,480**

Position Responsibilities:

- Medical Directorship agreement with responsibilities to establish a structural heart program, provide program oversight and stewardship aligned with the strategic initiatives adopted by the District Board of Directors for this key service line
- In collaboration with TCHD, the Medical Director of Cardiology Structural Heart will provide educational opportunities for both district employees and local medical groups
- The medical director will have shared responsibility for the quality of the program and service line growth.

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, VP Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the establishment of the medical directorship for Structural Heart Disease in Cardiology with services provided by Aaron Yung, M.D. for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, for an annual cost not to exceed $30,240 and a total term cost not to exceed $60,480.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT FOR INVASIVE CARDIOLOGY 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: Aaron Yung M.D. –Invasive Cardiology, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, Beginning, July 1, 2025 - Ending, June 30, 2026

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	12	144	$2,520	$30,240

Position Responsibilities:

- Physicians 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-VP Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Aaron Yung, M.D. as the medical director for Invasive Cardiology for term of 12 months, beginning, July 1, 2025 and ending, June 30, 2026, 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: June 18, 2025
PHYSICIAN AGREEMENT MEDICAL DIRECTOR – CARDIOTHORACIC SURGERY

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

Physician's Name: Darrell Wu, M.D. - Cardiothoracic Medical Director

Area of Service: Cardiovascular Health Institute (CVHI)

Term of Agreement: 12 months, Beginning, July 1, 2025 - Ending, June 30, 2026

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	12	144	$2,520	**$30,240**

Position Responsibilities:

- Physicians 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-VP Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize Darrell Wu, M.D. as the Cardiothoracic medical director for term of 12 months, beginning, July 1, 2025 and ending, June 30, 2026, 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: June 18, 2025
PHYSICIAN AGREEMENT for MEDICAL DIRECTOR - CARDIAC REHAB

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

Physician's Name: Karim El-Sherief, M.D.

Area of Service: Cardiac Rehabilitation Services

Term of Agreement: 24 months, Beginning, July 1, 2025 – Ending, June 30, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 Month (Term) Cost
$150	44	528	$6,600	$79,200	**$158,400**

Position Responsibilities:

- Cardiac Rehabilitation Program Medical Director
- Maintain TCMC's main-campus cardiac rehabilitation program as the physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.

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

Person responsible for oversight of agreement: Eva England-VP Ancillary Services

Motion:

I move that Finance Operations & Planning Committee recommend that TCHD Board of Directors authorize Dr. Karim El-Sherief as the medical director for Cardiac Rehabilitation for a term of 24 months beginning July 1, 2025 and ending, June 30, 2027, not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $150 for an annual cost of $79,200 and a total term cost not to exceed $158,400.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18,2025
PHYSICIAN AGREEMENT for MEDICAL DIRECTOR, VASCULAR SURGERY

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, M.D. - Vascular Surgery, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2025 – Ending, June 30, 2026

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	12	144	$2,520	$30,240

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Eva England-VP Ancillary Services

Motion:

I move that the Finance, Operations & Planning Committee authorize Mohammad Jamshidi-Nezhad, M.D. as the medical director for Vascular Surgery for term of 12 months, beginning, July 1, 2025 and ending, June 30, 2026, 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: June 18, 2025
PHYSICIAN AGREEMENT for CARDIOVASCULAR HEALTH INSTITUTE - MEDICAL DIRECTOR

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

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

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, Beginning, July 1, 2025 - Ending, June 30, 2026

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	8	96	$1,680	$20,160

Position Responsibilities:

- Physicians 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-VP Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve Dr. Donald Ponec as the Cardiovascular Health Institute (CVHI) medical director for term of 12 months, beginning, July 1, 2025 and ending, June 30, 2026, not to exceed an average 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual and total term cost of $20,160.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT for CARDIOVASCULAR HEALTH INSTITUTE - QUALITY COMMITTEE

Type of Agreement		Medical Directors		Panel	X	Other: CVHI Quality Committee
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, July 1, 2025 – Ending, June 30, 2026

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-VP Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Andrew Deemer as Cardiovascular Health Institute – Quality Committee members for a term of 12 months beginning, July 1, 2025 and ending, June 30, 2026, 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: June 18, 2025
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, July 1, 2025– Ending, June 30, 2026

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-VP Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Aaron Yung as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning, July 1, 2025 and ending, June 30, 2026, 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: June 18,2025
PHYSICIAN AGREEMENT for CARDIOVASCULAR HEALTH INSTITUTE - QUALITY COMMITTEE

Type of Agreement		Medical Directors		Panel	X	Other: Quality 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, July 1, 2025 – Ending, June 30, 2026

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-VP Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Donald Ponec as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning, July 1, 2025 and ending, June 30, 2026, 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: June 18, 2025
PHYSICIAN AGREEMENT for CARDIOVASCULAR HEALTH INSTITUTE - OPERATIONS COMMITTEE

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: Darrell Wu, M.D.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2025 – Ending, June 30, 2026

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-VP Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Darrell Wu, M.D. as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning July 1, 2025 and ending, June 30, 2026 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: June 18, 2025
ED ON-CALL COVERAGE - UROLOGY

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

Physicians' Names: Aaron G. Boonjindasup, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., Caroline J. Vilchis, M.D., Robert Shapiro, M.D.

Area of Service: Emergency Department On-Call: Urology

Term of Agreement: 24 months, Beginning July 1, 2025 – Ending June 30, 2027

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

Old Rate/New Rate	Annualized Increase	Term (24 Months)	Total Term Cost (NTE)
$800 / $850	$50 X 365 = $18,250	FY2026	$310,250
		FY2027	$310,250
		Total Term Cost	**$620,500**

Description of Services:

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

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

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 the renewal of the Emergency Department On-Call panel for Urology to include Aaron G. Boonjindasup, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., Caroline J. Vilchis, M.D., and Robert Shapiro, M.D., for a term of 24 months, beginning July 1, 2025 and ending June 30, 2027, at a shared panel total term cost not to exceed $620,500.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – SPINE SURGERY

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

Physician's Name: Payam Moazzaz, M.D., Kevin Yoo, M.D., Sunil Jeswani, M.D., Braden McKnight, M.D.

Area of Service: Emergency Department On-Call: Spine Surgery

Term of Agreement: 24 months, Beginning, July 1, 2025 - Ending, June 30, 2027

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

Old Rate/New Rate	Annualized Increase	Term (24 Months)	Total Term Cost
$450 / $475	$25 X 365 = $9,125	FY2026	$173,375
		FY2027	$173,375
		Total Term Cost	**$346,750**

Description of Services/Supplies:

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

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

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 the renewal of the Emergency Department On-Call coverage panel for spine surgery to include Payam Moazzaz, M.D., Kevin Yoo, M.D., Sunil Jeswani, M.D. and Braden McKnight, M.D. for a term of 24 months, beginning July 1, 2025 and ending, June 30, 2027, with an annual cost of $173,375 and total term cost of $346,750.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT / OTOLARYNGOLOGY

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

Physician's Name: Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Ashish Wadhwa, M.D., Sarah Carroll, M.D., Richard Liu, M.D., Amit Date, M.D.

Area of Service: Emergency Department On-Call: ENT / Otolaryngology

Term of Agreement: 24 months, Beginning, July 1, 2025 - Ending, June 30, 2027

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

Old Rate/New Rate	Annualized Increase	Term	Annual Cost
$650 / $675	$25 X 365 = $9,125	Year 1	$246,375
$675 / $700	$25 X 365 = $9,125	Year 2	$255,500
		Total Term Cost	**$501,875**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all ENT - Otolaryngology 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: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the agreement with Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Ashish Wadhwa, M.D., Sarah Carroll, M.D., Richard Liu, M.D., and Amit Date, M.D. as part of the existing ED On-Call coverage panel for ENT/Otolaryngology services for a term of 24 months, beginning July 1, 2025 and ending, June 30, 2027, with a shared total term cost of $501,875.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITEE
DATE OF MEETING: June 18, 2025
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ORAL/MAXILLOFACIAL SURGERY

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

Physician's Name: Brian Mudd, D.D.S.

Area of Service: Emergency Department On-Call: Oral Maxillofacial Surgery

Term of Agreement: 24 months, Beginning, July 1, 2025 - Ending, June 30, 2027

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

Rate/Day	Annual Cost	Total Term Cost
$500	$182,500	**$365,000**

Description of Services/Supplies:

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

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		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 the renewal of the Emergency Department on-call coverage panel for Oral-Maxillofacial Surgery with Brian Mudd, D.D.S., for a term of 24 months, beginning July 1, 2025 and ending, June 30, 2027, for an annual cost of $182,500 and total term cost of $365,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
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

Physicians' Names: Hellen Chiao, M.D., Christopher Devereaux, M.D., Javaid Shad, M.D., Michael Shim, M.D., Matthew Viernes, M.D.

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

Term of Agreement: 24 months, Beginning July 1, 2025 – Ending June 30, 2027

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

Year	Service	Old Rate / New Rate	Annualized Increase	Total Term Cost
1: FY26	GI	$1,050 / $1,250	$200 X 365 = $73,000	$456,250
	ERCP	$700	-	$255,500
			Year 1 Total (FY26)	**$711,750**
2: FY27	GI	$1,250 / $1,400	$150 X 365 = $54,750	$511,000
	ERCP	$700	-	$255,500
			Year 2 Total (FY27)	**$766,500**

Description of Services/Supplies:

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

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

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 the renewal of the Emergency Department on-call coverage panel for Gastroenterology General and ERCP with Hellen Chiao, M.D., Christopher Devereaux, M.D., Javaid Shad, M.D., Michael Shim, M.D., and Eric Viernes, M.D., for a term of 24 months, beginning July 1, 2025, and ending June 30, 2027, for a total term cost not to exceed $1,478,250.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
LOCUM TENENS COVERAGE AGREEMENT – PRIMARY CARE, SEASIDE MEDICAL

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

Physician's Name: Jeff Raunig, M.D., Inc.

Area of Service: Primary Care, Seaside Medical Group Locum Tenens Coverage Agreement

Term of Agreement: 12 months, Beginning, June 16, 2025 – Ending, June 15, 2026

Daily Rate	Total Term Cost
$2,000	**$50,000**

Description of Services/Supplies:

- Direct clinical care and after hours call for patients of the clinic

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:		Yes	X	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 the agreement with Jeff Raunig, M.D., Inc. for locum tenens coverage at Seaside Medical for a term of 12 months beginning June 16, 2025 and ending June 15, 2026 for an annual and total term cost not to exceed $50,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
LOCUM TENENS COVERAGE AGREEMENT – GREATER TRI-CITY IPA

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

Vendor's Name: Greater Tri-Cities IPA Medical Group, Inc.

Area of Service: Primary Care, Seaside Medical Group Locum Tenens Coverage Agreement

Term of Agreement: 12 months, Beginning, June 16, 2025 – Ending, June 15, 2026

Daily Rate	Total Term Cost
$900	$20,000

Description of Services/Supplies:

- Mid-level practitioner clinical care and after hours call for patients of the clinic
- Prorated to $450/day for half day coverage
- Only pay for coverage dates, not the entire amount

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer: Pending	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:		Yes	X	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 the agreement with Greater Tri-Cities IPA Medical Group, Inc. for locum tenens coverage at Seaside Medical for a term of 12 months beginning June 16, 2025 and ending June 15, 2026 for an annual and total term cost not to exceed $20,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
SERVICE AND TECHNOLOGY AGREEMENT

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

Vendor's Name: Abbott Service and Technology Plan

Area of Service: Cardiology Electrophysiology Program

Term of Agreement: 36 months, Beginning June 1, 2025 - Ending May 31, 2028

Year 1	Year 2 & Year 3	Total Term Cost
$186,200	$178,200	$542,600

Description of Services/Software:

- Service agreement for the current Ensite to include the Ultrasound and TEE probe currently not covered.
- The agreement also includes a complete upgrade to the new platform for Pulse Field Ablation (PFA) Volt.
- The PFA Volt to provide next generation ablation to include Enhanced Safety profile, streamlined and efficient workflow, fast recovery and patient comfort.

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

Person responsible for oversight of agreement: Eva England, VP Ancillary Service

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Abbott, Inc. for service and technology agreement for a term of 36 months beginning June 1, 2025 - ending May 31, 2028 for a total cost for the term of $542,600.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: June 18, 2025
MASTER SUBSCRIPTION AND SERVICES AGREEMENT

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

Vendor's Name: Iodine Software, LLC

Area of Service: Clinical Documentation and Revenue Cycle

Term of Agreement: 36 months, Beginning July 1, 2025 - Ending June 30, 2028

Year	Annual Cost	Total Term Cost
1	$558,843	N/A
2	$439,785	N/A
3	$461,775	$1,460,404

- Year 1 annual cost of $558,843 includes a $140,000 implementation fee due at time of implementation. The remainder of year 1 costs ($418,843) will consist of four equal, quarterly payments of $104,710.75.
- Year 2 annual cost of $439,785 will consist of two semi-annual equal payments of $219,892.50.
- Year 3 annual cost will be due on the anniversary of the effective date in its entirety.
- Years 2 and 3 have a 5% CPI escalator included.
- Total cost of the 3-year term is $1,460,404.

Description of Services/Supplies:

- This is a Clinical Documentation Improvement (CDI) technology solution that uses Ai to read, interrupt, and understand the full clinical record for every patient, every day to identify gaps between clinical evidence and physician documentation to increase documentation accuracy, leading to appropriate financial reimbursement.

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

Person responsible for oversight of agreement: Mark Albright, Chief Information Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Iodine Software, LLC for a subscription and services agreement for a term of 36 months beginning July 1, 2025 and ending June 30, 2028 for a total term cost of $1,460,404.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA

June 18, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Activated Clotting Time Testing by Medtronic ACT Plus Procedure	2 year review, practice change	Forward to BOD for Approval
2. Amnisure Placental Alpha - 1 Microglobulin (PAMG1) Test for Rupture of Fetal Membranes (ROM) - Procedure	RETIRE	Forward to BOD for Approval
3. Collection of a Blood Specimen by Skin Puncture Procedure	2 year review, practice change	Forward to BOD for Approval
4. HMS Plus Hemostasis Management System: Activated Clotting Time, Heparin Assay, Heparin Dose Response Procedure	2 year review	Forward to BOD for Approval
5. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	3 year review	Forward to BOD for Approval
6. Newborn Screening Collection of Specimen Procedure	RETIRE	Forward to BOD for Approval
7. Nitrazine Test on Vaginal Fluid Procedure	RETIRE	Forward to BOD for Approval
8. Patient Controlled Analgesia (PCA) Procedure	3 year review, practice change	Forward to BOD for Approval
9. Siemens Rapidpoint 500 Procedure	2 year review, practice change	Forward to BOD for Approval
10. Urine Dipstick Analysis Manual Read Procedure	RETIRE	Forward to BOD for Approval
11. Urine Dipstick Analysis Using Siemens Clinitek Status + Connect Procedure	RETIRE	Forward to BOD for Approval
12. Urine Dipstik Using McKesson Consult 120 Urine Analyzer Procedure	RETIRE	Forward to BOD for Approval
13. Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure	RETIRE	Forward to BOD for Approval
Administrative		
1. Medicare Hospital Readmission Billing 290	3 year review	Forward to BOD for Approval
2. Lactation Accommodation Policy 402	NEW	Forward to BOD for Approval
Employee Health & Wellness		
1. Temporary Modified Duty for Industrial Injuries Policy	Practice change	Forward to BOD for Approval
Laboratory General		
1. Laboratory Organization Quality System Essentials QSE.01	2 year review	Forward to BOD for Approval
Pharmacy		

ADMINISTRATION CONSENT AGENDA
June 18, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
1. Peri-operative Antimicrobials Policy	3 year review, practice change	Forward to BOD for Approval
Surgical Services		
1. Anesthesia Type, Location and Monitoring Policy	3 year review	Forward to BOD for Approval
2. Local Anesthesia in Operating Room Policy	3 year review	Forward to BOD for Approval
Telemetry		
1. Skin and Wound Team Rounds	RETIRE	Forward to BOD for Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ACTIVATED CLOTTING TIME TESTING BY MEDTRONIC ACT PLUS**
Purpose:	To accurately measure the clotting time of heparinized patients.
Supportive Data:	~~Authorized to perform procedure: RN, LVN, Perfusionist, CV tech with appropriate orientation, training, and competency validation.~~ ACT testing is under the direction, authority, jurisdiction and responsibility of the Laboratory **Medical** Director.
Equipment:	Medtronic ACT Plus Medtronic ACTtrac (electronic QC) Temperature Verification Cartridge CLOTtrac HR controls Syringes, no larger than 10 mL 19-gauge blunt tip needle or other blood collection needle HR-ACT cartridges
Authorized to Perform:	See **Point of Care Quality Assurance Policy**

A. **SPECIMEN:**

1. Fresh whole blood collected during angiogram or operative procedure, 400 microliters per cartridge channel.
2. Fresh whole blood specimens should be tested as quickly as possible following sample collection. Test within sixty (60) seconds when there is no anticoagulant on board. Test within two (2) minutes when the sample is heparinized.

B. **PROCEDURE:**

1. HR-ACT Patient Test:
   a. From the Main Menu, select HR-ACT as the cartridge type.
      i. Note: Lot numbers and expiration dates for cartridges and controls must be entered prior to running a test (see below).
   b. Verify the correct Patient ID **(identification)** in the upper right ~~hand~~ corner of the screen. If the ID is not correct, from the Main Menu enter the Patient ID (~~10-digit~~ financial number~~/ i.e. 600 #~~) and User ID (employee ID) numbers.
   c. Pre-warm the cartridge for at least three (3) to five (5) minutes (up to twelve ~~(~~[12~~)~~] hours).
   d. Tap or shake the HR-ACT cartridge to re-suspend the kaolin activator.
   e. Using a syringe and blunt tip needle, fill each cartridge chamber with the appropriate patient sample to the level between the fill lines (400 microliters per channel).
   f. Insert the cartridge into the ACT Plus, and close the actuator heat block to initiate the test.
   g. Clot formation is signaled by an audible tone, the actuator heat block opens and the results are displayed.
   h. Manually Transmit Patient Tests to the lab data manager and the patient's electronic health record: From the main menu, select Transmit Test Results. Select Transmit Patient Tests. Exit to the main menu.
2. To Remove and Add a New Cartridge Lot/ Exp Date:
   a. From the Main Menu select Cartridge Lot.
   b. Use the Up/Down arrows to select HR-ACT.
   c. Press Remove Lot.
   d. Use the Up/Down arrows to select and highlight the lot to be removed.
   e. Press Remove Selected Lot to delete the selected cartridge lot number.

Patient Care Services Content Expert Review	Clinical Policies & Procedures	Nursing Executive Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/07, 10/10,01/14, 11/15, 12/19, 02/22, **12/24**	11/10, 02/14, 12/15, 01/20, 03/22, **02/25**	11/10, 02/14, 01/16, 02/20, 05/22, 06/22, **03/25**	04/18, 04/20, 08/22, **05/25**	03/14, 04/18, 05/20, 09/22, **05/25**	06/20, 12/22, **06/25**	01/11, 04/14, 05/18, n/a	01/11, 04/14, 05/18, 06/20, 12/22

f. Press Add Lot Number and enter the lot number with the barcode scanner. The lot number and expiration date will populate their respective fields.

3. To Remove and Add a New Control Lot/ Exp Date:
   a. From the Quality Control Menu select Control Lot.
   b. Use the Up/Down arrows to select the control type.
   c. Press Remove Lot.
   d. Use the Up/Down arrows to select and highlight the lot to be removed.
   e. Press Remove Selected Lot to delete the selected lot number.
   f. Press Add Lot Number and enter the lot number with the barcode scanner. The lot number and expiration date will populate their respective fields.
   g. Press Set Range and enter the control range.
   h. Press Enter to confirm the range.

C. **PRINCIPLE:**

1. The ACT Plus is a coagulation instrument intended for determining coagulation endpoints in fresh whole blood; the endpoint is formation of fibrin. The clotting times are performed in duplicate and the results for each channel, the average of the two channels and the difference are displayed.
2. High Range ACT (HR-ACT): The HR-ACT is a kaolin activated clotting time test performed on fresh whole blood where the heparin concentration is one (1) unit/ mL or higher.

D. **QUALITY CONTROL (QC):**

1. If proper QC is not performed or is out of range, the QC lockout feature will be engaged preventing patient testing until QC status is acceptable.
2. Quality Control testing for the ACT Plus is performed using a combination of liquid controls and electronic (ACTtrac) controls. According to Clinical Laboratory Improvement Amendments (CLIA) guidelines, two (2) levels of control for coagulation procedures should be performed every eight hours of patient testing.
3. Electronic Control: The ACTtrac is a battery-powered software used to identify instruments that no longer fall within mechanical calibration specifications.
   a. To perform an ACTtrac test:
      i. From the Main Menu, select ACTtrac as the cartridge type.
      ii. Enter zero (0) as the Patient ID and the appropriate User ID. (The system will not accept user ID's that have not been entered into the data management program).
      iii. Select the Quality Control menu. Select Control Type, press key until the same control range as selected on the ACTtrac is displayed. Verify the control lot #. Press Enter to confirm.
      iv. Place ACTtrac into the heat block and close to start the test. The test is complete upon hearing an audible tone with the results displayed.
      v. Push the Quality Control button again and select the second range to be tested by pressing the Control Type key until the same range to be tested on the ACTtrac is displayed. Press Enter to confirm.
      vi. Place ACTtrac into the heat block and close to start the test. The test is complete upon hearing an audible tone with the results displayed.
      vii. The ACT Plus will indicate if the QC passed or failed. This will complete the level one and level two electronic controls required every eight hours when the ACT Plus is in use.
4. Liquid Controls: Two (2) levels of liquid control are performed for the HR-ACT (CLOTtrac HR normal and abnormal). Used in conjunction with the ACTtrac electronic control, liquid controls are performed every seven days and with a change in cartridge lot number or new Shipment.
   a. Control storage and stability: Store controls in the refrigerator, between 2° and 10°C.
   b. Controls are stable until the expiration date on the package when stored at refrigeration temperatures. CLOTtrac controls are stable for two (2) hours following reconstitution.

c. Preparation: Follow instructions on current package insert of controls if different than below.
   i. Remove controls and deionized water diluent from the refrigerator and bring to room temperature for approximately ten (10) minutes.
   ii. Add 1.8 mL of deionized water to the lyophilized sheep blood.
   iii. Allow at least ten (10) minutes for adequate rehydration of the normal control and twenty-five (25) minutes for rehydration of the abnormal control. Do not agitate or mix until completely rehydrated.
   iv. Shake the control vigorously to mix until the red blood cells are uniformly dispersed and the control is completely reconstituted.

d. Performance:
   i. Select HR-ACT as the cartridge type.
   ii. Enter zero (0) as the Patient ID and the appropriate User ID.
   iii. Select Quality Control. Select Control Type, press key until the correct control HR-NM or HR-AB is displayed. Press Enter to confirm. The current control lot number will be displayed.
      1) Note: Lot numbers and expiration dates for cartridges and controls must be entered prior to running a test (see below).
   iv. Pre-warm the cartridge for at least three (3) to five (5) minutes (up to twelve [12] hours).
   v. Tap or shake the HR-ACT cartridge to re-suspend the kaolin activator.
   vi. Using a syringe and blunt tip needle, fill each cartridge chamber with the appropriate control to the level between the fill lines 400 microliters per channel).
   vii. Insert the cartridge into the ACT Plus and close the actuator heat block to initiate the test.
   viii. The ACT Plus will incubate the control sample for 300 seconds and then begin the clot detection cycle.
   ix. Clot formation is signaled by an audible tone, the actuator heat block opens and the results are displayed. The ACT Plus will indicate if the QC passed or failed.

5. Transmit Data: Quality Control Data must be manually transmitted to the laboratory data manager (via network connection). Each week, after performing liquid controls, transmit data.
   a. From the Main Menu, select Transmit Test Results.
   b. Press Transmit Unsent QC tests.
   c. Press Transmit Unsent Patient tests.
   d. Exit to the Main Menu.

E. CALCULATIONS:

1. The ACT Plus calculates the mean or average clotting time for the duplicate channels and the difference in seconds between channels when a High Range ACT test is performed.

F. REFERENCE RANGE:

1. Duplicate clotting times for the HR-ACT should fall within 10% of each other for baseline or normal samples and 12% of each other for prolonged or heparinized samples. The operable range of the Instrument is 25 – 999 seconds.
   a. Normal Un-Heparinized Range: 96 – 172 sec
   b. Therapeutic Range:
      i. OR — greater than or equal to (≥)(≥) 480 sec
      ii. Cath Lab — greater than or equal to (≥) (≥) 200 sec; based on clinical judgment
      iii. IR — greater than or equal to (≥) (≥) 200 sec; based on clinical judgment

G. NOTES AND LIMITATIONS:

1. The HR-ACT is intended for use with fresh whole blood where the heparin concentration is one (1) units/mL or greater. During cardiopulmonary bypass the HR-ACT may be affected by the following: dilution of plasma coagulation factors, the use of citrated blood products, use of anti-platelet agents, hypothermia, change in platelet number or function.
2. Interfering Substances: Activated blood specimens, either in-vivo (patient's coagulation mechanism activated) or in-vitro, due to improper sample collection and handling may cause erroneous results. Sample collection and testing should be repeated if improper collection is suspected or if test results are questionable.

H. **MAINTENANCE:**

1. Record **m**Maintenance on the ~~Instrument~~ **ACT PLUS** Maintenance Log.
2. Routine Cleaning: Clean the exposed surfaces of the actuator and dispenser and the instrument case using a hospital approved disinfectant between patients' testing
3. Discard all of the completed testing materials and controls in the provided and approved waste containers.
4. Temperature Verification: Verification of the ACT Plus heat block should be performed once a month and may be done with a Temperature Verification Cartridge that is supplied with the instrument or with calibrated thermometer and water-filled cartridge.
   a. Using the Temperature Verification Cartridge:
      i. From the Quality Control menu enter User ID.
      ii. Select Temperature Adjustment.
      iii. Insert the Temperature Verification Cartridge into the actuator heat block.
      iv. Wait 10 minutes for temperature equilibration to occur.
      v. Press the button on the Temperature Verification Cartridge for temperature reading.
      vi. Enter the reading from the Temperature Verification Cartridge using the numeric keypad. The entered value will appear highlighted in the Thermometer Reading on the display.
      vii. Press Enter to confirm.
      viii. Select Repeat Adjustment variable function key to repeat the temperature adjustment if necessary.
   b. Using a Thermometer:
      i. From the Quality Control menu enter User ID.
      ii. Remove the plunger assembly from a cartridge and fill with 0.2 to 0.3 mL of water.
      iii. Insert the cartridge into the actuator heat block.
      iv. Select Temperature Adjustment.
      v. Place a calibrated thermometer in one of the cartridge reaction chambers.
      vi. After about 5 minutes check the thermometer reading.
      vii. Enter the reading from the thermometer using the numeric keypad. The entered value will appear highlighted in the Thermometer Reading on the display.
      viii. Press Enter to confirm.
      ix. Select Repeat Adjustment variable function key to repeat the temperature adjustment if necessary.
   c. Notes:
      i. The instrument displayed temperature and thermometer measured temperature should read between 36.5° C to 37.5° C.
      ii. The thermometer temperature should be within ± 0.5° C of the instrument displayed temperature.
      iii. The time, date and temperatures of the thermometer and the display will be logged in the instrument's temperature log.
      iv. Wait a minimum of 10 minutes before repeat adjustments are performed.
      v. Values must be between 35° C and 39° C.
5. Actuator Assembly Cleaning:

a. The Actuator Assembly should be cleaned monthly or as soon as possible after contamination with blood. The exposed surfaces of the actuator assembly (with the actuator heat block in the open position) should be cleaned with one of following cleaning detergents: isopropyl alcohol, methanol, propyl alcohol, glutaraldehyde, bleach, ethanol, Liqui-Nox®, parachlorometaxylenol, hydrogen peroxide, or mild detergent.
   i. Dip a swab in cleaning solution.
   ii. Swab the flag lift wire, removing all blood.
   iii. Swab inside the actuator assembly cover, especially the detector and emitter areas of the photo-optical sensor. Remove any excess cleaning solution with a dry swab. If blood should get into the detector of the lamp area and cannot be removed with a swab, Error Code "4" may be displayed.

I. **TROUBLESHOOTING:**

1. Refer to the ACT Plus Operator's Manual for Cause and Resolution for System Messages.

J. **REFERENCE(S):**

1. Medtronic ACT Plus Automated Coagulation Timer Operators Manual. Rev. 1.0, 4/04.
2. ACT Plus Individualized Quality Control Plan (IQCP) in Point of Care/ Lab binder.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**AMNISURE PLACENTAL ALPHA-1 MICROGLOBULIN (PAMG1) TEST FOR RUPTURE OF FETAL MEMBRANES (ROM)**
Purpose:	The AmniSure ROM Test is a rapid, non-instrumented, qualitative immunochromatographic test for the in vaginal discharge of pregnant women.
Supportive Data:	The timely and accurate diagnosis of rupture of (fetal) membranes (ROM) is crucial because ROM may be associated with serious neonatal and maternal consequences. Failure to identify patients with ROM can result in the failure to intervene appropriately. CLIA classified as Moderately Complex.
Equipment:	Test kit (with sterile swab, solution vial, test strip) Timer (with attached vial holder)

RETIRED DUE TO THE SUSPENSION OF LABOR AND DELIVERY

A. **PRINCIPLE:**

1. The AmniSure ROM uses the principles of immunochromatography to detect human PAMG-1 (placental alpha-1 microglobulin) protein present in amniotic fluid of pregnant women. The test employs highly sensitive monoclonal antibodies that detect even a minimum amount of the protein, which is present in cervico-vaginal discharge after the rupture of the (fetal) membranes. Placental Microglobulin was selected as a marker of fetal membrane rupture due to its unique characteristics (i.e. high level in amniotic fluid, low level in blood, and extremely low background level in cervico-vaginal discharge when the membranes are intact).

B. **PROCEDURE:**

1. Open the test kit and remove contents.
2. Take the solvent vial by its cap and shake well to make sure all liquid in the vial has dropped on the bottom, then open the solvent vial and place in a vertical position.
3. Remove the sterile swab from its package, the polyester tip of the swab should not touch anything prior to insertion into vagina, hold the swab in the middle of its shaft and carefully insert the polyester tip of the swab into the vagina until the fingers contact the skin (no more than 5-7 cm deep). Withdraw the swab from the vagina after one minute.
4. After the swab has been removed from the vagina, immediately place the polyester tip into the provided solvent vial and rinse by rotating for one minute.
5. Tear open the foil pouch at the test notches and remove the AmniSure ROM test strip.
6. Dip the white end of the strip (marked with arrows facing downward) into the vial with solvent.
7. Remove the test strip from the vial if two lines are clearly visible in the test region or after 10 minutes sharp. Read the results by placing the test strip on a clean, dry and flat surface in a well-lit environment. A negative result must not be read until the full 10 minutes has elapsed.
8. Discard the testing and sampling materials into the waste management container.

C. **REPORTING RESULTS:**

1. There are three possible result interpretations:
   a. Negative, indicated by the presence of a control line and no test line.

   i.
   b. Positive, indicated by two lines in the test region.

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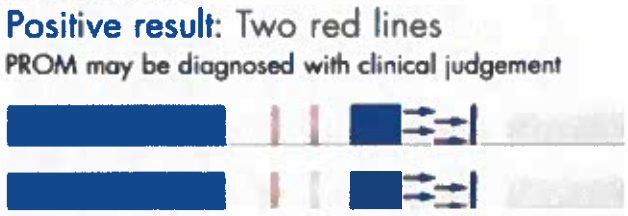
i. The intensity of the test line may vary; the test result is valid even if the lines are faint or uneven.



ii.

c. Invalid, indicated by no lines or only a test line.
   i. Invalid results require a retest.
   ii. Report invalid tests to the POC coordinator. Do not throw away package with lot number on it.

iii.

2. Do not read or interpret after 15 minutes have passed since placing the strip into the vial.

D. **DOCUMENTATION:**
1. Input results of the control line and test line through the glucometer.
2. Document the membrane status, date, time, color, amount and odor of fluid in the patients EHR.

E. **QUALITY CONTROL:**
1. Internal Controls
   a. Each AmniSure ROM Test has built in reagent and procedural controls to assure accurate reading of the results.
   b. The appearance of line in the control region verifies the integrity of the test procedure.
2. External Controls
   a. External controls (positive and negative) must be performed upon every new lot, new shipment, monthly on every box currently in use, and if there is suspicion that the product performance is compromised.
   b. Obtain liquid external controls package from the lab prior to testing. The package contains:
      i. negative control
      ii. Two solvent vials
   c. Use the solvent vials provided in the package.
   d. Uncap both controls and solvent vials. Pour each solvent to the corresponding controls, recap and shake vigorously for 30 secs to ensure reconstitution.
   e. Tear open the foil pouch at the test notches and remove the AmniSure test strip.
   f. Dip the white end of the strip (marked with arrows facing downward) into the vial with solvent.
   g. Remove the test strip from the vial if two lines are clearly visible in the test region or after 10 minutes sharp. Read the results by placing the test strip on a clean, dry and flat surface in a well-lit environment.
   h. Interpret results as mentioned in the section above

F. **STORAGE AND STABILITY:**
1. Store the kit in a dry place at 4 to 25°C. Do not freeze.
2. When stored in the foil pouch at the recommended temperature, the test is stable until the "Use By" date on the foil pouch.
3. Use the AmniSure ROM Test within six hours after removing from foil pouch.
4. Each test is a single use disposable unit and cannot be reused.

G. **LIMITATIONS:**

1. The AmniSure ROM Test results are qualitative. Make no quantitative interpretation based on the test results.
2. Vaginal infections, urine and sperm do not interfere with the results.
3. When there is a significant presence of blood on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.
4. In very rare cases when a sample is taken 12 hours or later after a rupture, a false-negative result may occur due to obstruction of the rupture by fetus or resealing of the amniotic sac.
5. Use results in conjunction with other clinical information.
6. Failure to detect membrane rupture does not assure the absence of membrane rupture.
7. Women may labor spontaneously despite a negative test result.
8. The performance of the AmniSure ROM Test has not been established in the presence of the following contaminants: anti-fungal creams or suppositories, K-Y Jelly, Monistat Yeast Infection Treatment, Baby Powder (Starch and Talc), Replens Feminine Moisturizer or Baby Oil.
9. The performance of the AmniSure ROM Test has not been established in the presence of meconium in the amniotic fluid.
10. Placenta previa and performing digital exams prior to sample collection can lead to inaccurate test results.
11. Test should not be performed within 6 hours after the removal of disinfectant solutions or medications from the vagina.
12. Test should be run immediately after sample is obtained. If sample cannot be processed immediately for testing, it must be run within 30 minutes from collection time.

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

1. Patient Care Services Policy: Identification, Patient

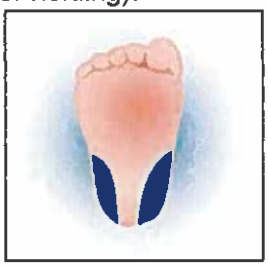
I. **REFERENCE(S):**

1. AmniSure International US package insert. ASP 1100-US0002. 8/10/2010
2. AmniSure Individualized Quality Control Plan (IQCP) in Point of Care/Lab binder
3. AmniSure® ROM (Rupture of [fetal] Membranes) Test Package insert. 1090607 Rev. 04 2019/4/01

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**COLLECTION OF BLOOD SPECIMEN BY SKIN PUNCTURE**
Purpose:	To outline the procedure for collection of blood specimen by skin puncture.
Supportive Data:	Skin puncture is applicable for: 1. Severely burned patients 2. Extremely obese patients 3. Patients with thrombotic tendencies 4. Patients with malignancies for whom venipuncture is reserved for therapeutic purposes 5. Geriatric patients or patients in whom superficial veins are not accessible or fragile 6. Patients performing tests at home (e.g. blood glucose) 7. Newborn/pediatric patients
Equipment:	1. Tenderfoot ~~(NSY)~~ and Preemie Tenderfoot ~~(NICU)~~ 2. Automatic lancet device 3. Heel warmer 4. Alcohol prep pad or Chlorhexidine Gluconate prep pad and Saline wipe 5. Capillary blood collection tubes 6. Gauze Pads 7. Spot Bandages

A. **PROCEDURE:**

1. Verify order for blood sampling.
2. Identify the patient per Patient Care Services Policy: Identification, Patient.
3. Ensure the blood specimen is collected from the individual designated on the specimen labels or requisition slip.
4. Choose the Puncture Site:
   a. Each patient should be assessed individually to choose the optimal blood-sampling method.
      i. Venipuncture should be performed in the event finger stick cannot be obtained.
   b. It is recommended greater than 2 **milliliters** (mL) be drawn via venipuncture.
   c. Nonpharmacologic comfort measures should be considered for patients undergoing painful procedures such as skin puncture.
   d. Infant Heel Stick:
      i. Warm the infant's heel: Use a heel warmer according to manufacturer's instructions.
      ii. Registered Nurse may provide the patient with oral sucrose and pacifier per physician/Allied Healthcare Professional (AHP) order.
      iii. Provide developmental positioning (for example swaddling or holding).
      iv. Site of Puncture: The blood must be obtained from the infant's heel using the most medial or lateral portion of the plantar surface of the heel, where "medial" is defined as closest to the midline of the body, "lateral" is defined as away from the midline of the body, and "plantar surface" as the walking surface of the foot.



      v. Assess the sampling site and select an area without excessive previous punctures, hematomas, or infection.
      vi. Contraindications to performing heel sticks are bruising or hematoma on the feet; feet that are edematous, injured, or infected; and feet with anomalies upon which pressures should be avoided.

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e. Child~~ren~~ and Adult Finger Stick:
   i. The puncture shall be on the palmar surface (pad) of the distal phalanx and not at the side or tip of the finger.
   ii. Avoid puncturing the fifth finger if possible.
   iii. The skin puncture site must be warm and not swollen (edematous).

5. Clean the Puncture Site:
   a. Disinfect the site for sample collection with alcohol pad and allow it to dry. Betadine or iodine shall not be used to clean and disinfect skin-puncture sites.
      i. For ~~NICU~~ infants: disinfect skin surfaces with Chlorhexadine Gluconate prep pads ~~(available in NICU)~~. Wipe away all disinfectant with saline wipe after procedure is complete. Alcohol should not be utilized for ~~NICU~~ infants.
6. Select Puncture Device:
   a. Infants: Use an automated heel lancing device that is appropriate size for the patient to perform the heel stick to ensure the proper depth.
   b. Finger Sticks: Use the appropriate automatic lancet device to ensure the proper depth.
7. Order of Draw: If multiple specimens are to be collected, including preservative (EDTA – Lavender Cap) specimens, the EDTA specimen is drawn first to assure adequate volume (at least to the bottom 250 **microliter (µ~~u~~L)** line but not more than the 500 µ~~u~~L line) and accurate hematology test results. Recap and mix IMMEDIATELY. Other additive specimens (Green top) are collected next and clotted specimens (Red top) last.
8. Perform the puncture:

   a. Puncture the chosen site that has been prepared.
   b. Wipe the first drop of blood with dry gauze pad since it is most likely to contain excess tissue fluid.
   c. A second drop of blood will form over the puncture site. When a micro collection device touches this drop, blood will flow into the tubes by capillary action.
   d. During specimen collection, allow capillaries to refill (apply gentle pressure and then release) Avoid excessive squeezing of the heel). Fill specimen containers to the specified volume.
   e. Allow blood drops to fall freely into the tube (avoid scooping or scraping blood from the heel or finger).
   f. Fill specimen containers to the specified volume. Cap the tube when it is filled.
   g. Each additive tube must be mixed by gentle inversion 8-10 times immediately after collection.
9. Post Puncture Bleeding:
   a. Infant's Heel: Hold a gauze pad pressed against the puncture site until the bleeding stops.
   b. Finger Stick: Apply pressure with a clean gauze pad until bleeding stops. Place a bandage on the site, if necessary.
10. Dispose the automated lancing device in a sharps container.
11. Labeling Policy:
   a. Refer to Patient Care Services Specimen Labeling Procedure.

B. **REFERENCE(S):**

1. Ohlsson, Shah VS A. "Venipuncture versus heel lance for blood sampling in term neonates." Cochrane Database System. 19 Apr. 2010. Web 24 May 2012. www.2.cochrane.org/reviews/en/ab001452.html.
2. Robbins, Meyers R. Pediatric Nutrition Practice Group. 2nd ed. Chicago: American Dietetic Association, 2011. Print.
3. Heel Stick (Neonatal) Extended Text. (n.d.). Retrieved March 4th, 2022, from Point of Care Elsevier Performance Manager: https://point-of-

care.elsevierperformancemanager.com/skills/1233/extended-text?skillId=NN_003&virtualname=tricity-caoceanside#scrollToTop

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HMS PLUS HEMOSTASIS MANAGEMENT SYSTEM: ACTIVATED CLOTTING TIME, HEPARIN ASSAY, HEPARIN DOSE RESPONSE**
Purpose:	To monitor heparin management during cardiopulmonary bypass.
Supportive Data:	Point of Care Quality Assurance Procedure
Authorized to Perform:	Perfusionist

A. **DEFINITION:**

1. The Medtronic HMS Plus Hemostasis Management System Operator's Manual has been reviewed and found acceptable to National Committee for Clinical Laboratory Standards (NCCLS) standards. Testing should follow manufacturer instructions and recommendations as indicated in the user manual and package inserts. Exceptions or clarifications specific to Tri-City Medical Center are listed in this procedure.

B. **INTRODUCTION/PRINCIPLE:**

1. The HMS Plus instrument is an integrated system consisting of a component for tracking clot detection and computing results, a component for sample delivery, and the single use test cartridges for actual performance of the tests.
2. The detection process uses the plunger assembly within the cartridge. This assembly is lifted and dropped through the sample/reagent mixture by a lifting mechanism in the HMS Plus actuator. As the sample clots, a fibrin web forms around the daisy, located on the bottom of the plunger assembly, and impedes the rate of decent of the assembly. A photo optical system located in the actuator assembly of the instrument detects this change in fall rate. The end point of the test is the time at which clot formation is detected; from these clotting times, derived results are calculated for all tests.

C. **SPECIMEN:**

1. Fresh whole blood, collected in a 3 **milliliter** (-mL) Monoject syringe that is supplied with the cartridges. Blood may be obtained either by venipuncture or from arterial or venous access lines. See instructions below.
   a. Venipuncture Collection: The venipuncture must be fast, non-traumatic, and the first 2 to 3 ml of blood collected and discarded in a separate syringe in order to prevent contamination of the test sample with tissue activator (thromboplastin) and the potential for erroneous results. Blood should flow quickly into the syringe.
   b. Indwelling Catheter Collection: Flush the line with 5 mL saline, and using separate, single use syringes, collect at least 5 mL or 6 dead space volumes of blood and discard prior to collection of the test sample in order to eliminate the risk of excess dilution and contamination of the sample with heparin from the catheter or line.
2. Minimum sample volumes:
   a.

HDR	3.0 mL
HPT (4 channel)	1.5 mL
HPT (6 channel)	2.5 mL
HPT and HR-ACT	2.5 mL

3. Handling Conditions:
   a. Specimens should be tested as quickly as possible following sample collection.
      i. HDR: within 60 seconds, since the specimen is unheparinized.
      ii. HPT and HR-ACT: within 60 seconds when there is no anticoagulant on board. Within 2 minutes when sample is heparinized.

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D. **REAGENTS/SUPPLIES:**

1. Refer to HMS Plus Operator's manual, Chapter 4-2: Cartridge Design.
2. Refer to HMS Plus Operator's manual, Chapter 4-3: Types of Test Cartridges
   a. Heparin Dose Response (HDR): The HDR is a modified HR-ACT, which measures the *in vitro* anticoagulant response to a known concentration of heparin. This response can be used to evaluate a patient's resistance or sensitivity to heparin. It can also be used to estimate a minimum heparin dose required to achieve a desired target clotting time (HR-ACT).
   b. Heparin Assay (HPT): The Heparin Assay test uses the principle of heparin/ protamine titration to quantitatively determine the concentration of heparin in the sample. The heparin concentration determined by the HPT test is used to calculate any additional heparin required to maintain the patient at the [Protocol Hep Conc] entered into the system.
   c. Activated Clotting Time (HR-ACT): The HR-ACT is a functional evaluation of the intrinsic coagulation system. It evaluates heparin anticoagulation as well as numerous factors affecting intrinsic clotting.
3. Cartridge Preparation:
   a. HDR: Cartridges should be gently shaken or tapped to re-suspend the kaolin and pre-warmed in the heat block of the HMS Plus for at least 3 minutes prior to using.
   b. HPT: Gently shake or tap the cartridge before use. Pre-warming of the HPT cartridge is not required.
   c. HR-ACT: Cartridges should be gently shaken or tapped to re-suspend the kaolin and pre-warmed for at least 3 minutes in the heat block of the HMS Plus.
4. Precautions:
   a. HPT: If the heparin concentration is measured at Channel 1 in a Heparin Assay cartridge that does not have a zero (protamine) in Channel 1, the actual heparin may be lower than the measured value. Similarly, if it is measured in Channel 4 of a four-channel cartridge or Channel 6 of a six-channel cartridge, the actual heparin value may be higher than the measured value. In these cases, another test with a different cartridge (lower or higher as needed) should be run to confirm the result.
   b. Regarding Heparin Concentration: see HMS Plus Operators manual 2-6.
   c. Regarding Heparin Dose Response: see HMS Plus Operators Manual 2-6.
5. Instrumentation/Calibration:
   a. Refer to HMS Plus Operator's Manual, Chapter 1: Product Description: Application and Use. Refer to HMS Plus Operator's manual, Chapter 3: Installation and Setup. No user Calibration.

E. **QUALITY CONTROL:**

1. Refer to HMS Plus Operator's manual, Chapter 7: Maintenance and Quality control.
2. Liquid quality control must be run:
   a. On each new lot/shipment of test cartridges (Refer to New Reagent Lot Validation)
   b. Once per week
   c. Electronic quality control must be run each 8 hours of use (once per shift)
3. New Reagent Lot Validation.
   a. For ACT and HPT cartridges, test liquid controls on new lots/shipments of cartridges before use.
      i. If controls fall within the Manufacturer established ranges, or "pass", the new lot/shipment of cartridges is considered acceptable for use.
   b. For HDR cartridges, run a patient on the old and new lots concurrently.
      i. For the new lot of reagent to be considered acceptable for use, the difference in results must be clinically insignificant, as determined by the Perfusionist.
   c. Indicate on the "New Reagent Lot Validation Log" that the lot number has been tested and is acceptable for patient use.

d. The laboratory will review control data to ensure that control and patient ranges are similar across different lots of cartridges.

4. Notes:
   a. Before performing a quality control test, valid lot numbers and expiration dates for both cartridges and controls must be entered. In the case of the HR-ACT controls the ranges for the controls must also be entered.
   b. Because controls are produced using prior USP heparin formulation, the heparin type should be set to [Porcine] to run liquid controls. Attempts to run the controls while in the [IU] heparin type setting will result in longer than expected run times for the control test and may produce a failed control result—run times exceeding 249 seconds. (Notice dated 3/8/10).
5. Instructions for performing Heparin Assay CONTROLS:
   a. Set heparin type:
      i. From main menu, select "instrument parameters"
      ii. Select "heparin type"
      iii. Toggle to [porcine]
      iv. Press "enter" to confirm selection
      v. Perform QC testing
   b. Quality control records are maintained in the instrument and periodically downloaded and reviewed by the Laboratory designee.

QC RANGES HEPARIN ASSAY:

Four-Channel			
HPT Control	**Cartridge Type (mg/kg)**	**Required Channel Detection**	**Required Clotting Time**
Red/Yellow	0.0 – 0.9 RED	4	< 249 sec
Red/Yellow	0.0 – 1.5 YELLOW	3 or 4	< 249 sec
Tan/Silver	1.5 – 3.0 TAN	4	< 249 sec
Tan/Silver	2.0 – 3.5 SILVER	3 or 4	< 249 sec
Blue/Gold	2.5 – 4.0 BLUE	3 or 4	< 249 sec
Green/White	3.5 – 5.0 GREEN	3 or 4	< 249 sec
Purple/Black	4.5 – 6.0 PURPLE	3 or 4	< 249 sec

Six-Channel			
HPT Control	**Cartridge Type (mg/kg)**	**Required Channel Detection**	**Required Clotting Time**
Orange	0.0 – 2.5 ORANGE	5 or 6	< 249 sec
Blue/Gold	1.5 – 4.0 GOLD	5 or 6	< 249 sec
Green/White	2.5 – 5.0 WHITE	5 or 6	< 249 sec
Purple/Black	3.5 – 6.0 BLACK	5 or 6	< 249 sec

QC RANGES HR-Act:

Ranges will change lot to lot—refer to the package insert.	
CLOTtrac HR Normal	75 – 115
CLOTtrac HR Abnormal	270 – 710

F. **MAINTENANCE:**

1. Refer to HMS Plus Operator's manual, Chapter 7: Maintenance and Quality control.
   a. To be completed monthly:
      i. Verify dispenser volume delivery
      ii. Verify heat block temperature
   b. To be completed routinely:

i. Clean the instrument case and exposed surfaces of the actuator and dispenser of dust and dried blood
ii. Clean/ Replace salvage reservoir (located under the dispenser).

c. Maintenance is recorded on the Lab generated form: HMS Plus Maintenance Log.
d. Discard all the completed testing materials and controls in the provided and appropriate waste containers.

G. **PROCEDURE:**

1. Refer to HMS Plus Operator's manual, Chapter 5: Operating Instructions.
   a. Note: Users of the HMS Plus must be aware of which type of heparin is being administered and configure the HMS Plus appropriately. Due to the change in potency, when NEW USP heparin is used, the HMS instrument "heparin type" must be set to "IU" to ensure correct blood dispensing and calculations of results. (Notice dated 12/19/09)
   b. Instructions for performing HPT and HDR PATIENT tests with new USP Heparin:
   c. Set heparin type:
      i. From main menu, select "instrument parameters"
      ii. Select "heparin type"
      iii. Toggle to [iu]
      iv. Press "enter" to confirm selection
      v. Perform qc testing

H. **CALCULATIONS:**

1. Refer to HMS Plus Operator's manual, Chapter 4-10: Calculations.
   a. Blood Volume Calculations
   b. Heparin Dose Response Calculations
   c. Heparin Bolus Dose Calculations
   d. Heparin Assay Calculations

I. **TECHNICAL NOTES:**

1. Refer to HMS Plus Operator's manual Chapter 2: Warnings and Operational Precautions.

J. **LIMITATIONS:**

1. Refer to HMS Plus Operator's manual, Chapter 2: Warnings and Operational Precautions.
2. Difficulty in collection of the sample for testing may result in activation and erroneous results. If the test results do not correlate with the patient's clinical picture the test should be repeated on a new sample.

K. **REPORTING RESULTS:**

1. Results are recorded in the patient medical record.
2. POCC evaluates held up patients' results that are pending to post on patients' charts whenever needed.

L. **FORM(S):**

1. ACT/HMS Plus New Reagent Lot Validation Log
2. HMS Plus Maintenance Log

M. **REFERENCE(S):**

1. Medtronic HMS Plus Hemostasis Management System Operator's Manual. 2012 Rev. 1C
2. Medtronic. HEPtrac™ Electronic Quality Control Operator's Manual, 1998.
3. Medtronic. Heparin Assay Cartridges. Package Insert. **M957143A001, Rev. 1A**~~2004-A10740001-02~~.
4. Medtronic. Heparin Assay Controls. Package Insert. **M956268A001, Rev. 1A** ~~2004-A08717001-01~~.

5. Medtronic. HR-ACT Cartridges. Package Insert. **M956359A001, Rev. A1**~~2003-UC200402200ML~~.
6. Medtronic. HR-ACT Controls. Package Insert. **M956049A001 Rev. A1, M956050A001 Rev B1**~~2004. A08718003-01~~.
7. Medtronic. Heparin Dose Response Cartridges. **M957144A001, Rev. A1**~~Package Insert~~.
8. **Point-of-Care In Vitro Diagnostic (IVD) Testing; Approved Guideline—Second Edition. CLSI POCT04-A2. 2006**~~NCCLS Point-of-Care In Vitro Diagnostic (IVD) Testing; Approved Guideline, AST2-A, Volume 19, Number 9, June 1999~~.
9. HMS Plus Individualized Quality Control Plan (IQCP)

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INFUSION PUMP – SYRINGE OR PATIENT CONTROLLED ANALGESIC (PCA) MODULE INFUSION SYSTEM WITH GUARDRAILS**
Purpose:	To regulate intravenous (IV) infusion using an electronic control device.
Supportive Data:	The Alaris Intravenous Infusion Pump with Guardrails System provides medication error prevention software to protect patients at the point of infusion delivery.
Equipment:	1. Alaris administration set 2. Primary IV solution 3. Pump programmer point of care (POC) 4. Pump Syringe Module or Patient Controlled Analgesic (PCA) Module

A. **PROCEDURE:**

1. Syringe Module:
   a. Prior to the start of an infusion program, confirm syringe type and size. The system will provide a prompt for the programmer to select both the syringe type and size.
      i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient.
   b. Priming the Alaris Syringe Module:
      i. Prime tubing prior to attaching system to patient with normal saline.
      ii. Attach administration set to syringe and prime tubing with the medication that is ordered.
      iii. Once set is primed, close slide clamp.
   c. Loading the Alaris Syringe Module:
      i. Prior to loading syringe, close roller tubing clamp to prevent uncontrolled flow.
      ii. Open syringe barrel clamp until it clears syringe chamber.
      iii. Twist gripper control clockwise and raise device head to fully extended position.
      iv. Insert syringe barrel flange between barrel flange grippers.
      v. Lock syringe in place by closing barrel clamp.
      vi. Twist gripper control clockwise then lower drive head.
      vii. Lock plunger in place with plunger grippers.
   d. Programming Guardrails:
      i. See Patient Care Services Procedure: Infusion Pump- Infusion System with Guardrails
   e. Removing the Alaris Syringe Module:
      i. Silence alarm.
      ii. Close roller tubing clamp.
      iii. Open plunger grippers and syringe barrel clamp.
      iv. Remove syringe by applying downward pressure to remove disc.
   f. Near End of Infusion:
      i. The system will alternate between Near End and remaining volume to be infused (VTBI).
      ii. The audio prompt requires being silenced just once and will not reoccur following initial silencing.
2. PCA Syringe Module:
   a. Select syringe type and size.
   b. Prime tubing prior to attaching tubing to patient:
      i. Option One: Manually express air from the administration tubing set by:
         1) Prime tubing prior to attaching system to patient with normal saline.
         2) Attach administration set to syringe and prime tubing with the medication that is ordered.

Revision Dates	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/08, 04/09, 01/18, **08/24**	07/11, 03/15, 02/18, 12/20, **02/25**	08/11,03/15, 08/21, **03/25**	n/a	05/15, 03/18, 09/21, **04/25**	10/11, 06/15, 03/18, 01/22	02/22, **06/25**	11/11, 07/15, 04/18, n/a	11/11, 07/15, 04/18, 02/22

3) Once set is primed, close slide clamp.

ii. Option Two: Prime tubing using Alaris PCA Module.

iii. The tubing may be primed from the Infusion Mode Screen prior to programming the PCA Module:

1) Select Options key.
2) Press Prime Set with Syringe.
3) Press and hold Prime key to prime tubing.
4) Press Exit when prime is complete.

c. After priming tubing, close slide clamp.

3. Initial Set-Up:
   a. Label syringe per the Patient Care Services Policy: Patient Controlled Analgesia (PCA).
   b. Load syringe with administration set attached.
   c. Press System On key.
   d. Select Yes or No to New Patient.
   e. Select appropriate profile.
   f. Press Channel Select key.
   g. Set key to Program position.
   h. Press Confirm time setting.
   i. Choose correct syringe type and size.
      i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient.
   j. Select correct medication and concentration.
   k. Enter the dose and time limits.
   l. Enter the total dosage patient may receive as ordered.
   m. Responds to appropriate clinical advisory.
   n. Close and lock door.
   o. Attach administration set tubing set to patient.
   p. Verify entered prescription with a second Registered Nurse (RN).
   q. Press Start to begin PCA Module.
   r. Document in the medical record per the Patient Care Services Policy: Patient Controlled Analgesia (PCA).
4. Changing Syringe:
   a. Press Pause.
   b. Close roller tubing clamp.
   c. Unlock door and remove old syringe.
   d. Press Silence.
   e. Date and time new syringe and attach to tubing.
   f. Load new syringe.
   g. Set key to Program position, close door.
   h. Press Channel Select.
   i. Select correct syringe type and size.
   j. Press Confirm.
   k. Press Restore.
   l. Verify entered drug, concentration, and settings.
   m. Lock door and open roller tubing clamp.
   n. Press Start.
5. Administering a Bolus:
   a. Press Channel Select.
   b. Set key to Program position and enter authorization code.
   c. Enter bolus dose amount and lock door.
   d. Press Confirm.
   e. Confirm settings and press Start.
   f. Document bolus in the medical record.
6. Reviewing History:

a. Review patient history at the beginning of the shift and every four hours.
b. Press Channel Select Key.
c. Press Options.
d. Press Patient History.
e. Review drug totals.
f. Press Zoom key to review time intervals.
g. Press Detail to collect average dose per hour.
h. Press Main History.
i. To clear patient history, press Clear History and select Yes.
    i. Clear patient history every four hours and prior to transferring a patient to another nursing unit.
j. To view 24 hours totals, select 24 h Totals.
k. Press Exit after viewing history.
l. Press Start to return to program.
m. Document patient history every four (4) hours in the patient's electronic health record (EHR).

7. Documentation:
    a. Document the start and change of syringes in the EHR.
    b. A second RN must verify for accuracy the initiation, change in dosage or any boluses and document it in the electronic medication administration record (eMAR).

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

1. Patient Care Services Policy: Patient Controlled Analgesia (PCA)
2. Patient Care Services Procedure: Infusion Pump- Infusion System with Guardrails

C. **REFERENCE(S):**

1. **Becton Dickinson CareFusion. (2021). Alaris syringe module v12: Quick reference guide. Retrieved from https://www.bd.com/content/dam/bd-assets/na/medication-management-solutions/documents/brochure/BD%20Alaris%20Syringe%20Module%20.pdf** ~~Cardinal Health. (2010-2014). Alaris syringe module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf~~
2. **Becton Dickinson CareFusion. (2021). Alaris PCA module v12: Quick reference guide. Retrieved from https://www.bd.com/content/dam/bd-assets/na/medication-management-solutions/documents/brochure/PCA_Module_v12_QRG_5_19JUL2021.pdf** ~~Cardinal Health. (2010-2014). Alaris pca module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	NEWBORN SCREENING, COLLECTION OF SPECIMEN
Purpose:	All newborn babies are required to have a newborn screening test before the baby is discharged. Proper collection is mandato… the proper collection of these blood speci… Program to detect such inborn errors as p… hypothyroidism, and other metabolic/genetic disorders.
Supportive Data:	Required under California Department of Health Newborn Screening – Title 17.
Equipment:	1. Newborn Screening Form 2. Skin cleanser per unit standards 3. Sterile Lancet type device 4. Dry gauze 5. Heel Warmer 6. Single dose, pre-filled twist tip vial Sucrose 24% (RN to administer, if ordered) (note: this is outside the scope of practice for phlebotomist)

RETIRE - DUE TO THE SUSPENSION OF LABOR AND DELIVERY

A. **PROCEDURE:**

1. Initial newborn screening specimens shall be collected on State provided filter forms
   a. Clinical staff shall accurately complete the demographic data. The follow-up outpatient provider (physician) and provider number must be completely accurate.
      i. A ballpoint pen should be used to print clearly.
      ii. If the form is not completed in its entirety, the lab must contact the nurse to complete the form.
   b. The nurse or phlebotomist must fill in the date, time of collection, and initial as the collector.
2. Follow proper patient identification and labeling procedure:
   a. Verify the infant's name and medical record number on the armband against all the demographics on the Newborn Screening Form.
   b. Place additional infant label on back of Newborn (NB) Screen Blood Collection card to ensure specimen test card is still identified with NB should the top page with infant label become separated. Attach label to back side of lower portion. Lab will not process if it is separated.
   c. Verify all information on the Newborn Screening Form is correct with a second RN.
3. Timing of Collection:
   a. Collect the specimen between 24-48 hours of age.
   b. If for any reason (e.g., transfusion, discharge earlier than 12 hours or hospital error) the specimen is collected prior to 12 hours, a second specimen will be required.
   c. In Critically ill newborns, the attending NICU Physician may postpone the collection of newborn screening specimen until the newborn's emergency condition is stabilized.
4. Dried Blood Spot (DBS) Collection: Instructions for collecting adequate dried blood spots are on the back of the California Newborn Screening Specimen Collection Card.
   a. Do not handle the blood collection area of specimen collection card prior to, during, or following sampling.
   b. A new test request form must be used for each collection. If a mishap occurs during a collection, use a new specimen collection card.
   c. Do not use capillary tubes for collecting the blood to apply to the card. It can damage the filter paper, resulting in an inadequate specimen.

Patient Care Content Expert	Clinical Policies & Procedures	Nursing Leadership	Perinatal Collaborative Practice	Department of Pediatrics	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/00, 05/12, 02/15, 11/16, 02/21, **11/24**	05/12, 02/15, 11/16, 03/17, 10/21, **02/25**	05/12, 02/15, 05/17, 11/21, **03/25**	08/16, 07/17, 03/22, n/a	08/17, 04/22, n/a	03/16, 09/17, 08/22, **05/25**	09/12, 10/17, 09/22, **05/25**	11/22, **06/25**	10/12, 11/17, n/a	11/12, 12/17, 11/22

d. See Patient Care Services Procedure: Collection of Blood Specimen by Skin Puncture for specimen collection.
e. Follow instructions on Newborn Screening Collection card.
i. Fill all circles.

5. Use of Venous or Arterial Blood:
a. A heel stick is strongly preferred.
b. If unable to obtain a heel stick specimen due to prematurity or other issues with infant, arterial or venous blood may be used after the line has been properly cleared.
c. Allow blood to freely drop from the syringe onto the filter paper, filling each circle completely.
d. Mark "Other" in type of specimen category on test request form, and indicate source of blood (Umbilical Arterial Catheter, etc.)

6. Infants Requiring Transfusions. If a transfusion is anticipated:
a. Collect the specimen prior to the transfusion of red blood cells (RBC), even if the newborn is under 12 hours of age. Infants who are transfused with red blood cells must have a specimen collected prior to the transfusion. (Transfusions with plasma, platelets, or albumin will not significantly affect the screening.)
b. If the neonate is less than 12 hours old at the time the pre-transfusion specimen is collected or if no adequate specimen was obtained prior to transfusion, a specimen should be collected 24 – 48 hours after the last transfusion.

7. Processing Newborn Screening Forms:
a. Allow the blood to thoroughly dry at room temperature for at least three (3) hours and follow hospital policy for processing the specimen. Keep away from heat lamps, direct sunlight, and humidity.
i. Note: Touching or smearing the blood spots should be avoided. Blood spots on the filter paper should not be heated, stacked or allowed to touch other surfaces during the drying process.
b. The health care provider will order the Newborn Metabolic Screening (NBMS) test in the Electronic health record (EHR).
c. Place in an unsealed paper envelop
d. The newborn screening requisition form will be taken to the Laboratory and the clerical staff will receive them and place the Accession Number on the slip.
i. Note: The lab staff will call nursing for information if the forms are not completely filled out.
e. The clerical staff will log these specimens on the Newborn Screening Form log. Specimens that are awaiting transport shall be stored at room temperature, away from heat and moisture.

8. Document completion and RN verification/ witness of the newborn screen in the EHR.

B. **LABORATORY:**

1. The clerical or phlebotomy staff will receive the specimen in the Laboratory Information System (LIS) and place the Accession Number on the slip.
a. If dispatched receive using the miscellaneous reference lab as the location.
b. If the patient was discharged and the NBMS discontinued or was not initially ordered, re-order the NBMS using Department Order Entry using Miscellaneous Reference Lab as the location.

2. Check the NBMS collection form for completeness and that the collection time is greater than 12 hours of age.
a. Lab staff will call nursing for information if the forms are not completely filled out.

3. The clerical staff will log these specimens on the Newborn Screening Form Log and place them in the appropriate bin in the Chemistry refrigerator #5 at 2-8 degrees C for courier pickup.

4. Completion in Cerner:
a. Using Batch Result Entry enter Newborn Metabolic Screening.

b. A list of NBMSs will display. The default entry is "See Separate Report".
   i. Be sure all accession numbers have a check mark displayed.
c. Click Verify.

C. **PROCEDURE IN EVENT SPECIMEN IS NOT COLLECTED PRIOR TO DISCHARGE:**

1. Notify the appropriate Department Leader that the specimen was not collected. Arrangements for follow-up of infant will be made by the appropriate Department Leader.
2. If no specimen is obtained for Newborn Screening, fill in "Specimen Not Obtained" section on the Newborn Metabolic Screening form. Situations which might apply include:
   a. A newborn that is transferred to another facility.
      i. The receiving hospital is responsible for obtaining the specimen.
   b. A newborn that expires prior to 48 hours of age.
   c. Staff error results in infant being discharged without specimen being collected.
3. If newborn's parent(s) refuses testing, the "Newborn Screening Test Refusal" (NBS-TR) form must be completed and submitted.
4. NBS-TR forms may be obtained from the OB Clinical Manager, OB Charge Nurse, OB Patient Data Coordinator, or the NICU Unit Secretary.

D. **PROCEDURE IN EVENT NBS RESULT IS INVALID OR ABNORMAL:**

1. The performing laboratory contacts the pediatrician provided on the NBS form for recollection of an invalid result, abnormal results and subsequent testing needs.

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

1. NICU Pain Management, Neonates & Infants Policy

F. **REFERENCE(S):**

1. "Blood Collection on Filter Paper for Neonatal Screening Programs" NCCLS Document LA4-A2 Vol. 12, No. 13, July 2002.
2. AWHONN Evidence-based Clinical Practice Guideline. Neonatal Skin Care. 2008.
3. Besuner, P. (2007). Association of Women's Health, Obstetric and Neonatal Nurses - Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC
4. State of California Website, www.dhs.ca.gov.pcfh/gdb/html/NBS/ProgramOVforProviders.htm
5. The California Newborn Screening Program. (2013, April). New Addition to Newborn Screening: Severe Combined Immunodeficiency (SCID). *Newborn Screening News Issue #16, pp.1-4*

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**NITRAZINE TEST ON VAGINAL FLUID**
Purpose:	To assist in the evaluation of vaginal fluid pH for the presence of amniotic fluid.
Equipment:	Gloves Swab Phenaphthazine/Nitrazine paper pH 5.0 buffer and pH 7.0 buffer

RETIRE - DUE TO THE SUSPENSION OF LABOR AND DELIVERY

A. **DEFINITIONS:**

1. Buffer - a solution that resists changes in pH when acid or alkali is added to it. Buffers typically involve a weak acid or alkali together with one of its salts.
2. CLIA - Clinical Laboratory Improvement Amendments
3. Nitrazine- see Phenaphthazine
4. pH – a measure of hydrogen ion concentration, a measure of the acidity or alkalinity of a solution.
5. Phenaphthazine- commonly known as nitrazine, a pH indicator dye used in healthcare.
6. POC – Point of Care
7. QC – Quality Control, performed to ensure the validity of test and test results.
8. Vaginal fluid – fluid that drains from the opening of the vagina.

B. **POLICY:**

1. The nitrazine test is a screening test performed on amniotic fluid to evaluate a suspected rupture of membranes. A Registered Nurse (RN) is authorized to perform this procedure. Testing is under the supervision of the Laboratory Point of Care (POC) Coordinator and under the jurisdiction of the Laboratory Medical Director.

C. **PRINCIPLE:**

1. Phenaphthazine paper is a Nitrazine indicator paper with a wide range of colors intended for invitro, semi quantitative determination of pH in the 4.5 – 7.5 range, used to interpret the alkaline nature of vaginal fluid. This test involves putting a drop of fluid obtained from the vagina onto paper strips. The strips change color depending on the pH of the fluid.

D. **SPECIMEN:**

1. Patient Preparation:
   a. This procedure may be performed during a speculum examination.
2. Type of Specimen:
   a. Vaginal Fluid

E. **REAGENTS/SUPPLIES:**

1. Phenaphthazine/ Nitrazine paper
   a. Storage: Room Temperature
   b. Stability : Unopened – until expiry on the dispenser; Opened – 6 months
2. pH 5.0 buffer and pH 7.0 buffer
   a. Storage: Room Temperature
   b. Stability: Until expiry date on the bottle

F. **INSTRUMENTATION:** N/A

G. **QUALITY CONTROL (QC):**

1. QC Materials: pH 5.0 buffer and pH 7.0 buffer.
2. Test the control buffers per POC testing procedure.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/03, 4/04, 4/06; 6/09, 07/15, 05/18, 11/19, 03/22, **10/24**	07/11, 08/15, 0718, 12/19, 01/20, 04/22, **02/25**	08/11, 09/15, 07/18, 02/20, 05/22, **03/25**	03/16, 08/18, 04/20, 08/22, **05/25**	n/a	10/11, 04/16, 08/18, 05/20, 09/22, **05/25**	09/18, 06/20, 12/22	11/11, 05/16, n/a	11/11, 05/16, 09/18, 06/20, 12/22

3. Perform QC test with a new lot and monthly.
4. Document results through the glucometer.
5. If the control results are not within acceptable limits the test is considered invalid and further patient testing is not allowed until corrective action steps are successful and documented.

H. **PROCEDURE:**

1. Quality Control:
   a. Tear off a strip of Phenaphthazine paper from the roll.
   b. Dispense a drop of the pH 5.0 buffer solution onto the strip of pH paper.
   c. Immediately match the color of the pH paper close with the closest color on the color chart supplied with the Phenaphthazine paper dispenser.
   d. Repeat steps 1-3 with pH 7.0 buffer solution.
   e. Record the QC result through the glucometer.
2. Patient Testing:
   a. Perform hand hygiene and apply gloves.
   b. Verify patient identification according to policy.
   c. Swab the fluid pooling in the vagina or along the sidewall of the vagina (avoiding the cervix) using a cotton tip applicator.
   d. Touch the applicator to the test paper ensuring the chemically treated paper is totally moistened.
   e. Read the nitrazine paper immediately.
   f. Compare the paper visually to the color scale printed on the outside of the nitrazine dispenser.

I. **CALCULATIONS:** N/A

J. **EXPECTED VALUES/ REFERENCE RANGES/ ACTION VALUES**

Color	pH	Report As
Yellow	4.5	Negative: Membranes probably not ruptured
Yellow-green	5.0	
Olive	5.5	
Olive-green	6.0	
Blue-green	6.5	Positive: Membranes probably ruptured
Blue-gray	7.0	
Deep blue	7.5	
Unclear or other color	?	Equivocal: May be due to blood, cervical mucus or semen

K. **DOCUMENTING RESULTS:**

1. Input results through the glucometer
2. Document the result in the electronic health record. Enter the following:
   a. Date and time.
   b. Result – negative, positive or equivocal

L. **TECHNICAL NOTES:**

1. The base stock color of the Phenaphthazine paper may vary from lot to lot, from tan to olive green. This will not affect the accuracy of the results.
2. Normal amniotic fluid is neutral (pH 7.0) or slightly alkaline (pH 7.25). In the presence of amniotic fluid the moistened nitrazine paper will change from a yellow color to a dark blue color.
3. Color comparison recommended under a combination of fluorescent light and daylight.
4. Nitrazine test is considered a waived test under (CLIA) 88 Federal Regulations.
5. Personnel performing the testing must be certified prior to performing patient testing. Certification is achieved through a training program coordinated by the nursing education department in

conjunction with the lab. Competency is assessed and documented annually. Competency records are maintained on the nursing units.

6. Proficiency testing is coordinated through the laboratory staff and performed by testing personnel on the nursing units.

M. LIMITATIONS:

1. The nitrazine test is not considered a definitive test for diagnosing ruptured membranes.
2. A false negative result may occur if there has been prolonged rupture of membranes (longer than 24 hours) or when only a small quantity of fluid is present.
3. A false positive may occur if vaginal secretion has been contaminated with blood, urine or antiseptic solution. The pH of blood, vaginal mucus and some secretions associated with vaginal infection is also alkaline.

N. REFERENCE(S):

1. Kennedy, B.B., Ruth, J.R., Martin, E.J. (2009). *Intrapartum management modules – A perinatal education program (4th ed.)*. Wolters Kluwer Health/Lippincott Williams & Wilkins: Philadelphia, PA.
2. Clinical Laboratory Improvement Amendments of 1988 Federal Regulations
3. Micro Essential Laboratory. pHizatest® Phenaphthazine paper. Package Insert. Cat. No. 934. Nov 15, 2019.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PATIENT CONTROLLED ANALGESIA (PCA)**
Purpose:	To outline the interdisciplinary responsibilities for effective pain management utilizing patient controlled analgesia pump methodology.
Supportive Data:	Research has shown optimum analgesia can be achieved and maintained and sub-therapeutic levels or over-sedation avoided when patients control their own analgesia administration. The patient participates by initiating administration of the prescribed dose of an intravenous analgesic. Patient selection of the use of PCA must be appropriate based upon age, mental state, level of consciousness, psychological and/or intellectual capacity. PCA by proxy (anyone other than patient pressing button) is not practiced. Nursing will utilize patient/family reports of pain, nursing assessment and findings to determine appropriateness of administering analgesia.
Equipment:	1. PCA Pump 2. PCA Administration tubing 3. PCA Syringe

A. **DEFINITIONS:**

1. Patient Controlled Analgesia: an interactive method of pain management that allows the patient to actively participate in managing their pain.
2. ~~Basal rate: continuous infusion rate of medication~~
3. ~~3.~~**2.** PCA dose: dose self-administered by the patient
4. ~~4.~~**3.** Lockout: a safety mechanism that takes into consideration medication pharmacology to prevent 'dose stacking' leading to potential overdose. Patient will not be able to self-administer next PCA dose until lockout interval has lapsed
5. ~~5.~~**4.** Bolus dose: is a dose administered by a licensed provider in response to pain not effectively controlled by PCA.
6. ~~6.~~**5.** Multimodal analgesia: use of more than one method for controlling pain. May be pharmacological or non-pharmacological.
7. ~~7.~~**6.** PCA by proxy: unauthorized administration of a PCA dose by another person. This has a potential to produce significant harm and is therefore not permitted by this policy.
8. ~~8.~~**7.** Opiate naïve patient: any patient for whom accurate prescription and non-prescription drug history can be verified and documented as consuming less than 60mg of oral morphine equivalents per day continuously for at least 7 days. Patients, for whom accurate prior opiate consumption history cannot be verified, should be considered opiate-naïve.
9. ~~9.~~**8.** Opiate tolerant patient: Patients with documented history of consuming prescription and non-prescription opiates at doses higher or equal to 60mg of oral morphine equivalents per day for at least 7 consecutive days.
10. ~~10.~~**9.** Standard PCA orders – method of pain management allowing nurses to monitor and notify physician/Allied Health Professional for further orders to adjust the PCA settings
11. ~~11.~~**10.** Titratable PCA orders – method of pain management allowing nurses to monitor and adjust PCA setting using an approved PowerPlan based on adequacy of pain control, sedation and other side-effects.

B. **POLICY:**

1. PCA is a safe and effective mode of delivering pain medications and is often used in combination with other pain management modalities.
   a. Patient's ability to utilize PCA device and understanding of operation and rationale must be verified prior to initiation.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/93, 02/11; 05/14, 06/20, **07/22**	03/11;06/14, 06/20, **03/22**	03/11;06/14, 07/20, **04/23**	09/24	07/14, 05/21, **02/25**	04/11; 8/14, 07/21, **05/25**	08/21, **06/25**	05/11;10/14, n/a	7/03, 3/04, 2/06, 9/08, 05/11,11/14 Implemented 01/2016, 08/21

b. The goal of the individual patient's pain management shall be clear.
c. Assessment and re-assessment of patient's pain will be performed using appropriate tools per Patient Care Services (PCS) Policy: Pain Management.
d. Recognize the signs of adverse drug reactions and toxicities.
e. Recognize appropriate situations for bolus dose administration.
f. Proxy administration of bolus doses is not permitted.

2. Patients receiving PCA shall be educated on appropriate use.
   a. All components of pain management through PCA will be explained.
   b. Patients will be informed about common adverse affects of medications they are receiving.

C. **PROCEDURE STANDARD PCA:**

1. Physician/AHP responsibilities.
   a. Verify and document patient medication allergies.
   b. Assess patient for cognitive and physical ability to manage a PCA self-administration system
   c. Complete pre-admission/pre-op pain medication history.
      i. Accurate prior pain medication history allows for better initial PCA dose selection.
   d. Enter orders in the electronic health record (EHR).
      i. PCA orders will only be accepted via approved PowerPlan in the EHR
      ii. PCA orders will include:
         1) Medication name
         2) PCA Dose (mg, mcg)
         3) Lockout interval (min)
         ~~4) Basal rate (mg/hr, mcg/hr), if applicable or appropriate~~
         ~~5)~~**4)** Bolus dose (additional order)
   e. Manage potential adverse effects, especially constipation, nausea/vomiting, over sedation, respiratory depression, pruritus, confusion.
2. Pharmacist responsibilities:
   a. Verify and document patient medication allergies.
   b. Review outpatient pain medication requirements, concomitant drug-drug interactions (drugs that can cause sedation or respiratory depression), and high risk disease states (for example: history of chronic obstruction pulmonary disease with hypercapnea, sleep apnea).
   c. Verify physician/AHP orders a timely manner.
   d. Label all medication with patient name, medical record ~~(MR)~~ number **(MRN)**, medication name, concentration, dose and rate.
   e. Assist with safe and effective medication administration.
   f. Detect and report medication-related adverse events.
3. Nursing to complete the following prior to initiating PCA therapy for pain management:
   a. Verify patient's ability to utilize PCA device and understanding of operation and rationale.
   b. Instruct patient/family about danger of having others press PCA button for patient.
      i. Ensure the patient is given written and verbal information regarding the PCA and document in medical record.
         1) Refer to the Tri-City Medical Center Intranet under Patient Information.
   c. Verify IV site and patency.
   d. Check blood pressure, pulse, respiratory rate, and character of respiratory status.
   e. Verify pain level with implementation of consistent pain rating tool (i.e., numerical pain scale 0-10).
   f. Request patient's acceptable pain level (target pain level).
   g. Check sedation level using Pasero Opiod-Induced Sedation Scale (POSS)
   h. Initiate end tidal CO_2 ($EtCO_2$) monitoring.

i. If patient refuses EtCO2 monitoring, initiate continuous pulse oximetry
ii. Document refusal of $EtCO_2$ monitoring in the EHR. If patient also refuses continuous pulse oximetry, document refusal of pulse oximetry in the EHR

i. Confirm pharmacist verification of physician order.
j. Verify and document patient medication allergies.

4. Initiation:
   a. Administer ordered medication per PCS Policy: Medication Administration.
   b. Program the pump in milligram (mg) dose only, never by volume (mL).
      i. Verify with second RN any change in medication, concentration, infusion rate, new syringe, lockout interval or demand dose.
      ii. Lock PCA keys in Pyxis, do not leave in pump/controller.
      iii. Use PCA keys to change syringe, tubing, adjust parameters of dosage, lockout intervals or one (1) hour limits.
   c. Administer loading dose as appropriate.
   d. Administer bolus dose(s) as appropriate.
   e. Document initiation of medication and syringe change(s) in electronic medication administration record (eMAR).
   f. Document initial assessment in the PCA section in the EHR.
      i. Include baseline data prior to initiating PCA.
   g. Ensure Naloxone (Narcan) is available in Pyxis.
5. Maintenance/Assessment:
   a. Check syringe for proper medication, date on syringe and tubing, and confirm correct program of pump-controller with the orders by the oncoming shift. Document verification in the PCA section in the EHR (only requires one RN signature).
   b. Perform assessment including:
      i. Vital signs (blood pressure, pulse, respiratory rate, pain level and oxygen saturation if on pulse oximetry)
      ii. POSS score
      iii. $EtCO_2$ level
   c. Perform assessment upon initiation and any change in medication, concentration, infusion rate, lockout interval or PCA dose:
      i. Every one (1) hour times two **until stable**, then
      ii. Every two (2) hours times three **until stable**, then
      iii. Every four (4) hours until stable (stable is defined as patient at or below target pain level, respiratory rate is greater than or equal to 12, and level of sedation is less than or equal to 2 on the POSS)
      ~~iv. If unstable, POSS score 3 or greater and respiratory rate less 10 (mechanical breaths) assess:~~
         ~~1) Every one (1) hour times two, then~~
         ~~2) Every two (2) hours times three, then~~
         ~~3) Every four (4) hours until stable~~
   d. Document assessments in the PCA section in the **EHR**~~her,~~.
   e. Change the PCA tubing and syringe every 96 hours and label with date of next tubing change.
   f. Keep call bell within reach and encourage patient to ask for assistance as needed.
   g. Supervise ambulation.
6. Additional requirements for titratable PCA:
   a. Verify PCA orders include:
      i. Pathway (opiate naïve or opiate tolerant)
      ii. Loading dose - one-time bolus opiate to be administered immediately prior to PCA initiation
   b. Administer loading dose (DO NOT ADMINISTER if patient has signs of excessive sedation, hemodynamic instability or respiratory depression).

c. Start PCA therapy
   i. If pain level is less than 6 (numerical scale) or at target pain level, continue current settings
   ii. For pain level greater than or equal to 7 and patient does not exhibit excessive sedation:
      1) Administer bolus dose per PowerPlan.
      2) If unresponsive to bolus dose after at least 30 minutes, increase PCA dose/lockout interval in accordance with PowerPlan.
      3) If pain is not controlled after two (2) PCA dose adjustments, physician/AHP will be notified.

d. Assess pain response; RN may decrease PCA dose but not the lockout interval, per **physician orders**~~PowerPlan~~ after 2 consecutive pain assessments, if patients' pain is well controlled, to maintain goal pain level on lowest possible opioid dose.

7. Report to physician immediately if:
   a. Respiratory rate is less than 10 breaths per minute or apneic
   b. $EtCO_2$ alarms indicating hypercapnea or persistent hypoventilation
   c. Hypotension (decrease in systolic blood pressure 20 mmHg from baseline)
   d. Anaphylactic reaction
   e. Presence of persistent nausea, vomiting, rash, pruritus
   f. Ineffective pain relief with current order
   g. Patient level of consciousness unresponsive / POSS score is 3-4
8. Perform appropriate intervention(s) in the event of neurological, cardiovascular, or respiratory depression:
   a. Discontinue PCA administration
   b. Direct patient to breathe deeply
   c. Stimulate patient verbally and tactually
   d. Administer naloxone (**N**~~n~~arcan) IV push as ordered by physician and call Rapid Response Team
      i. Observe for increased respiratory rate within 1-2 minutes of Narcan administration.
   e. Notify physician of patient's condition
   f. Monitor vital signs every 15 minutes until patient stable

D. **DOCUMENTATION:**
1. Document assessments in the PCA section in the EHR
2. Document initiation of medication and syringes changes on the (eMAR)
3. Document all narcotic wasting in Pyxis.

E. **RELATED DOCUMENT(S):**
1. PCS Policy: Medication Administration
2. PCS Policy: Pain Management
3. Medication Currently Used for PCA

F. **REFERENCES:**
1. Harvard PCA Patient Controlled Analgesia System (Brochure) of Bard Electro Medical Systems, Inc.
2. *Warning Issued On Analgesia "By Proxy"*, RN Magazine, Vol. 68, No. 3, March 2005.Pullen Jr., Richard. *Managing I.V. Patient-Controlled Analgesia*, Nursing 2003. Volume 33, Number 7.
3. Alaris Infusion Pump Computer Based Training, located on the Tri-City Medical Center Intranet, http://etcmc/alaris/medley(tm)_system_v7_cbt/menu.htm.
~~3.~~ 4. **Grissinger, M. Beware of Basal Opioid Infusions with Patient-Controlled Analgesia. P&T, Vol 37, No, 11, November 2012. pp 605-606.**

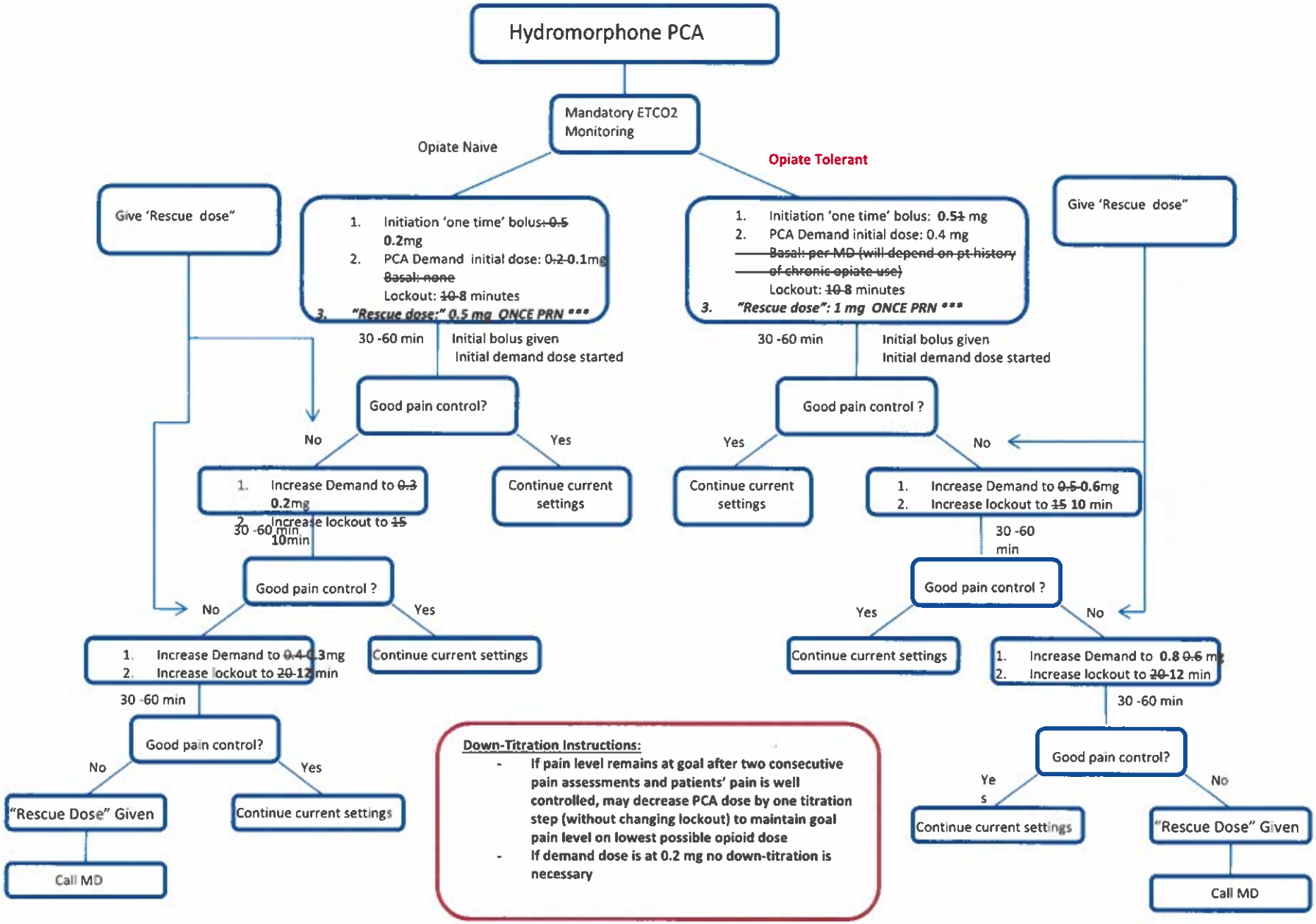
MEDICATIONS CURRENTLY USED FOR PCA					
Medication	**Side Effects**	**Route**	**Total Dose***	**Onset**	**Duration**
Opiods	Metabolized in liver excreted in urine				
Morphine	Respiratory depression, hypotension nausea and vomiting, Anaphylaxis, Histamine release.	IV IM/SQ	0.1-0.2 mg/kg 0.1-0.2 mg/kg	1-5 min 30 min	3-4 hr
Hydromorphone	Respiratory depression, somnolence, hypotension nausea and vomiting, urinary retention *5X more potent than Morphine mg for mg.*	IV IM SQ	1-4 mg every 4-6 hours	5-10 minutes	3-4 hr
~~Meperdine (DEMEROL) Only recommended if above PCA meds contraindicated.~~	~~Respiratory depression; Anxiety & agitation toxic metabolite can lower seizure threshold~~	~~IV/IM~~ ~~IV/IM~~ ~~IV/IM~~	~~25-30 mg~~ ~~1-2 mg/kg~~ ~~Max dose: 100 mg.~~ ~~Max dose in any 24 hours is 600mg~~	~~3-5 min.~~	~~2 hr~~
Reversal Agents					
Naloxone (NARCAN)	Withdrawal symptoms (agitation / HTN, increased HR)	IV/IM/SQ	PCA Order for RR <10 Is 40 mcg / 0.4mg IV q 1-2 Min Until RR >10 [0.4mg Narcan (1mL) + 9mL NS] usual dose 0.1-0.4mg	1-2 min (IV)	15-45 min

OPIOID NAÏVE

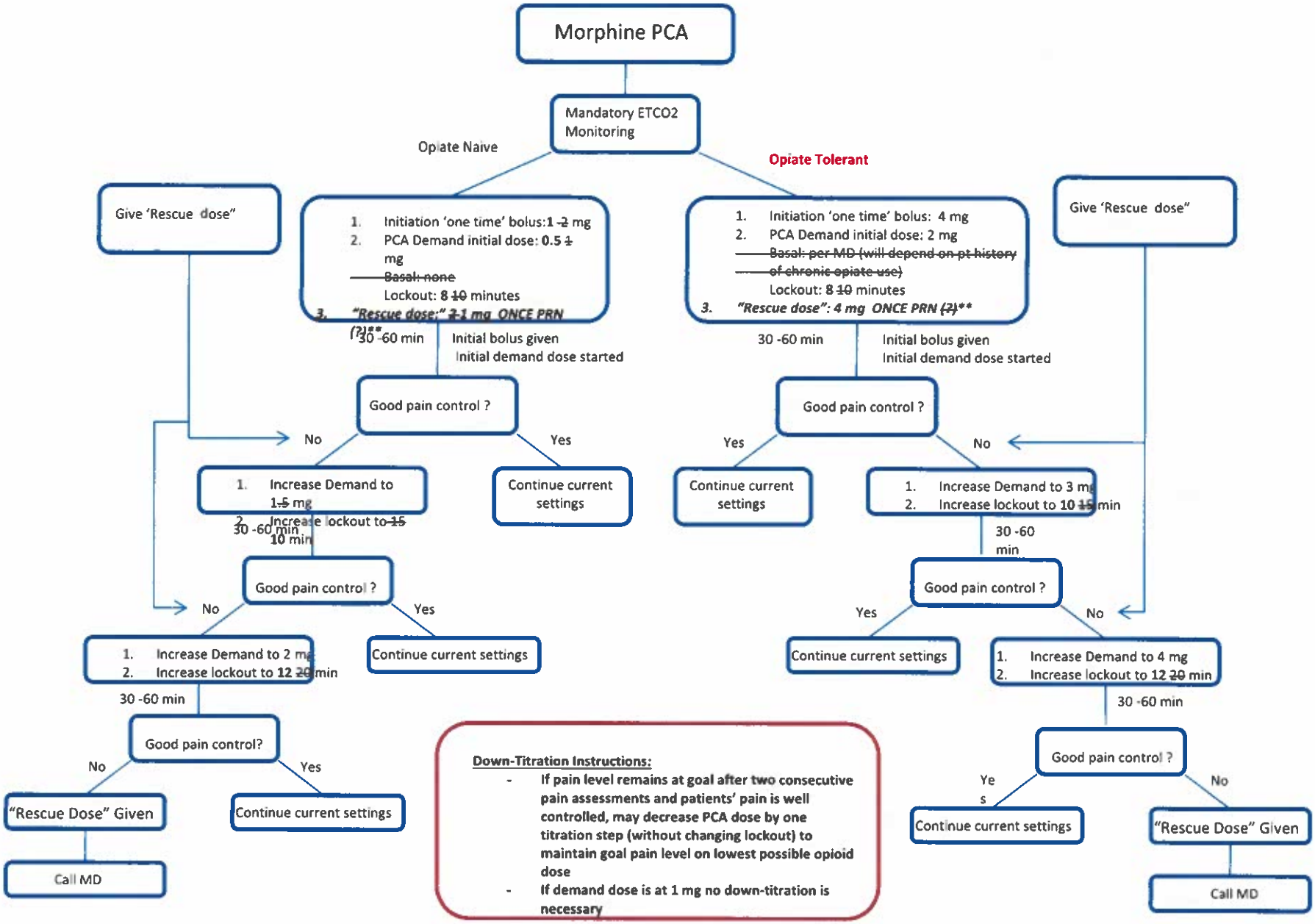
DRUG/ CONC.	BOLUS DOSE	PCA DOSE Demand Dose ORDER IN MGs	PCA DELAY Lockout IN MINUTES	~~ONE HR DOSAGE LIMIT IN mL's~~	~~ONE HR DOSAGE LIMIT IN MGs~~
MORPHINE	1	~~0.5~~1	~~8~~	~~7.5~~	~~7.5~~
1mg/ml		1	10	~~6.0~~	~~6.0~~
30 mg in 30 mL syringe		~~2~~ 1	~~12~~ 8	~~8.5~~	~~8.5~~
~~*60 ml syringe*~~		~~1~~	~~10~~	~~7.0~~	~~7.0~~
~~*55mg in 55 mL*~~		~~1~~	~~8~~	~~9.5~~	~~9.5~~
		~~1~~	~~10~~	~~8.0~~	~~8.0~~
HYDROMORPHONE (Dilaudid)	0.2	~~0.2~~0.1	~~8~~	~~7.5~~	~~1.5~~
0.2mg/ml		0.2	10	~~6.0~~	~~1.2~~
6 mg in 30 mL syringe		~~0.2~~0.3	~~12~~8	~~8.5~~	~~1.7~~
~~*60 ml syringe*~~		~~0.2~~	~~10~~	~~7.0~~	~~1.4~~
~~*10mg in 50mL*~~		~~0.2~~	~~8~~	~~9.5~~	~~1.9~~
		~~0.2~~	~~10~~	~~8.0~~	~~1.6~~
~~MEPERIDINE (Demerol)~~		~~10~~	~~20~~	~~3.0~~	~~30~~
~~10mg/ml~~		~~15~~	~~20~~	~~4.5~~	~~45~~
~~*60 ml syringe*~~		~~20~~	~~20~~	~~6.0~~	~~60~~
~~*550 mg in 55 mL*~~		~~15~~	~~20~~	~~5.5~~	~~55~~

OPIOID TOLERANT

DRUG/ CONC.	BOLUS DOSE	PCA DOSE Demand Dose ORDER IN MGs	PCA DELAY Lockout IN MINUTES
MORPHINE	4	2	8
1mg/ml		3	10
30 mg in 30 mL syringe		4	12
HYDROMORPHONE (Dilaudid)	0.5	0.4	8
0.2mg/ml		0.6	10
6 mg in 30 mL syringe		0.8	12



** "Rescue dose " could be reserved for patients who reached the final titration step without achieving pain control OR it could be given prior to initiation of each titration step .
MD will be contacted if the patient does not achieve pain control AND all titration options were exhausted by RN



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Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SIEMENS RAPIDPOINT ® 500**
Purpose:	The analysis of blood gases, electrolytes, ionized calcium, glucose, and hematocrit.
Supportive Data:	Siemens RAPIDPoint ® 500 Operator's Guide
Equipment:	RAPIDPoint ® 500 Analyzer
Authorized to Perform Procedure:	**See Point of Care Quality Assurance Policy**~~Registered Nurse (RN), Respiratory Care Practitioner (RCP), Perfusionist, Anesthesia Technician, Clinical Laboratory Scientist (CLS)~~
NOTE:	For more detailed information regarding technology, reagents, calibration points, etc., please refer to the laboratory and/or manufacturer's user manual.

A. **PRINCIPLE:**

1. The RAPIDPoint ® 500 system uses potentiometry, amperometry, and conductance to measure the concentration of analyte in the sample. An electrochemical interaction between the analyte of interest and the sensor generates an electrochemical signal that is proportional to the amount of analyte in the sample. Potentiometry is the technology that measures the difference/ potential between two electrodes in a solution without applied current. Amperometry involves applying voltage to an electrode and then measuring the current generated. Conductance is the readiness with which a conducting substance transmits electrical current.

B. **CLINICAL SIGNIFICANCE:**

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
SODIUM	Dehydration Diabetes insipidus Salt poisoning Skin losses Hyperaldosteronism CNS disorders	Dilutional hyponatremia (cirrhosis) Depletional hyponatremia Syndrome of inappropriate ADH
POTASSIUM	Renal glomerular disease Adrenocortical insufficiency Diabetic Ketoacidosis (DKA) Sepsis In vitro hemolysis	Renal tubular disease Hyperaldosteronism Treatment of DKA Hyperinsulinism Metabolic alkalosis Diuretic therapy
CHLORIDE	Prolonged diarrhea Renal tubular disease Hyperparathyroidism Dehydration	Prolonged vomiting Burns Salt-losing renal disease Overhydration Thiazide therapy
IONIZED CALCIUM	Dehydration Hyperparathyroidism Malignancies Immobilization Thiazide diuretics Vitamin D intoxication	Hypoparathyroidism Early neonatal hypocalcemia Chronic renal disease Pancreatitis Massive blood transfusions Severe malnutrition
GLUCOSE	Diabetes mellitus Pancreatitis	Insulinoma Adrenocortical insufficiency

Patient Care Services Content Review	Clinical Policies & Procedures Committee	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/09, 05/15, 04/18, 06/20, 07/22, **12/24**	07/11, 05/15, 05/18, 07/20, 08/22, **02/25**	08/11, 05/15, 05/18, 08/20, 09/22, **03/25**	03/16, 06/18, 09/20, 09/22, **05/25**	n/a	10/11, 04/16, 06/18, 09/20, 10/22, **05/25**	10/20, 12/22, **06/25**	11/11, 05/16, 07/18, n/a	11/11, 05/16, 07/18, 11/20, 12/22

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
GLUCOSE	Endocrine disorders (e.g. Cushing's syndrome) Drugs (e.g. steroids, thyrotoxicosis) Chronic renal failure Stress IV glucose infusion	Hypopituitarism Liver disease Ethanol ingestion Reactive hypoglycemia Glycogen storage disease
pH	Respiratory alkalosis Metabolic alkalosis	Respiratory acidosis Metabolic acidosis
PCO_2	Acute Respiratory Acidosis: • Depression of respiratory center • Suppressed neuromuscular system • Pulmonary disorders • Inadequate mechanical ventilation Chronic respiratory acidosis • Decreased alveolar ventilation • Hypoventilation Compensation in metabolic alkalosis	Respiratory alkalosis: • Increased stimulation of respiratory center • Hypermetabolic states • Mechanical hyperventilation Compensation in metabolic acidosis
PO_2	Breathing oxygen-enriched air	Carbon-monoxide exposure Pulmonary disorders Myocardial infarction Congestive heart failure
HCO_3	Primary metabolic alkalosis Compensation in respiratory acidosis	Primary metabolic acidosis Compensation in respiratory alkalosis
HEMATOCRIT	Dehydration Burns Impaired ventilation Renal disorders	Hemolytic anemias Iron deficiency Marrow depression Blood loss

C. **SPECIMEN:**

1. Specimen Type:

Sample Type	Collection Device	Minimum Fill Volume	Preparation
Arterial blood	Syringe	200 microliters for 1.0 mL syringe 800 microliters for 3.0 mL syringe 1.5 mL for 5.0 ml syringe	Expel air from the syringe and cap it immediately after obtaining the sample.
Venous blood			
Capillary blood	Capillary tube	175 microliters balanced heparin tubes (Minimum is 100 microliters)	Fill the tube completely and cap it securely.

a. For whole blood samples, use syringe or capillary tube. For whole blood venous specimens submitted to the laboratory, use lithium heparin. If staff are analyzing samples for ionized calcium lithium heparin can be used.

b. Other anticoagulants, such as benzalkonium heparin, EDTA, citrate, oxalate, and fluoride significantly affect blood pH, sodium, potassium, chloride, and ionized calcium results.
c. Antimicrobial compounds such as silver sulfadiazine and chlorhexidine, which are found in some central venous catheters, significantly affect sodium results and may affect subsequent sample analyses. Do not collect venous samples for electrolytes analysis from a central venous catheter that contains silver sulfadiazine or chlorhexidine.
d. Staff can introduce samples into the RAPIDPoint ® 500 system using the sample collection devices listed in the previous table.

2. Specimen Handling:
   a. Position any labels toward the back of the syringe barrel near the plunger so the label does not block the syringe from entering the system and cause it to fall off.
   b. Cap the sample device immediately after collection to avoid room air contamination.
   c. Analyze the sample as soon as possible to minimize oxygen consumption.
   d. Before analysis, roll the syringe or capillary tube between palms and gently invert it several times to mix the sample thoroughly. Blood cells settle during storage, and if the sample is not well mixed before analysis, the Hematocrit results obtained can be falsely decreased or increased. Mix all samples using a consistent technique. Ensure there are no air bubbles in the syringe after mixing.
   e. Dispose of used sample devices in a biohazard contamination bag.
3. Known Interfering Substances:
   a. Always select the mixed venous sample button to analyze mixed venous samples. Samples collected from some pulmonary artery catheters can contain the benzalkonium ion that interferes with analysis and affects results.

Analyte	Interfering Substance	Concentration Tested	Level of Interference
Ionized Calcium	Salicylic Acid	50 mg/dL 30 mg/dL	.098 mM (6%) .046 mM (3%)
Sodium	Dobutamine Benzalkonium Heparin Heparin Leo	5 mg/dL n/a 800-850 U/mL	6 mmol/L >50 mM -12.6 mM
Chloride	Salicylic Acid	50 mg/dL 20 mg/dL	9.5 mmol/L 1.8 mmol/L
Hematocrit	Dextran Leukocytes Protein Protein	3 g/dL 60,000 WBC cu/mm 12% 4%	5% 10% 4.9% -1.3%
Potassium	Benzalkonium Heparin		>0.15 mM

D. **REAGENTS/SUPPLIES:**
1. RAPIDPoint® 405/500 Systems Measurement Cartridge
2. RAPIDPoint® 405/500 Systems Wash/Waste Cartridge
3. RAPIDSystems™ AutomaticQC Cartridge
4. Syringe/ Capillary Tube

E. **CALIBRATION:**
1. The system performs calibrations automatically at prescribed intervals and with each sample if necessary.
2. The system automatically calibrates the sensors as follows:

a. One-point calibrations are scheduled to occur regularly at 30-minute intervals between calibrations.
b. Every fourth scheduled calibration is a two-point calibration.

3. No operator action is required for calibration. If necessary, the system can defer a calibration to analyze a sample. In this case the message informing staff that the system is busy contains a STAT button that lets staff interrupt the calibration. However, if the maximum time between automatic calibrations has elapsed, the system must complete the calibration before allowing sample analysis.
4. During calibration, if the system detects a problem for a parameter, the system repeats the calibration for as many as two times. The Additional Cal Required message appears on the printed report and in the events log. If the calibrations are not successful, the system turns the parameter off. Staff can continue to obtain results for the other parameters. However, staff must wait for the parameter to pass the next calibration to obtain results for the parameter the system turned off.
5. The system performs additional calibrations during sample analysis for the first four hours after staff installs a new measurement cartridge. These calibrations ensure that the cartridge is ready for sample analysis. When these additional calibrations are required, sample results do not update during analysis, analysis time is prolonged due to additional calibration.

F. **QUALITY CONTROL:**

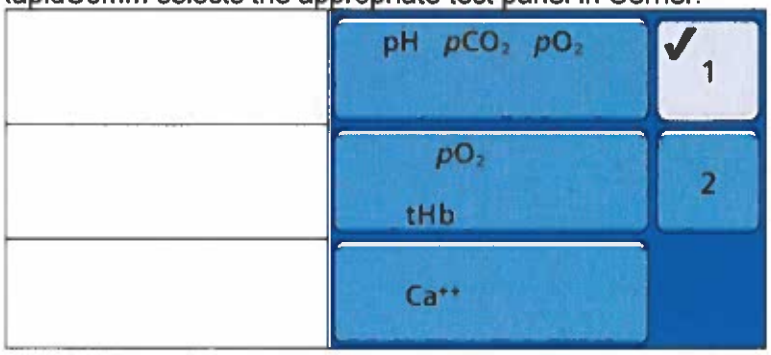
1. The Automatic QC (AQC) analysis option performs quality control analysis at the scheduled time and for the scheduled level. The cartridge contains all the levels of QC material needed to monitor system performance without operator intervention.
2. During AQC analysis, the system compares the results to the ranges for each parameter and identifies any results that are out of range. Any parameters that fail QC are turned off. The system repeats QC analysis if the first attempt fails and turns on any failed parameters that pass. Any parameters that fail the second QC analysis are turned off.
3. The system allows staff to analyze a sample from the AQC cartridge in addition to the scheduled AQC. When staff analyze an AQC sample, the results can affect parameter status. The system turns failed parameters on that pass QC analysis for the failed level and turns parameters off that do not pass QC analysis.
4. The system automatically sends the QC results to the RapidComm data management system. This is to be reviewed periodically by approved Laboratory personnel.
5. Staff can interrupt AQC between levels if an urgent patient sample needs to be analyzed. Touch STAT on the AQC Results screen to delay analysis of the next level of QC material. When the system is ready, analyze the patient sample. The system analyzes any remaining levels of QC after staff finish.

G. **PROCEDURE:**

1. Analyzing Patient Samples:
   a. Roll the syringe or the capillary tube between palms and gently invert it several times to mix the sample thoroughly.
   b. Touch the button for the patient SAMPLE TYPE. A checkmark indicates the button is selected. (Default is arterial syringe).

i.	Arterial (syringe)	
ii.	Capillary (175 microliters Cap tube)	
iii.	Venous (syringe)	
iv.	Mixed venous blood (this will only do a pO2)	

c. Touch (select) the panel of choice to perform testing. This is important so that RapidComm selects the appropriate test panel in Cerner.



d. Introduce the sample device into the sample port and touch the START button. The system aspirates the sample.
   i. Arterial or Venous: Place the syringe into the sample port.
   ii. Capillary: Insert the Capillary tube into the sample port until it clicks into place.

e. When prompted, remove the sample device from the sample port and touch the CONTINUE button.

f. When prompted, enter the following demographic information.
   i. Touch the Patient ID field and key in the patient's FIN number (**performed in ~~performed in ICU, ED, NICU, PACU and OR~~Departments outside the lab**) or the patient's accession number (performed in **the** Lab).
   ii. Touch the Patient Name field and key in the patient Last Name.
   iii. Touch the Temperature field and key in the patient's temperature

g. Touch the CONTINUE button.

h. View the results.

i. Touch the CONTINUE button when finished viewing results. The instrument will wash and prepare for the next sampling.

2. Recalling Patient Results: Use this procedure to view and print results for patient samples that have already been analyzed.

a. Touch the Recall button. The recall button is the "File Folder" icon located in the upper right ~~hand~~ corner of the screen.
   i. Touch Patients. The list of patient samples appears.
   ii. Touch the desired sample to view.
   iii. Use the arrow keys to view additional samples. Select the sample.
   iv. Touch the Results button to view the results.
      1) Edit sample demographics by pressing the Edit button (for example, to change the temperature). If changed this will not be corrected in Cerner.

The results have already been filed. To correct this in the computer, notify the laboratory.

2) To reprint results, touch the Print icon.

v. Staff may search for a sample by patient by pressing the Search button.

1) Enter in the Accession or FIN number and touch the CONTINUE button.

3. Result Symbols:

↑	The result is above the patient range.
↓	The result is below the patient range.
-----↑	The result is above the reporting range. Send to Laboratory for analysis.
-----↓	The result is below the reporting range. Send to Laboratory for analysis.
-----?	The system has an atypical response when measuring this parameter and cannot report the result. Analyze the sample again. When this symbol appears for the HCT, it may indicate that the HCT result was not reported because Na failed Required QC or it was not performed
u	The HCT was not corrected for Na or K because the sensor is out of calibration, turned off, or beyond the reporting range. The system uses a default value of 140 mmol/L for Na or a value of 4 mmol/L for K to determine the HCT result.

H. **PROCEDURE NOTES:**

1. Status of Parameter Buttons:

✓pH	Parameters with checkmarks are selected (Touch to deselect test)
pH	This parameter is available but not selected.
~~pH~~	This parameter is not available because the sensor is out of calibration.
~~pH~~	This parameter is not available because the sensor is out of calibration and is unlikely to become available with further calibrations.
	YELLOW BUTTON: not available because the sensor has failed QC.
	PURPLE BUTTON: not available because Required QC was not performed.

2. Send specimen to the laboratory if staff has any questions concerning the operation or results of the RAPIDPoint ® 500.
3. Troubleshooting
   a. The system messages can appear as follows:
      i. Messages can appear in a message box over the Analysis screen or over the Status screen.
      ii. Messages can appear in the events log at the Status screen or in the events log that staff access from the Recall menu. For example, after staff replaces a depleted wash/waste cartridge, the message about the cartridge no longer appears at the Status screen but remains in the events log that staff access from the Recall menu.
      iii. Refer to the Troubleshooting Section of the Siemens RAPIDPoint ® 500 Operator's Guide for the list of system diagnostic messages, its probable cause

and corresponding corrective action to be performed. If further help is required, call POC Coordinator or the lab.

4. Maintenance
   a. Cleaning and Disinfecting the Screen: Clean the touch screen as needed to remove dust, dirt, or splatters from the screen and disinfect the screen surface.
      i. Materials:
         1) Hospital-approved disinfectant wipe
         2) Lint-free cloth
      ii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
      iii. Touch the Status button and then touch Clean Screen. The Clean screen appears for 20 seconds. This allows staff to wipe the screen without activating any buttons. While the Clean Screen is displayed, wipe the screen with the wet wipe and then thoroughly dry the screen with the lint-free cloth to remove chemicals that may damage the screen.
      iv. Touch the Continue button to return to the Analysis screen.
   b. Cleaning and Disinfecting the Exterior Surfaces: Clean the exterior surfaces as needed to remove dust, dirt, and splatter from the surfaces, and disinfect the surfaces.
      i. Materials:
         1) Bleach disinfectant wipe
         ~~2) Alcohol Pad~~
      ii. Caution: Do not wet the sample port or the sensor contacts for the measurement and Automatic QC cartridges. When cleaning surfaces do not spray cleaning solution or other fluids into or on the sample port or the area behind the cartridges. The sensor contacts, which are located behind the cartridges, may be damaged if they get wet. Sensors inside the cartridge may be damaged if cleaning solution enters the sample port.
      iii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
      iv. To disinfect the exterior surfaces: wipe, let remain wet for two minutes, then dry with a lint-free cloth.
   c. Replacing the Printer Paper: Replace the printer paper when a pink stripe appears on the edge of the paper.
      i. Material:
         1) Printer paper
      ii. Grasp the latch on top of the touch screen and move the screen forward to expose the printer compartment.
      iii. Remove the old roll of paper:
         1) Open the printer compartment.
         2) If paper remains in the printer, tear off the paper below the printer. Caution: Do not pull the torn paper back through the printer. This can damage the printing mechanism.
         3) Turn the paper-advance knob clockwise to move the torn paper through the printer.
         4) Remove the old roll of paper.
         5) Save the spindle for use with the new roll of paper.
      iv. Install a new roll of paper:
         1) Note: When advancing the paper, watch the paper move through the printer to ensure that it exits the printer correctly.
         2) Get a new roll of paper and remove the outer wrapper.
         3) Insert the spindle through the roll of paper and place the paper in the printer compartment. Ensure that the paper is tightly wound and the ends of the spindle fit into the grooves on the sides of the compartment.
         4) Insert the paper from the bottom of the roll through the back of the printer. The system advances the paper automatically if the previous roll of paper was empty.

5) Turn the paper-advance knob clockwise to move 2-3 inches of paper through the top of the printer.
6) Note: When closing the printer compartment, ensure that the edge of the printer paper extends beyond the top of the printer.
7) Close the printer compartment.
8) Note: The first report printed after installing a new roll of paper does not have the Rapidpoint 500 name printed at the top.
9) Adjust the position of the screen for viewing.

d. Replacing the Air Filter
   i. Pull the air filter carrier out of the instrument (located on the bottom back right of the instrument).
   ii. Remove the filter from the carrier.
   iii. Install a new air filter in the carrier.
   iv. Reinstall the air filter carrier in the instrument.

~~G. **DOWNTIME**: N/A~~

~~H.~~**G. CALCULATIONS:**

1. The RAPIDPoint ® 500 analyzer contains a microprocessor that performs all calculations required for reporting results.

I. **AMR, CRR, REFERENCE RANGES, AND CRITICAL VALUES:**

1. Refer to Patient Care Services POC Quick Reference for AMR and Reference Ranges
2. Refer to Critical Tests and Critical Results Quick Reference Guide for Critical Results

J. **REPORTING OF RESULTS:**

1. Results coming from OR and PACU are automatically posted to Cerner thru RapidComm
2. Other location requires verification in RapidComm (Refer to RapidComm Instructions procedure)
   a. Open the RapidComm software to enter additional values (i.e. Draw Date & Time, Sample Site, Order Name, PCOM, FiO2/LPM, and Allen's Test).
   b. If there are critical results, results will be displayed in red font and the Notified and Read Back field should be completed with the person receiving the results and credentials (i.e. Jane D, RN or Dr. Doe, MD); the Notified and Confirmed by field should be completed with the operator giving the results and credentials (i.e. J Doe, RCP); and the Notified Time field should be completed.
   c. Once the results are reviewed, select OK for the results to record in Cerner.

K. **TECHNICAL NOTES:**

1. Refer to Appendix F: Principles of System Operation

L. **LIMITATIONS:**

1. Refer to Appendix E: Specifications section of the Siemens RAPIDPoint ® 500 Operator's Guide for the limitation of the system and each analytes.

~~M. **FORM(S)**: N/A~~

~~N.~~**M. RELATED DOCUMENT(S):**

1. ~~Laboratory Point of Care Procedure:~~ RapidComm Instructions
2. ~~Laboratory Point of Care:~~ Patient Care Services POC Quick Reference

3. ~~Laboratory General / Quality Assurance:~~ Critical Tests and Critical Results Quick Reference Guide
4. ~~Laboratory Point of Care:~~ Siemens RAPIDPoint ® 500 Operator's Guide

~~O.~~ ~~**EXTERNAL LINK(S):** N/A~~

~~P.~~**N. REFERENCE(S):**

1. Siemens RAPIDPoint® 500 System Operator's Guide 10631336 Rev. C, 2019-10

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTICK ANALYSIS, MANUAL READ PROCEDURE**
Purpose:	To outline nursing responsibilities for testing urine using dipsticks.
Supportive Data:	A Registered Nurse (RN) may perform under the direction, authority, jurisdicti Urine dipstick testing is considered de
Equipment:	Timer Paper Towel

RETIRE - DUE TO THE SUSPENSION OF LABOR AND DELIVERY

A. **POLICY:**

1. Urine dipsticks are inert plastic strips which have attached different reagent papers for measuring urine chemistries. The dipstick provides a rapid, simple method for measuring pH, leukocytes, nitrite, protein, glucose, ketones, urobilinogen, bilirubin, blood, and hemoglobin in urine specimens. Testing is considered definitive for the purposes of care and diagnosis

B. **PROCEDURE:**

1. Verify Quality Control (QC) has been completed within at least 24 hours.
   a. Quality Control: Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of test strips.
   a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well prior to testing
   b. Complete QC and record in log.
2. Collect voided urine in a clean container. A first-morning specimen is preferred, but random collections are acceptable.
   a. Test the urine within two hours (test immediately if testing for bilirubin or urobilinogen). If unable to test within two hours, refrigerate the specimen immediately and bring to room temperature before testing.
   b. Label the sample if the test is not performed at the bedside and in the presence of the patient.
   c. Mix well before testing.
3. Immerse the test strip into the container of urine and remove immediately.
   a. Make sure the reagent pads are totally immersed.
4. Draw the edge of the strip along the rim of the container to remove excess urine.
5. Turn the test strip on its side and tap once on an absorbent paper towel to remove excess urine.
   a. This also prevents the possible mixing of reagent chemicals which can produce reading difficulties.
6. Wait the appropriate time (per manufacturer's recommendation) and read the test. Accurate timing is essential.
   a. Color changes that occur after 2 minutes are of no clinical value.
   b. Match the test strip to the color and record results.
      i. Be sure the strip is properly oriented to the color chart on the test strip container.
      ii. Color changes that occur only along the edges of the pads should be ignored. Careful removal of excess urine will eliminate this effect.
7. Storage:
   a. Store all unused strips in the original bottle.
   b. Store at room temperature.

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c. Do not remove desiccant from bottle.
d. Do not store in direct sunlight.
e. Do not use strips after their expiration date.
f. Once opened, strips are good until the expiration date listed on the bottle or six months after the open date, whichever is sooner.

B. **REFERENCE RANGES:**

Test:	Glucose	Bilirubin	Ketones	Specific Gravity	Blood	pH	Protein	Urobilinogen	Nitrite	Leukocytes
Normal:	Neg	Neg	Neg	1.010–1.035	Neg	4.6-8.0	Neg	Neg	Neg	Neg

C. **LIMITATIONS:**
1. Protein: A visibly bloody urine may cause elevated results.
2. Blood: Capoten (captopril) may reduce sensitivity. Certain oxidizing contaminates, such as hypochlorite, may produce false positive results. Microbal peroxidase associated with urinary tract infection (UTI) may cause false positive reaction.
3. Leukocytes: Elevated glucose, (greater than or equal to [≥] 3g/dL), may cause decreased test results. The presence of cephalexin, cephalothin, or high concentration of oxalic acid may cause decreased test results. Tetracycline may cause decreased reactivity and high levels of the drug may cause a false negative reaction. Positive results may occasionally be due to contamination of specimen by vaginal discharge.
4. Nitrite: Pink spots or pink edges should not be interpreted as a positive result. A negative result does not rule out significant bacteriuria. False negative results may occur with shortened bladder incubation of the urine, absence of dietary nitrate, or the presence of nonreductive pathological microbes.
5. Glucose: Ketone bodies reduce the sensitivity of the test; a moderately high ketone levels (40mg/dL) may cause false negatives for specimens containing a small amount of glucose (75-125mg/dL) but the combination of such ketone levels and low glucose levels is metabolically improbable in screening.
6. Ketones: False trace results may occur with highly pigmented urine specimens or those containing large amounts of levodopa metabolites. Compounds such as mesna that contain sulfhydryl groups may cause false positive or an atypical color reaction.
7. pH: Bacterial growth by certain organisms may cause a marked alkaline shift (pH >8), usually because of the urea conversion to ammonia.
8. Specific Gravity: Highly buffered alkaline urines may cause low readings, while the presence of moderate quantities of protein (100-750 mg/dL) may cause elevated readings.
9. Bilirubin: Atypical colors (colors that are unlike the negative or positive color blocks shown on the color chart) may indicate that bilirubin-derived bile pigments are present in the urine sample and may be masking the bilirubin reaction. These colors may indicate bile pigment abnormalities and the urine specimen should be tested further (send to lab).
10. Urobilogen: Atypical color reactions may be obtained in the presence of high concentration of p-amino benzoic acid. False negative results may be obtained if formalin is present. Strip reactivity increases with temperature.

D. **DOCUMENTATION:**
1. Document the results in electronic health record.
2. Document QC results on the Point of Care Quality Control Log - Urine Dipstick Manual Read

E. **RELATED DOCUMENT(S):**
1. Point of Care Quality Control Log - Urine Dipstick Manual Read

F. **REFERENCE(S):**
1. Siemens Healthcare Multistix 10 SG Package Insert. TN30516A. 06/2010.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTICK ANALYSIS USING SIEMENS CLINITEK STATUS + CONNECT**
~~Purpose:~~	~~To provide an accurate and reliable method for reading urine dipstick results. Test results may provide information regard~~ **RETIRE - DUE TO THE SUSPENSION OF LABOR AND DELIVERY** ~~kidney and liver function, acid-base ba~~
~~Supportive Data:~~	~~A Registered Nurse (RN) may perform~~ ~~authority, jurisdiction, and responsibility of the Laboratory Director.~~

~~A. **PRINCIPLE:**~~

~~1. The Clinitek Status analyzer is for in vitro diagnostic use in the semi-quantitative detection of bilirubin, blood (occult), glucose, ketone (acetoacetic acid), leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen in urine samples.~~

~~a. The Clinitek Status+ Analyzer provides more regulatory control than the previous Clinitek Status model, including connectivity options and Quality Control (QC) lockout functions.~~

~~B. **SPECIMEN:**~~

~~1. First morning void specimen is preferred. If not available, use a specimen that has incubated in the bladder for at least 4 hours. A random void specimen is acceptable, but may not register positive nitrite results.~~

~~2. Collect in a clean dry container.~~

~~3. Label with patient identification.~~

~~4. Test within one hour of collection or refrigerate for up to 24 hours and bring to room temperature before testing. (Bilirubin and urobilinogen decrease with time).~~

~~C. **REAGENTS/ SUPPLIES:**~~

~~1. Siemens Multistix® 10 SG Reagent strips for urinalysis~~

~~a. Storage: 15 – 30°C (59 – 86°F)~~

~~b. Keep away from sunlight~~

~~2. Quality Controls (2 levels)~~

~~a. Storage:~~

~~i. Unopened bottle: 2 – 8°C stable until expiration~~

~~ii. Opened bottle: 20 – 25°C stable for 30 days~~

~~D. **QUALITY CONTROL:**~~

~~1. Quality Control: Two levels of Quality Control (QC) must be tested under the following conditions:~~

~~a. Daily before performing patient tests~~

~~b. Opening a new vial of test strips~~

~~c. Training of new users~~

~~2. QC Procedure:~~

~~a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well.~~

~~b. If QC needs to be performed, the "Strip Test" button will not be available, and the QC button will say "QC Test Due".~~

~~c. Select the QC button.~~

~~d. Select "QC Strip Test"~~

~~e. Operator: Select "Enter New Operator Name". Enter operator 'name' by~~

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i. Scanning badge barcode or
ii. Toggle to numeric and type numeric – Employee ID

f. Control: Select "Enter Lot and Expiration Date".
i. Scan the barcode for the QC lot number.
ii. Adjust the year and month of the expiration date.

g. Strip: Select "Enter new lot and expiration date".
i. Scan the barcode assigned to the vial of strips in use.
ii. Adjust the year and month of the expiration date.

h. Prepare Test:
i. Mix the QC Vial well. Press "Start". You have 8 seconds to complete the following steps:
1) Wet each pad of the strip with control material.
2) Tap the edge of the strip onto a paper towel to remove excess liquid.
3) Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
4) At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read. The instrument will compare the results obtained with pre-programmed expected results and determine a PASS or FAIL.
5) Dispose of the strip and wipe clean the test strip holder.
6) Repeat any levels of Failed QC as necessary.
7) Verify reagent strips and QC has been stored properly and are not expired.
8) Re-mix sample well.
9) Clean the test-table insert.
10) Refer to additional troubleshooting steps at the end of this procedure.
11) Contact the lab for support.

i. QC results are automatically log into the middleware.

E. **PROCEDURE FOR PATIENT TEST**:

1. Select "Strip Test"
2. Operator: Select "Enter New Operator Name". Enter operator 'name' by
a. Scanning badge barcode or
b. Toggle to numeric and type numeric- Employee ID
3. Patient Information: Select "Enter New Patient"
a. Enter the Patient's Last Name
b. Enter the Patient's ID
4. Strip: Select "Enter new lot and expiration date".
a. If available, select "use last lot" OR
b. Scan the barcode assigned to the vial of strips in use.
c. Adjust the year and month of the expiration date.
5. Prepare Test:
a. Mix the sample well. Press "Start". You have 8 seconds to complete the following steps:
b. Fully immerse the dipstick into the urine. Tilt slightly to the side ensuring all strip pads are wet. Slowly pull the strip out, dragging the edge of the strip along the rim of the vial to catch excess liquid.
c. Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
d. At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read.
e. The analyzer automatically performs a calibration each time a strip is read. Do not push or pull the test table or bump the instrument while it is calibrating.)

f. While the strip is reading, select the color and clarity of the urine.
g. Dispose of the strip and wipe clean the test strip holder.

6. Recall Results:
   a. From the main Select screen, touch the Recall Results button.
   b. Select to review Patient or Quality Control tests.
   c. Test results are listed chronologically, with the most recent being at the top. Use the up and down arrows to scroll and highlight the result you would like to recall. Touch Select to view.
   d. You may print. Touch done when finished.

F. **REFERENCE RANGES AND CRITICAL VALUES:**

1. Critical Values
   a. Glucose greater than or equal to 1000 mg/dL shall be reported to patient's licensed health care provider (RN or MD)
2. Reference Ranges
   a. Refer to Patient Care Services POC Quick Reference

G. **LIMITATIONS:**

1. Interfering substances may cause false positive or false negative results.
   a. Refer to Urine Dipstick Analysis Using Siemens Clinitek Status Procedure - Substances Conditions Affecting Test Results.

H. **METER MAINTENANCE AND CLEANING**:

1. The test table is to be kept clean if the analyzer is to operate properly.
2. Nursing shall be responsible for the daily cleaning of the test table insert and weekly cleaning of the meter.
   a. To clean the Test Table Insert:
      i. Remove the insert and thoroughly clean with a hospital approved disinfectant.
      ii. Rinse both sides under running water
      iii. Dry and replace insert
   b. To clean the Meter:
      i. Turn analyzer off
      ii. Wipe the outside with a damp (not wet) cloth and mild detergent
         1) May use a hospital approved disinfectant after wringing out excess liquid
         2) Avoid liquid from enter the printer compartment and under touch display
3. Lab shall perform other cleaning and maintenance to include cleaning of test table and white calibration bar monthly.
   a. To clean the Calibration Bar:
      i. Remove the insert from the test table.
      ii. Remove the test table by pulling it slowly out of the analyzer.
      iii. Drain the drip tray, if necessary.
      iv. Examine the white calibration bar on the test table for dirt or discoloration under good lighting. If it appears dirty or discolored, wet a cotton-tipped stick or lint free cloth with distilled water and gently wipe and clean the calibration bar.
      v. Do not scratch, touch or mark the Calibration bar.
      vi. Allow the calibration bar to air dry.
      vii. Insert the test table and table insert back.
4. Troubleshooting
   a. If the movement of the test table is irregular or slow, this may be due to:
      i. Heavy buildup of dried urine on the test table—clean the test table
      ii. Low battery power—replace the batteries or use the power supply.
   b. Refer to Siemens Clinitek Status®+Operators Guide for other troubleshooting procedures.

5. Complete the Point of Care Quality Control Log – Urine Clinitek.

I. **FORM(S):**

1. Point of Care Quality Control Log – Urine Clinitek

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

1. Urine Dipstick Analysis Using Siemens Clinitek Status Procedure - Substances/Conditions Affecting Test Results
2. Siemens Clinitek Status®+Operators Guide

K. **REFERENCE(S):**

1. Siemens Healthcare Multistix® 10SG Reagent Strips Package Insert. 11306391 Rev. A 07-2017
2. Siemens Clinitek Status®+Operators Guide 10490853 Rev. C, 2011-12

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTIK USING MCKESSON CONSULT 120 URINE ANALYZER**
Purpose:	To provide an accurate and reliable method for reading urine dipstick results. Test results may provide information regarding the status of liver function, acid-base balance, and urinary tract infection.
Supportive Data:	Mckesson Consult 120 Urine Analyzer is a CLIA waived test
Equipment/ Supplies:	Mckesson Consult 120 Urine Analyzer Mckesson Urine Reagent Strips 2 levels of Quality Control

RETIRE - DUE TO THE SUSPENSION OF LABOR AND DELIVERY

A. **PRINCIPLE:**

1. The McKesson Consult® 120 Urine Analyzer is intended for use in conjunction with the McKesson Consult® Urinalysis Reagent Strips for the semi-quantitative detection of the following analytes in urine: Glucose, Bilirubin, Ketone (Acetoacetic acid), Specific Gravity, pH, Blood, Protein, Urobilinogen, Leukocytes, Ascorbic Acid, as well as the qualitative detection of Nitrite. The instrument is intended for professional, in vitro diagnostic use only. The measurement can be used in general evaluation of health, and aids in the diagnosis and monitoring of metabolic or systemic diseases that affect kidney function, endocrine disorders and diseases or disorders of the urinary tract.

B. **SPECIMEN:**

1. A urine specimen must be collected in a clean and dry container and tested as soon as possible. Do not centrifuge. The use of urine preservatives is not recommended. If testing cannot be done within an hour after voiding, refrigerate the specimen immediately and let it return to room temperature before testing.
2. Prolonged storage of unpreserved urine at room temperature may result in microbial proliferation with resultant changes in pH. A shift to alkaline pH may cause false positive results with the protein test area.
3. Urine containing glucose may decrease in pH as organisms metabolize the glucose.
4. Contamination of the urine specimen with skin cleansers containing chlorhexidine may affect protein (and to a lesser extent, specific gravity and bilirubin) test results.

C. **REAGENTS / SUPPLIES:**

1. McKesson Consult® 120 Urine Analyzer – operating temperature is 0-40ºC (32-104ºF)
2. McKesson Consult® Urinalysis Reagent Strips should be stored at Room Temp or Refrigerated (2-30°C or 36-86°F)
   a. Unopened bottles: stable until expiration on the bottle
   b. Opened bottles: stable for 3 months

2. Consult® Diagnostics Liquid Urine Control – stored @ 2-8°C (36-46°F)
   a. Unopened bottles: stable until expiration on the bottle
   b. Opened bottles: stable for 30 days

B. **CALIBRATION:**

1. An automatic calibration is done before each test.

C. **QUALITY CONTROL:**

1. Performance of reagent strips should be confirmed by running 2 levels of controls in the following conditions:
   a. Run control on each day of use before performing patient tests

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b. Run control on new lot and/or new shipment of reagent strips
c. Run control when you open a new bottle of reagent strips
d. Run control to ensure reagent storage integrity; train new users; confirm test performance; and when patients' clinical conditions or symptoms do not match the results obtained on the test strips

2. If the QC tests do not provide expected results, perform the following checks:
a. Ensure the strips used are not past their expiration date.
b. Ensure strips are fresh from a new canister.
c. Ensure the controls are not past their expiration date.
d. Repeat the test to ensure no errors were made during the test.

D. **PROCEDURE**:

1. Quality Control:
a. Ensure the operating Mode is set to QC. All test numbers in QC mode will begin with 2. This allows results to be searched for and found easily.
b. Allow the strip and urine controls to reach room temperature at 15-30ºC (59-86ºF) prior to testing.
c. The urine control test procedures are the same as Normal Operation. Refer to the procedure below.

2. Patient Test:
a. Allow the strip, urine specimen, and/or controls to reach room temperature at 15-30ºC (59-86ºF) prior to testing.
b. Remove the strips from the closed canister. Use them as soon as possible. Tightly close the canister after removing the strips.
c. Press START for the strip prompt. Wait for the audible triple beep to immerse the strip.
d. The countdown clock is displayed on the bottom right. The clock will start to count down from 65. The operator has 3 seconds before the triple beep sounds to immerse the strip into the urine.
e. Upon hearing the triple beep and/or seeing the countdown clock reach 62, completely immerse the reagent areas of the strip in fresh, well-mixed urine. Immediately remove the strip to avoid dissolving the reagents.
f. Run the edge of the strip against the rim of the urine specimen container to remove excess urine. Hold the strip in a horizontal position. Bring the edge of the strip into contact with an absorbent material (e.g. a paper towel). This prevents mixing chemicals from adjacent reagent areas.
g. Place the strip with the reagent area facing up, onto the Strip Holder Channel. Make sure the strip end touches the Strip Holder Backstop.
h. When the countdown clock on the display reaches 1, the Strip Holder will carry the strip inside and begin testing.
i. The results will be displayed on the screen and stored in memory after each test. Any abnormal results will be highlighted on the screen and flagged on the print out.
j. If Auto-print is set to on the results will be printed. If Auto-print is set to off, press Print to print the results.
k. Remove the used strip from the Strip Holder when the strip carrier moves out. Discard the used strip

E. **MAINTENANCE**:

1. Refer to the Maintenance Section of the Mckesson Consult® 120 Operators Manual for cleaning and disinfecting of the analyzer and strip holder.

F. **TROUBLESHOOTING**:

1. Refer to the Troubleshooting section of Mckesson Consult® 120 Operators Manual for possible problem and corresponding solutions.

G. **AMR, CRR, REFERENCE RANGES, AND CRITICAL VALUES**:
The following are the reference ranges for qualitative urinalysis:

1. Specific Gravity: 1.016 - 1.022 (normal fluid intake)
2. pH: 5.0 – 8.0.
3. Protein: Negative
4. Glucose: Negative
5. Ketone: Negative (NOTE: Detectable levels of ketones can be found in the urine during physiological stress such as exercise and dieting)
6. Bilirubin: Negative
7. Blood: Negative
8. Leukocyte Esterase: Negative
9. Nitrite: Negative
10. Urobilinogen: <2.0 mg/dL

H. **REPORTING RESULTS:**

1. Results are recorded on the electronic medical record of the clinic

I. **TECHNICAL NOTES:**

1. Refer to the Mckesson Consult 120 Operators Manual for Performance Characteristics of Urinalysis Reagent Strips

J. **LIMITATIONS:**

1. Refer to Limitations section and Interference Studies of the Consult Diagnostics 10SG Urine Reagent Strips Package Insert

K. **FORMS:**

1. Point of Care Quality Control Log – Urine Consult

L. **RELATED DOCUMENTS: N/A**

M. **EXTERNAL LINKS:**

1. Mckesson Consult® 120 Urine Analyzer Operators Manual https://imgcdn.mckesson.com/CumulusWeb/Click_and_learn/121-120_manual_2016-03.pdf
2. Consult Diagnostics 10SG Urine Reagent Strips Package Inserts: https://imgcdn.mckesson.com/CumulusWeb/Click_and_learn/liquid_urine_control_insert_2017-05.pdf
3. Consult Diagnostics Liquid Controls: https://imgcdn.mckesson.com/CumulusWeb/Click_and_learn/IFU_163-89116_2017-05.pdf

N. **REFERENCES:**

1. Mckesson Consult® 120 Urine Analyzer Operators Manual
2. Mckesson Consult Diagnostics 10SG Urine Reagent Strips Package Inserts. Rev. 00 03/15
3. Mckesson Consult Diagnostics Premium Liquid Controls Package Inserts Rev. 2 5/17

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**WHOLE BLOOD PT/INR USING THE ROCHE COAGUCHEK XS PLUS METER**
~~Purpose:~~	~~To provide an accurate and reliable m~~ ~~in the point of care setting.~~
~~Supportive Data:~~	~~Point of Care~~ ~~The CoaguChek XS Plus is a CLIA w~~ ~~Roche Technical Support: 1-800-428-4674. www.coaguchek.com~~
~~Equipment:~~	~~CoaguChek XS Plus meter~~ ~~CoaguChek XS PT test strips~~ ~~CoaguChek XS PT test strip code chip (from same box as test strip)~~ ~~CoaguChek XS Plus Liquid Controls~~ ~~CoaguChek XS Plus Liquid Control code chip~~ ~~Lancet (at least 1.8mm depth)~~ ~~Alcohol wipe or soap and water~~ ~~Gauze or tissue~~ ~~Bandages~~
~~Authorized to Perform:~~	~~Registered Nurse (RN), License Vocational Nurse (LVN), Medical Assistant (MA)~~

RETIRE - DUE TO THE SUSPENSION OF LABOR AND DELIVERY

A. ~~**INTRODUCTION/PRINCIPLE:**~~

1. ~~Prothrombin Time (PT) is a test of the blood's ability to clot. Blood clots form in response to vessel injury to prevent excessive loss of blood. If blood clots form inappropriately and lodge in the vascular system of important organs, serious consequences such as stroke can result. In certain medical conditions (i.e. atrial fibrillation or mechanical heart valves) blood clots are more likely to form, and there is increased risk of stroke. Oral anticoagulants are used to prevent clots in these conditions.~~
2. ~~Oral anticoagulants have a narrow therapeutic range and the response to a standard dose varies widely both between patients and within a patient over time. Patients undergoing oral anticoagulant therapy must have their level of anticoagulation monitored often. Dosage adjustments should be made as needed to ensure maximum safety and efficacy.~~
3. ~~The PT test is the principle assay used to monitor oral anticoagulant therapy. The dosage of oral anticoagulant is adjusted based on the PT test results to recommended therapeutic ranges. The PT can be reported in seconds or as an International Normalized Ratio (INR). The INR is a mathematical conversion that compensates for differences between PT methods.~~
4. ~~The CoaguChek XS Plus test strip and meter will provide an electrochemical measurement of Prothrombin time following activation of blood coagulation with human recombinant thromboplastin. In simple terms, blood works with the chemicals in the test strip to make a small electric current in the test strip that measures blood clotting time.~~

B. ~~**SPECIMEN:**~~

1. ~~Requirements:~~
   a. ~~Fresh capillary whole blood or fresh venous whole blood drawn in an anticoagulant-free plastic syringe.~~
   b. ~~The blood sample must be applied to the test strip within 10 minutes of removing the strip from its container.~~
   c. ~~Capillary sample must be applied to the strip within 15 seconds of the fingerstick.~~
   d. ~~Minimum sample size is 10 uL of blood.~~
2. ~~Criteria for rejecting specimens:~~
   a. ~~Plasma or serum cannot be used.~~
   b. ~~Sample size cannot be less than 10 uL.~~
   c. ~~Additional blood sample must not be added to the test strip once testing has begun.~~

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05/13, 11/17, 05/20, 07/22, **10/24**	06/13, 12/17, 06/20, 08/22, **02/25**	06/13, 01/18, 07/20, 09/22, **03/25**	04/18, 09/20, 09/22, **05/25**	n/a	07/13, 04/18, 09/20, 10/22, **05/25**	10/20, 12/22, **06/25**	08/13, 05/18, n/a	08/13, 05/18, 11/20, 12/22

d. Meter will beep to indicate that sufficient flood has been applied and that testing has begun.
e. Venous sample cannot be collected in a syringe containing anticoagulant, or into a glass tube or syringe.
f. Sample must be used immediately after collection.
g. Do not collect from an arm receiving an infusion line for intravenous (IV) therapy.

3. Collecting a Fingerstick Sample:
   a. Prepare lancet device according to manufacturer's instructions. Set it aside until finger puncture is needed.
   b. Warm the hand by having the patient hold it under their arm, using a hand warmer, or washing with warm water.
   c. If possible, have the patient hold his or her arm down to the side, so the hand is below the waist, for about 30 seconds to increase blood flow.
   d. Massage the finger from its base.
   e. Clean the selected finger with alcohol wipe or use soap and warm water. Allow to air dry completely.
   f. Prepare the meter.
   g. When the meter displays the flashing test strip and blood drop symbols, with the hand still down, stick the side of the finger with a lancet. Do not wipe away the first drop of blood. Do not puncture the finger until the flashing test strip and blood drop symbol appears on the meter screen.
   h. Gently squeeze and release the finger from the base to develop a hanging drop of blood.
   i. Blood should be applied within 15 seconds of the puncture. Do not touch the strip with the finger. Do not apply a second drop or disturb the strip while testing.
   j. While the flashing test strip and drop of blood symbols are flashing on the display, apply the first drop of blood as outlined in Performing a Test Procedure.

C. **STORAGE AND STABILITY:**
1. Store test strips in their container, with the cap closed.
2. Store test strips at room temperature or in the refrigerator (2-30 °C or 36-86 °F).
3. When stored properly, the test strips can be used until the expiration date printed on the test strip container.
4. Store test strips in a cooler with an ice pack when transporting in a car.
5. Dispose of strips past their "use by" date.
6. Use the test strip within 10 minutes after removing it from the container.
7. Do not open a vial of test strips or touch a test strip with wet hands or gloves. This may damage the test strips.
8. Close the container tightly.
9. A blue color on the back of the test strip indicated storage conditions have been maintained. A lavender or purple color indicates that storage conditions have been exceeded. Do not use and dispose of any test strips with a lavender or purple color on the back.

D. **OPERATING CONDITIONS**
1. Temperature: Use between 59°F and 90°F (15°C and 32°C). Relative Humidity: Use between 10-85%.
2. Use only fingertips on touchscreen.
3. Place on level, vibration-free surface while testing.
4. Do not use near strong magnetic fields.

E. **METER SET-UP (CHANGES FROM DEFAULT SETTINGS)**
1. Lockouts > QC > New Code > YES

F. **QUALITY CONTROL:**
1. The CoaguChek XS System has quality control functions integrated into the meter and test

strips; two levels of QC are automatically run with every patient test. If the QC results are acceptable, the patient results will display.

2. Liquid controls must be performed on each new shipment and lot of test strips. Record results on the Quality Control Log.

G. **PROCEDURE:**

1. Before Testing:
   a. A code chip is required for each lot of test strips. The XS Plus meter will store data from 60 code chips.
   b. Leave the code chip in the meter to protect the electrical contacts.
   c. Inserting the Code Chip:
      i. Be certain the meter is Off.
      ii. Remove the old code chip and throw it away.
      iii. Make sure the 3-number code on the new test strip container matches the 3-number code on the new code chip.
      iv. Insert the code chip into the code chip slot on the meter with the printed side facing up it snaps into place.
2. Performing a test:
   a. Use hand hygiene.
   b. Prepare the lancet device according to manufacturer's instructions.
   c. Place meter on a flat surface, free of vibrations, or hold it so it is roughly horizontal.
   d. Turn the meter on using the power button.
   e. The main menu will be displayed. Check the battery level (if there are no bars left in the battery symbol, it is not possible to perform any more tests). Check that the date and time are correct.
   f. Select 'Patient Test'.
   g. Enter the patient ID, then press OK. Select the patient from the list, or select 'New Patient' and enter a patient ID.
   h. The test strip symbol prompts staff to enter a test strip. Remove a test strip from the container and close the container tightly. Hold the strip so the print is facing upward. Slide the strip into the test strip guide in the direction indicated by the arrows. Slide it in as far as it will go. A beep tone indicates the meter has detected the strip.
      i. If this is a new lot of test strip, it is necessary to run liquid QC first. Refer to Performing Liquid Quality Control procedure.
   i. An hourglass symbol shows that the meter is warming (approximately 30 seconds).
   j. When the meter is ready, the flashing test strip and blood drop symbols appear. The meter begins a countdown, staff have 120 seconds to apply blood to the test strip. Do not obtain sample until the flashing test strip and drop of blood appear on the display. Strip must be used within 10 minutes of removing it from the container.
   k. Identify the sample target area on the test strip.
   l. Collect the fingerstick blood sample as outlined in "Specimen":
   m. Do not wipe away the first drop of blood.
   n. Apply the first drop of blood to the top or side of the target area within 15 seconds of puncture. Do not touch the strip with the finger.
      i. Note: dose the target area by bringing the patient's finger to the top of the test strip, or keeping the meter level, by bringing the meter to the patient's finger so that the side of the test strip touches the blood drop. Do not apply a second drop. Do not touch strip while a test is in progress.
      ii. Be certain that blood covers the sample target area completely.
      iii. The meter beeps when it detects the drop. The flashing blood drop symbol disappears. Do not add more sample. Do not touch the test strip or move the meter until the result is displayed.
   o. Wait for results—this takes about one minute.
   p. If retest is necessary, use a new fingerstick from the opposite hand and a new test strip.

q. Read and record results. Remove the test strip.
r. Turn the meter Off.
s. Dispose of materials in biohazard or sharps container.

3. Performing Liquid Quality Control:
   a. Remove control vials from the fridge.
   b. Open the lid of the control bottle and remove the rubber cap.
   c. Hold the dropper with the sealed dropper neck pointing upward, then cut off the end of the cap with scissors. Ensure dropper is away from face to prevent contamination. Do not squeeze the bulb of the dropper while cutting the tip.
   d. Apply gentle pressure to the reservoir to transfer the entire contents of the dropper to the bottle. Make sure the dropper does not come in contact with the dried control plasma.
   e. Close the bottle. Keep the dropper at hand.
   f. Swirl the bottle using a circular motion to completely dissolve all the control plasma inside. Do not shake the bottle or turn it on its side. The solution is not ready to be applied to the test strip. (Controls may be used up to 30 minutes after reconstitution.)
   g. Turn the meter on. Check the battery level, date, and time.
   h. Select QC Test.
   i. Remove a test strip from the container, close the container, and insert the test strip into the meter.
      i. If using a new test strip lot and have not inserted the test strip code chip, do so now.
      ii. If using a new control lot, insert the code chip that came with the control solution.
   j. Select the code already stored for control or select New Code to use a new control solution.
   k. Select the level for this measurement.
   l. The hourglass will appear while the strip is warming.
   m. When the strip and dropper symbol display, apply the sample. Staff has120 seconds to complete this step.
      i. Using the dropper, draw up the dissolved contents of the vial.
      ii. Apply a single drop of solution to the test strip. Enough sample is applied when the meter beeps.
   n. The result will be displayed and saved to memory.
   o. If liquid QC test fails, an arrow will be displayed and flash. Repeat first with the same control and a new test strip. If the control still fails, repeat with a new vial of control. If control continues to fail, contact the laboratory.
   p. Remove the test strip and turn the meter off.

4. Recalling Results:
   a. From the main menu, select 'Memory'.
   b. Select 'Patient Result' or 'QC Result'.
   c. Scroll through the data using the up and down arrows. The most recent test is listed at the top.
   d. Select a result. The patient ID, test result, date and time of test, and strip code is displayed.
   e. If the 'individual' symbol is selected, only results for this patient will be displayed.

5. Cleaning the Meter:
   a. Use only 70% isopropyl alcohol or 10% bleach to clean the meter housing:
      i. With the meter turned OFF, ensure the blue test strip guide cover remains tightly closed while cleaning the housing.
      ii. Make sure no liquid enters the meter or accumulates near any opening.
      iii. Let the disinfectant sit on the meter for at least two minutes for alcohol wipes and five minutes for bleach wipes.
      iv. Wipe away residual moisture and fluids after cleaning the housing.
      v. Allow wiped areas to dry for at least 15 minutes before performing a test.
   b. Use only 70% isopropyl alcohol or 10% bleach to clean the test strip guide upon opening

a new bottle of test strips. Use of any other cleaning solutions can result in damage to the meter or incorrect patient results.

c. With the meter turned off, open the cover of the test strip guide by pressing its front edge upward.
d. Move the cover safely away from the meter. Then rinse the cover with water or wipe it clean.
e. Hold the meter upright with the test strip guide facing down. (This will help prevent fluid from entering the meter.) Clean the easily accessible areas of the test strip guide with a cotton-tipped swab. Ensure the swab is only damp, not wet. Caution: do not insert any objects into the test strip guide. Doing so could damage the electrical contacts behind the test strip guide. Wipe the test strip guide area. Let the cleaning solution sit for at least one minute.
f. Wipe away any residual moisture and fluids. Let the inside of the test strip guide dry for at least 15 minutes with the cover off.
g. Close the cover. Make sure it snaps into place.

6. Troubleshooting:
   a. If the meter displays a message other than a result, refer to the Error Messages section of the CoaguChek XS Plus System User Manual.
7. Calculations: n/a
8. Expected values/reference range/critical values:
   a. Normal Range:
      i. The CoaguChek XS meter displays results in units equivalent to those used for the laboratory plasma measurements.
      ii. Normal, healthy, warfarin free individuals: 0.9 – 1.0 INR
   b. Therapeutic Range: must be determined by the physician/Allied Health Professional (AHP) for each patient based on the reason for anticoagulation therapy and how each patient responds to treatment.
      i. Less intense 2.0-3.0 INR
      ii. More intense 2.5-3.5 INR (mechanical heart valves, etc)
   c. Reportable range:
      i. The meter will display results 0.8 – 8.0 INR.
      ii. Any INR greater than or equal to 3.1 must be verified by the laboratory.
   d. Unexpected results:
      i. If the meter displays an unusual test result, check the strip code, date, and time programmed into the meter.
      ii. Repeat the test with a new fingerstick and test strip. If the result is still unexpected, draw a sample for the laboratory.
   e. Limitations:
      i. This method should not be used for patients being treated with Hirudin.
      ii. Hematocrit ranges between 25-55% do not significantly affect test results.
      iii. The presence of anti-phospholipid antibodies (such as lupus Ab) can lead to prolonged clotting times. Test using a lab APA-insensitive method.
      iv. Do not use the meter near strong electromagnetic fields.
      v. Results are unaffected by heparin levels up to 0.8U/mL and low molecular weight heparin levels up to 2 IU anti-factor Xa activity/mL.
      vi. Failure to follow cleaning procedures correctly can lead to a falsely elevated result.
   f. Reporting results:
      i. Record the result in the patient's chart.
      ii. Record the result on the XS Plus Patient Test Log (for regulatory requirements).

H. **REFERENCE(S):**

1. Roche Diagnostics. CoaguChek XS PT Test Product Insert. 7/2010. 05967716001 (02).
2. Roche Diagnostics. CoaguChek XS Plus System Policies and Procedures. 2007. 05021499001-

00-0807.
3. Roche Diagnostics. CoaguChek XS Plus System User Manual. 05021464001 (02) 2009-11 USA.
4. Roche Diagnostics. CoaguChek XS Plus System Policy and Procedure manual CD 2012.

Tri-City Medical Center	Administrative – District Operations
PROCEDURE:	**MEDICARE HOSPITAL READMISSION BILLING 8610-290**
Purpose:	To outline responsibilities and processes to be completed to ensure Medicare patients readmitted as an inpatient are billed appropriately.

A. **DEFINITION:**

1. Readmission – a case in which the beneficiary is readmitted to a hospital less than 31 days after being discharged from a hospital

B. **PURPOSE:**

1. To outline responsibilities and processes to be completed to ensure Medicare patients readmitted as an inpatient are billed appropriately.

C. **RESPONSIBILITY: MEDICAL RECORDS/HEALTH INFORMATION MANAGEMENT (HIM) CODER**

1. The Coding Manager will review the account(s) to be combined sent from Patient Accounting
2. The Coder will print a final Coding Summary from electronic health record (EHR) Cerner for both the initial and subsequent admissions.
   a. Do NOT change codes in the EHR (integrity of the data for the individual encounter to be maintained)
   b. Enter an Encounter Note in the EHR for EACH encounter
   c. The original discharged encounter will almost always be utilized for the Combined billing
      i. The Coder may assess both accounts taking into consideration the following to determine if it is better to use a subsequent encounter for the combined billing:
         1) Length of Stay
         2) Number of Diagnoses and Procedures on each account
            a) Example: the original encounter was very short, subsequent encounter very long with multiple procedures and diagnosis codes
   d. Enter an Account Note
      i. If the encounter has been saved as Complete enter an account note
         1) "**International Classification of Disease (**ICD)-10 Diagnosis (Dx) and Procedure (Px) codes have been added to this account from Financial # xxxxxxxxxx for the purpose of Combined billing
      ii. If the account has been saved as Incomplete, enter and account note as above with the additional information (one or both of the following):
         1) Please amend the discharge (or admission) date and notify the ~~Lead Coder~~ Coding Manager when completed so the correct the procedure dates be finalized.
         2) Please edit the discharge disposition to "xxx" and notify Patient Accounting when completed so the coding process can be finalized.
   e. Notify the Patient Financial Services Supervisor via email of the account number to be used for the combined billing (Winning encounter).

Department Review	Administrative Policies & Procedures Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Board of Directors
12/10, 3/15, 05/18, 06/21, **04/25**	05/18, 08/21, **06/25**	n/a	n/a	02/11, 06/15, 08/18, 01/22, **06/25**	01/22

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE: NEW **SUBJECT:** Lactation Accommodation

REVISION DATE: **POLICY NUMBER:** 8610-402

Administrative Content Expert Approval:	**02/25**
Administrative Policies & Procedures Committee Approval:	**06/25**
Pharmacy & Therapeutics Committee:	**n/a**
Medical Executive Committee:	**n/a**
Administration Approval:	**06/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To comply with federal and state laws, Tri-City Healthcare District (TCHD) is committed to providing a supportive environment for employees who are nursing mothers. This policy outlines the rights and responsibilities related to lactation accommodation in the workplace, including an employee's right to request such accommodation.

B. **POLICY:**

1. Break Time for Expression of Breast Milk
   a. TCHD shall provide a reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth each time such employee has need to express the milk.
   b. The break time shall, if possible, run concurrently with any break time already provided to the employee.
   c. Additional break time requested to express breast milk beyond rest periods defined in Timekeeping and Break policy 401 will be unpaid.
2. Lactation Space
   a. TCHD shall provide a private place, other than a bathroom, in close proximity to your work area, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.
   b. Designated space(s) shall:
      i. Be safe, clean, and free from hazardous materials;
      ii. Contain a surface to place a breast pump and personal items and a place to sit;
      iii. Access to electricity or alternative devices, including but not limited to, extension cords or charging stations needed to operate an electric or battery-powered breast pump;
      iv. Access to a sink with running water and a refrigerator suitable for storing milk, in close proximity to the employee's workspace.

C. **PROCEDURE:**

1. Employees needing lactation accommodations should inform their supervisor, manager, or designee to arrange suitable break times and lactation space.
2. Department supervisor, manager, or designee are responsible for ensuring that employees who need to express breast milk are provided with the required break time and appropriate lactation space.
3. Department supervisor, manager, or designee unable to provide the break time and/or a location at the time of the request, shall provide a written response to the employee.

4. Employees have the right to file a complaint with the Labor Commissioner for any violation of rights. If an employee believes their rights have been violated, they may submit a complaint to the Labor Commissioner's Office. For additional information or to file a complaint, visit www.dir.ca.gov.

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

1. CDPH Lactation Accommodation Laws
2. State of California Department of Industrial Relations Lactation Accommodation
3. DOL EEOC Time and Place to Pump at Work: Your Rights

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

1. Administrative Policy: Timekeeping and Break Policy 8610-401

Tri-City Medical Center
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE: 06/99 **SUBJECT:** Temporary Modified Duty for Industrial Injuries

REVISION DATE: 05/2008, 05/2011, 09/14

Employee Health Department Approval:	**~~06/20~~03/25**
Infection Control Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~03/23~~06/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/23**

A. **PURPOSE:**

1. To provide a process to reasonably accommodate provider's restrictions for employees who are injured on the job.
2. To keep employees, who are receiving workers' compensation benefits, working in a productive capacity while protecting their healing injury.
3. To provide a uniform and fair application of a program for modified duty (which includes the definitions in section C) for occupational injuries among the various departments the following policy is hereby adopted and made applicable to all employees.

B. **PROCEDURE:**

1. After an employee has met modified duty requirements (as verified by Employee Health Services or designee) and as work is available, an employee will be assigned a modified duty position.
2. The modified duty assignment will accommodate the employee's stated restrictions as assigned by a medical provider.
3. Although TCHD will attempt to accommodate an employee on modified duty (due to availability), there is no guarantee of placement.
4. Modified duty is considered a temporary assignment, **and** ~~usually lasting no longer than~~ **shall not exceed** 90 **calendar** days. **An additional extension of 90 calendar days will be considered on a case by case basis with a written request for the extension from the Department Manager and the approval from Human Resources Department. However, in no circumstance shall an extension be granted if it would exceed the total duration of 180 calendar days for the same injury or illness.**
5. In addition, no modified duty assignment will become permanent.

C. **DEFINITIONS:**

1. Light Duty – The injured employee is brought back to work and placed temporarily within an existing job that is not as physically taxing or demanding as their normal job.
2. Restricted Work - The injured employee is brought back to their normal job with restrictions assigned by the doctor.
3. Transitional Work – The injured employee is brought back to a position that has been specifically created to accommodate the restrictions of a specifically injured employee if the need for such work should arise and such an assignment does not cause a financial hardship on the organization.

D. **MODIFIED DUTY GUIDELINES:**

1. Before an employee starts an approved modified duty assignment, the following must occur:

2. Employee Health Services or designee will:
   a. Meet with the injured employee and review the physician's written approval for modified duty, and the return to work policy.
   b. Complete the Notice of Offer of Modified or Alternative Work Form or Transitional Duty Agreement, if applicable
   c. Employee will read and receive the "Employee Responsibilities While on Light Duty" Form and be able to communicate a clear understanding of expectations.
3. If it is not possible to place the injured employee within their department, Employee Health or designee will contact managers for placement.
4. Department Managers must give consideration to the type of work assigned for the modified duty person.
   a. Assignments shall not put patients or staff at risk of injury
   b. Injured Security Officers, who are on modified duty, shall not be assigned responsibilities of a Security Officer. Responsibilities of this position put the Security Officer at risk of exceeding modified duty restrictions which could result in further injury.
5. If there is no meaningful work available that the injured employee is capable of performing, the injured employee will be sent home subject to being called back should appropriate modified duty become available. A modified duty assignment is not guaranteed to an injured employee, but TCHD will attempt to make work available. In no event will a position be created for the sole purpose of utilizing the injured employee in a modified duty status or shall a modification of job duties be made which allows the employee to perform in a modified duty capacity.
6. The refusal of any modified duty position shall be handled by the organization pursuant to the provisions of the worker's compensation regulations and may include the suspension of benefits for the refusal of a position within the limitations set forth by the appropriate medical provider.
7. A modified duty assignment can end when the employee has reached the 90 day maximum, is released to full duty by a medical provider, or has reached maximum medical improvement.
8. This modified duty work shall be separate and distinct from TCHD's EEO policy which shall address issues of accommodation pursuant to the ADA, FMLA, or CFRA or other federal and state requirements that may apply to TCHD. Under no circumstances should this policy be used in situations where the EEO policy shall apply.

E. **COMPENSATION:**
1. Employees' pay while on the modified duty program will be determined by Workers' Compensation regulations and TCHD pay practice.
2. It is the responsibility of Manager/Supervisor to approve the employee's time card at the end of each pay period.

F. **CRITERIA TO RETURN TO WORK:**
1. After receiving medical treatment, the employee must receive a return to work authorization form from their treating provider and return it to Employee Health Services.
2. The return to work authorization is specific and may include:
   a. A full release to work, without restrictions or limitations,
   b. A modified release to work with specific restrictions or limitations,
   c. Release to remain off work for a particular time period (Temporary Disability)

G. **RELATED DOCUMENT(S):**
1. Employee Responsibilities While on the Light Modified Duty.

Tri-City Medical Center
Oceanside, California

LABORATORY
GENERAL/QUALITY MANAGEMENT

ISSUE DATE: 11/99

SUBJECT: Laboratory Organization Quality System Essentials

REVISION DATE(S): 05/07, 11/07, 05/08, 05/09, 05/10, 05/11, 05/12, 05/13, 05/14, 05/15, 07/16, 06/18, 06/19, 03/21, ~~05~~08/24

Department Approval:	**~~08/24~~11/24**
Laboratory Medical Director Approval:	**~~08/24~~11/24**
Medical Executive Committee Approval:	**~~n/a~~01/25**
Administrative Approval:	**~~03/22~~06/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/24**

A. **DEFINITION(S):**

1. Clinical Laboratory Improvement Amendments (CLIA): United States federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research. The CLIA Program sets standards and issues certificates for clinical laboratory testing.
2. CLIA 88: 1988 amendments to the Public Health Service Act that established quality standards for all laboratory testing the ensure the accuracy, reliability, and timeliness of patient test results. CLIA '88 regulations apply to all clinical laboratories in the United States, including those in hospitals, clinics, and physician offices. They are enforced by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).
3. Quality Assurance (QA): Focuses on the entire laboratory testing process rather than just the equipment. QA encompasses a set of systematic activities and processes aimed at providing confidence that the laboratory consistently produces accurate and reliable results. QA components can include establishing standard operating procedures (SOPs), conducting proficiency testing, training and certifying laboratory personnel and ensuring compliance with regulatory requirements.
4. Quality Control (QC): The set of procedures and policies designed to monitor and maintain the precision and accuracy of laboratory equipment and testing processes. It involves daily checks, calibration, and verification to confirm that instruments are operating correctly and producing reliable results. QC components can include calibrating instruments, conducting internal quality control checks, monitoring environmental conditions and identifying and promptly addressing errors.
5. Quality Management: Oversees the entire laboratory operation, monitoring QC and QA programs as well as administrative considerations that influence the quality and efficiency of the laboratory operation.
6. Quality Management System (QMS): A QMS is a set of policies, processes, procedures, and resources designed to ensure high quality in an organization's services.
7. Quality System Essentials (QSE): QSEs represent the fundamental components necessary to ensure the accuracy, reliability, and integrity of laboratory testing processes within the QMS. These essentials encompass aspects such as leadership commitment to quality, adherence to regulatory standards, continuous improvement initiatives, and employee training and competency assessments.
8. Test Complexity: A test scoring system used by the FDA to categorize laboratory tests. Test complexity is scored as waived, moderate, or high. Test complexity determines the level of quality oversight for the performing laboratory.

a. Nonwaived: Tests categorized as either moderate complexity (including provider-performed microscopy) or high complexity.
b. Waived: A category of tests defined as "simple laboratory examinations and procedures which have an insignificant risk of an erroneous result."
c. Test complexity can be determined by accessing the CLIA database at https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/Search.cfm

9. Test System: The process that includes pre-analytic, analytic, and post-analytic steps used to produce a test result or set of results. A test system may be manual, automated, multi-channel or single-use and can include reagents, components, equipment and/or instruments required to produce results. A test system may encompass multiple identical analyzers or devices. Different test systems may be used for the same analyte.

B. **POLICY:**

1. Organization: This QSE describes the organizational structure of the laboratory, including how the lab is structured, assignment of roles and responsibilities, and communication within the lab.
2. Lab Structure:
   a. The lab is divided into eight sections. Each section includes the appropriately qualified personnel to carry out assigned tasks and follow the directives of the Laboratory Quality Management Plan. The quality manager has delegated authority and direct responsibility to oversee compliance with the laboratory's QMS.
      i. Pre-Analytical Services (includes phlebotomy, specimen processing, clerical processes and reference lab coordination)
      ii. Hematology, Coagulation, and Urinalysis
         1) From a personnel and delegation standpoint, these subsections are treated as a single section under the Hematology Technical Specialist.
      iii. Chemistry
      iv. Transfusion Service (Blood Bank)
      v. Microbiology
      vi. Point of Care
      vii. Anatomic Pathology (includes Histology, Cytology, and Pathology Clerical)
         1) This section interfaces directly with the Pathologists.
         2) Pathologists report to the Laboratory Director.
      viii. Laboratory Information System
   b. Each lab section is led by an appropriately qualified technical specialist (clinical lab), supervisor (anatomic pathology) or coordinator (ancillary lab services). The section leads report to Laboratory Leadership.
   c. Laboratory Leadership reports to the Laboratory Director and the Senior Director of Ancillary Services (or similar position).
   d. For a visual guide to lab structure, refer to the Laboratory Organizational Chart.
3. Lab Quality Management Roles and Responsibilities:
   a. Laboratory Director:
      i. Oversees all Quality Assurance (QA) and Quality Improvement (QI) activities. Participates in the Laboratory Operations Team Meetings. Communicates Laboratory QA/QI activities to the Medical Staff through the Medical Executive Committee.
      ii. Responsible for quality control for the laboratory and delegates quality control activity to the Technical Specialists.
         1) Quality Control includes review of patient results, quality control values, and instrument performance records.
         2) Each section has a defined system of Quality Control, which describes the review process, its timeliness and those responsible for implementing it. The Quality Control system for each section also defines the tolerance limits, corrective actions, and documentation policies.
            a) Refer to individual section Quality Assurance Plans.
         3) Method Comparisons

a) Method comparison involves assessing whether a new measurement method is comparable to an established method. It is used when two methods can be used to test an analyte to see if the results are comparable. It is also used to test the validation of a new instrument or method or to verify that an instrument or method performs to the manufacturer's standard.
b) Refer to the Instrument and Method Validation and Verification procedure.

iii. Delegates Responsibility:
1) The Laboratory Director may delegate specific responsibilities to key Laboratory Leadership team members under CLIA 88 (DRA.11425). Refer to the Director Delegation Table to review the delegated activities.
2) The delegation is assigned through completion of the Laboratory Director Letter of Delegation.
3) Designee competency is reviewed annually by the lab director. Refer to the Laboratory Medical Director Delegated Duties Annual Competency Assessment

iv. Ensures the Laboratory Quality Management Plan is implemented throughout the laboratory.
v. Ensures communication of lab data.
vi. Ensures provision of appropriate pathology procedures.
vii. Ensures provision of consultations regarding the medical provision of lab data.
viii. Interacts with government and other agencies as appropriate.
ix. Ensures provision of educational programs; strategic planning and research and development appropriate to the needs of the laboratory.
x. Ensures sufficient personnel with adequate documented training and experience and who meet the personnel requirements of Clinical Laboratory Improvement Amendments (CLIA)-88 to meet the needs of the lab.
xi. Ensures implementation of a safe laboratory environment in compliance with applicable regulations.
xii. Evaluates and selects Referral Laboratories:
1) The selection of the referral laboratory is made by the Laboratory Director after review of the laboratory and consultation with the institutional medical staff (where appropriate).
2) Selection of referral laboratories used by the clinical laboratory is based upon licensure, accreditation and quality of performance of the lab.
3) All referral laboratories used by TCMC must be licensed by the state in which they operate (where applicable) and maintain accreditation status through qualified be accredited by either the Joint Commission on Accreditation of Hospital Organizations or the College of American Pathologists and must submit copies of their accreditation and licensure documentation.
4) The referral laboratories must maintain an acceptable level of performance as determined by specimen handling, result reporting, timeliness of reporting, and quality assurance practices as determined by the Laboratory Director.

b. Laboratory Leadership:
i. Reviews all RL Solutions Quality Tracking. Reviews and disseminates reports to appropriate lab staff for their investigation.
ii. Coordinates QA activities of Lab with respect to Patient Care Services.
iii. Participates in the Laboratory Huddle and presides in the absence of the Laboratory Administrative Director.
iv. Coordinates meetings with Nursing Unit Manager or directors and other ancillary departments. Coordinates lab CQI and assists in facilitating between lab sections. Represents the laboratory at one or more governance council.

c. Supervisors, Technical Specialists and Coordinators, where applicable:
   i. Responsible for daily and monthly QA activities.
   ii. Reports problems and corrective actions during daily Laboratory Huddle.
   iii. Responsible for maintaining documentation of QA monitors.
   iv. Responsible for performing competency assessment and for monitoring the effectiveness of the assessment.
   v. Responsible for forming section Quality Teams when indicated.
   vi. Facilitates CQI activities in their section.
   vii. Responsible for documenting CQI activities and reporting at Lab Operations Team meetings.

4. Communication Within the Laboratory:
   a. The laboratory never closes. The clinical lab has personnel on-site 24 hours per day. Lab sections with business hours have personnel on call during off hours. The phone numbers for on call lines are posted throughout the lab.
   b. Due to the persistence of lab staffing, it is imperative for the lab to follow robust communication standards.
      i. Hand-off communication takes place during shift changes, when clinical lab personnel follow the Laboratory Hand Off Communication procedure. Following this procedure includes completing a hand-off communication form.
      ii. In addition to hand-off communication, Laboratory Leadership also participates in a daily Laboratory Huddle. During this huddle, lab operational issues are discussed. The Laboratory Huddle form is completed and posted on the lab whiteboard for all personnel to review as needed.
         1) Note: The Lab Huddle is considered open, in that all lab personnel are welcome to attend and contribute.

5. Laboratory Administration:
   a. The lab follows the administration guidelines as outlined by the hospital.
   b. When necessary, clarifications and additional guidelines for laboratory personnel are addended to hospital administration policies.
   c. Refer to the Laboratory Administrative Manual procedure.

C. **FORM(S):**
1. Laboratory Medical Director Delegated Duties Annual Competency Assessment
2. Laboratory Director Letter of Delegation

D. **RELATED DOCUMENT(S):**
1. Laboratory Quality Management Plan Overview
2. Laboratory Scope of Service
3. Laboratory Organizational Chart
4. Instrument and Method Validation and Verification
5. Director Delegation Table
6. Laboratory Hand Off Communication
7. Laboratory Administrative Manual

E. **REFERENCES:**
1. College of American Pathologists. (2023). Laboratory general checklist. CAP Accreditation Program, 09.22.2021, 62–74.
2. Clinical and Laboratory Standards Institute (CLSI). A Quality Management System Model for Laboratory Services. 5th ed. CLSI guideline QMS01. Clinical and Laboratory Standards Institute, Wayne, PA; 2019.
3. Valenstein P. Quality Management In Clinical Laboratories. Chicago, IL: CAP Press, 2005.
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5. California Association of Hospital and Health Systems. Guide to Record Retention. 2005.
6. American Association of Blood Banks. Technical Manual, (current edition; updated annually).

7. College of American Pathologists. Inspection and Accreditation Checklist, Section 1 General Laboratory.
8. NCCLS. How to define and determine reference intervals in the clinical laboratory; approved guideline C28 A2. Wayne, PA: NCCLS, 2000
9. California Business and Professions Code Section 1260-1275.
10. California Code of Regulation 1050.
11. College of America Pathologists. Reference Range Service (RRS2-A) Kit Instructions. 2010
12. Van der Meulen EA, et al. Use of small-sample-based reference limits on a group basis. Clin Chem. 1994;40:1698-1702
13. Department of Health and Human Services, Centers for Medicare and Medicaid Services.
14. Clinical Laboratory Improvement Amendments Of 1988; final rule. Fed Register. 1992(Feb 28):7164 [42CFR493.1213] (10/1/2011)
15. http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/IVDRegulatoryAssistance/ucm124208.htm
16. California's Business and Professions Code (BPC) section 1200 et. Seq., www.leginfo.ca.gov/calaw.
17. Title 17 California Code of Regulations (CCR), section 1029 et. Seq. www.calregs.com

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 04/22 **SUBJECT:** Peri-operative Antimicrobials

REVISION DATE:

Pharmacy Department Approval:	~~11/20~~09/24
Infection Control Committee	~~11/20~~10/24
Operating Room Committee Approval:	~~02/22~~12/24
Pharmacy & Therapeutics Committee Approval:	~~01/21~~02/25
Medical Executive Committee Approval:	~~03/22~~05/25
Administration Approval:	~~04/22~~06/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/22

A. **POLICY:**

1. To provide a guideline ~~for~~ **to ensure** the safe and effective utilization of peri-operative antimicrobials for surgical site infection prevention
2. Appropriate use of antimicrobial prophylaxis prevents post-operative infections at the site of surgery, post-operative morbidity and mortality due to infectious complications, reduces the duration and cost of the patient's health care needs, and minimizes the adverse consequences for the microbial flora of the patient or institution

B. **PROCEDURE:**

1. Pre-operative dose timing
   - **a. See "Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals" Table for a list of optimal administration times for re-dosing and prior to surgeries for selected antimicrobials.**
   - **b. For patients already on antimicrobials or not on antimicrobials prior to surgery**
     - **i. Pre-operative antimicrobial prophylaxis dose should still be given. Prophylaxis provides activity against organisms that commonly cause infection at the incision site, which may differ from the antimicrobials used to treat the active infection.**
     - **ii. Exception: if the antimicrobial selected for prophylaxis is the same as the antimicrobial the patient is received or provides similar coverage. Use "Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals" Table to determine the next dose needed for pre-operative and/or intraoperative coverage to ensure therapeutic drug levels.**
       - **1) If vancomycin or aminoglycoside needs to be re-dosed, pharmacy may be consulted for optimal re-dosing recommendations.**
   - ~~a. Patients receiving therapeutic antimicrobials for a remote infection before surgery should also be given antimicrobial prophylaxis before surgery~~
     - ~~i. If the agents used therapeutically are appropriate for surgical prophylaxis, administering an extra dose within 60 minutes before surgical incision is sufficient. Otherwise, the antimicrobial prophylaxis recommended for the planned procedure should be used (See Peri-operative Antimicrobial Recommendations)~~
   - **c.** The optimal time for administration of preoperative doses ~~is within~~**should ideally be completed within** 60 minutes before surgical incision
   - ~~b.~~ Antimicrobial administration needs to be timed such that the bactericidal concentration of the agent is established in the serum and tissues when the incision is made. For the

prevention of surgical site infections, it is important to infuse most, if not ALL of the drug before incision is made

~~i.~~

~~c.~~

d. Fluoroquinolones and vancomycin require administration over 1-2 hours; therefore, administration of these agents should begin ~~within 60~~-120 minutes before surgical incision

~~d.~~**e.** **Other pre-operative prophylactic antimicrobial infusions should not start on the medical floors, unless the time required for infusion is too long for the infusion to be completed before the incision.**

~~e.a. Antimicrobial administration needs to be timed such that the bactericidal concentration of the agent is established in the serum and tissues when the incision is made. For the prevention of surgical site infections, it is important to infuse most, if not ALL of the drug before incision is made~~

~~f. SeePeri-operative Antimicrobial Re-dosing Intervals and Infusion Times Recommendations for timing recommendations~~

2. Antimicrobial selection and dosing
   - **a.** The agent chosen should have activity against the most common surgical-site pathogens
   - **b.** **It is the responsibility of the physician making the incision to order pre-operative prophylactic antimicrobials.**
   - **c.** **It is the responsibility of the RN to check the physician orders for a pre-operative prophylactic antimicrobial.**
   - ~~a.~~**d.** **Consider the addition of vancomycin or clindamycin for patients known to be colonized with MRSA.**
   - ~~b.~~**e.** Recommendations for the selection of prophylactic antimicrobials for various surgical procedures are provided in Peri-operative Antimicrobial Recommendations
   - ~~c.~~**f.** Alternative antimicrobial combinations aside from those recommended **in the Preferred Surgical Antimicrobial Prophylaxis by Surgery Type Table** ~~in Peri-operative Antimicrobial Recommendations~~ may be warranted if prior culture results determine patient is colonized at the surgical site or currently infected with a pathogen not commonly covered by the recommended antimicrobial
3. Antimicrobial re-dosing intervals
   - **a.** Intra-operative re-dosing is needed to ensure adequate serum and tissue concentrations of the antimicrobial
   - **b.** **Refer to "Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals" Table to determine when specific antimicrobials need to be re-dosed during the procedure**
   - **c.** Re-dosing interval should be measured from the time of administration of the pre-operative dose, not from the beginning of the procedure
   - ~~a.~~**d.** if there ~~duration of the procedure exceeds two half-lives of the drug or there~~ is excessive blood losse during the procedure (>1,500 mL ~~blood loss~~), **consider re-dosing antimicrobial earlier than specified time in "Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals" Table**

   ~~b.a. Re-dosing interval should be measured from the time of administration of the pre-operative dose, not from the beginning of the procedure~~

   - **e.** Re-dosing may not be warranted in patients in whom the half-life of the antimicrobial agent is prolonged (e.g., patients with renal insufficiency or renal failure)
   - ~~c.~~**f.** **If vancomycin or aminoglycoside needs to be re-dosed, pharmacy may be consulted for optimal re-dosing recommendations.**
4. Peri-operative antimicrobial duration
   - **a.** **In most procedures, no doses after incision closure are necessary.**
   - ~~a.~~**b.** Evidence supports that post-operative antimicrobial administration is not necessary for most procedures and guidelines recommend that in clean and clean-contaminated

procedures, administration of additional prophylactic antimicrobial agents is not necessary after surgical incision is closed, even in the presence of a drain

~~b.~~**c.** If post-operative antimicrobials are ordered, the duration of antimicrobial prophylaxis should be less than 24 hours ~~for most procedures~~**after surgery completion.**

i. A duration of up to 48 hours for cardiothoracic prophylaxis has been an accepted practice, but with little evidence supporting the practice

ii. There is no data to support the continuation of antimicrobial prophylaxis until all indwelling drains and intravascular catheters are removed and has the potential to lead to antimicrobial resistance or *Clostridioides difficile* infection.

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

1. ~~Peri-operativeAntimicrobial Recommendations~~**Preferred Surgical Antimicrobial Prophylaxis by Surgery Type**
2. ~~Peri-operative Antimicrobial Re-dosing Intervals and Infusion Times Recommendations~~**Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals**

D. **REFERENCE(S):**

1. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com.
2. Bratzler DW, Dellinger EP, Olsen KM, et al; American Society of Health-System Pharmacists; Infectious Disease Society of America; Surgical Infection Society; Society for Healthcare Epidemiology of America. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.
3. Berrios-Torres SI, Umscheld CA, Bratzler DWm et al. Centers for disease control and prevention guidelines for the prevention of surgical site infection. JAMA Surgery. 2017 Aug 1; 152(8):784-791

Tri-City Medical Center
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Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals~~Antimicrobial Re-dosing Intervals and Infusion Times~~ Recommendations

Antimicrobial	Pre-op Dose	Infusion Time	Re-Dosing	Time of Initiation prior to cut for adequate levels
Commonly Used				
Cefazolin	< 120kg = 2g ≥ 120kg = 3g	5min IVP or 30min IVPB	q4hr	10-60min
Vancomycin	≤ 80kg = 1g 81-119kg = 1.5g ≥ 120 kg = 2g	60min IVPB 90min IVPB 120min IVPB	q12h	60-90min 90-120min 120-180min
Clindamycin	900mg	30min IVPB	q6h	30-60min
Other				
Ampicillin-Sulbactam	3g	15min IVPB	q2h	10-60min
Azithromycin	500mg	60min	NA	60min
Cefoxitin	2g	5min IVP or 30min IVPB	q2h	10-60min
Cefotetan	2g	5min IVP or 30min IVPB	q6h	10-60min
Ceftriaxone	2g	5min IVP or 30min IVPB	NA	10-60min
Ciprofloxacin	400mg	60min IVPB	NA	60min
Ertapenem	1g	30min IVPB	NA	30-60min
Gentamicin	5mg/kg**	30min IVPB	NA	30-60min
Levofloxacin	500mg	60min IVPB	NA	60min
Metronidazole	500mg	30min IVPB	q8h	30-60min
Piperacillin-tazobactam	4.5g	30min IVPB	q2hr for 2 re-doses	10-60min

*Re-Dosing: for excessive blood loss (1,500mL) or if duration of procedure exceeds the duration of the antimicrobial used. This insures therapeutic levels at the time of incision, throughout the surgery, and at closure of surgical wound.
**Based on dosing weight. Use adjusted body weight if >20% ideal body weight.

~~Antimicrobial~~	~~Half-life in Adults with Normal Renal Function, hr~~	~~Intra-operative Re-dosing Interval~~	~~Infuse over time~~	~~Time of INITIATION prior to cut for adequate levels~~	~~Delayed Procedure Re-Dosing Interval~~
~~Ampicillin-sulbactam~~	~~0.8-1.3~~	~~2 hrs~~	~~30 min Min: 15 min~~	~~Optimal: 30 min Min: 15 min~~	~~1-2 hrs: 1.5g >2 hrs: 3g~~

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Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing IntervalsAntimicrobial Re-dosing Intervals and Infusion Times Recommendations

Antimicrobial	Half-life in Adults with Normal Renal Function, hr	Intra-operative Re-dosing Interval	Infuse over time	Time of INITIATION prior to cut for adequate levels	Delayed Procedure Re-Dosing Interval
Ampicillin	1-1.9	2 hrs	30 min Min: 15 min	Optimal: 30 min Min: 15 min	1-2 hrs: 1g >2 hrs: 2g
Aztreonam	1.3-2.4	4 hrs	30 min Min: 5 min	Optimal: 30 min Min: 10 min	1-2 hrs: 1g >2 hrs: 2g
Cefazolin	1.2-2.2	4 hrs	30 min Min: 5 min	Optimal: 30 min Min: 10 min	1-2 hrs: 1g >2 hrs: 2g
Cefuroxime	1-2	4 hrs	30 min Min: 5 min	Optimal: 30 min Min: 10 min	1-2 hrs: 750mg >2 hrs: 1g
Cefotaxime	0.9-1.7	3 hrs	30 min Min: 5 min	Optimal: 30 min Min: 15 min	1-2 hrs: 1g >2 hrs: 2g
Cefoxitin	0.7-1.1	2 hrs	30 min Min: 5 min	Optimal: 30 min Min: 15 min	1-2 hrs: 1g >2 hrs: 2g
Cefotetan	2.8-4.6	6 hrs	30 min Min: 5 min	Optimal: 30 min Min: 15 min	1-2 hrs: 1g >2 hrs: 2g
Ceftriaxone	5.4-10.9	NA	30 min	Optimal: 30 min Min: 15 min	1-2 hrs: 1g >2 hrs: 2g
Ciprofloxacin	3-7	NA	60 min	Optimal: 60 min Min: 30 min	2-6 hrs: 200mg >6 hrs:400mg
Clindamycin	2-4	6 hrs	30 min	Optimal: 30 min Min: 15 min	1-3 hrs: 300mg >3 hrs: 600mg
Ertapenem	3-5	NA	30 min	Optimal: 30 min Min: 15 min	1-2 hrs: 500mg >2 hrs: 1g
Fluconazole	30	NA	400mg = 120 min	Optimal: 60 min Min: 30 min	2-6 hrs: 200mg >6 hrs: 400mg
Gentamicin	2-3	NA	30 min Min: 15 min	Optimal: 30 min Min: 15 min	1-3 hrs: 2.5mg/kg >3 hrs: 5mg/kg

Peri-Operative Antimicrobial Dosing, Infusion Times, and Re-Dosing Intervals~~Antimicrobial Re-dosing Intervals and Infusion Times~~ Recommendations

~~Antimicrobial~~	~~Half-life in Adults with Normal Renal Function, hr~~	~~Intra-operative Re-dosing Interval~~	~~Infuse over time~~	~~Time of INITIATION prior to cut for adequate levels~~	~~Delayed Procedure Re-Dosing Interval~~
~~Levofloxacin~~	~~6-8~~	~~NA~~	~~60 min~~	~~Optimal: 60 min Min: 30 min~~	~~2-6 hrs: 250mg >6 hrs: 500g~~
~~Metronidazole~~	~~6-8~~	~~NA~~	~~60 min Min: 30 min~~	~~Optimal: 30 min Min: 15 min~~	~~2-6 hrs: 250mg >6 hrs:500mg~~
~~Moxifloxacin~~	~~8-15~~	~~NA~~	~~60 min~~	~~Optimal: 60 min Min: 30 min~~	~~2-6 hrs: 200mg >6 hrs:400mg~~
~~Piperacillin-tazobactam~~	~~0.7-1.2~~	~~2 hrs~~	~~30 min~~	~~Optimal: 30 min Min: 15 min~~	~~>2 hrs: 3.375g~~
~~Vancomycin~~	~~4-8~~	~~NA~~	~~1g = 60 min 1.5 g = 120 min~~	~~Optimal: 90 min Min: 60 min~~	~~2-6 hrs: 500mg >6 hrs: 1g~~

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Peri-operative Antimicrobial Recommendations

Surgery Type	First Line	Penicillin Allergy	Severe Beta-lactam Allergy
Cardiac			
Coronary artery bypass graft (CABG), CABG with valve implant, valve replacement, other cardiac procedures	Cefazolin	Cefazolin	Vancomycin
	Known MRSA colonization: Vancomycin AND cefazolin		
Cardiac device insertion (i.e. pacemaker implantation)	Cefazolin	Cefazolin	Vancomycin
	Known MRSA colonization: Vancomycin AND cefazolin		
Ventricular Assist Device	Cefazolin + Vancomycin		Vancomycin
Thoracic (non-cardiac)			
Thoracic Procedures	Cefazolin	Cefazolin	Vancomycin
	Known MRSA colonization: Vancomycin AND cefazolin		
Vascular			
Vascular Procedures (i.e. amputation [lower extremity for ischemia], arterial surgery, graft replacement or repair)	Cefazolin	Cefazolin	Vancomycin
	Known MRSA colonization: Vancomycin AND cefazolin		
Head & Neck			
Clean procedures (thyroidectomy, etc.) Clean procedures with prosthesis placement (neck dissections, parotidectomy)	Cefazolin	Cefazolin	Clindamycin
Clean-contaminated (oropharyngeal mucosae is compromised)	Cefazolin + Metronidazole	Cefazolin + Metronidazole	Clindamycin
Urology Empiric recommendations when no pre-operative urine cx data is available or cultures were negative.			
Lower tract instrumentation with risk of infection (i.e. transrectal prostate biopsy)	Cefazolin	Cefazolin	Levofloxacin
Clean without entry into urinary tract	Cefazolin	Cefazolin	Clindamycin
Clean with entry into urinary tract	Cefazolin	Cefazolin	Clindamycin + Gentamicin
Transurethral surgery (TURP, TURBT), urethroscopy, cystourethroscopy, or stone manipulation	Cefazolin	Cefazolin	Gentamicin
Clean-contaminated procedures with entry into urinary tract (i.e. radical cystectomy with ileal conduit, cystoprostatectomy, entry into GI tract)	Cefoxitin	Cefoxitin	Levofloxacin + Metronidazole
Prosthetic material placed (i.e. penile prosthesis, etc.)	Cefazolin + Gentamicin	Cefazolin + Gentamicin	Vancomycin + Gentamicin
Orthopedics and Spine			
Clean operations of hand, knee, foot (without implantation of foreign material)	None	None	none
Internal fixation of fracture Implantation of internal fixation devices i.e. nails, screws, wires)	Cefazolin	Cefazolin	Vancomycin

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Peri-operative Antimicrobial Recommendations

Total Joint Replacement (primary or revision WITHOUT infection)	**Known MRSA colonization: Vancomycin AND cefazolin**		
Orthopedics and Spine			
Revision joint replacement WITH infection	**MD discretion**	**MD discretion**	**MD discretion**
Spinal procedures: laminectomy, discectomy, spinal fusion, or with and without instrumentation	**Cefazolin**	**Cefazolin**	**Vancomycin**
	Known MRSA colonization: Vancomycin AND cefazolin		
Neurosurgery			
Neurosurgery procedures (i.e. CSF shunting, elective craniotomy, implantation of intrathecal pumps)	**Cefazolin**	**Cefazolin**	**Vancomycin**
	Known MRSA colonization: Vancomycin AND cefazolin		
General Surgery			
Esophageal and Gastroduodenal (i.e. PEG placement, bariatric procedures)	**Cefazolin**	**Cefazolin**	**Clindamycin + Gentamicin**
Colorectal, Appendectomy, and Small Bowel Surgery	**Cefoxitin**	**Cefoxitin**	**Levofloxacin + Metronidazole**
Biliary procedures (open and laparoscopic)	**Cefazolin**	**Cefazolin**	**Levofloxacin + Metronidazole**
Hernia repair (hernioplasty and herniorrhaphy)	**Cefazolin**	**Cefazolin**	**Vancomycin**
Obstetrics & Gynecology (OB-GYN)			
Elective cesarean delivery **Non-elective cesarean delivery**	**Cefazolin** **Cefazolin + Azithromycin**	**Cefazolin** **Cefazolin + Azithromycin**	**Clindamycin + Gentamicin** **Clindamycin + Gentamicin + Azithromycin**
Hysterectomy (abdominal, vaginal, or laparoscopic)	**Cefazolin**	**Cefazolin**	**Clindamycin + Gentamicin**
****If patient does not have a history of positive MRSA culture, MRSA colonization, or have risk factors for MRSA, cefazolin alone is sufficient.**			

~~Type of Procedure~~	~~Pre-op~~	~~Alternative in β-lactam allergy~~
~~Coronary artery bypass, cardiac device insertion procedure (e.g. pacemaker implantation), ventricular assist devices~~	~~Cefazolin 2 g (3 g in pts weighing >120 kg) or cefuroxime 1.5 g~~	~~Clindamycin 900 mg or vancomycin 15 mg/kg~~
~~Open biliary procedure~~	~~Cefazolin 2 g (3 g in pts weighing >120 kg), cefoxitin 2 g, cefotetan 2 g, ceftriaxone 2 g, or ampicillin-sulbactam 3 g~~	~~Metronidazole 500 mg + aminoglycoside[1] or fluoroquinolone[2]~~ ~~Clindamycin 900 mg or vancomycin 15 mg/kg +~~

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Oceanside, California

Peri-operative Antimicrobial Recommendations

Type of Procedure		Pre-op	Alternative in β-lactam allergy
			aminoglycoside[1] or aztreonam 2 g or fluoroquinolone[2]
Laparoscopic biliary procedure	Elective, low risk	None	None
	Elective, high risk	Cefazolin 2 g (3 g in pts weighing >120 kg), cefoxitin 2 g, cefotetan 2 g, ceftriaxone 2 g, or ampicillin-sulbactam 3 g	Clindamycin 900 mg or vancomycin 15 mg/kg + aminoglycoside[1] or aztreonam 2 g or fluoroquinolone[2] Metronidazole 500 mg + aminoglycoside[1] or fluoroquinolone[2]
Appendectomy for uncomplicated appendicitis		Cefoxitin 2 g, cefotetan 2 g, or cefazolin 2 g, (3 g in pts weighing >120 kg) + metronidazole 500 mg	Clindamycin 900 mg + aminoglycoside[1] or aztreonam 2 g or fluoroquinolone[2] Metronidazole 500 mg + aminoglycoside[1] or fluoroquinolone[2]
Small intestine	Non obstructive	Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg + aminoglycoside[1] or aztreonam 2 g or fluoroquinolone[2]
	Obstructed	Cefazolin 2 g (3 g in pts weighing >120 kg) + metronidazole 500 mg, cefoxitin 2 g, cefotetan 2 g	Metronidazole 500 mg + aminoglycoside[1] or fluoroquinolone[2]
Hernia repair (hernioplasty and herniorrhaphy)		Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Colorectal		Cefazolin 2 g (3 g in pts weighing >120 kg) + metronidazole 500 mg, cefoxitin 2 g, cefotetan 2 g, ampicillin-sulbactam 3 g, ceftriaxone 2 g + metronidazole 500 mg, or ertapenem 1 g	Clindamycin 900 mg + aminoglycoside[1] or aztreonam 2 g or fluoroquinolone[2] Metronidazole 500 mg + aminoglycoside[1] or fluoroquinolone[2]
Elective craniotomy and cerebrospinal fluid shunting procedure		Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Implantation of intrathecal pumps		Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Clean operations of hand, knee, or foot (not involving foreign material)		None	N/A
Spinal procedures with and without instrumentation		Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg

Tri-City Medical Center
Oceanside, California

Peri-operative Antimicrobial Recommendations

Type of Procedure	Pre-op	Alternative in β-lactam allergy
Hip fracture repair	Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Implantation of internal fixation devices	Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Total joint replacement	Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Lower tract instrumentation with risk factors for infection (includes transrectal prostate biopsy)	Fluoroquinolone[2], trimethoprim-sulfamethoxazole[3], or cefazolin 2 g (3 g in pts weighing >120 kg)	Aminoglycoside[1] ± clindamycin 900 mg
Clean without entry into urinary tract	Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg
Clean with entry into urinary tract	Cefazolin 2 g (3 g in pts weighing >120 kg)	Fluoroquinolone[2] or aminoglycoside[1] ± clindamycin 900 mg
Involving Implanted prosthesis	Cefazolin 2 g (3 g in pts weighing >120 kg) ± aminoglycoside[1], or cefazolin ± aztreonam 2 g, or ampicillin-sulbactam 3 g	Clindamycin 900 mg ± aminoglycoside[1] or aztreonam 2 g, vancomycin 15 mg/kg ± aminoglycoside[1] or aztreonam 2 g
Clean-contaminated	Cefoxitin 2 g or cefazolin 2 g (3 g in pts weighing >120 kg) + metronidazole 500 mg	Fluoroquinolone[2] or aminoglycoside[1] + metronidazole 500 mg or clindamycin 900 mg
Vascular procedures	Cefazolin 2 g (3 g in pts weighing >120 kg)	Clindamycin 900 mg or vancomycin 15 mg/kg

1. Aminoglycoside dose: gentamicin 5mg/kg based on dosing weight; use adjusted body weight if obese (>20% ideal body weight)
2. Fluoroquinolone dose: levofloxacin 500mg or ciprofloxacin 400mg
3. Trimethoprim-sulfamethoxazole dose: 160mg of trimethoprim component

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09

SUBJECT: Anesthesia: Type, Location And Monitoring of

REVISION DATE~~(S)~~: 05/15,; 11/15,~~;~~ 04/17

Surgical Services Department Approval:	**~~02/20~~01/24**
Department of Anesthesiology Approval:	**~~03/20~~09/24**
Operating Room Committee Approval:	**~~07/20~~12/24**
Pharmacy and Therapeutics Approval:	**~~05/21~~02/25**
Medical Executive Committee Approval:	**~~07/21~~05/25**
Administration Approval	**~~08/21~~06/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/21**

A. **PURPOSE:**
1. To provide guidelines for type, location and monitoring of Anesthesia Services throughout Tri-City Medical Center under various forms of anesthesia.

B. **DEFINITION(S):**
1. General Anesthesia: Depression of consciousness caused by the administration of anesthetic agents during which the patient is not arousable.
2. Spinal Anesthesia: Injection of anesthetic substances in the spinal fluid.
3. Epidural Anesthesia: Injection of anesthesia substances in the epidural space.
4. Regional Anesthesia: A region of the body anesthetized with local anesthesia.
5. MAC: Monitored Anesthesia Care- Anesthesia provider present during a procedure and includes varying levels of sedation, analgesia and anxiolysis as necessary.
6. Intravenous (IV) Sedation: Depressed level of consciousness induced by the administration of sedatives in which patients retain the ability to maintain an open airway and respond to physical stimulation or verbal commands.
7. PACU: Post Anesthesia Care Unit.

C. **POLICY:**
1. General Guidelines:
   a. A pre-anesthesia assessment is performed for each patient before anesthesia induction.
   b. Each patient's anesthesia care is planned.
   c. Anesthesia options and risks are discussed with the patient and family, if appropriate, prior to administration.
   d. Each patient's physiological status is monitored during anesthesia administration.
   e. The patient's post-procedure status is assessed on admission to and before discharge from the PACU.
   f. Patients are discharged by a qualified licensed independent practitioner or according to criteria approved by the medical staff.
2. Type and Location:
   a. General and regional anesthesia may be performed in Surgery, Interventional Radiology (IR), Cardiac Catheterization Lab (Cath Lab), Labor & Delivery, and in other designated monitored units (e.g., Emergency Department, PACU).
   b. MAC may be performed in Cath Lab, Surgical Services, IR, Intensive Care Unit (ICU), and in other designated monitored units.

c. IV sedation may be performed in the Emergency Department (by non-anesthesia providers), Surgical Services, IR, ICU, and in other designated monitored units.

D. **REFERENCES:**

1. Title XXII §70233 & 70235.
2. The Joint Commission 2021

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 09/18 **SUBJECT:** Local Anesthesia in Operating Room

REVISION DATE(S): 09/18

Surgical Services Department Approval:	~~02/20~~10/23
Department of Anesthesiology Approval:	~~03/20~~09/24
Operating Room Committee Approval:	~~06/20~~12/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~09/20~~05/25
Administration Approval:	~~10/20~~06/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

A. **PURPOSE:**
1. To define the patient selection criteria and monitoring requirements for patients receiving local anesthesia without sedation in the Operating Room (OR).
2. To provide guidance for patient assessment, patient monitoring, recognition and treatment of local anesthetic systemic toxicity (LAST), assessment for local anesthetic allergies, and documentation of patient care for patients receiving local anesthesia in the OR.

B. **DEFINITIONS:**
1. Local anesthesia: the administration of a local anesthetic agent to one part of the body by injection, infiltration or topical application, usually administered by the surgeon.
2. ASA Physical Status Classification: American Society of Anesthesiologists Patient Physical Status Profile, classifying patients as:
   a. ASA I: Normal, healthy patient.
   b. ASA II: Patient with mild systemic disease.
   c. ASA III: Patient with severe systemic disease.
   d. ASA IV: Patient with a severe systemic disease that is a constant threat to life.
   e. ASA V: Moribund patient not expected to survive without the operation.
   f. ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes.
3. Local anesthetic systemic toxicity (LAST): An uncommon, potentially fatal, toxic reaction that occurs when the threshold blood levels of a local anesthetic are exceeded by an inadvertent, intravascular injection or slow systemic absorption of a large, extravascular volume of local anesthetic. Symptoms of toxicity include, but are not limited to:
   a. Metallic taste
   b. Numbness of the tongue and lips
   c. Auditory changes (e.g., tinnitus)
   d. Light-headedness
   e. Dysarthria (e.g., slurred speech)
   f. Shivering
   g. Tremors
   h. Confusion
   i. Agitation
   j. Syncope
   k. Seizures

l. Coma
m. Tachycardia/hypertension (initially)
n. Bradycardia/hypotension (with increased toxicity)
o. Ventricular arrhythmias
p. Asystole
q. Respiratory arrest

C. **POLICY:**

1. A preoperative nursing assessment shall be performed for the patient who will receive local anesthesia, including review of patient's:
   a. Allergies and sensitivities
   b. Age
   c. Height, weight, and body mass index
   d. Current medications and use of alternative/complementary therapies
   e. NPO status
   f. Medical history (i.e., history and physical, progress notes)
   g. Laboratory test results
   h. Diagnostic test results
   i. Baseline cardiac status (e.g., heart rate, blood pressure)
   j. Baseline respiratory status (e.g., respiratory rate, rhythm, SpO_2)
   k. Baseline skin condition for integrity (e.g., rash, breaks, ecchymosis)
   l. Baseline neurological status
   m. Sensory impairments (e.g., visual, auditory)
   n. Ability to tolerate required operative position with draping for the duration of the procedure
   o. Level of anxiety
   p. Level of pain
   q. Perceptions of surgery
   r. Need for intravenous access
2. The surgeon shall determine patient acuity preoperatively using ASA Physical Status Classification.
3. Patients receiving local anesthesia in the OR are monitored by the Perioperative Registered Nurse (RN).
4. Patient selection criteria for local anesthesia:
   a. ASA I or II.
   b. Patient must be NPO prior to procedure time for:
      i. Two (2) hours after clear liquids
      ii. Eight (8) hours after solids
   c. Patients must have a functioning IV.
5. Case selection for local anesthesia:
   a. Minor procedures less than 60 minutes in duration.
   b. The patient's cooperation is necessary for the procedure.
6. Cases performed under local anesthesia with nurse monitored care shall have "under local anesthesia" included on the procedural consent form.
7. Staffing requirements:
   a. The RN monitoring the patient receiving local anesthesia shall have no other duties or responsibilities during the case.
   b. RN's shall have documented competency on monitoring patients receiving local anesthesia and signs and symptoms of local anesthetic systemic toxicity.
8. The RN shall monitor/assess the patient continuously during the procedure and document every five (5) minutes or more often if significant changes in the patient's condition occurs during the procedure:
   a. Blood Pressure
   b. Heart Rate

c. Respiratory Rate
d. O_2 saturation
e. Level of sedation for adults using the RASS Scale:

4	Combative	Overly combative or violent, immediate danger to staff
3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
2	Agitated	Frequent non-purposeful movement or patient-ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice
-2	Light Sedation	Briefly, less than 10 seconds, awakening with eye contact to voice
-3	Moderate Sedation	Any movement, but no eye contact to voice
-4	Deep Sedation	No response to voice, but any movement to physical stimulation
-5	Unresponsive	No response to voice or physical stimulation

f. Pain level

9. Document on the Sedation Flow Sheet.
10. Supplemental oxygen, suction apparatus, and emergency crash cart shall be readily available for use.
11. Medications shall be dispensed under the physician's order.
12. The RN circulator shall document the local anesthetic administered, including the:
    a. Medication name
    b. Strength
    c. Total amount administered
    d. Route
    e. Time
    f. Expiration date
    g. Lot number
    h. Response
    i. Adverse reactions (if applicable)
13. Monitor patient for signs and symptoms of an allergic reaction to a local anesthetic, including:
    a. Anxiety
    b. Bronchospasm
    c. Dizziness
    d. Dyspnea
    e. Erythema
    f. Edema
    g. Cardiac arrhythmias (i.e., tachycardia, bradycardia)
    h. Hypotension
    i. Nausea
    j. Pallor
    k. Palpitations
    l. Pruritus
    m. Rash
    n. Syncope
    o. Urticaria
14. The Surgery RN shall monitor the patient for signs and symptoms of LAST. If LAST occurs:

a. Call for help (i.e., Page "Any Available Anesthesiologist STAT" to the OR and notify the OR Supervisor/designee to recruit available help [e.g., Anesthesia Tech, additional RN's])
b. Maintain patient's airway
c. Ventilate with 100% oxygen
d. Call for the crash cart and 20% lipid emulsion bag (from Surgery Pyxis Medstation)
e. Assist with basic or advanced cardiac life support
f. Be prepared to establish or assist with IV access
g. Be prepared to assist with the administration of 20% lipid emulsion therapy

15. Monitor the patient for the desired response to local anesthetic medications.
16. Post-procedure:
    a. Inpatients receiving local only anesthesia for surgery will be returned to their room upon completion of their procedure, unless there is a physician order for PACU recovery/observation.
    b. Same Day Surgery (outpatients) will be transferred to PACU post-procedure for discharge.
17. The circulating RN shall provide hand-off report to the post-procedure RN, including procedure performed, medications administered, IV's in place, and how the patient tolerated the procedure.

D. **REFERENCE(S)**:

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

Tri-City Medical Cen
Oceanside, California

RETIRE – no longer perform

TELEMETRY

ISSUE DATE: 08/17	**SUBJECT:** Skin and Wound Team, Rounds
REVISION DATE: 08/17	**POLICY NUMBER:** 6150- 119

Department Approval:	~~07/15~~05/25
Division of Cardiology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/25
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

~~A. PURPOSE:~~

~~1. Decrease the risk of skin impairment presented by the development of stage II or III pressure ulcers (PU) to zero for patients admitted or transferred to the Telemetry Unit by establishing:~~
~~a. Registered Nurse (RNs) Skin and Wound Champions~~
~~b. Weekly unit skin and wound rounds~~
~~2. To identify the process for performing weekly skins and wound rounds.~~

~~B. DEFINITION(S):~~

~~1. RN Skin and Wound Champions – Telemetry RNs identified as skin and wound experts and mentors for the unit~~
~~2. Telemetry Skin and Wound Team – RN Skin and Wound Champions, Advanced Care Technicians (ACT), and Lift Team Technicians (LTT) assigned to the rounding unit, when available~~
~~3. Skin and Wounds Rounds – Weekly skin assessment of patients scheduled by RN Skin and Wound Champions based on the criteria listed in this policy~~

~~C. POLICY:~~

~~1. Skin and Wound rounds:~~
~~a. Occur weekly for one (1) to two (2) hours based on patients' location on Telemetry or the RN Skin and Wound Champion's discretion.~~
~~b. Initiated by a RN Skin and Wound Champion with the participation of the following staff when available:~~
~~i. ACT assigned to the unit~~
~~ii. LTT assigned to the unit~~
~~iii. Primary RN or Relief RN~~
~~iv. PRN Nurse~~
~~2. Criteria for identifying patients that may be assessed during Skin and Wound rounds~~
~~a. Braden score of 18 or below~~
~~b. Upon the request of the Primary RN, one patient per RN~~
~~c. Patients hospitalized greater than two days and non-ambulatory~~
~~d. Post-operative patient not ambulating~~
~~e. New admissions or transfers~~
~~3. RN Skin and Wound champions will:~~
~~a. Update primary RNs on the skin interventions provided~~
~~b. Educate primary RNs, if required, on the following:~~
~~i. Basic skin assessment and documentation requirements~~
~~ii. Preventative skin interventions~~
~~iii. Proper patient positioning~~

iv. Obtaining photographs of skin and wound abnormalities

D. PROCEDURE:

1. Print and review the daily census to identify patients
   a. Rounds may be limited to one unit or patients on multiple units on Telemetry
2. Obtain permission from primary RN assigned to patients to perform a skin assessment
3. Verify with primary RN skin interventions that are in place
4. Assess patients' skin as outlined in the Standards of Patient Care. Notify the primary RN or Relief RN immediately at the patient's bedside when the following are identified:
5. Document assessment findings and interventions initiated in the Electronic Health Record (EHR)
6. Update the primary RN

E. RELATED DOCUMENT(S):

1. Patient Care Services Policy: Skin and Wound Care

F. REFERENCE(S):

1. National Pressure Ulcer Advisory Panel (NPUAP). (2016). National pressure ulcer advisory panel (npuap) announces a change in terminology from pressure to pressure injury and updates the stages of pressure injury: Reference Tool. Retrieved from http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

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

May 29, 2025 – 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 May 29, 2025.

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

Director Sheila Brown
Director Nina Chaya, M.D.
Director George Coulter
Director Rocky Chavez (via teleconference)
Director Gigi Gleason
Director Adela Sanchez
Director Tracy Younger (via teleconference)

Also present were:

Gene Ma, M.D., Chief Executive Officer
Anh Nguyen, Interim Chief Financial Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

In Chairperson Younger's "physical" absence, Vice Chairperson Chaya 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 Sanchez to approve the agenda as presented. The motion passed unanimously (7-0).

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

   Vice Chairperson Chaya made an oral announcement of the items listed on the May 29, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Real Property Negotiators relative to APN:166-051-39-16, Conference with Labor Negotiators, Public Employee Evaluation: Executive Management and Public Employee Evaluation: CEO.

4. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 2:35 p.m. The motion passed unanimously (7-0).

5. At 3:20 p.m., the Board returned to Open Session with attendance as previously noted.

6. Report from Board Counsel on any action taken in Closed Session.

Board Counsel Scott stated he would provide a report out of Closed Session at the beginning of today's open session.

7. Adjournment

There being no further business, Vice Chairperson Chaya adjourned the meeting at 3:20 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
May 29, 2025 – 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 May 29, 2025.

In Chairperson Younger's "physical" absence, Vice Chairperson Chaya chaired today's meeting.

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

Director Sheila D. Brown
Director Rocky J. Chavez (via teleconference)
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi S. Gleason
Director Adela I. Sanchez
Director Tracy M. Younger (via teleconference)

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, Foundation President
Dr. Henry F. Showah, Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Vice Chairperson Chaya called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Report from Closed Session

   Board Counsel Jeff Scott reported the Board met in Closed Session with its Real Property Negotiator concerning APN:166-05-39-16 and took no action.

   The Board also met in Closed Session with their Labor Negotiator pursuant to Health & Safety Code 54957.6 and took no action.

   The Board also met in Closed Session for an Employee Evaluation of the Executive Management team pursuant to Government Code Section 54957(b)(i) and directed the CEO to take appropriate action.

Finally, the Board met in Closed Session for the Evaluation of the Chief Executive Officer pursuant to Government Code Section 54957(b)(1) and authorized the Board President to take appropriate action.

3. Pledge of Allegiance

   Roger Cortez, Chief Compliance Officer led the Pledge of Allegiance.

4. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Brown to approve the agenda as presented. The motion passed unanimously (7-0).

5. Public Comments – Announcement

   Vice Chairperson Chaya read the Public Comments section listed on the May 29, 2025 Regular Board of Directors Meeting Agenda.

6. Special Presentation

   Nurses and Support Staff of the Year for 2025

   a. Nurse of the Year (Inpatient) – Tami George, RN
   b. Nurse of the Year (Outpatient) – Bernadette Rosete, RN
   c. Patient Care Support Staff of the Year – Neil Damayo, ACT

   On behalf of the Nursing Division, Joanne Barnett, Senior Director, expressed her appreciation to the Board of Directors for the opportunity to recognize the recipients of the annual Nursing Division Awards. Ms. Barnett introduced Tami George, RN, who was honored as Inpatient Nurse of the Year, accompanied by her manager, Debbie Engelhart. She also introduced Bernadette Rosete, RN, accompanied by her manager, Tony Vitrano. Although Neil Damayo, ACT, Patient Care Support Staff, was unable to attend the meeting, his contributions were acknowledged. Ms. Barnett shared remarks and accolades from colleagues highlighting the outstanding dedication and accomplishments of the award recipients.

   On behalf of the Board of Directors, Vice Chairperson Chaya congratulated this year's award recipients.

7. April 2025 Financial Statements – Anh Nguyen, Chief Financial Officer

   Anh Nguyen, CFO, reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

   Fiscal year to date financials as follows: (Dollars in Thousands):
   - Net Operating Revenue – $247,286
   - Operating Expense – $282,572
   - EBITDA – $18,778
   - EROE – $3,857

   Fiscal year to date Key Indicators as follows:
   - Average Daily Census – 125

- Adjusted Patient Days – 63,375
- Surgery Cases – 4,499
- ED Visits – 39,360

Current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $26,355
- Operating Expense – $25,176
- EBITDA – $3,761
- EROE – $2,343

Anh also presented graphs including Average Length of Stay, Paid Full Time Equivalents per Adjusted Occupied Bed and Emergency Department Visits, all of which are trending in the right direction.

7. New Business

A. Presentation and consideration of potential TCHD Affiliation

I. Presentation of Potential Affiliation Partners – Chris Benson, Juniper Advisory

a. Sharp Healthcare Alliance Term Sheet Proposal
b. UC San Diego Health Affiliation Proposal

Chris Benson, representing Juniper Advisory, provided a comprehensive presentation outlining the affiliation process and progress to date. The presentation included the following components:

- Activities to Date
- Partners
- Proposals
- Next Steps
- Partnership Objectives

Mr. Benson reported that 25 potential partners were initially contacted, resulting in indications of interest from three organizations. Ultimately, two formal proposals were received: one from Sharp HealthCare and one from UC San Diego Health. Mr. Benson provided a detailed summary of each proposal, highlighting key elements of the proposed partnerships. The presentation concluded with a review of the overall partnership objectives. (The complete proposals were included in the Board's agenda materials.)

II. Comments from Potential Affiliation Partners' CEO

Chris Howard, CEO of Sharp HealthCare, and Patty Maysent, CEO of UC San Diego Health, each addressed the Board, sharing their respective visions, capabilities, and commitments to supporting Tri-City Healthcare District through a potential partnership.

III. Comments from Members of the Public

Vice Chairperson Chaya invited public comment and recognized the following individuals:

- Marvin Mizell, former Board member and resident of Vista, delivered an eloquent message emphasizing the importance of simplicity and trust in supporting Sharp HealthCare, encouraging all to seize the second opportunity and choose Sharp.

- Dr. Ma, who read into the record an email from community member Sarah Spinks, expressing general support for seeking a strategic partnership focused on prioritizing the health and well-being of the community.

- Randy Lenac, Grossmont Hospital Board Member (three terms), who also expressed support for Sharp HealthCare.

- Chris Kaiser, representing San Diego County, who voiced concerns regarding UC San Diego Health's alignment and encouraged the Board to carefully consider trust, transparency, and the long-term implications of the partnership.

Hearing no additional public comments, Vice Chairperson Chaya proceeded to request feedback from the Ad Hoc Affiliation Committee.

III. Recommendation from Ad Hoc Affiliation Committee

Director Sanchez, speaking on behalf of the Ad Hoc Affiliation Committee, acknowledged the extensive and diligent work undertaken over the past several years to identify a long-term partner that best serves the interests of patients, staff, and the broader community. Director Sanchez emphasized that the committee, with the assistance of third-party advisors, thoroughly evaluated over 25 potential partners before receiving two final, well-considered proposals. Input from staff, community stakeholders, and projections for future growth were carefully considered throughout the process.

Following exhaustive deliberation, the Ad Hoc Committee reached consensus that one proposal provides the clearest and most sustainable path forward. Director Sanchez expressed gratitude to the public, community members, leadership, and the prospective partners for their input and engagement throughout the process.

The Ad Hoc Affiliation Committee formally recommended that Tri-City Healthcare District enter into exclusive negotiations with Sharp HealthCare. Key highlights of the Sharp HealthCare proposal include:

- A long-term lease structure modeled after the successful Grossmont Hospital public-private partnership, with over 30 years of proven outcomes.

- Full assumption of the hospital's financial liabilities by Sharp HealthCare, providing financial stability.

- Over $100 million in capital commitments, including seismic compliance upgrades to support a minimum of 175 licensed beds.

- Employment opportunities for existing hospital staff, recognition of current labor union contracts, and a commitment to bargain in good faith.

- Retention of an independent Medical Staff and Foundation, which will continue as a separate supporting entity for the hospital.

- Sharp HealthCare will manage hospital operations under the long-term lease agreement, while the District will retain an important oversight role.

- The final lease agreement will be subject to voter approval by the residents of the communities served by the District.

Board Discussion and Possible Action

It was moved by Director Sanchez to approve the Sharp Term Sheet; authorize staff, consultants, and our attorneys to negotiate and execute a Letter of Intent consistent with the Term Sheet; and move forward with the due diligence and consideration of the definitive agreements for a long-term lease with Sharp Healthcare. Director Gleason seconded the motion.

Director Brown expressed that her primary concern throughout the process has been ensuring meaningful community engagement. She further emphasized the importance of maintaining services for the uninsured and preserving equivalent service lines ("like-for-like" services) as part of any proposed affiliation.

Director Brown requested clarification regarding the minimum requirement of 175 beds, which Dr. Ma then provided.

Director Younger extended appreciation to all participants attending this important meeting, particularly the Board members for their thoughtful evaluation of the proposals. Director Younger also recognized and thanked Chris Howard of Sharp HealthCare and Patty Maysent of UC San Diego Health for their attendance and presentations. She noted that, while both healthcare systems submitted strong and competitive proposals, the Ad Hoc Committee has recommended moving forward with the selected partner. Director Younger further observed that the non-selected system offers distinct programs that could complement, rather than duplicate, those of the recommended partner, potentially resulting in long-term benefits for all three organizations. She concluded by thanking the Ad Hoc Committee for its dedicated work throughout the affiliation process.

Director Chaya expressed gratitude to Juniper Advisory for their comprehensive presentation and invaluable guidance throughout this complex but essential process. She also extended sincere appreciation to Dr. Ma and his team for their collaboration and assistance in providing data to support the evaluation. Director Chaya concluded by again thanking both Patty Maysent and Chris Howard for taking the time to engage directly with the Board.

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

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

B. Consideration to approve the sale of Medical Office Suites at 2095 West Vista Way, Oceanside, CA 92056, subject to final approval by Tri-City Medical Center's lender

Jeremy Raimo, Chief Operating Officer, presented a proposal for the sale of Tri-City Healthcare District's 86% ownership interest in the property located at 2095 West Vista Way. Mr. Raimo noted that the District has maintained ownership of the property for many years and that the building is now well-positioned for renovation and revitalization under new ownership. The proposal presented for Board consideration recommends the disposition of the District's 86% ownership interest to an investor for the purchase price of $4.5 million.

It was moved by Director Brown to approve the sale of Tri-City Healthcare District's eighteen (18) medical office suites located at 2095 West Vista Way, Vista, California, to Archer Property Partners, LLC, for a total purchase price of Four Million Five Hundred Thousand Dollars ($4,500,000), subject to final approval by Tri-City Medical Center's lender. This motion authorizes District representatives to execute all necessary agreements and related documents and to take appropriate actions required to finalize the transaction, subject to all applicable legal and regulatory conditions. Director Gleason seconded the motion.

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

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

C. Consideration to approve an increase in contract maximum allowable by $350,000 for previously approved locum tenens pathology coverage with Barton & Associates to fulfill a critical service need.

Dr. Ma reported that the Board previously approved the use of locum tenens coverage following the departure of the District's contracted pathology group. To address this need, a contract was executed with Barton to provide temporary pathology services. Dr. Ma explained that the Request for Proposals (RFP) process to secure permanent coverage took longer than anticipated, extending the duration of the locum tenens arrangement. Although permanent coverage was secured as of February, the contract extension required to bridge the gap exceeded Dr. Ma's individual signature authority. In the interest of full transparency, Dr. Ma requested Board approval of the additional expenditures associated with the extended locum tenens coverage, which has now concluded.

It was moved by Director Sanchez to approve an increase in contract maximum allowable by $350,000 for a previously approved agreement with Barton & Associates to provide Locum Tenens Pathology Services for a term of 12 months, beginning July 1, 2025 and ending June 30, 2026, with a term cost not to exceed an additional $350,000. Director Gleason seconded the motion.

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

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

8. Old Business – None

9. Chief of Staff

   a. Consideration to approve the May 2025 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on May 22, 2025.

   b. Consideration of NP – Emergency Medicine Clinical Privilege Request Form

   c. Consideration of Medical Staff Bylaws Revisions

It was moved by Director Brown to approve the May 2025 Credentialing Actions and Reappointments Involving the Medical Staff; the Emergency Medicine Clinical Privilege Request Form and Medical Staff Bylaws revisions as recommended by the Medical Executive Committee on May 22, 2025. Director Sanchez seconded the motion.

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

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

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

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 pubic.

13. Comments from Chief Executive Officer

Dr. Ma echoed previous remarks, noting that the Board was faced with selecting between two outstanding health systems, each offering exceptional proposals. While either choice would have been a strong one, Dr. Ma emphasized that the selected partner represents a phenomenal choice, not only based on the strength of the proposal, but also due to the critical philosophical alignment that is essential for a successful long-term partnership. He underscored that Sharp Health Plan is the highest-rated health plan in California, further affirming the strength of the partnership.

Dr. Ma extended his sincere gratitude to Chris Howard and the Sharp HealthCare leadership team for their unwavering commitment throughout the process. He acknowledged that Mr. Howard's steadfast leadership is reflected throughout the entire Sharp organization and in its continued service to the community.

Dr. Ma also recognized and thanked several individuals who played significant roles behind the scenes, including Tricia Colletti, Brett McClain, Allison Fleury, Rick Grossman, and Scott Evans. He further acknowledged the considerable efforts of UC San Diego Health, recognizing the work and dedication required throughout the process.

In closing, Dr. Ma expressed his deep appreciation to the Board, commending its steadfast commitment and leadership throughout this extensive process. He emphasized that the Board's dedication and vision have made this achievement possible, and that the entire community owes the Board a significant debt of gratitude.

13. Board Communications

Vice Chairperson Chaya emphasized the Board's ongoing commitment to serving the community, stating that the primary goal is to ensure that accessible healthcare remains available to all members of the community for generations to come.

Director Sanchez extended congratulations to all staff members, particularly those recognized during today's meeting, for their outstanding service and dedication. She also wished everyone a happy Memorial Day and expressed gratitude to Director Chavez, a veteran and valued member of the Board, as well as to all staff who have served in the military, as the community pauses to honor both past and present veterans.

Director Brown acknowledged and commended the staff for their contributions during both Hospital Week and Nurse's Week, sharing her appreciation for the opportunity to attend the recent celebration. She expressed her admiration for the staff's hard work, dedication, and commitment to excellence. Director Brown also recognized Memorial Day and expressed gratitude to all veterans who have served and sacrificed.

Director Gleason expressed appreciation to the Ad Hoc Affiliation Committee and the leadership team, acknowledging their commitment, dedication, and tireless efforts throughout the affiliation process. She noted that the Board would not have reached this important milestone without their hard work.

14. Adjournment

There being no further business, Vice Chairperson Chaya adjourned the meeting at 4:50 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending May 31, 2025

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term 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)	57,663.11	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)	39,582.19	07/01/17	08/31/26	**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)	22,565.63	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)	9,118.21	04/01/23	03/31/26	**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)	16,350.14	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)	26,670.90	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)	13,794.33	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)	34,015.00	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)	11,165.33	05/01/23	06/30/25	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**266,400.05**				

(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 May 2025

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6171	ONS CHEMO	041625 EDU	325.00	84593	GOODRICH JORDYN
6185	CHEMO	33125 EXP	552.00	84590	FURIAK OLIVIA
8381	HPSA CONF	043025 EDU	550.00	84146	JACKSON SHELDON
8740	ASRT CEU	050225 EDU	135.00	84413	HAVENER ABIGAIL
8740	MASTERS	042325 EDU	5,000.00	84591	HERVAS JASMINE
8740	ASPEN	050225 EDU	200.00	84279	CESAR GABRIELA
8740	CCRN	51325 EDU	200.00	82567	JENNIFER GLEAVES
8740	MSN	51325 EDU	2,550.00	84421	SHOEMAKER SHANNON
8754	RISK MANGMT	052125 EDU	149.99	84410	LUBEGA JUDITH

**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.