

**TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
November 6, 2014 - 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056**

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	2 Hours	
	a. Conference with Legal Counsel – Potential Litigation Gov. Code Section 54956.9(d) (3 Matters)		
	b. Conference with Legal Counsel – Existing Litigation Gov. Code Section 54956.9(d)1, (d)4 (1) Larry Anderson Employment Claims (2) TCHD vs. Burlew Case No. 37-2014-00034015-CU-NP-NC		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	d. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		

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

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

	Agenda Item	Time Allotted	Requestor
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement 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 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Community Activity Report – EBOLA – Sharon Schultz, CNE	10 min.	S. Schultz
13	Special Presentation – None		
14	Report from TCHD Auxiliary – Sandy Tucker, President	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business		
	a. Approval of an agreement with Cepheid for the GeneXpert Microbiology System for a term of 60 months (5 years) beginning December 1, 2014 through November 30, 2019 for an annual cost of \$166,704, and a total cost for the term of \$883,520 and (2) Cerner interface charges which will be determined, estimated at \$20,000 – Presentation by Dr. Marcus Contardo	5 min.	FO&P Comm./ Dr. Contardo
	b. Approval to appoint Ms. Kathryn Fitzwilliam to a two year term on the Audit, Compliance & Ethics Committee	3 min.	Audit, Comp./ Ethics Comm.
	c. Approval to appoint Mr. Barton Sharp to a two year term on the Audit, Compliance & Ethics Committee	3 min.	Audit, Comp./ Ethics Comm
	d. Certificate of appreciation to Mr. Robert Pearman for his two terms of service on the Audit, Compliance & Ethics Committee	3 min.	Audit, Comp./ Ethics Comm
18	Old Business - None	5 min.	Chair
19	Chief of Staff a. Consideration of October 2014 Credentialing Actions Involving the Medical Staff – New Appointments Only	5 min.	Standard
20	Consideration of Consent Calendar (1) Medical Staff Credentials for October, 2014 (2) Medical Executive Committee Summary Report (3) Board Committees (1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.	5 min.	Standard Standard

	Agenda Item	Time Allotted	Requestor
	<p>(2) All items listed were recommended by the Committee. (3) Requested items to be pulled <u>require a second.</u></p> <p>A. Human Resources Committee Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes)</p> <p>1. Approval of Administrative Policy & Procedure #8610-403 – Harassment Policy</p> <p>2. Approval of Administrative Policy& Procedure #8610-448 – Reduction in Work Force</p> <p>B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats - 0 <i>No meeting held in October, 2014</i></p> <p>C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes)</p> <p>D. Finance, Operations & Planning Committee Director Dagostino, Committee Chair Open Community Seats - 1 (Committee minutes included in Board Agenda packets for informational purposes.)</p> <p>a. Approval of an expenditure for the Cardiovascular Institute Medical Directorship Agreements with Drs. David Spiegel, Kathleen Paveglio, Donald Ponec, Andrew Deemer, Theodore Folkerth and Paul Mazur for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$171,360 with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p> <p>b. Approval of an expenditure for the Cardiovascular Institute Committee Physician Agreements with Dr. Mohammed Jamshidi, Theodore Folkerth, David Spiegel, John Kroener, Kathleen Paveglio and Donald Ponec for a 12-month term beginning July 1, 2014 through June 30, 2015 at an annual amount not to exceed \$30,240, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p> <p>c. Approval of an expenditure for the Orthopedic & Spine Institute Co-Management Agreement for a 12-month term beginning October 28, 2014 and ending on October 27,</p>		<p>HR Comm.</p> <p>Emp. Fid. Subcomm.</p> <p>CHAC Comm.</p> <p>FO&P Comm.</p>

	Agenda Item	Time Allotted	Requestor
	<p>2015, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval. Total compensation shall not exceed \$750,000.</p> <p>d. Approval of an expenditure for the Orthopedic & Spine Institute Medical Directorship agreements with Dr. Neville Alleyne, James Esch, James Helgager and Lokesh Tantuwaya for a 12-month term beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$124,080 with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p> <p>e. Approval of an expenditure for the Orthopedic & Spine Institute Committee Physician agreements with Drs. Neville Alleyne, Andrew Cooperman, Janet Dunlap, Andrew Hartman, James Helgager and Payam Moazzaz for a 12-month term beginning July 1, 2014 through June 30, 2015 at an annual amount not to exceed \$50,760 with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p> <p>f. Approval of an expenditure for the Neuroscience Institute Committee Physician Agreements with Drs. Tyrone Hardy, Gregory Sahagian, Kevin Yoo, Donald Ponec, Jack Schim and Lokesh Tantuwaya for a 12-month term, beginning July 15, 2014 through July 14, 2015 at an annual amount not to exceed \$30,240 with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of manager approval.</p> <p>g. Approval of a service agreement with General Electric Healthcare for two radiology CT scanners for a term of 36 months, beginning October 1, 2014 through September 30, 2017 for an annual cost of \$216,504 and a total cost for the term of \$649,512.</p> <p>h. Approval of the purchase of two manufacture refurbished C-arms at a total cost of \$299,251.</p> <p>i. Approval of a Medical Director Agreement with Dr. Gary M. Willard for Outpatient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program for a term of 24 months beginning July 1, 2014 through June 30, 2016, not to exceed an average of 35 hours per month or 420 hours annually, at an hourly rate of \$190 and a total for the term of \$159,600.</p> <p>j. Approval of physician agreement for Clinical and Anatomic Pathology Laboratory with Dr. Marcus Contardo and North Coast Pathology Medical Group, as TCHD's exclusive provider of Lab and Pathology Services for a term of 36 months beginning August 1, 2014 through July 31, 2017, not to exceed an annual cost of \$312,000 and a total cost for the term of \$936,000.</p>		

	Agenda Item	Time Allotted	Requestor
	<p>E. Professional Affairs Committee Director Reno, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.)</p> <p>1. <u>Patient Care Services Policies & Procedures:</u></p> <ul style="list-style-type: none"> a. Code Triage Alert, Emergency Department- Procedure b. End Tidal CO2 (EtCo 2) Monitor- Procedure c. Medication Recall- Policy d. Pain Management- Policy e. Patient Controlled Analgesia- Procedure f. Point of Care Testing Competency Assessment- Procedure g. Pre-Printed Orders- Policy h. Pulse Oximetry- Procedure i. Sponges, Sharps, and Instruments Counts, Prevention of Retained Surgical Objects- Procedure j. Wound VAC (Vacuum Assisted Procedure), Negative Pressure Therapy- Policy <p>2. <u>Administrative Policies & Procedures:</u></p> <ul style="list-style-type: none"> a. Purpose and Responsibility of Risk Management- Policy <p>3. <u>Unit Specific Emergency</u></p> <ul style="list-style-type: none"> a. Culture Follow-up, Emergency Department – Policy b. Triage of Emergency Department Patients – Procedures <p>4. <u>NICU</u></p> <ul style="list-style-type: none"> a. Chest Tube, Care of Infants with Pneumothorax- Procedure b. Nasogastric (NG) and Orogastic (OG) Tube Insertion, Maintenance, and Removal- Procedure c. Pain Management, Neonates and Infants- Policy d. Patient Assignments in NICU- Procedure e. Patient Classifications (Acuity) in NICU- Procedure f. Pre-Post Weights for Breastfed Infants in NICU- Procedure g. Replogle Tube Insertion and Maintenance- Procedure h. Staffing Policy for High Census- Policy <p>5. <u>Women and Children's Services</u></p> <ul style="list-style-type: none"> a. Neonatal Resuscitation Team for Scheduled Cesarean Sections – Procedure b. Placenta Release to Patient/Family <p>6. <u>Staffing Resource</u></p> <ul style="list-style-type: none"> a. Disaster Call Back List-Policy <p>F. Governance & Legislative Committee Director Schallock, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes.)</p>		<p>PAC Comm.</p> <p>Gov. & Leg. Comm.</p>

	Agenda Item	Time Allotted	Requestor
	<ol style="list-style-type: none"> 1. Approval of Community Healthcare & Alliance Committee Charter. 2. Approval that changes to Medical Staff Policy and Procedure and Departmental Rules and Regulations be reviewed at Governance Committee prior to Board approval. 3. Approval of Board Policy 14-044 – Distribution of Tickets and Passes to District-Sponsored or Controlled Events and Donated Tickets and Passes 4. Approval of AP&P 8610-483 – Conflicts of Interest and Acceptance of Gifts 5. Approval of Pharmacy Services Policy 8390-10025 – Pharmaceutical Vendors 6. <u>Medical Staff Department/Divisions Rules & Regulations</u> <ol style="list-style-type: none"> 1. Division of Cardiology Rules & Regulations 2. Division of Neonatology Rules & Regulations 3. Department of OB/GYN Rules & Regulations 4. Department of Radiology Rules & Regulations 7. <u>Medical Staff Policies:</u> <ol style="list-style-type: none"> 1. Name Tags for Health Care Practitioners, 8710-521 2. Physician Surgical Assistant 8710-536 3. Suspension for Delinquent Medical Record, 8710-519 8. <u>Medical Staff Standardized Procedures:</u> <ol style="list-style-type: none"> 1. NICU Nurse Practitioner Standardized Procedures <p>G. Audit & Compliance Committee Director Finnila, Committee Chair Open Community Seats – 2 (Committee minutes included in Board Agenda packets for informational purposes.)</p>		Audit, Comp. & Ethics Comm.
	(5) Minutes – Approval of <ol style="list-style-type: none"> a) September 25, 2014 – Regular Board of Directors Meeting b) September 23, 2014 – Special Board of Directors Meeting c) October 21, 2014 – Special Board of Directors Meeting d) October 28, 2014 – Special Board of Directors Meeting 		Standard
	(6) Meetings and Conferences		Standard
	(7) Dues and Memberships - None		Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) <ol style="list-style-type: none"> (a) Dashboard - Included (b) Construction Report - Included (c) Lease Report – (September, 2014) 	0-5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(d) Reimbursement Disclosure Report - (September, 2014) (e) Seminar/Conference Reports - None		
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board.	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session (Includes 10 minutes for recess to accommodate KOCT tape change)	2 hours/ 15 min.	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 21, 2014
PROPOSAL FOR: Laboratory Microbiology – GeneXpert System

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

Vendor/Instrument Name: Cepheid GeneXpert System

Area of Service: Laboratory – Molecular PCR (Polymerase Chain Reaction)
Microbiology Diagnostic Testing

Term of Agreement: 60 months Beginning 12/1/2014, Ending 11/30/2019

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$13,892	\$166,704	\$833,520

Description of Services/Supplies:

- This instrument exploits nucleic acid amplification technology to provide the rapid detection of significant disease-causing organisms and certain inborn diseases.
- Its rapid in-vitro reaction provides for the definitive identification of common infections of importance in Tri-City Hospital and community settings. And, it allows us to limit high-cost, labor-intensive, culture-based testing to only those applications where it is deemed necessary...thus utilizing our precious CLS staff at their highest and best use.
- It replaces traditional culture methods, which usually take 2 or more days, with a method yielding actionable results in 4 hours or less. (Compare to TB cultures.) And, this speed comes with gold-standard sensitivity and specificity.
- Adoption will have significant positive impacts on: antibiotic stewardship, infection control, the earlier initiation of correct antibiotic treatment, reducing the use of broad-spectrum antibiotics, and public health. The technology provides a short path to major impacts on patient care.
- Optimized as it is to run from a direct swab from the patient without sample preparation or DNA extraction, the time-to-result can be as short as 1.5 hours.
- It profoundly affects Tri-City's ability to successfully identify and rapidly isolate potentially infectious patients. And conversely.
- It will enable us to work smarter and faster.
- Approximated annual expense increase to operationalize GeneXpert solution is \$38,000 (5 year \$190,000)

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement:
Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize (1) the agreement with Cepheid for the GeneXpert Microbiology System for a term of 60 months (5 years), beginning 12/1/2014 and ending 11/30/2019, for an annual cost of \$166,704, and a total cost for the term of \$833,520, and (2) Cerner interface charges which will be determined, estimated at \$20,000.



AUDIT, COMPLIANCE & ETHICS COMMITTEE
October 16, 2014

CONTACT: Ramona Finnila, Chairperson

Agenda Item: Consideration to appoint Ms. Kathryn Fitzwilliam to a two-year term on the Audit, Compliance & Ethics Committee.

Background: Ms. Fitzwilliam interviewed along with five other individuals for one of two open slots on the Audit, Compliance & Ethics Committee. The committee unanimously supported appointment of Ms. Fitzwilliam.

Recommendation: The Audit, Compliance & Ethics Committee recommended the Board appoint Ms. Kathryn Fitzwilliam to a two-year term on the Committee. This recommendation is being brought to the Board for approval.

4-30-14

Kathryn Fitzwilliam
6041 Patmos Way, Oceanside, CA 92056
(760) 941 3288
kfitzwill@hotmail.com

April 23rd, 2014

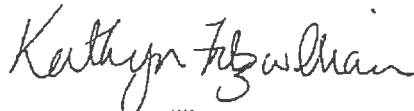
Dear Teri:

I have attached my resume for consideration for the open position on the Tri-City Healthcare District, Audit/Compliance/Ethics Committee. I noticed this opening on the website but also know Ira Landis who has just vacated this position after his four year tenure.

As you can see I am a professional with over 20 years of audit experience both with a Public Accounting firm and in industry and in addition I have a lot of experience with process improvement and business systems design and implementation. I think this background positions me well to make a valuable contribution to the Tri-City Healthcare District Board of Directors.

I can be reached by email or at the number noted above for any questions you may have about my qualifications. I look forward to hearing from you.

Sincerely;



Kathryn Fitzwilliam

PROFESSIONAL EXPERIENCE

Life Technologies Inc, Carlsbad, California

2007 – 2014

Director, Accounting & Finance

Reporting to the Chief Accounting Officer of a \$3.5 billion biotech company, with a staff of 4 responsible, in a leadership role, for integration of specific accounting functions of acquired companies, design and implementation of a European Finance shared services, implementation, upgrades and enhancements of major ERP systems and the management of the Global SOX 404 program for both Finance and IT controls including internal control design and rationalization.

Gateway Inc, Irvine, California

2003 – 2006

VP, Internal Audit

Reporting to the Audit Committee and CFO with a staff of 10, responsible for financial, operational and IT audit activity for \$4.0 billion technology company. Achievements include: the re-establishment of the audit department; development of a staffing model using internal and co-sourced resources; budget development; design and implementation of an audit methodology; project scoping, design implementation and execution of the Sarbanes Oxley 404 program. Specific responsibilities include: strategic, financial and fraud annual risk assessment; development of annual risk-based audit plan; audit execution, reporting and follow up; disclosure committee reporting; and strategic and tactical management of the successful Sarbanes Oxley program including process narratives, control matrices, process testing and remediation plan development.

The Walt Disney Company, Burbank, California

2000 – 2003

Director, Management Audit

Reporting to VP of Internal Audit, one of three Directors, responsible for: global risk assessment for all divisions of The Walt Disney Company; preparing an annual risk based audit plan; directing audit execution; communicating findings and required action plans to senior management; and monitoring company control self assessment results. Scope included all financial and operational areas and specific responsibilities for all IT processes. Direct reports of three managers and 10 professional staff. Achievements included implementing a co-sourced audit arrangement and new audit methodology resulting in 100% productivity improvement over 2 years.

Kelly Services, Inc., Troy, Michigan

1995 - 2000

Director, Business Systems

1998- 2000

Directed staff of 10 who maintained, developed and implemented systems for a subsidiary of Kelly Services. Responsible for: business process re-engineering; implementation of Oracle Financials, HRMS and Payroll; Y2K remediation of in-house UNIX systems; system security

and disaster recovery planning; selection and implementation of package software. Also conducted post implementation reviews of Oracle systems worldwide and provided project plans and project management to resolve issues.

Director Internal Audit 1997 - 1998

Reporting to VP, Internal Audit managed Financial, IT, Operational and International subsidiary audits for \$4.0 billion organization. Responsible for: identifying audit risk; preparing annual risk-based audit plan; planning audit engagements; developing and reviewing audit programs; performing fieldwork; due diligence reviews for acquisitions; communicating findings and recommendations to audit committee and senior management both verbally and in written audit reports.

IT Audit Manager 1996 - 1997

Supervised IT Auditors and conducted technical audits including: application reviews; consulting on new applications; general control reviews; security and control audits. Conducted financial and IT audits for international subsidiaries and participated extensively with outside auditors during annual audits.

Senior Information Systems Auditor 1995 - 1996

Conducted IT audits, prepared and delivered verbal and written audit reports.

Deloitte & Touche LLP, Detroit, Michigan 1992 - 1995

Senior Business Systems Consultant

Consulting Assignments

Consulted with clients in various businesses on projects including: strategic information system planning; system design and selection; system integration and implementation.

Accounting Assignments

Acted as interim Director of Finance for two separate companies undergoing major re-organizations. Benefits to clients included more efficient processes, dramatically improved cash flows, improved staff morale, and smooth transition to new incumbents.

Auditing Assignments

Supervised and managed annual financial audits for a wide variety of middle market clients including manufacturing, real estate, service and wholesale distribution clients.

Amerisure, Southfield, Michigan 1990 - 1991

Business Systems Analyst

As an internal consultant for a major insurance company, identified, designed, documented and implemented custom system enhancements for a comprehensive mainframe insurance package.

Fanuc Robotics, Auburn Hills, Michigan 1989 - 1990

Interim Controller and MIS Director – UK subsidiary

Responsible for design and implementation of all accounting and information systems for newly acquired UK subsidiary. Managed accounting and administrative staff.

ParaData Computer Networks, Inc., Farmington Hills, Michigan 1983 - 1989

Senior Sales Account Manager

Product Development Manager

Customer Training and Support Manager

EDUCATION, PROFESSIONAL QUALIFICATIONS AND HONORS

Walsh College of Accountancy and Business Administration, Troy, Michigan

Bachelor of Accountancy, GPA 3.96/4.0, Presidential Scholarship, President's Honor Roll

Oakland Community College, Farmington Hills, Michigan

Associate Degree in Computer Science, Summa Cum Laude, GPA 4.00/4.00, and Dean's Honor Roll

Certified Public Accountant, licensed in State of Michigan, status registered

Certified Information Systems Auditor (non current on CPE's)

AICPA Elijah Watts Sells Award with High Distinction for CPA examination achievement (top 100 in country, out of 70,000)

Financial Executive Institute Award - Walsh College recipient for academic achievement



AUDIT, COMPLIANCE & ETHICS COMMITTEE
October 16, 2014

CONTACT: Ramona Finnila, Chairperson

Agenda Item: Consideration to appoint Mr. Barton C. Sharp to a two-year term on the Audit, Compliance & Ethics Committee.

Background: Mr. Sharp interviewed along with five other individuals for one of two open slots on the Audit, Compliance & Ethics Committee. The committee unanimously supported appointment of Mr. Sharp.

Recommendation: The Audit, Compliance & Ethics Committee recommended the Board appoint Mr. Barton Sharp to a two-year term on the Committee. This recommendation is being brought to the Board for approval.

Rec'd
9-23-14

Bart Sharp biography

Born in San Diego Calif

Joined the Navy. Stationed in San Diego @ San Diego Naval Medical Center working as senior corpsman medical surgical and as a lifeguard in special services. met my future wife Sandra there as she was working in the outpatient dependents clinic.

I have held mgmt positions with JC Penney in merchandise management and Walt Disney company. As buyer manager and as manager training and development at Disneyland

President of a 30 store. Gift store chain in so Calif

Owner of 9 hotel gift shops which we. Sold in 1993

worked for Smyth Retail Systems from 1993 until 2003 at which time we purchased the Company with a small group of investors. I took a inactive role in 2008

2011/2012 Served on San Diego county grand jury as chairman health and human services committee, chairman public relations /recruitment committee, member of the education committee and member of the complaints committee.

Member Past Grand Jury Association of San Diego County

Board Member United States Selective Service System

My wife Sandra is a Registered Nurse retired from Scripps Hospital after 26 years.

Specializing in Medical Surgical and Women's Health as a Postpartum Nurse and Lactation Consultant

She is a Board Member Of Calavera Hills RV Park Corporation since 1992, Currently serving as President

My wife and I serve as camp hosts at Campground by the Lake at So Lake Tahoe Calif

Owned and operated by the city of So Lake Tahoe We also serve as camp hosts at Silver Strand State Beach Campground at Coronado Ca

we have 3 grown children and 3 grandchildren



Medical Staff Office
Tri-City Medical Center

4002 Vista Way, Oceanside, CA 92056-4506 • (760) 940-3001

TO: Larry Schallock, Chairperson
FROM: Scott Worman, M.D., Chief of Staff
DATE: November 6, 2014
SUBJECT: Medical Executive Committee Credentialing Recommendations – New Appointments

The attached Medical Staff New Appointments Credentials report was reviewed and approved at Credentials Committee on October 8, 2014. Their recommendations were reviewed and approved by the Medical Executive Committee on October 27, 2014. This report is forwarded to the Board of Directors with recommendations for approval:

SUBMITTED BY:

 Scott Worman, M.D., Chief of Staff

 Date

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

 Julie Nygaard, Secretary
 For and on behalf of the TCHD Board of Directors

 Date



**TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
October 8, 2014**

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 11/06/2014 – 10/31/2016)

Medical Staff – Appoint to Provisional Staff and grant privileges as delineated:

Barboza, Richard M., MD – Anesthesiology
Capella, Marina N., MD – Pediatrics
Faravardeh, Armand, MD – Nephrology/Medicine
Iyengar, Srinivas S., MD – Ophthalmology/Surgery
Jurewitz, William H., MD – Obstetrics/Gynecology
Latendresse, Thomas R., MD – Anesthesiology
McCammack, Bradley D., MD – Pediatrics
Sadler, Charlotte A., MD – Emergency Medicine
Slater, Madeline L., MD – Infectious Disease/Medicine
Smith, Erica A., MD – Anesthesiology
Stephens, Robert, MD – Anesthesiology

Allied Health Professionals – Appoint to Allied Health Professional Staff and grant privileges as delineated:

Willett, Brie A., PA-C – Emergency Medicine

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Medical Staff:

None

Allied Health Professionals:

None

TEMPORARY PRIVILEGES:

Medical Staff/Allied Health Professionals:

Gandhi, Dhruvil P., MD – Colon-Rectal Surgery/Surgery – Robotic Surgery – Multi Port (da Vinci)
Smith, Erica A., MD – Anesthesiology
Stephens, Robert, MD – Anesthesiology

TEMPORARY MEDICAL STAFF MEMBERSHIP:

Medical Staff:

None



TO: Larry Schallock, Chairperson

FROM: Scott Worman, M.D., Chief of Staff

DATE: November 6, 2014

SUBJECT: Medical Executive Committee Credentialing Recommendations – Reappointments

The attached Medical Staff Reappointments Credentials report was reviewed and approved at Credentials Committee on October 8, 2014. Their recommendations were reviewed and approved by the Medical Executive Committee on October 27, 2014. This report is forwarded to the Board of Directors with recommendations for approval:

SUBMITTED BY:

Scott Worman, M.D., Chief of Staff

Date

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

Julie Nygaard, Secretary
For and on behalf of the TCHD Board of Directors

Date



**TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
October 8, 2014**

Attachment B

REAPPOINTMENTS

MEDICAL STAFF

NONE

ALLIED HEALTH PROFESSIONALS

NONE

RESIGNATIONS (Effective specified date)

Voluntary:

Brogoitti, Teresa A., OT, Surgery (effective 07/31/2014)
Goldberg, Ruth, CNM, OB/GYN (effective 09/05/2014)
Lee, Michael J., MD, Anesthesiology (effective 09/30/2014)
Silverberg, Heather I., MD, Pediatrics (effective 08/20/2014)
Simpson, Jessica B., MD, OB/GYN (effective 07/30/2014)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
October 8, 2014

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 10/30/2014, unless specified otherwise)

Gandhi, Dhruvil, MD, Surgery/General & Vascular Surgery

Add: Robotic surgery – Multiple Port (da Vinci) – temporary privileges requested beginning 10/9/14

Hanna, Karen, MD, Surgery/General & Vascular Surgery

Add: Bariatric Surgery category

- Roux en Y gastric bypass, open and laparoscopic
- Sleeve gastrectomy, open and laparoscopic
- Adjustable gastric banding, op-en and laparoscopic
- Revisional metabolic and bariatric surgery, open and laparoscopic
- Biliopancreatic diversion, with or without duodenal switch, open and laparoscopic

Toosie, Katayoun, MD, Surgery/General & Vascular Surgery

Add: Privileges as listed on new GVS privilege form; privileges have been re-categorized

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
October 8, 2014

Attachment B

PROCTORING RECOMMENDATIONS (Effective 10/30/14, unless otherwise specified)

Aminlari, Amy, MD, Emergency Medicine

Release from proctoring: General Patient Care category

Choudry, Bilal, MD, Medicine/Neurology

Release from proctoring: Admit patients
Consultation, including via telemedicine
History and physical, including via telemedicine

Fowler, Blake, MD, Anesthesiology

Release from proctoring: General anesthesia
Regional anesthesia

Hanna, Karen, MD, Surgery/General & Vascular Surgery

Release from proctoring: Basic General Surgery Privilege category

Kyaw, Naing, MD, Medicine/Internal Medicine

Release from proctoring: Admit patients, Internal Medicine
Consultation, Internal Medicine, including via telemedicine
History and physical, Internal Medicine, including via telemedicine
Admit patients, Nephrology
Consultation, Nephrology, including via telemedicine
History and physical, Nephrology, including via telemedicine

Seif, David, MD, Anesthesiology

Release from proctoring: Regional anesthesia

Theisen, April, PA, Emergency Medicine/Allied Health Professional

Release from proctoring: Arthrocentesis

Quick, Alexander, MD, Anesthesiology (100% Complete)

Release from proctoring: General anesthesia and Regional anesthesia

Uher, Romana, MD, Pediatrics/Neonatology (100% Complete)

Release from specific proctoring: Consultation
Invasive Procedures Category
Non-Invasive Procedures Category
Moderate sedation

TRI-CITY MEDICAL CENTER
MEDICAL EXECUTIVE COMMITTEE
OPEN SESSION – Report to Board of Directors
Monday, August 25, 2014

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATIONS
1. Administrative Reports	
A. CEO Report	<p>Tim Moran, CEO reported the following:</p> <ul style="list-style-type: none"> ➤ TCMC is doing well financially showing a profit of approximately \$500,000 ahead of the planned budget for the month of July. ➤ Currently the previous fiscal year financials are being audited and it is expected TCMC will receive a clean audit with no extraordinary adjustments of any kind. <p>In addition to the financial reports, Mr. Moran disclosed information regarding recent reports to regulatory entities:</p> <ul style="list-style-type: none"> ➤ There was an anonymous complaint about life safety concerns reported to the Joint Commission. A surveyor came to investigate the complaint and tour the facility. ➤ There was a PHI breach reported to CDPH. <p>Lastly, Mr. Moran reported he will begin his "Community Breakfasts" tomorrow; these will occur approximately every 2 weeks.</p>
B. Board Member Report	<p>James Dagostino, Board of Directors, reported the following:</p> <ul style="list-style-type: none"> ➤ The Compliance Officer position is open and candidates are being interviewed. In addition, the Board is reviewing how the Legal Department will work once a Compliance Officer is in position. Lastly, after the November elections; the Board will need to decide how the Board will be configured and then the expectation is the Board of Directors will begin to look at the campus and determine what type of equipment and services are needed for the future of the hospital. ➤ There are several public forums scheduled over the next 2 months. ➤ On August 7, Tim Moran was introduced to the community with over 200 community members in attendance.
2. Committee/Department Reports	<p>Radiology: Reported the following:</p> <ul style="list-style-type: none"> ➤ Started a Joint Neonatology-Radiology Conference to meet monthly

**TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS**
October 14, 2014

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Director James Dagostino, Dr. Gene Ma, Dr. Hamid Movahedian, Dr. Martin Nielsen, Henry Holloway, Salvador Pilar, Virginia Carson
Non-Voting Members Present:	Sharon Schultz, CNE/CCO; Esther Beverly, VP of HR; Daniel Kanter, Esq.
Others Present:	Frances Carbajal, Quinn Abler
Members Absent:	Tim Moran, CEO; Sydelle Gale

Topic	Discussion	Action Follow-up	Person(s) Responsible
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1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of October 14, 2014 meeting. Director Dagostino moved and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the September 11, 2014 meeting. Director Reno moved and Director Dagostino seconded the motion. The motion was carried unanimously.		Chair Kellett

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Topic	Discussion	Action Follow-up	Person(s) Responsible
5. Old Business			
a. Policy Discussion/Action Separation Policy & Procedure Update	The Committee reviewed Policy 8610-XXX. Chair Kellett called for a motion to send Policy 8610-XXX to the Board of Directors for approval with amendments. Director Reno moved and Director Dagostino seconded the motion. The motion was carried unanimously.	Policy 8610- XXX amended to be sent to Board of Directors for approval at the November 2014 meeting.	Esther Beverly
b. New Business			
a. B.O.D Dashboard- Stakeholder Experience	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed.		Chair Kellett
b. Review HR Metrics	Quinn Abler, HR Director presented the quarterly metrics. Quarterly headcount and annual turnover rates by union & overall. TCHD turnover rates are overall low & within national benchmarks.		Esther Beverly
c. Review Workers Comp Cases	Rudy Gastelum, EHS Director presented a high level review of quarterly work comp. retention rates and current broker info. The committee discussed retention rates & practice, claim counts, incurred cost, new third party administrator & broker info, medical provider network, injury management counselor & department reports.		Esther Beverly
d. Review Training & Education Topics	<p>Esther discussed plans to develop a 6-month program to be delivered in a blended learning approach to include leader-led, web-based, NetLearning and facilitated discussions with key executives. A pilot group is also being looked at for pre and post assessment of the training.</p> <p>Other continuing education opportunities include:</p> <ul style="list-style-type: none"> • New Employee Manual • "Training on the Collective Bargaining Agreements" 		Esther Beverly

Topic	Discussion	Action Follow-up	Person(s) Responsible
	<ul style="list-style-type: none"> • "How to Conduct an Investigation" • "Managing Performance Issues" • Sexual Harassment and Discrimination • Behavioral-Based Interviewing 		
e. Key Grievances/ER-LR Data Topics	Esther explained current status on CNA & SEIU grievances and one non-represented employee fair treatment process. The committee discussed the current process for dealing and following up with grievances &/or employee issues.		Esther Beverly
f. Policy Discussion/Action Policy 8610-455 Confidentiality	The Committee reviewed Policy 8610-455. Chair Kellett called for a motion to send Policy 8610-455 to the Board of Directors for approval. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-455 to be sent to Board of Directors for approval at the November 2014 meeting	Esther Beverly
c. Work Plan	The work plan was reviewed.	No items for November.	Chair Kellett
d. Committee Communications	None		Chair Kellett
e. Date of next meeting	November 11, 2014	If needed only.	Chair Kellett
f. Adjournment	Chair Kellett adjourned the meeting at 2:00 p.m.		Chair Kellett

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 05/83

SUBJECT: Harassment Policy

REVISION DATE: 01/09; 04/12; 02/13; 12/13

POLICY NUMBER: 8610-403

Human Resources Committee Approval:

12/13

Board of Directors Approval:

12/13

A. PURPOSE:

Tri-City Healthcare District (TCHD) is committed to providing a workplace free of harassment, based on race, religious creed (including religious dress and grooming practices), color, national origin, ancestry, physical disability, mental disability, medical condition (including AIDS and/or HIV status), genetic information, military and veteran status, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, pregnancy, childbirth, breastfeeding, and/or related medical conditions. These characteristics are defined as "protected classes." TCHD will not tolerate harassment of employees or non-employees by managers, supervisors, employees, co-workers, vendors, or third-party providers.

B. DEFINITIONS OF SEXUAL HARASSMENT

1. Quid Pro Quo Sexual Harassment: Submission to unwelcome sexual advances or requests for sexual favors that are made a condition of employment or the receipt of employment opportunities (If you do this; I'll do that.)
2. Hostile Work Environment: Unwelcome verbal, physical, or visual conduct of a sexual nature that unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment.

C. EXAMPLES OF SEXUAL HARASSMENT:

1. Unlawful harassment includes any of the following:
 - a. Verbal Harassment – Includes epithets, derogatory comments, or slurs based on any of the protected classes defined above, verbal sexual advances, repeated unwelcome sexual flirtations or propositions and requests for sexual favors. Additionally, continued or repeated comments of a sexual nature, graphic verbal commentaries about an individual's body, bullying, sexually degrading words used to describe an individual, or suggestive or obscene letters, notes, or invitations, also constitute verbal harassment.
 - b. Physical Harassment – Includes conduct such as unwanted touching, spanking, offensive or abusive contact, assault, impeding or blocking movement, bullying, or physical interference with normal work or movement.
 - c. Visual Forms of Harassment – Include derogatory posters, notices bulletins, cartoons or drawings on the basis of any protected class. Leering, making sexual gestures, and displaying sexually suggestive objects or pictures also constitute harassment (e.g. displaying on walls, cubicles, file cabinets and computer screens).
2. Sexual harassment, as prohibited by law, is distinguished from a consensual sexual relationship by the elements of coercion, threat, unwanted attention, unwelcome or unwanted sexual advances, requests for sexual favors, and other verbal, visual or physical conduct of sexual

nature, without regard to the sex of the harasser and victim where either:

- a. Submission to or rejection of such conduct is made either explicitly a term or condition of employment or participation in other TCHD activities; or
 - b. Submission to or rejection of such conduct by an individual is used as a basis for evaluation in making personnel decisions affecting an individual; or
 - c. Such conduct unreasonably interferes with an individual's performance or creating an intimidating, bullying, hostile, or offensive work environment.
3. It is also unlawful and inappropriate for a patient to receive unwanted sexual advances or to be the subject of an intimidating, bullying, hostile or offensive patient care environment by a TCHD employee.

D. POLICY:

1. Every incidence of harassment will be investigated promptly, thoroughly, and in as confidential a manner as possible.
2. TCHD will not tolerate retaliation against any employee for cooperating in an investigation or reporting or making a complaint of harassment. Retaliation is an unwarranted, adverse action taken against an employee who reports misconduct. Retaliation may include, but is not limited to, changing the employee's work schedule without legitimate business justification, unwarranted negative performance review, disciplinary action taken against the employee without legitimate business reasons.
3. If TCHD determines that an employee has engaged in harassment or retaliation, appropriate disciplinary action will be taken. Disciplinary action for a violation of this policy can range from verbal or written warnings up to and including termination of employment.
4. Medical Staff members are required to uphold federal and state laws prohibiting harassment. TCHD takes any complaints of violations of this policy by Medical Staff seriously. Violations of this policy regarding harassment are grounds for corrective action in accordance with the Medical Staff Bylaws and policies.

E. PROCEDURE:

1. Any incident of harassment whether directed to the employee or overseen or overheard by another employee should be reported promptly to the employee's supervisor or manager (or to any other member of management) or to a Human Resources representative. Managers who receive complaints or who observe harassing conduct must inform a Human Resources representative immediately. Documentation of the incident by the employee is encouraged.
2. If the employee's supervisor is the individual who is harassing the employee, he/she may report the complaint to another manager or a Human Resources representative.
3. An employee will be advised when an investigation is completed and the results of that investigation.
4. In addition to notifying TCHD about harassment or retaliation complaints, affected employees may also direct their complaints to the California Department of Fair Employment and Housing (DFEH), which has the authority to conduct investigations of the facts. The deadline for filing complaints with DFEH is one year from the date of the alleged unlawful conduct. If a matter

before DFEH is not resolved through conference, conciliation, mediation or persuasion, DFEH may bring a civil action on behalf of the person claiming to be aggrieved. Employees can contact DFEH by referring to the information on TCHD's DFEH poster or by checking the state government listing in the local telephone directory.



Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 11/94 SUBJECT: Reduction in Work Force

REVISION DATE: 8/96; 1/97; 2/98; 8/00; 6/03; POLICY NUMBER: 8610-448
10/05; 12/08; 08/09; 05/11

Administrative Policies & Procedures Committee Approval:	01/11
Executive Council Approval:	02/11
Human Resources Committee Approval:	05/11
Board of Directors Approval:	05/11

A. **INTRODUCTION:**

1. Tri-City Healthcare District (TCHD) reserves the unrestricted right to engage in a Reduction in Force (RIF). No TCHD employee, representative or agent has the authority to limit this right, and any attempt to do so shall be null and void.
2. The Chief Executive Officer (CEO) has the ability to implement a RIF at his/her sole discretion, at any time, and in any manner, that he/she deems in the best interests of TCHD. This policy may be amended, revised or completely restated at any time before, after or during any particular RIF. The adoption and/or implementation of this policy does not create and shall not be deemed to confer upon any employee any right to continued employment, or to transfer or rehire following an RIF.
3. This policy shall not supersede any agreement between TCHD and the exclusive representative of any bargaining unit of TCHD employees and shall not abrogate the rights of any such employees under the Meyers-Milias-Brown Act and the Worker Adjustment and Retraining Notification Act (WARN Act), if applicable.

B. **PURPOSE:**

1. It is the purpose of this policy to allow an RIF to proceed while limiting disruption to TCHD operations and adverse effects upon TCHD employees. A principal goal of any RIF will be to retain those personnel necessary to meet the operating needs of the District and its patients. All other considerations are subject to, and limited by, this overriding goal.

C. **PROCESS:**

1. A RIF may be implemented District-wide, by department, by work group, by job classification or by some other criterion identified by the CEO or designee. Once the scope of the RIF has been determined, the Vice President (VP) of Human Resources (HR) will work with each affected department to identify positions that may be eliminated as part of the RIF. In identifying these positions, the VP of HR and department supervisors may consider the specific experience, training, and competencies of the incumbents in those positions. By way of example, they may consider whether an incumbent has the ability to perform duties that would allow the position he/she occupies to be restructured and to avoid elimination under the RIF.
2. Subject to the second sentence of C.1., above, after identifying the positions to be eliminated, the VP of HR and the affected supervisors will identify the individuals to be laid off as part of the RIF. Selection of such individuals shall be at TCHD's sole and absolute discretion, based upon the operating needs of TCHD and the needs of its patients, provided, however, that individuals may not be identified by lay off based on their race, national origin, gender, disability, or other characteristic protected under state or federal law, or in retaliation for any protected activity.
3. Notification of the individuals selected to be laid off as part of the RIF shall be provided in compliance with applicable state and federal laws.

D. **TRANSFER/REHIRE:**

1. Employees who are selected for layoff may apply to transfer to any open position in the District for which they are qualified.
2. Employees who have been laid off may be considered for re-hire as long as they are otherwise in good standing and possess the qualifications of the position for which they are applying. It is an employee's responsibility to inquire and apply for any job openings.
3. Employees who are rehired in the first six months following an RIF shall maintain their prior seniority date. Reinstatement of benefits will begin the 1st of the month following the date of re-hire.
4. TCHD will cease payments of any outstanding severance amounts payable under Policy # 454 for any employee rehired following an RIF.
5. The VP of HR, in consultation with the department head, shall have discretion and authority to approve if any employee is eligible for a transfer or for re-hire into a position not previously held by the employee.

**Employee Fiduciary Subcommittee
(No meeting held in
October, 2014)**

**Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
Meeting Minutes
October 9, 2014 Assembly Room 1**

Members present:	Board of Directors Chairman Larry Schallack; CHAC Chair Julie Nygaard; Linda Allington; Marilyn Anderson; Xiomara Arroyo; Rev. Carol Brooks; Mary Lou Cliff; Marge Coon; Rosemary Eshelman; Gigi Gleason; Carol Herrera; Robin Iveson; Linda Ledesma; Gina McBride; Jack Nelson; Barbara Perez; Don Reedy; Bret Schanzenbach; Laura Vines and Hope Wrisley
Non-Voting Members:	Tim Moran, CEO; David Bennett, Sr. VP & CMO; Francisco Valle, Sr. Director Marketing, Communications, and Public Affairs; Roma Ferriter; Audrey Lopez; Dr. Victor Souza
Others Present:	Vicki Ogilvie, CHAC Coordinator
Members Absent:	Director Paul Campo; Casey Fatch, COO; Darryl Hebert; Marilou dela Rosa Hruby; Jerry Salyer and Fernando Sanudo

Topic	Discussion	Action Follow-up	Person(s) Responsible
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1. Call To Order	The meeting was called to order at 12:30 p.m., in Assembly Room 1 at Tri-City Medical Center by Chair Julie Nygaard.		
2. Approval of Agenda	Chair Julie Nygaard called for approval of the Agenda. Ms. Marge Coon moved to approve the motion. Ms. Carol Herrera seconded it. Motion was approved unanimously. Chair Nygaard then introduced newly appointed CHAC members: Xiomara Arroyo and Linda Ledesma. Chair Nygaard mentioned to the committee that Ms. Barbara Perez will be the new member of CHAC representing the Oceanside Unified School District.		
3. Public Comments - Announcement	No public comments were made.		
4. Ratification of Minutes	Chair Julie Nygaard asked to approve the September 11, 2014 Meeting Minutes. A correction was noted to Item 1 - Call to Order: 911 should be written as 9/11 in the minutes. Correction was acknowledged. Then, Ms. Gigi Gleason moved to approve with the correction noted. Reverend Carol Brooks seconded it. Motion was approved with two abstentions: Ms. Hope Wrisley and Ms. Mary Lou Cliff abstained for not being present at the September meeting.		

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Topic	Discussion	Action Follow-up	Person(s) Responsible
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5. New Business			
<p>a. Tri-City Medical Center Update</p> <p>Chair Julie Nygaard invited Mr. Tim Moran to provide the Tri-City Medical Center update. Mr. Moran:</p> <ul style="list-style-type: none"> • Emphasized that excellent care is provided to patients at Tri-City Medical Center by highly qualified Physicians and staff. • Mentioned that he often receives compliments about the great care received by patients at Tri-City Medical Center. • Shared that the hospital is financially stable and that an external audit completed reported no findings. • Made a statement to dispel the rumor that Tri-City Medical Center is being sold: "He said this is not true". Mr. Moran reaffirmed that he has been pleased of the work done in collaboration with the Board of Directors to advance Tri-City Medical Center. • Encouraged CHAC members to attend the biweekly Community Breakfast where he shares with the community TCMC's achievements and latest developments. • Talked about his frequent visits to Primary Care Doctors to learn about their priorities. • Highlighted the release of the first Annual Report to The Community by the Tri-City Healthcare District as well as the economic impact of the hospital on the community including: <ul style="list-style-type: none"> ▪ Over \$180 million in payroll. ▪ \$8.9 million in uncompensated care. This uncompensated care provided by Tri-City Medical Center is more than the \$8.0 million in actual tax revenues it receives each year. • Informed the committee about the Corporate Philanthropy Award granted to Tri-City Medical Center by the North County Philanthropy Council for demonstrating outstanding civic and charitable responsibility to North County. • Reaffirmed that the Board of Directors approved opening a new Crisis Stabilization Unit at Tri-City Medical Center to try to address some of the major behavioral health issues affecting our community. • Mentioned that the Campus Medical Office Building was now in possession and control of Tri-City Medical Center and that a plan had been developed to secure tenants. 			

Topic	Discussion	Action Follow-up	Person(s) Responsible
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b. Auxiliary Department Update	<p>Chair Nygaard introduced Mr. Pat Morocco, First Vice President of the Auxiliary Department.</p> <p>Mr. Morocco:</p> <ul style="list-style-type: none"> • Talked about his background and how it led him to become a volunteer at Tri-City Medical Center. • Presented the history of Tri-City Hospital, now Tri-City Medical Center. Provided a summary of the Auxiliary Department including having 450 Auxiliary Members with some of them with more than 35 years of service at our hospital, and 60 Jr. Auxiliary Members who are in High School. • Emphasized that the Auxilians have backgrounds that range from having worked for example as Chief Executive Officers, school teachers, policemen, and firemen as well as widows or widowers, and moms or dads. • Reiterated that the Auxilians both enjoy helping others and function as patient advocates who visit all new patients to make their stay as comfortable as possible. Mr. Morocco also highlighted that Auxilians deliver the newspaper to patients daily, both in English and Spanish, and that they volunteer about 80 thousand hours per year. • Mentioned that a team of 51 Auxilians run the hospital's Gift shop which generates net profits of about \$10 thousand per month. This money goes right back to Tri-City Medical Center. • Explained that the Auxilians fund a scholarship program for youth attending local colleges. Scholarships given last year totaled over \$38 thousand. 		
6. Old Business			
a. Report on Behavioral Health Sub-Committee	Ms. Gigi Gleason reported about the Behavioral Health Workshops hosted by Tri-City Healthcare District. Two three-hour workshops were held with over 30 community professionals from the Tri-City area in attendance including Director Julie Nygaard. Ms. Gleason mentioned that an ad-hoc committee will be established to tackle the recommendations from the workshops.	To present a full report at a future CHAC meeting.	Ms. Gigi Gleason and Mr. Francisco Valle
7. Confirm Date and Time of Next Meeting	The November CHAC meeting has been cancelled. There is no CHAC meeting scheduled in December. A time and date for the January CHAC meeting will be communicated.	To communicate the time and date for the January CHAC meeting.	Mr. Francisco Valle

Topic	Discussion	Action Follow-up	Person(s) Responsible
8. Committee Communications	<p>CHAC Chair Nygaard invited Committee members to share news about their organizations and about events in their communities.</p> <p>The following items were shared by Committee members:</p> <ul style="list-style-type: none">• Ms. Rosemary Eshelman shared that from October 27th to 31st the schools in the Carlsbad Unified School District will be celebrating Red Ribbon Week. This program is about young people making healthy choices including staying away from substance abuse. Ms. Eshelman stated her appreciation for the sponsorship received from Tri-City Medical Center to make this program possible.• Ms. Linda Allington extended an invitation to the Open House of the Carlsbad Fire and Police Departments on Saturday, October 11th from 10 a.m. to 2 p.m. There will be live demonstrations and Displays and Tours of facilities.• Ms. Linda Ledesma shared that Ms. Rosemary Eshelman was selected by the Red Ribbon organization to be named the Person of Education for the County.• Ms. Audrey Lopez mentioned that the County of San Diego's Health and Human Services will be offering free flu shots at Crown Heights Community Center on Friday November, 7, 2014.• Ms. Hope Wrisley said that the Carlsbad City Council honored "Kids for Peace". This organization was established several years ago at Jefferson Elementary, and now has over 250 Chapters throughout the Country. The motto for "Kids for Peace" is "Kindness Matters".• Ms. Roma Ferriter said that starting on November 16th North County Health Services will assist North County residents sign up for Open Enrollment at the Library, Community Centers and Homeless Shelters.• Ms. Xiomara Arroyo shared that Wells Fargo Bank partnered with the Mexican Consulate to offer a Health and Wellness Fair on October 18th at the Escondido Resurrection Church. North County Health Services will be there to share other resources.• Mr. Don Reedy mentioned that the Oceanside Chamber launched a Hispanic Initiative to serve Hispanic owned businesses, and invited CHAC members to pass the word out.• Ms. Marilyn Anderson said that the City of Vista will provide	<p>To send to all CHAC members the flyer for this event.</p>	<p>Vicki Ogilvie</p>

Topic	Discussion	Action Follow-up	Person(s) Responsible
	<ul style="list-style-type: none"> • Haunted Paranormal Education at the Adobe this month. • Ms. Barbara Perez, the new CHAC member representing Oceanside Unified School District, mentioned that her School District is working on a program called "Restorative Practices or Justice". This program is based on the idea that students can recognize and own their behaviors, make amends for wrong doings, and plan for successful reintegration back into schools. • Ms. Perez also made the CHAC members aware of an Alternative to Suspension Program for kids who can attend an Alternative school where they can continue to work on school assignments including homework. • Ms. Gigi Gleason announced that Tri-City Medical Center will be hosting a FY 2015 Grant Forum at the Wellness Center in Carlsbad again this year on November 12th from 10:00 a.m. to 12:00 Noon. • Mr. Francisco Valle mentioned that Tri-City Medical Center will be the presenting sponsor for "Dia de los Muertos" on October 26th at Mission San Luis Rey, and "Bike the Coast" on November 1st by the Pier in Oceanside. Mr. Valle invited CHAC members to attend these events. • Board of Directors Chairman Schallock shared that the City of Oceanside and Tri-City Medical Center are sponsors of O'side Turkey Trot. This is a holiday tradition that has helped to raise funds for area schools and non-profits. This is a holiday run. People are invited to "Move Their Feet Before They Eat". 	To mail a Grant Forum package to CHAC members for them to share with non-profit organization.	Mr. Francisco Valle
9. Public Comments	No comments were made.		
10. Adjournment	CHAC Chair Nygaard adjourned the meeting at 1:30 p.m.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
October 21, 2014

Members Present	Dr. James Dagostino, Director Kellett, M.D., Director Paul Campo Robert Knezek, Kathleen Mendez Dr. Frank Corona, Steve Harrington, Dr. Contardo, William McGaughey
Non-Voting Members:	Tim Moran, CEO, Casey Fatch, COO, Steve Dietlin, CFO, Matt Mushet, Legal Affairs, Wayne Knight, Sr. VP, Medical Services,
Others Present:	Director Julie Nygaard, Linda Cline, Carol Smyth, Sharon Schultz, Jeremy Raimo Charlene Carty. Jane Dunmeyer, David Bennett, Ray Rivas, Steve Young Donna Dempster, Scott Livingstone, Tom Moore, Colleen Thompson, Chris Miechowski
Absent:	Dr. Kroener

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:30 pm.		
2. Approval of Agenda		<u>MOTION</u> It was moved by Director Campo, Director Kellett seconded and was unanimously approved, that the agenda of September 16, 2014 be approved.	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostin

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Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of September 16, 2014		Minutes ratified <u>MOTION</u> It was moved by Director Kellett, Director Campo seconded and was approved with Bill McGaughey abstaining, that the minutes of September 16, 2014 be approved as written.	
5. Old Business	None		
6. For Information only	None		
7. a. Cardiovascular Institute Medical Director Agreements	<p>Director Dagostino requested Jeremy Raimo give a brief overview of what the Institutes were for the newer members that were not familiar with them.</p> <p>Jeremy Raimo explained this was a business decision that was made back in 2010 to identify and enhance quality through Cardiovascular, Orthopedic & Spine. Oncology was also discussed but not brought forward instead we created the Neuroscience Institute. These institutes were not created to drive volume or reduction on spend. Each year the Hospital sits down with the members of the Institute to help make changes to further assist with the success of the programs.</p>	<u>MOTION</u> Dr. Corona moved, Dr. Contardo seconded and it was unanimously approved that the Finance, Operations and Planning committee recommend that the TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Cardiovascular Institute Medical Directorship Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$171,360, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>What the Institutes were designed to do and what they have actually done for our quality has been very successful and effective.</p> <p>Jeremy Raimo pointed out that some of the renewals have start dates of July 1 and July 15th. These were brought forward to the Committee previously, however, were pulled so that the District could confer with Legal to be sure the District was not breaching any rules of the Institute by bringing them to Committee.</p> <p>Cardiovascular Institute Medical Director Agreements</p> <p>These terms are the same terms as previously approved in the CVI documents.</p> <p>The Medical Director is responsible for the medical direction of the Specialty Area and the performance of the other medical administrative services.</p> <p>Discussion ensued regarding how the physicians in the LLC were paid. The money comes from the District who funds the LLC and they are budgeted amounts.</p>		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
b. Cardiovascular Institute Committee Physician Agreements	<p>These terms are the same terms as previously approved in the CVI documents and are budgeted.</p> <p>The Committee Physicians oversee operations and quality.</p>	<p><u>MOTION</u></p> <p>Dr. Corona moved, Dr. Contardo seconded and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Director find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Cardiovascular Institute Committee Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$30,240, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p>	Jeremy Raimo
c. Orthopedic & Spine Institute Co-Management Agreement	<p>Jeremy Raimo explained that the Co-Management Agreements:</p> <ul style="list-style-type: none"> • Provide structure that is consistent with the Institute's guiding principles of hospital physician collaboration and integrated leadership. • Establishes an entity that is consistent with integrated delivery and provides a foundation for business and payer initiatives. 	<p><u>MOTION</u></p> <p>Director Campo moved, Dr. Corona seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Orthopedic & Spine Institute Co-Management Agreement for a 12-month term, beginning October 28, 2014 and ending October 27, 2015, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p>	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
d. Orthopedic & Spine Institute Medical Directorship Agreements	<p>These terms are the same terms as previously approved in the OSI documents (co-management agreement) and budgeted.</p> <p>Physician shall service as Medical Director and shall be responsible for the medical direction of the Specialty Area and the performance of the other medical administrative services.</p>	<p>MOTION-</p> <p>Director Campo moved, Dr. Corona seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Orthopedic & Spine Medical Directorship Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$124,080, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval</p>	Jeremy Raimo
e. Orthopedic & Spine Institute Committee Physician Agreements	<p>These terms are the same terms as previously approved in the OSI documents (co-management agreement) and budgeted.</p>	<p>MOTION</p> <p>Director Campo moved, Dr. Corona seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Orthopedic & Spine Institute Committee Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at the amount not to exceed \$50,760, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.</p>	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
f. Neuroscience Institute Committee Physician Agreements	Leadership has not been completed. The Institute has been formed.	<u>MOTION</u> Director Campo moved, Dr. Corona seconded and it was unanimously approved that Finance Operations and Planning Committee recommend that TCHD Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Neuroscience Institute Committee Agreements for a 12-month term, beginning July 15, 2014 and ending July 14, 2015, at an annual amount not to exceed \$30,240, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.	Jeremy Raimo
g. Physician Agreement for Supervision of Residents	After a brief discussion with the Committee this item was pulled from the agenda for further work.	<u>Pulled</u>	Donna Dempster

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
h. General Electric Healthcare CAT Scan Service Agreement	<p>Steve Young stated this is a service agreement with original equipment manufacturer for two CT scanners located on the main campus and the outpatient facility.</p> <p>Service agreement includes radiation reduction software when performing cardiac heart scanning at an annual cost of \$25,000. Software is fully owned at the end of 3 year term.</p> <p>The cost of services does not increase with this agreement.</p> <p>Radiation reduction software reduces patient radiation exposure up to 70%</p>	<p><u>MOTION</u></p> <p>Director Campo moved, Director Kellett seconded and it was unanimously approved that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with General Electric Healthcare for a service agreement on two radiology CT scanners for a term of 36 months, beginning 10/1/2014 and ending 9/30/2017 for an annual cost of \$216,504, and a total cost for the term of \$649,512.</p>	Steve Young
i. Cepheid GeneXpert System	<p>Dr. Contardo explained this system and exactly how it works.</p> <p>This system replaces traditional culture methods, which usually take 2 or more days, with a method yielding actionable results in 4 hours or less. This speed comes with gold-standard sensitivity and specificity.</p> <p>It profoundly affects Tri-City's ability to successfully identify and rapidly isolate potentially infectious patients and conversely will enable us to work smarter and</p>	<p><u>MOTION</u></p> <p>Director Kellett moved, Director Campo seconded and it was unanimously approved that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize (1) the agreement with Cepheid for the GeneXpert Microbiology System for a term of 60 months (5 years), beginning 12/1/2014 and ending 11/30/2019, for an annual cost of \$166,704, and a total cost for the term of \$883,520, and (2) Cerner interface charges which will be determined, estimated at \$20,000.</p>	Steve Young/Dr. Contardo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
j. Two Fluoroscopy C-Arm System	faster. Steve Young explained this system is needed to support increased orthopedic and spine surgery. Purchase will eliminate the rental expense of a 12 inch system expense \$6,000/month. Both systems are manufacture refurbished with a 1 year full warranty. After the warranty expires repair work will be done by the Hospital Bio-Med department.	<u>MOTION</u> Dr. Corona moved, Dr. Contardo seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize the purchase of two manufacture refurbished C-arms at a total cost of \$299,251	Steve Young
k. Dr. Gary Willard increase in hours	Sharon Schultz stated that after further meetings with Dr. Willard it was determined that is was justified to add 10 additional hours per month for the Outpatient Wound Care Clinic. Consulting for inpatient wound care has increased from 20 to 25 hours per month.	<u>MOTION</u> Director. Kellett moved, Director Campo seconded and it was unanimously approved that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize Dr. Gary M. Willard as the Medical Director for Out Patient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program for a term of 24 months beginning July 1, 2014 and ending June 30, 2016. Not to exceed an average of 35 hours per month or 420 hours annually, at an hourly rate of \$190 and a total for the term of \$159,600.	Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible																						
I. North Coast Pathology-Renewal	<p>Dr. Contardo stepped out of the room while this item was discussed.</p> <p>This agreement is fair market value. There is no rate increase.</p> <p>Dr. Corona stated the Medical Staff is very happy with the work that Dr. Contardo and the North Coast Pathology Medical Group does and there are no issues.</p>	<p>MOTION</p> <p>Director Campo moved, Director Kellett seconded and it was approved with Dr Contardo abstaining that Finance, Operations and Planning Committee recommend that the Board of Directors of Tri-City Healthcare District authorize Dr. Marcus Contardo and North Coast Pathology Medical Group, as the TCHD's exclusive provider of Lab and Pathology services for a term of 36 months beginning August 1, 2014 and ending July 31, 2017. Not to exceed an annual cost of \$312,000 and a total cost for the term of \$936,000.</p>	Casey Fatch																						
m. Financials-September	<p>Steve Dietlin gave the presentation on the financials ending September 30 2014 (dollars in thousands)</p> <p>Fiscal Year to Date</p> <table><tr><td>Operating Revenue</td><td>\$ 81,089</td></tr><tr><td>Operating Expense</td><td>\$ 81,902</td></tr><tr><td>EROE</td><td>\$ 132</td></tr><tr><td>EBITA</td><td>\$ 4,204</td></tr></table> <p>TCMC –Key Indicators –FYTD</p> <table><tr><td>Avg. Daily Census</td><td>194</td></tr><tr><td>Adjusted Patient Days</td><td>28,810</td></tr><tr><td>Surgery Cases</td><td>1,660</td></tr><tr><td>Deliveries</td><td>751</td></tr><tr><td>ED Visits</td><td>17,703</td></tr></table> <p>Current Month</p> <table><tr><td>Operating Revenue</td><td>\$ 27,124</td></tr><tr><td>Operating Expense</td><td>\$ 27,309</td></tr></table>	Operating Revenue	\$ 81,089	Operating Expense	\$ 81,902	EROE	\$ 132	EBITA	\$ 4,204	Avg. Daily Census	194	Adjusted Patient Days	28,810	Surgery Cases	1,660	Deliveries	751	ED Visits	17,703	Operating Revenue	\$ 27,124	Operating Expense	\$ 27,309		Steve Dietlin
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Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible								
	<p>EROE \$ 112</p> <p>EBIDA \$ 1,456</p> <p><u>Net Patient A/R & Days in Net A/R By Fiscal Year</u></p> <table><tr><td>Net patient Accounts (in millions)</td><td>\$ 40.9</td></tr><tr><td>Days in Net A/R</td><td>47.9</td></tr></table> <p><u>TCMC-Net patient A/R & Days in Net A/R Dollars in Millions)</u></p> <table><tr><td>Net Patient Accounts Receivable (in Millions)</td><td>\$41.0</td></tr><tr><td>Days in Net A/R</td><td>48.5</td></tr></table> <p>Graphs:</p> <ul style="list-style-type: none">• TCMC-Net Days in Patient Accounts Receivable• TCMC-Average Daily Census- Total Hospital-Excluding Newborns• TCMC-Adjusted Patient Days• TCMC-Paid Full Time Equivalents• TCMC-Emergency Department Visits• TCMC-EROE and EBITA	Net patient Accounts (in millions)	\$ 40.9	Days in Net A/R	47.9	Net Patient Accounts Receivable (in Millions)	\$41.0	Days in Net A/R	48.5		
Net patient Accounts (in millions)	\$ 40.9										
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Net Patient Accounts Receivable (in Millions)	\$41.0										
Days in Net A/R	48.5										
n. Work Plan <ul style="list-style-type: none">• Construction Report• Off-site Infusion Center		Director Dagostino asked if anyone had questions on the Construction write ups. <ul style="list-style-type: none">• Wayne Knight stated the PCP Clinic is ahead of schedule and should be completed in December.• Director Campo noted we are slightly off budget. Casey Fatch stated we									

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		have Business Development getting the word out regarding the Off-Site Infusion Center.	
8. Comments by Committee Members.		None	Chair
9. Date of next meeting.	November 18, 2014		Chair
10. Community Openings.	One	Director Dagostino explained we have 5 candidates. However, since the election is next month the committee thought it prudent to hold the interviews in January in the event there is a change of the Board at the October elections.	Chair
11. Adjournment.	Meeting adjourned 2:00 pm.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
October 21, 2014
Cardiovascular Institute Medical Directorship Agreements

Type of Agreement	XX	Medical Directors		Panel		Other:
Status of Agreement		New Agreement	XX	Renewal		

Physician Names:

David Spiegel, M.D., Invasive Cardiology
 Kathleen Paveglio, M.D., Non-Invasive Cardiology
 Donald Ponec, M.D., Interventional Radiology & Institute Medical Director
 Andrew Deemer, M.D., Vascular Surgery
 Theodore Folkerth, M.D., Cardiothoracic Surgery (Co-Medical)*
 Paul Mazur, M.D., Cardiothoracic Surgery (Co-Medical)*

Areas of Service: Cardiovascular Institute (CVI)

Term of Agreement: 12 months, beginning July 1, 2014 and ending June 30, 2015

Maximum Totals:

Rate/ Hour	# of Medical Directorship Agreements	Hours per Month per Medical Directorship Agreement	Hours per Year per Medical Directorship Agreement	Monthly Cost per Medical Directorship Agreement	Annual Cost per Medical Directorship Agreement	12 month (Term) Cost Total
\$210	6	Institute Med. Director: 8 All others: 12	Institute Med. Director: 96 All others: 144	Institute Med. Director: \$1,680 All others: \$2,520	Institute Medical Director: \$20,160 All others: 30,240	\$171,360

These terms are the same terms as previously approved in the CVI documents (co-management agreement) and budget. *CT Surgery will share the 12 hours/month through a co-medical directorship arrangement.

Documents prepared by approved outside Counsel	X	Yes		No
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Is Agreement a Regulatory Requirement:		Yes	X	No
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Person responsible for oversight of agreement: Wayne Knight Sr., Vice President, Medical Services/Andrea Benton, Business Development Manager

Position Responsibilities:

Physician shall serve as Medical Director and shall be responsible for the medical direction of the Specialty Area and the performance of the other medical administrative services which include but is not limited to:

- Providing clinical consultation for the Specialty Area as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Institute's Specialty Area;
- Developing, implementing, and evaluating a utilization review program, a quality assurance and performance improvement program, and a risk management program for the Specialty Area;
- Establishing and evaluating policies, procedures, and protocols for the Specialty Area for patient care and developments in cardiovascular services, including new treatment modalities, drug information and other relevant developments;
- Recommending, developing and implementing new services to be provided by the Specialty Area;
- Identifying equipment needs and coordinating standardization of instrumentation, equipment and supplies for the Specialty Area;
- Facilitating effective communications with attending and referring physicians and the Specialty Area;
- Assisting in interviewing and training new personnel for the Specialty Area

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Cardiovascular Institute Medical Directorship Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$171,360, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.

FINANCE, OPERATIONS & PLANNING COMMITTEE
October 21, 2014
Cardiovascular Institute Committee Physician Agreements

Type of Agreement		Medical Directors		Panel	XX	Other: Committee
Status of Agreement		New Agreement	XX	Renewal		

Physician Name	Operations Committee		Quality Committee	
	New	Renewal	New	Renewal
Mohammed Jamshidi, DO		X		
Theodore Folkerth, MD		X		
David Spiegel, MD		X		
John Kroener, MD				X
Kathleen Paveglio, MD				X
Donald Ponec, MD				X

Areas of Service: Cardiovascular Institute (CVI)

Term of Agreement: 12 months, beginning July 1, 2014 and ending June 30, 2015

Maximum Totals:

Rate/Hour	# of Committee Agreements	Hours per Month per Physician Agreement	Hours per Year per Physician Agreement	Monthly Cost per Physician Agreement	Annual Cost per Physician Agreement	12 month (Term) Cost Total
\$210	6	2	24	\$420	\$5,040	\$30,240

These terms are the same terms as previously approved in the CVI documents (co-management agreement) and budget.

Documents prepared by approved outside Counsel	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Wayne Knight Sr., Vice President, Medical Services/Andrea Benton, Business Development Manager

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the



Cardiovascular Institute Committee Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$30,240, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.



FINANCE, OPERATIONS & PLANNING COMMITTEE
October 21, 2014
Orthopedic & Spine Institute Co-Management Agreements

Type of Agreement		Medical Directors		Panel	XX	Other: Co-Management Agreement
Status of Agreement		New Agreement	XX	Renewal		

Executive Summary:

The Tri-City Orthopedic Institute LLC ("Institute") was established on October 28, 2010 through the execution of a three year Co-Management Agreement. The agreement was renewed for a fourth year in 2013 and is set to expire October 27, 2014. It may be renewed by mutual consent of the District and the Institute, and has been already approved by the Institute's Board of Managers.

The Co-Management Agreement:

- Provides structure that is consistent with the Institute's guiding principles of hospital physician collaboration and integrated leadership, and
- Establishes an entity that is consistent with integrated delivery and provides a foundation for business and payer initiatives.

Areas of Service: Orthopedic & Spine Institute (OSI)

Term of Agreement: 12 months, beginning October 28, 2014 and ending October 27, 2015

Legal: The original agreement was established and structured by the law firm of Squire, Sanders and Dempsey LLP and approved by TCHD Counsel.

Financial:

Description	Proposed
Base Management Fee	\$350,000
Performance Improvement Incentive Fee	\$400,000

Person responsible for oversight of agreement: Wayne Knight Sr. Vice President, Medical Services/Andrea Benton, Business Development Manager

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the

communities served by the District to approve an expenditure for the Orthopedic & Spine Institute Co-Management Agreement for a 12-month term, beginning October 28, 2014 and ending October 27, 2015, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval. Total compensation (Base Management Fee plus Quality Improvement and Operations Improvement Compensation) shall not exceed \$750,000.

**EXHIBIT 4.1
FEE SCHEDULE**

During the initial term of this Agreement Hospital shall pay Institute Manager for Administrative Services, Specialty Medical Director Services and Institute Medical Director Services as follows:

1. Base Management Fee:

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
\$350,000	\$350,000	\$350,000

Payment of the base management fee is subject to verification of time records documenting the number of hours of Administrative Services, Specialty Medical Director Services and Institute Medical Director Services as required in the Agreement. Any time deficiency shall result in a reduction in the base management fee calculated by multiplying the number of deficient hours by the hourly rate for that position as set forth below.

A. Compensation Rates for Medical Director Services

Directorship Position	Hourly Rate	Max. Compensated Hours/Month	Max. Compensated Hours/Year	Max. Annual Comp.*
Institute Medical Director	\$235	8	96	\$22,560
Spine Surgery	\$235	12	144	\$33,840
Joint Replacement	\$235	12	144	\$33,840
Neurosurgery	\$235	12	144	\$33,840

B. Compensation Rates for Medical Management Services

Committee	No. of Physicians	Max. Compensated Mtgs/Year	Max. Compensated Hours/Mtg.	Hourly Rate	Max. Annual Comp. Physician *
Quality	3	12	2	\$235	\$16,920
Operations	3	12	2	\$235	\$16,920
Board of Managers	3	4	2	N/A	0
Ad Hoc Consultants and Committees			96	\$235	22,560

* subject to documentation requirements.

2. Compensation for achievement of Improvement Initiatives during the initial term of this Agreement:

A. Quality Improvement Compensation. Up to \$200,000 in each year for achieving the Quality Improvement Initiatives as described in Exhibit 2.8. All or less than the entire performance bonus may be awarded depending on achievement level. The awarded bonus would be paid annually within thirty (30) days of the end of the 12-month period to which it relates, subject to the approval of the Managing Board of the Institute Manager and the District Board.

B. Operations Improvement Compensation. Up to \$200,000 in each year for achieving the Operations Improvement Initiatives as described in Exhibit 2.8. All or less than the entire performance bonus may be awarded depending on achievement level. The awarded bonus would be paid annually within thirty (30) days of the end of the 12-month period to which it relates, subject to the approval of the Managing Board of the Institute Manager and the District Board.

C. Shared Savings Improvement Compensation. Subject to the provisions of Section 6.2, and as defined in Section 2.3.3, Shared Savings Improvement Compensation shall not exceed fifty percent (50%) of the cost savings through achievement of Performance Measures identified by the Program Administrator in each year, as described in Exhibit 2.8. The performance bonus shall be awarded based on achievement level. The awarded bonus would be paid annually within thirty (30) days of the end of the 12-month period to which it relates, subject to the approval of the Managing Board of the Institute Manager and the District Board.

3. Notwithstanding any payments under the Shared Savings Program, total compensation (Base Management Fee plus Quality Improvement and Operations Improvement Compensation) shall not exceed \$750,000 in any year of this Agreement.

FINANCE, OPERATIONS & PLANNING COMMITTEE
October 21, 2014
Orthopedic & Spine Institute Medical Directorship Agreements

Type of Agreement	XX	Medical Directors		Panel		Other:
Status of Agreement		New Agreement	XX	Renewal		

Physician Names: Neville Alleyne, M.D. Spine Surgery
James Esch, M.D. Institute Medical Director
James Helgager, M.D. Joint Replacement
Lokesh Tantuwaya, M.D. Neurosurgery

Areas of Service: Orthopedic & Spine Institute (OSI)

Term of Agreement: 12 months, beginning July 1, 2014 and ending June 30, 2015

Maximum Totals:

Rate/ Hour	# of Medical Directorship Agreements	Hours per Month per Medical Directorship Agreement	Hours per Year per Medical Directorship Agreement	Monthly Cost per Medical Directorship Agreement	Annual Cost per Medical Directorship Agreement	12 month (Term) Cost Total
\$235	4	Institute Med. Director: 8 All others: 12	Institute Med. Director: 96 All others: 144	Institute Med. Director: \$1,880 All others: \$2,820	Institute Medical Director: \$22,560 All others: 33,840	\$124,080

These terms are the same terms as previously approved in the OSI documents (co-management agreement) and budget.

Documents prepared by approved outside Counsel	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Wayne Knight Sr., Vice President, Medical Services/Andrea Benton, Business Development Manager

Position Responsibilities:

Physician shall serve as Medical Director and shall be responsible for the medical direction of the Specialty Area and the performance of the other medical administrative services which include but is not limited to:

- Providing clinical consultation for the Specialty Area as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Institute's Specialty Area;
- Developing, implementing, and evaluating a utilization review program, a quality assurance and performance improvement program, and a risk management program for the Specialty Area;
- Establishing and evaluating policies, procedures, and protocols for the Specialty Area for patient care and developments in orthopedic and spine services, including new treatment modalities, drug information and other relevant developments;
- Recommending, developing and implementing new services to be provided by the Specialty Area;
- Identifying equipment needs and coordinating standardization of instrumentation, equipment and supplies for the Specialty Area;
- Facilitating effective communications with attending and referring physicians and the Specialty Area;
- Assisting in interviewing and training new personnel for the Specialty Area

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Orthopedic & Spine Medical Directorship Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$124,080, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.

FINANCE, OPERATIONS & PLANNING COMMITTEE
October 21, 2014
Orthopedic & Spine Institute Committee Physician Agreements

Type of Agreement		Medical Directors		Panel	XX	Other: Committee
Status of Agreement	XX	New Agreement	XX	Renewal		

Physician Name	Operations Committee		Quality Committee		Shared Savings Committee	
	New	Renewal	New	Renewal	New	Renewal
Neville Alleyne, MD					X	
Andrew Cooperman, MD		X		X		
Janet Dunlap, MD				X		
Andrew Hartman, MD						X
James Helgager, MD		X			X	
Payam Moazzaz, MD	X		X			

Areas of Service: Orthopedic & Spine Institute (OSI)

Term of Agreement: 12 months, beginning July 1, 2014 and ending June 30, 2015

Maximum Totals:

Rate/Hour	# of Committee Agreements	Hours per Month per Physician Agreement	Hours per Year per Physician Agreement	Monthly Cost per Physician Agreement	Annual Cost per Physician Agreement	12 month (Term) Cost Total
\$235	9	2	24	\$470	\$5,640	\$50,760

These terms are the same terms as previously approved in the OSI documents (co-management agreement) and budget.

Documents prepared by approved outside Counsel	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Wayne Knight Sr., Vice President, Medical Services/Andrea Benton, Business Development Manager

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the Orthopedic &

Spine Institute Committee Agreements for a 12-month term, beginning July 1, 2014 and ending June 30, 2015, at an annual amount not to exceed \$50,760, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.

FINANCE, OPERATIONS & PLANNING COMMITTEE
October 21, 2014
Neuroscience Institute Committee Physician Agreements

Type of Agreement		Medical Directors		Panel	XX	Other: Committee
Status of Agreement	XX	New Agreement		Renewal		

Physician Name	Operations Committee		Quality Committee	
	New	Renewal	New	Renewal
Tyrone Hardy, MD	X			
Gregory Sahagian, MD	X			
Kevin Yoo, MD	X			
Donald Ponec, MD			X	
Jack Schim, MD			X	
Lokesh Tantuwaya, MD			X	

Areas of Service: Neuroscience Institute (NSI)

Term of Agreement: 12 months, beginning July 15, 2014 and ending July 14, 2015

Maximum Totals:

Rate/Hour	# of Committee Agreements	Hours per Month per Physician Agreement	Hours per Year per Physician Agreement	Monthly Cost per Physician Agreement	Annual Cost per Physician Agreement	12 month (Term) Cost Total
\$210	6	2	24	\$420	\$5,040	\$30,240

These terms are the same terms as previously approved in the NSI documents (co-management agreement) and budget.

Documents prepared by approved outside Counsel	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement: Wayne Knight Sr., Vice President, Medical Services/Andrea Benton, Business Development Manager

Motion:

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve an expenditure for the

Neuroscience Institute Committee Agreements for a 12-month term, beginning July 15, 2014 and ending July 14, 2015, at an annual amount not to exceed \$30,240, with the option to renew for an additional year by mutual consent of the District and the Institute subsequent to the Institute's Board of Manager approval.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 21, 2014
PROPOSAL FOR: General Electric Healthcare CT Equipment Service Contrast

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

Vendor Name: General Electric Healthcare

Area of Service: CAT Scan - Radiology

Term of Agreement: 36 months Beginning 10/1/2014 - Ending 9/30/2017

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$18,042	\$216,504	\$649,512

Description of Services/Supplies:

- Service agreement with original equipment manufacturer for two CT scanners located on the main campus and the outpatient facility.
- CT service with GE pricing matches competitive 3rd party bids. Complexity of equipment and scan volumes support OEM contract direction.
- Service agreement includes radiation reduction software when performing cardiac heart scanning at an annual cost of \$25,900. Software is fully owned at the end of 3 year term.
- The cost of service does not increase with this agreement. The annual spend only increases for the cost of the radiation software added to the one of the scanners covered.
- Radiation reduction software reduces patient radiation exposure up to 70%.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Steve Young, Imaging Director, Casey Fatch, COO, Executive VP

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with General Electric Healthcare for a service agreement on two radiology CT scanners for a term of 36 months, beginning 10/1/2014 and ending 9/30/2017 for an annual cost of \$216,504, and a total cost for the term of \$649,512.

FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: October 24, 2014

PROPOSAL FOR: Two Fluoroscopy C-Arm Systems

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

Vendor Name: GE Healthcare

Area of Service: Radiology/Surgery

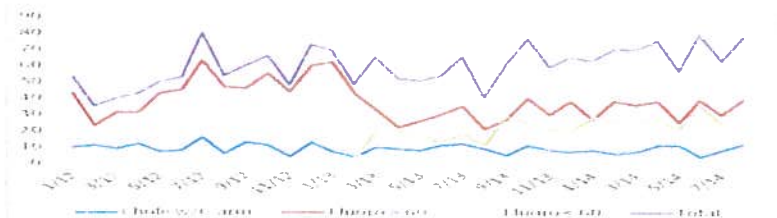
Term of Agreement: N/A

Maximum Totals:

Equipment Description	Unit Cost	Total Cost + Tax
12 Inch GE C-Arm	\$149,178	\$160,739
9 Inch GE C-Arm	\$128,550	\$138,512
		Total \$299,251

Description of Services/Supplies:

- Systems needed to support increased orthopedic and spine surgery.
- Complex cases duration impacting current C-Arm inventory.
- Purchase will eliminate the rental expense of a 12 inch system expense \$6,000/month.
- Both systems are manufacture refurbished with a 1 year full warranty.



Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No

Person responsible for oversight of agreement:

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the purchase of two manufacture refurbished C-arms at a total cost of \$299,251.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 21, 2014
Renewal/Amendment of Wound Care Medical Director Agreement

Type of Agreement	X	Medical Director		Panel		Other:
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates/Add'l Duties

Name: Dr. Gary M. Willard

Area of Service: Medical Director Agreement (Renewal and Amendment)

For coverage of Out Patient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program

Term of Agreement: Twenty four (24) month term beg. July 1, 2014 through June 30, 2016

Rates and Totals: Hourly Rate of \$190.00; 35 hours per month/420 hours per year
 Amendment to add 10 hours per month for the Outpatient Wound Care Clinic.
 Consulting for inpatient wound care has increased from 20 to 25 hours per month.

Monthly Cost of \$6,650 and Total Contract amount not to exceed \$159,600.

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Max. Annual Cost	24 month (Term) Cost
\$190.00	35	420	\$6,650	\$79,800	\$159,600

Position Responsibilities:

1. Consultation on wound interventions with recommendations
2. Plan of Care for ongoing treatment
3. Duties as the Outpatient Wound Care Medical Director include:
 - Establishing guidelines, protocols, and standards for quality patient care the monitoring of quality outcomes
 - Assuring accuracy of medical record compliance for all physician disciplines within the service
 - Providing educational training for medical staff, nursing staff and ancillary staff on a continuous basis
 - Assuring compliance with CMS requirements for care, documentation and correct coding initiatives
 - Conducting clinical data collection and research in wound care

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Sharon Schultz, CNE; Kim Posten, RN Manager.

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Gary M. Willard as the Medical Director for Out Patient Wound Clinic, Hyperbaric Medicine and Inpatient Wound Care Program for a term of 24 months beginning July 1, 2014 and ending June 30, 2016. Not to exceed an average of 35 hours per month or 420 hours annually, at an hourly rate of \$190 and a total for the term of \$159,600.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 21, 2014
PHYSICIAN AGREEMENT for Clinical & Anatomic Pathology Laboratory

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

Physicians Name: Marcus Contardo, MD (North Coast Pathology Medical Group, NCPMG)

Area of Service: Clinical & Anatomic Pathology Laboratory Services

Term of Agreement: 36 months Beginning: August 1, 2014 Ending: July 31, 2017

Maximum Totals:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	36 month (Term) Cost
N/A	N/A	N/A	\$26,000	\$312,000	\$936,000

Position Responsibilities:

- NCPMG will exclusively provide all anatomic pathology and clinical pathology (laboratory medicine) professional services in the Department.
- NCPMG will provide an exclusive full-time pathologist Laboratory Director for the Clinical Laboratory and Department of Pathology.
- NCPMG will provide oversight of all professional services in the Department.
- NCPMG will ensure that there are sufficient physicians available as needed and/or on-call for the Department seven days per week, 24 hours per day.
- Assist TCHD in developing, implementing and evaluating a utilization review program, a quality assurance program and a risk management program for the Department.
- Assist TCHD in establishing and evaluating policies, procedures, and protocols for patient care in Pathology and Lab.
- Assist TCHD in meeting accreditation and licensing requirements of the College of American Pathologists, the Joint Commission, the FDA and the CA DHS.
- Assist TCHD in negotiating contracts with providers of outside materials and reference services to the Clinical Laboratory.
- Recommend, develop and implement new services to be provided.
- Facilitate effective communications with attending and referring physicians.
- Assure all medical services provided are consistent with TCHD's mission, vision and service standards.

Concept Submitted to Legal:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No

Person responsible for oversight of agreement: Steve Young, Ancillary Director, Casey Fatch, COO

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Marcus Contardo and North Coast Pathology Medical Group, as the TCHD's exclusive provider of Lab and Pathology services for a term of 36 months beginning August 1, 2014 and ending July 31, 2017. Not to exceed an annual cost of \$312,000 and a total cost for the term of \$936,000.



Physician Compensation and Production: 2013 Report Based on 2012 Data

Metric **Specialty** Demographics Analysis

all Regions Avg.

Pathology: Anatomic & Clinical

Summary Table by Specialty

Metric	Phys	MedPracs	Mean	Std Dev	10th % tile	25th % tile	Median	75th % tile	90th % tile
[+] Total Compensation	272	63	\$407,688	\$140,728	\$263,973	\$302,192	\$386,170	\$482,937	\$626,622
[+] Collections TC/NPP Excl	102	31	\$443,882	\$226,704	\$198,723	\$299,390	\$396,192	\$542,717	\$853,756
[+] Compensation to Collections Ratio, TC/NPP Excl	102	31	1.041	0.476	0.515	0.772	0.942	1.195	1.683
[+] Physician Work RVUs, NPP Excl	226	52	7,736	3,924	3,585	5,027	7,154	9,779	12,283
[+] Compensation to Physician Work RVUs Ratio, NPP Excl	226	52	\$61.45	\$38.58	\$37.68	\$45.41	\$53.63	\$67.15	\$88.43
[+] Total RVUs, TC/NPP Excl	68	22	13,248	6,429	6,003	8,325	12,381	16,357	21,674
[+] Compensation to Total RVUs Ratio, TC/NPP Excl	68	22	\$35.14	\$12.94	\$22.07	\$26.70	\$32.13	\$44.07	\$55.48

Pathology: Anatomic & Clinical

Data in this report is reported by
Geographic Section

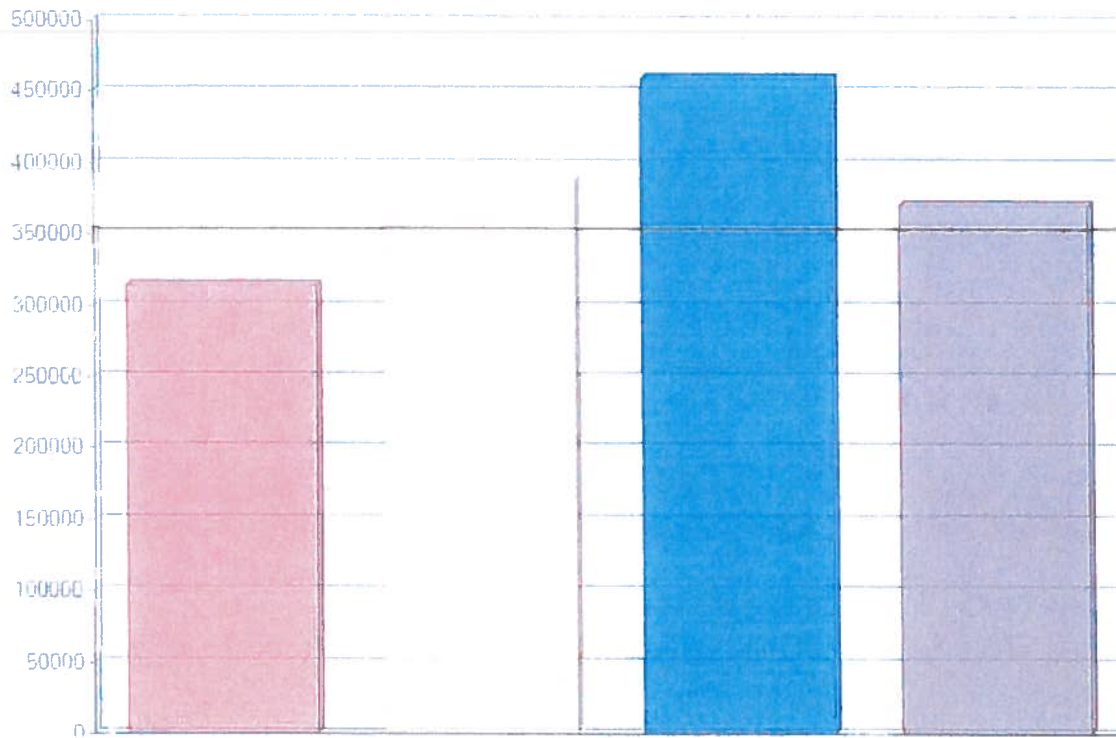
Physician Compensation and Production 2013 Report Based on 2012 Data

Prepared for Pamela Smith

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Metric	Phys	Med Pracs	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Total Compensation	232	34	\$420,221	\$195,371	\$229,317	\$300,122	\$355,272	\$469,925	\$679,641

Median



Metric	Phys	MedPracs	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Eastern	62	8	\$351,697	\$168,448	\$213,272	\$254,414	\$314,470	\$353,592	\$486,548
Midwest	79	16	\$436,458	\$167,972	\$277,016	\$346,270	\$387,960	\$516,230	\$678,283
Southern	55	4	\$514,854	\$255,290	\$272,112	\$319,499	\$459,863	\$662,852	\$976,757
Western	36	6	\$358,026	\$109,870	\$218,554	\$271,979	\$370,962	\$429,444	\$432,152

**Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
October 23, 2014**

<p>Members Present: Chairman Director RoseMarie Reno, Director Jim Dagostino, Director Ramona Finnila, Dr. Frank Corona, Dr. Marcus Contardo and Dr. Jamie Johnson.</p> <p>Non-Voting Members Present: Tim Moran, CEO, Casey Fatch, Exe. VP & COO, Sharon Schultz, CNE/Sr. VP, Marcia Cavanaugh, Sr. Director of Quality & Risk Management, Jami Pearson, Director for Quality and Regulatory.</p> <p>Others present: Jody Root, General Counsel, Donna Dempster, Director of Medical Staff, Sharon Davies, Dr. Mazarei, Mimi Mateo, Megan McGraw, Patricia Guerra, Monica Marshall and Karren Hertz.</p> <p>Members absent: Dr. Scott Worman</p>	
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Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Chair RoseMarie Reno called the meeting to order at 12:05 p.m. in Assembly Room 1.		Chair Reno
2. Approval of Agenda	The group reviewed the agenda. There were no additions or modifications made.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Finnila.	Chair Reno
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Reno read the paragraph regarding comments from members of the public.	Announcement by Director Reno.	Chair Reno

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
<p>2. End Tidal CO2 (EtCO2) Monitor – Procedure</p> <p>3. Medication Recall – Policy</p> <p>4. Pain Management – Policy</p> <p>5. Patient Controlled Analgesia – Procedure</p> <p>6. Point of Care Testing Competency Assessment- Procedure</p> <p>7. Pre-Printed Orders- Policy</p> <p>8. Pulse Oximetry- Procedure</p> <p>9. Sponges, Sharps and Instrument Counts, Prevention of Retained Surgical Objects- Procedure</p>	<p>better in the morning than later.</p> <p>It was clarified by Sharon that a patient can refuse oxygen; this needs to be documented and then a patient should sign that he/she declined the equipment.</p> <p>The adult evaluation resource guide which has a pain scale from 0-10 is a guide for pain but it is considered subjective based on patient's response.</p> <p>Director Dagostino asked what a Power Plan is and it was clarified that a Power Plan is a group of orders that can be implemented together by physicians.</p> <p>The word identification was mentioned twice in the beginning part of the policy; one was deleted.</p> <p>Clarification was made on the spine cases and xray before and after the surgery. The spelling of thoracoscopy was also corrected.</p>	<p>seconded the motion to approve all the Patient Care policies and procedures with suggested additions and move forward for Board approval.</p>	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
10. Wound VAC, Negative Pressure Therapy- Policy Administrative Policies and Procedures: <ol style="list-style-type: none"> Purpose of Responsibility of Risk Management 	<p>The Board mentioned that this is a good policy especially the part where it was mentioned that this function will work closely with the hospital's Compliance Officer.</p>	<p>*The Administrative policy was approved with no changes. Director Dagostino moved the motion and Director Finnila seconded to move forward for Board approval.</p>	Monica Marshall
Unit Specific Policies and Procedures: <u>Emergency</u> <ol style="list-style-type: none"> Culture Follow-Up, Emergency Dept- Policy Triage of Emergency Department Patients- Procedure 	<p>It was reported that it is possible for patients in the ED to leave with a positive culture.</p> <p>Director Finnila asked for a short explanation and clarification if an employee gets hurt while working. Staff needs to go to Employee Health and if it is after hours, the employee needs to go to the ED.</p> <p>Director Reno had a question on diverting the ED patients and also on the 10-bed hold unit area. It was reported that we are no longer doing the bed hold in the ED.</p>	<p>*The ED policies were approved and are moving forward for Board approval as moved by Director Dagostino and seconded by Dr. Corona.</p>	Monica Marshall
<u>NICU</u> <ol style="list-style-type: none"> Chest Tube, Care of Infants with a Pneumothorax- Procedure Nasogastric (NG) and 		<p>Director Reno requested that Administration revisit a "Hold Unit" even 6 or so beds.</p> <p>*The NICU policies were approved and are moving forward for Board approval as moved by Director Dagostino and</p>	Administration Monica Marshall

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
<p>Orgastric (OG) Tube Insertion, Maintenance and Removal- Procedure</p> <p>3. Pain Management</p> <p>4. Neonates & Infants- Policy</p> <p>5. Patient Assignments in NICU- Procedure</p> <p>6. Patient Classifications (acuity) in NICU- Procedure</p> <p>7. Pre-Post Weights for Breastfed Infants in NICU- Procedure- Procedure</p> <p>8. Replogle Tube Insertion and Maintenance- Procedure</p> <p>9. Staffing Policy for High Census- Policy</p>	<p>There was a clarification made to Director Finnila that pre and post weights are being done for NICU as an evidence-based practice.</p>	<p>seconded by Dr. Corona.</p>	
<p><u>Women and Children's Services</u></p> <p>1. Neonatal Resuscitation Team for Scheduled Cesarean Sections- Procedure</p>	<p>There were no changes and questions pertaining to this policy.</p>	<p>*The Women's and Children's procedure was approved with the amended changes. Director Finnila moved the motion and Dr. Corona seconded. Policies will move forward for Board approval.</p>	<p>Monica Marshall</p>
<p><u>Staffing Resource</u></p> <p>1. Disaster Call Back List- Policy</p>	<p>There were no changes and questions pertaining to this policy.</p>	<p>*The Staffing Resource policy was approved with the amended changes. Director Finnila moved the motion and Dr. Corona seconded. Policies will move forward for Board approval.</p>	<p>Monica Marshall</p>

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
8. Closed Session	Director Reno made a motion to go into Closed Session.	Director Finnila moved, Dr. Corona seconded and it was unanimously approved to go into closed session at 12:35 PM.	Chair Reno
10. Return to Open Session	The Committee return to Open Session at 1:55 PM.		Chair Reno
11. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Chair Reno
12. Comments from Members of the Committee	No Comments.		Chair Reno
13. Adjournment	Meeting adjourned at 2:10 PM		Chair Reno



PROFESSIONAL AFFAIRS COMMITTEE

October 23, 2014

CONTACT: Sharon Schultz, CNE

<u>Patient Care Services Policies & Procedures</u>		
1. Code Triage Alert, Emergency Department – Procedure	3 Year Review	Forward to BOD for approval
2. End Tidal CO ₂ (EtCO ₂) Monitor- Procedure	3 Year Review	Forward to BOD for approval
3. Medication Recall -Policy	3 Year Review	Forward to BOD for approval
4. Pain Management - Policy	Practice Change	Forward to BOD for approval
5. Patient Controlled Analgesia - Procedure	Practice Change	Forward to BOD for approval
6. Point of Care Testing Competency Assessment- Procedure	3 Year Review	Forward to BOD for approval
7. Pre-Printed Orders – Policy	3 Year Review	Forward to BOD for approval
8. Pulse Oximetry – Procedure	3 Year Review	Forward to BOD for approval
9. Sponges, Sharps and Instrument Counts, Prevention of Retained Surgical Objects - Procedure	Practice Change	Forward to BOD for approval
10. Wound VAC, Negative Pressure Therapy – Policy	3 Year Review	Forward to BOD for approval
<u>Administrative Policies & Procedures</u>		
1. Purpose of Responsibility of Risk Management- Policy	3 Year Review	Forward to BOD for approval
<u>Unit Specific</u>		
<u>Emergency</u>		
1. Culture Follow Up, Emergency Department – Policy	NEW	Forward to BOD for approval
2. Triage of Emergency Department Patients – Procedure	Practice Change	Forward to BOD for approval
<u>NICU</u>		
1. Chest Tube, Care of Infants with a Pneumothrax- Procedure	Practice Change	Forward All to BOD for approval
2. Nasogastric (NG) and Orogastric (OG) tube Insertion, Maintenance and Removal- Procedure	Practice Change	
3. Pain Management Neonates & Infants- Policy	Practice Change	
4. Patient Assignments in NICU- Procedure	Practice Change	
5. Patient Classifications (Acuity) in NICU- Procedure	NEW	



PROFESSIONAL AFFAIRS COMMITTEE

October 23, 2014

CONTACT: Sharon Schultz, CNE

Page 2 of 2

6. Pre-Post Weights for Breastfed Infants in NICU- Procedure	NEW	Forward to BOD for approval
7. Replogle Tube Insertion and Maintenance- Procedure	NEW	Forward to BOD for approval
8. Staffing Policy for High Census- Policy	Practice Change	Forward to BOD for approval
<u>Unit Specific (continued)</u>		
<u>Women and Children's Services</u>		
1. Neonatal Resuscitation Team for Scheduled Cesarean Sections- Procedure	NEW	Forward to BOD for approval
2. Placenta Release To Patient/Family	NEW	Forward to BOD for approval
<u>Staffing Resource</u>		
1. Disaster Call Back List- Policy	3 year review	Forward to BOD for approval

**PROCEDURE: CODE TRIAGE ALERT, EMERGENCY DEPARTMENT**

Purpose: To ensure patients have access to appropriate care when patient care demands exceed resources. To provide care at safe and consistent levels regardless of census overall.

A. DEFINITIONS:

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

B. PROCEDURE:

1. Bed census information is communicated to the **ED Assistant Nurse Manager (ANM)/Charge RN ED Assistant Nurse Manager (ANM)**, by Patient Placement Coordinator (PPC) ~~or the Administrative Supervisor (AS)~~ when the hospital is experiencing limited availability of staffing and/or beds. ~~unable to accommodate an increase of patients. This shall occur 24 hours per day, 7 days per week.~~
- 1.2. **Communication will occur 24/7 with updates at least every 2 hours, unless otherwise determined. Communication will be conducted via the daily Administrative Supervisor Report, through phone conversations between the ED and the Administrative Supervisor, and during routine and emergency bed meetings as appropriate.**
 - a. During the RED Zone, the ED ANM shall communicate with the PPC/AS for all diversions, critical patients, and codes.
 - b. PPC/AS and ED ANM shall communicate with updates at least every 2 hours, unless otherwise determined.
 - c. ED Leadership shall communicate with the ED ANM every 2 hours from 0500-2200.
2. ~~A "Code Triage" is indicated when all the following occurs:~~
 - a. ~~Stations A, B, C and D are at full capacity with emergent (red) and urgent (yellow) patients~~
 - b. ~~Fast Track is full with semi-urgent (green) and non-urgent (blue) patients~~
 - c. ~~Hall spaces are utilized~~
 - d. ~~Inpatient beds are not available within the next 2 hours~~
 - e. ~~Waiting area has more than 25 patients or greater than three (3) urgent category patients awaiting care~~
 - f. ~~Approximately 75 patients are in the care process~~
- 2.3. **The ED ANM, ED Manager/Director, and the sSenior Administrator/Clinical Operations Manager on call will determine when a hospital response (Code Triage**

Review/Revision Date	Clinical Policies & Procedures	Nursing Patient Executive Care Quality Committee	Department of Emergency Medicine	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
9/07;5.14	11/07, 1/10, 6/10;5/14	12/07, 1/10, 7/10; 6/14	7/14	1/08, 07/10; 8/14	2/08, 08/10	2/08, 08/10

- ~~– Yellow or Code Triage – Red) is necessary and notify the AS and PBX. ED ANM, Station B or C ED Physician and ED Manager determine when a Hospital response is necessary and notify the PPC/AS and PBX.~~
3. ~~PBX initiates the “Code Triage” via an overhead page as well as individual notification to the following people to increase the responsiveness and improve patient flow:~~
- ~~a. Behavioral Health Director~~
 - ~~b. Case Management Director~~
 - ~~c. Emergency Department Registration~~
 - ~~d. Environmental Services (EVS)~~
 - ~~e. Laboratory~~
 - ~~f. Nursing Directors~~
 - ~~g. Nursing Managers~~
 - ~~h. Patient Placement Coordinator/Administrative Supervisor (PPC/AS)~~
 - ~~i. Pharmacy~~
 - ~~j. Radiology~~
 - ~~k. Respiratory~~
 - ~~l. Security~~
 - ~~m. The following people should be contacted for additional assistance by the PPC/AS:~~
 - ~~i. Administrator on Call~~
 - ~~ii. Chief Nurse Executive (CNE)~~
 - ~~iii. Supply Chain Management~~
 - ~~iv. Medical Staff Office~~
4. ~~During Code Triage:~~
- ~~a. Nurse Manager/designee rounds on units to assess Census Status and communicates pending discharges to the PPC/AS.~~
 - ~~b. Bed meetings are held in the Staffing Office while in Red Census Zone.~~
 - ~~i. Nurse Managers/designee, ANM's, and PPC/AS attend the bed meetings to assess overall staffing and Census Zone Status.~~
 - ~~ii. Status updates are given every 2 hours to Nursing Leadership.~~
 - ~~c. Managers communicate the following information to the PPC/AS prior to leaving for the day:~~
 - ~~i. Bed availability~~
 - ~~ii. Unit ability to assist in patient admission, transfer, and discharge~~
 - ~~iii. Action plan for next 12 hours~~
 - ~~d. Final Zone status updates until 0315 staffing meeting, unless additional interventions are needed.~~
- 5.4. Code Triage Response
- a. **Code Triage – Yellow:**
 - i. **AS/PFC will initiate emergency bed meeting at 0830 in the staffing office or French Room. Attendees will include:**
 - 1) **All inpatient representatives (ANM, Manager, or Director)**
 - 2) **Surgery representative (ANM, Manager, or Director)**
 - 3) **Administrative Supervisor/PFC**
 - 4) **Case Management Director**
 - 5) **Staffing eOffice representative**
 - 6) **AIONEX representative**
 - ii. **Recommended actions include:**
 - 1) **Assess all unit censuses and potential discharges.**
 - 2) **Case Management to contact attending physicians to obtain discharges and plan early rounds as appropriate. Initiate active discharge planning to include disposition, education, and transportation.**

- 3) Call in extra staff as needed and/or adjust existing staff to accommodate patients. Consider increasing to 1:5 ratio in Med/Surg unit as appropriate. Utilize premium or incentive pay for staff and agencies.
- 4) Remove barriers to flow including charge nurse to charge nurse report.
- 5) Consider sending inpatient staff to ED to “pull” patients and receive face to face report.

b. Code Triage – Red:

i. AS/PFC will initiate emergency bed meeting STAT in the staffing office, French Room, or via conference call. Attendees will include:

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

ii. Recommended Actions include:

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


C. RELATED DOCUMENTS

1. Code Triage Contact List

2. Code Triage Census Zones

- a. ~~When the Hospital is in the “RED Zone,” the Code Triage team shall be paged to respond and shall initiate actions to potentially bring the Facility back to “Green Zone.”~~
- b. ~~The Team shall meet in French Room 1 within 10 minutes of the call out (Monday – Friday normal business hours) or 30 minutes after hours or on weekends.~~

- i. ~~Code Triage team includes the following:~~
 - 1) ~~Director /Manager/ANM ED~~
 - 2) ~~ED Case Manager~~
 - 3) ~~EVS Representative~~
 - 4) ~~Laboratory~~
 - 5) ~~Supply Chain Management~~
 - 6) ~~Nursing Director/Manager Critical Care and Acute Care Services (ACS)~~
 - 7) ~~Pharmacy~~
 - 8) ~~Radiology~~
 - 9) ~~Respiratory~~
 - 10) ~~Security~~
 - 11) ~~Lift Team Representative~~
- ii. ~~The following team members are required:~~
 - 1) ~~Administrator on call~~
 - 2) ~~CNE and Senior VP of Operations~~
 - 3) ~~Medical Staff Office~~
- iii. ~~Recommended actions are as follows:~~
 - 1) ~~ANM's from Critical Care and ACS shall fax a list of pending discharges and open beds to the nursing office within 10 minutes of the Code triage page.~~
 - 2) ~~Physicians are asked to discharge to accommodate admissions.~~
 - a) ~~If a discharge order is not written, physicians shall be contacted to assist with patient flow.~~
 - b) ~~Resistance to provide discharge orders shall be referred to the medical director during RED Census Alert.~~
 - 3) ~~Patients leaving within one hour and waiting for transportation may be moved to 3NS or to open waiting areas with staff oversight.~~
 - 4) ~~Skilled Nursing Facility transfers shall be aggressively sought by Case Management Staff.~~
 - 5) ~~Consideration shall be given when canceling elective surgeries in consultation with the CNE or the Administrator on Call.~~
- iv.i. ~~The ED Director shall notify PBX to announce "Code Triage, all clear" when the situation has been stabilized.~~

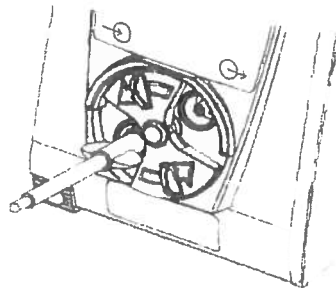
 Tri-City Medical Center		Distribution: Patient Care Services
PROCEDURE:	End Tidal CO₂ (EtCO₂) Monitor	
Purpose:	To provide continued assessment of patient physiologic response to medications causing sedation and to alert RN for changes in EtCO ₂ and periods of apnea	
Equipment:	Alaris [®] End Tidal CO ₂ module Disposable EtCO ₂ cannula	

A. POLICY:

1. EtCO₂ monitoring may be used:
 - a. In conjunction with medications known to cause sedation
 - b. To monitor for respiratory depression.
2. Contraindications are:
 - a. Patients receiving Palliative Care for terminally ill conditions where medication is used for comfort and system management for end of life care.
 - b. Patients in active labor.
 - c. Patients receiving mechanical ventilation.
 - d. Non-ventilated tracheotomy patients.
3. The purpose and function of the EtCO₂ monitor should be explained to the patient. Patient education information is to be given to patient/family during pre-operative education and/or at initiation of medications known to cause sedation.
4. Patient/family instruction should be reinforced post-operatively as needed.
5. If patient refuses to have the EtCO₂ monitor when ordered, document that the patient refuses in a clinical note in Cerner.
6. For patient receiving patient controlled analgesia (PCA) see Patient Care Services Patient Controlled Analgesia Procedure

B. PROCEDURE: SET UP AND PROGRAMMING OF ETCO₂ MODULE

1. Assemble equipment.
2. Explain EtCO₂ monitoring to patient and family. Assure that the patient has received EtCO₂ patient education guide.
3. Attaching the EtCO₂ cannula to the EtCO₂ module:
 - a. Turn the gas inlet/exhaust door (protective cover) counterclockwise until you can clearly see the gas inlet on the lower left corner of the unit.
 - b. While holding the door open, press the brightly colored end of the EtCO₂ cannula into the gas inlet and twist it gently but firmly clockwise until it is securely attached to the module.
 - c. After securing the disposable to the module, release the door.



- d. Place the EtCO₂ cannula on patient
 - i. Non intubated patient:
 - 1) Apply as you would a nasal cannula.

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NEW	06/14	06/14	09/14	09/14		

- 2) EtCO₂ cannula may be changed PRN.
 - ii. Patients requiring oxygen (O₂):
 - 1) Replace O₂ cannula with EtCO₂ cannula and attach O₂ arm connector to O₂ flow meter.
 - 2) When EtCO₂ module is discontinued, patient may continue to require O₂, replace EtCO₂ cannula with standard O₂ cannula
4. Perform following steps for the Alaris[®] ET CO₂ set up
 - a. Power on system
 - b. Choose **Yes** or **No** to **New Patient?**
 - c. Confirm current profile or select a new profile
 - d. Press **channel select** key on the ET CO₂ module
 - i. **Sensor warming** and then **searching** appear in Channel Message display until EtCO₂ and respiratory rate readings stabilize (up to 60 seconds).
5. Alarm limits:
 - a. EtCO₂ Monitor Settings include the following:
 - i. EtCO₂ value.
 - 1) Normal range (for a typical patient): 35-45 mmHg
 - ii. Respiratory Rate (RR) in breaths per minute
 - iii. No breath periods indicating potential apnea
 - iv. EtCO₂ Waveform (capnogram)
 - v. Fractional Inspired Carbon Dioxide (FiCO₂) value.
 - 1) Normal (for a typical patient): 0 mmHg
 - b. EtCO₂ preset monitor default values are.
 - i. High EtCO₂ 60.
 - ii. Low EtCO₂ 10.
 - iii. High RR 48.
 - iv. Low RR – < 6 monitor will alarm, < 5/4 will pause any continuous infusion of medications
 - v. No breath detected alarms at 30 seconds
 - c. To change the alarm limits:
 - i. The following alarm limits on the Alaris[®] EtCO₂ module may be changed after completing patient assessment and collaborating with Respiratory Therapist or physician to determine a patient's normal parameters:
 - 1) EtCO₂ High.
 - 2) EtCO₂ Low.
 - 3) RR High.
 - 4) RR Low.
 - 5) No Breath limit.
 - ii. Press the Channel Select key on the Alaris[®] EtCO₂ module
 - iii. On the EtCO₂ Main Display, press the limits soft key.
 - iv. For each limit you want to modify, press the soft key on the Alaris[®] PC point-of-care unit and change the value by one of the following methods:
 - 1) Enter a new value using the numeric keys.
 - 2) Change the value using the up and down arrow keys.
 - v. After making all of your changes, press the Confirm soft key to confirm the new limits.
 - vi. Document changes outside the default settings in a clinical note
6. Monitoring:
 - a. To view EtCO₂ information while a patient is monitored, press the Channel Select key on the Alaris EtCO₂ module. From top to bottom on the Main EtCO₂ Display screen, the following information is visible:
 - i. Current EtCO₂ value in mmHg with upper and lower alarm limits.
 - ii. Current RR (respiratory rate) in breaths per minute.
 - iii. Capnogram or EtCO₂ waveform

7. EtCO₂ Trend Data:
 - a. The following information appears on the EtCO₂ Trend Data display.
 - i. Time period for data collection.
 - ii. Average EtCO₂ with maximum (MAX) and minimum (MIN) values.
 - iii. Average RR with maximum (MAX) and minimum (MIN) values.
 - iv. Alarm icon with "F" in the Time column to indicate high FiCO₂ alarm limit violations.
 - v. Alarm icons indicating there were alarm violations with those values.
 - b. To access the EtCO₂ trend data.
 - i. Press the Channel Select key on the Alaris® EtCO₂ module.
 - ii. Press the Trend soft key on the Alaris® PC point-of-care unit.
 - iii. Six data collection periods are displayed on a single screen page. To move from page to page, press the Page Up and Page Down soft keys.
 - iv. To move the cursor and scroll through the data one row at a time, press the up arrow and down arrow changing the Data Collection Time Period.
 - c. To zoom in or out of a time period.
 - i. Move the cursor to the desired time period for start of review.
 - ii. Press the Zoom soft key.
 - iii. Each press of the zoom soft key changes one time period. Available time periods are 120, 60, 30, 5, and 1 minute(s). Repeated pressing of the Zoom soft key cycles through the time period choices.
 - d. Patient Controlled Analgesia (PCA) and EtCO₂ Trend Data.
 - i. The following information appears on the combined Trend Data screen.
 - 1) Time period for data collection.
 - 2) Total dose of medication infused through the Alaris® PCA module*.
 - 3) Average EtCO₂.
 - 4) Average RR.
 - 5) Alarm icons indicating alarm violations.
 - ii. The TOTAL DOSE column includes all infusions that have gone through the PCA module during that time period. This includes all PCA doses, Bolus doses, Loading doses, and Continuous infusions.
 - iii. To access PCA and EtCO₂ Trend Data.
 - 1) Press the Channel Select key on the Alaris® EtCO₂ module.
 - 2) Press the Options key on the Alaris® PC point-of-care unit.
 - 3) On the Channel Options screen, press the PCA/ EtCO₂Trend data soft key.
8. Alarms
 - a. Pre-Silencing Alarms.
 - i. The Pre-Silence feature allows you to silence alarms before they occur. For example, if you know you will be taking the disposable off your patient for a period of 2 minutes, you can first Pre-Silence the alarms and then take off the disposable. Monitoring audio alarms can be pre-silenced for 120 seconds. This does not apply to infusion alarms, which cannot be pre-silenced. While monitoring alarm tones are silenced, visual alarm indicators remain active.
 - ii. To pre silence monitoring audio alarms, press the Silence key on the Alaris® PC point-of-care unit. You will then see an alarm icon with an X over it next to the EtCO₂channel on the Main Display
 - iii. Canceling pre-Silence.
 - 1) To cancel the pre-silence state before 120 seconds has elapsed:
 - 2) Press the Channel Select key on the Alaris® EtCO₂ module.
 - 3) On the EtCO₂ Main screen, press the Cancel Silence soft key.
 - b. Disposable Disconnected Alarm.
 - i. This alarm occurs when the EtCO₂ module is not detecting the Microstream disposable. Securely attach the disposable to the module as previously described by twisting it clockwise gently but firmly until secure. Important: If the disposable is not securely attached, the monitor will not accurately measure EtCO₂ and RR.

- ii. The EtCO₂ module will automatically try to clear the filter in the disposable if it becomes wet from condensation or secretions. Monitoring data is not available during the clearing process. You may get low EtCO₂ readings or a disposable disconnected alarm.
 - iii. Disconnect Occluded Disposable Alarm
 - 1) This alarm occurs after the EtCO₂ module has tried to clear the disposable and is unsuccessful. Try the following troubleshooting steps.
 - 2) If a second alarm occurs, discard the occluded disposable and attach a new one.
 - c. Disconnect Occluded Disposable Alarm
 - i. This alarm occurs after the EtCO₂ module has tried to clear the disposable and is unsuccessful. Try the following troubleshooting steps.
 - 1) First try disconnecting and reconnecting the disposable and allow the module to reset.
 - 2) If a second alarm occurs, discard the occluded disposable and attach a new one.
 - ii. The EtCO₂ module has an automatic Autozero Feature. During this time the module is baselining to ambient air, which ensures accurate readings. The module will initiate the Autozero Feature whenever it is determined necessary. During the auto zero process, a message will display on the module indicating AUTOZERO IN PROGRESS. No monitoring data will be available at this time.
 - 1) Autozero in Progress Advisory.
 - a) The EtCO₂ module has an automatic Autozero Feature. During this time the module is baselining to ambient air, which ensures accurate readings. The module will initiate the Autozero Feature whenever it is determined necessary. During the auto zero process, a message will display on the module indicating AUTOZERO IN PROGRESS. No monitoring data will be available at this time.
 - d. Changing the Waveform Height.
 - i. If the EtCO₂ value goes beyond the height of the waveform scale (in mmHg), the top of the waveform is unreadable. Change the waveform height, will allow you to visualize the entire waveform. To change waveform height.
 - 1) Press the Channel Select key on the Alaris® EtCO₂ module.
 - 2) Press the Options key on the Alaris® PC point-of-care unit.
 - 3) Press the Waveform time scale soft key and change it to the desired time scale.

C. **ASSESSMENT/INTERVENTIONS:**

- 1. EtCO₂ /PCA trends should be assessed every shift and PRN.
- 2. High EtCO₂ greater than 60mm Hg (Changes to EtCO₂ alarm settings will be made in collaboration with Respiratory Therapist, RN, and/or Physician based on patient's clinical history).
 - a. Assess patient for proper cannula placement.
 - b. Hypoventilation – patient is not breathing enough (slow deep breaths).
 - c. Check the patient for normal signs of ventilation – pause the PCA.
 - d. Increase ventilation by stimulation.
 - e. Assess vital signs for decompensation – SpO₂, BP, RR, HR and LOC.
 - f. If patients EtCO₂ does not trend with patients normal, defined limits within 5 minutes, collaborate with Respiratory Therapy via page.
 - g. If patient does not respond to stimulus and vital signs prove to be decompensating, call the Rapid Response Team (RRT) to bedside for support and use the pre-ordered reversal agent ordered on the PCA CPOE order set if appropriate.
- 3. Low EtCO₂ less than 10mmHg (Changes to EtCO₂ alarm settings will be made in collaboration with Respiratory Therapist, RN, and/or Physician based on patient's clinical history).
 - a. Assess patient for proper cannula placement.

- b. Hyperventilation – patient is over breathing.
 - c. Check the patient for increased RR and work of breathing.
 - d. Verify the PCA is working correctly and delivering the appropriate amount of medication.
 - e. Decrease ventilation. Assess pain level using pain scale.
 - f. Monitor vital signs.
 - g. If patient's EtCO₂ does not trend within normal limits within 5 minutes, and pain is controlled, collaborate with Respiratory Therapy.
 - h. Based on bedside physician's order consider: adjusting pain medication and alternative care.
4. Respiratory Rate less than 6
- a. Assess patient for proper cannula placement.
 - b. Verify hypoventilation via assessment of respiratory rate, quality and depth.
 - c. If patient receiving PCA, a respiratory rate < 4 will auto pause PCA.
 - d. Increase ventilation by stimulating patient.
 - e. Assess SPO₂, LOC, vital Signs.
 - f. If patient's RR does not return to normal defined limits within 5 minutes and/or vital signs prove to be decompensating call RRT and use the pre-ordered reversal agent ordered on the PCA CPOE order set if appropriate.
 - g. If patient is noted to be over sedated but does not cause an alarm call RRT and notify physician

D. **DISCONTINUATION:**

- 1. EtCO₂ trend should be evaluated prior to discontinuation. Patient should meet the following criteria before EtCO₂ can be discontinued:
 - a. The patient is no longer receiving concomitant medications with sedation affect (examples: Opioids, anti-anxiety, anti-nausea, or anti-histamine being used at or around the same times).
 - b. Patient has gone 24 hours without periods of hypoventilation less than 12 breaths per minute
 - c. Patient has not received unplanned reversal agents.
 - d. Patient has not received moderate sedation or general anesthesia within the past 4 hours.
 - e. Patient does not have a diagnosis of Obstructive Sleep Apnea (OSA), or suspected OSA.
- 2. If patient has ongoing episodes of hypoventilation during the last 24 hours, do not discontinue the EtCO₂ monitor. Consult with physician to possibly decrease pain medication if appropriate and continue monitoring patient.

E. **DOCUMENTATION:**

- 1. EtCO₂ monitoring will be documented with vital signs unless patient requires more frequent monitoring due to respirations or CO₂ levels that are outside of the normal ranges
 - a. For patients receiving PCA vital signs will be assessed per the PCS Patient Controlled Analgesia Procedure.

F. **RELATED DOCUMENTS:**

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

G. **REFERENCES:**

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

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 02/03 **SUBJECT:** Medication Recall

REVISION DATE: 06/03, 08/05; 01/06; 03/08; 02/09
07/11, **POLICY NUMBER:** IV.I.9

Clinical Policies & Procedures Committee Approval: ~~06/11~~ 05/14

Nursing Executive Council Approval: ~~06/11~~ 05/14

Pharmacy and Therapeutics Committee Approval: 07/14

Medical Executive Committee Approval: 09/14

Professional Affairs Committee Approval: 07/11

Board of Directors Approval: 07/11

A. POLICY:

1. The ~~Pharmaceutical Services~~ **Pharmacy** Department shall maintain a system whereby drugs subject to recall are immediately identified, removed from active inventory, and sequestered.
2. The ~~Pharmaceutical Services~~ **Pharmacy** Department is notified of manufacturer's or Food and Drug Administration (FDA's) recall or medication discontinuation proceedings through direct mail, wholesaler's notification, written or electronic FDA Safety Alert or Recall Notification.
 - a. Chronological files of such notifications, alerts, and recall notices shall be maintained for at least one (1) year.

B. PROCEDURE:

1. When the ~~Pharmaceutical Services~~ **Pharmacy** Department receives information about a medication recall or discontinuation by the manufacturer or the FDA for safety reasons:
 - a. All individuals ordering, dispensing, and/or administering recalled or discontinued medications are notified.
 - b. Patients will be notified of the recall or discontinuation if required by law or regulation.
2. The pharmaceutical buyer or designee shall remove all lots of a recalled drug if found in inventory. **Recalled medications are replaced with an unaffected lot number of the same medications or generic equivalent, when available.**
 - a. A record of actions taken shall be written on the recall notice; including none found in inventory and the date the action was taken.
 - b. The notice is forwarded to the Director of ~~Pharmacy~~ **Pharmaceutical Services** or designee upon completion of the recall action.
3. All drug storage areas of the hospital shall be inspected, including satellite pharmacies, surgery and other floor stock areas if applicable.
4. **Recalled medications are quarantined in a designated area separate from active stock. This area is clearly identified.**
5. **Recalled medications are returned in accordance with manufacturers/recall notice specifications.**
- 3-6. **Medications recalled for safety reasons are reported to the Pharmacy and Therapeutics Committee.**

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 12/93 **SUBJECT:** Pain Management

REVISION DATE: 05/94, 08/97, 09/00, 07/03, 05/05,
04/06; 11/07; 4/08, 11/08, 12/08,
1/12; **POLICY NUMBER:** IV.W

Clinical Policies & Procedures Committee Approval: 07/12 06/14
Nurse Executive Committee Approval: 08/12 06/14
Pharmacy & Therapeutics Committee Approval: 07/14
Medical Executive Committee Approval: 11/12 08/14
Professional Affairs Committee Approval: 01/13
Board of Directors Approval: 01/13

A. **PURPOSE:** To use effective pain management techniques to provide appropriate pain relief designed for each patient on an individual basis.

B. **POLICY:**

1. Pain management begins with the assessment of the patient's level of pain at the time of admission, continues throughout their stay, and is considered in discharge planning.
 - a. Perform a pain assessment with each patient report of new or different pain
2. Pain management is an interdisciplinary process.
3. All patients have a right to pain relief and shall receive pain management.
4. The patient (including neonatal, pediatric, adolescent, and adult) and family/caregiver are educated about the following as appropriate to his/her condition and assessed needs for understanding:
 - a. Pain
 - b. Risk for pain
 - c. Importance of effective pain management
 - d. Pain assessment process
 - e. Methods for pain management
5. Patient shall be assured of adequate pain management.
 - a. Information shall be obtained from the patient and/or family/caregiver as appropriate with regard to cultural, ethnic, and/or religious preference in determining methods of pain management (e.g. pharmacologic versus non-pharmacologic).
6. Pain level assessment is considered the "fifth" vital sign. Assessment and reassessment of pain level and pain relief shall be performed with routine vital signs and as needed. Findings shall be documented in the medical record.
- 6-7. ~~Since any medications used to manage pain are known to cause sedation, a~~ All patients will be assessed for sedation/over-sedation prior to administration of opiates, muscle relaxers, tramadol and such medications commonly used for pain known to cause sedation (for example hydromorphone, hydrocodone and dilaudid) as well as following their administration (see list of Commonly Used Pain Medications Known to Cause Sedation).
- 7-8. Health care providers shall maintain patient safety while managing the patient's pain.
- 8-9. An appropriate pain rating scale shall be used to assess pain that is consistent with the patient's age, condition, and ability to understand. (see Attachment A):

C. **PROCEDURE:**

1. Provide a calm, supportive atmosphere.

2. Assess patient's characteristics of pain consistent with the patient's age, condition, and ability to understand (may include but is not limited to):
 - a. Acceptable pain level
 - i. If patient is unable to verbalize acceptable level, document reason in the medical record.
 - ii. If condition changes and patient is able to verbalize acceptable pain level, the level must be documented.
 - b. Physical, behavior, and emotional signs and symptoms of pain
 - i. Presence of pain
 - ii. Physical exam and observation of pain site as clinically indicated which may include intensity, location, quality, duration, alleviating factors and/or aggravating factors.
3. Document pain assessment in the medical record.
 - 3-a. **Document pre and post-intervention sedation using Pasero Opiate Sedation Scale (POSS) appropriate sedation scale (see Sedation Evaluation Resource Guide Attachment 3)**
4. **Call the physician for clarification** When multiple pain medications are ordered for the same patient without a designated pain level, ~~the physician will be called for clarification~~ (see Patient Care Services Policy Medication Administration).
 - 5-a. Pain levels are defined as:
 - a.i. Mild pain (pain level 1 – 3)
 - b.ii. Moderate pain (pain level 4 – 7)
 - c.iii. Severe pain (pain level 8 – 10)
- 6-5. **Perform appropriate interventions** Based on the patient's stated pain level, appropriate interventions shall be performed as needed to achieve patient's acceptable pain level.
 - a. Pharmacologic interventions require a ~~physician~~ **physician/licensed independent practioner (LIP)** order.
 - b. Non-pharmacologic interventions that do not require a ~~physician~~ **physician/LIP** order may include the following:
 - i. Children, adolescents, adults:
 - 1) Distraction
 - 2) Positioning
 - 3) Relaxation
 - 4) Music therapy
 - 5) Guided imagery
 - 6) Massage
 - 7) Range of motion
 - 7-8) **Heat or cold therapy**
 - ii. Infants:
 - 1) Swaddling
 - 2) Holding
 - 3) Repositioning
 - 4) Pacifier
 - 5) Oral Sucrose
 - c. Non-pharmacologic interventions that require a ~~physician~~ **physician/LIP** order may include the following:
 - i. ~~Heat or cold therapy~~ **Mechanical devices providing heat or cold therapy**
 - ii. Transcutaneous Electrical Stimulation (TENS)
 - d. Reassessment of pain level **and level of consciousness** ~~potential medication-induced sedation~~ shall be done thirty-sixty (30-60) minutes after intravenous, intramuscular, or subcutaneous intervention. Document in PRN response in medical record.
 - e. Reassessment of pain level **and level of consciousness** ~~potential medication-induced sedation~~ shall be done one (1-2) hour(s) after PO intervention. Document in PRN response in medical record.

- e.f. **Medication-induced sedation should be re-assigned prior to IV or PO intervention to determine if patient is eligible to receive the intervention.**
 - f.g. ~~Notify the physician~~**physician/LIP** if pain is not relieved by ~~non-pharmacologic~~ further interventions ~~obtained pain is not relieved by interventions~~ within one (1) hour and no other interventions are available to the patient.
 - i. If the patient refuses pain intervention measures/procedures, the care provider shall discuss the patient's pain management goals with the patient and reassess potential interventions. Refusal of pain management intervention, reassessment findings, and discussion with patient regarding pain management shall be documented in the medical record.
 - i.h. **Notify the physician**physician/LIP if patient continues to report unacceptable pain level, but is not eligible to receive additional interventions due to excessive sedation.****
- 7.6. ~~Educate P~~**patient teaching** regarding pain management ~~and shall be documented~~ **education** in the medical record.
- 8.a. The "Patient's Rights Regarding Pain Control" is located in the Patient Handbook.
- 9.7. ~~Consider P~~**patient/f**family preferences, as well as cultural, ethnic, and religious beliefs, ~~shall be considered~~ when determining the pharmacological and non-pharmacological methods to be used for pain management.

D. **SPECIAL CIRCUMSTANCES:**

1. Assess for existence of special circumstances (elderly, aphasia, dementia, mental disabilities, age, coma, and end of life), which require modification of traditional approaches to assessment; in the patient with known pathology or behavior that indicates the presence of pain.
 - a. Pain in the elderly
 - i. Allow patient to use appropriate aids he/she requires for seeing/hearing
 - ii. Be aware that pain perception does not decrease with age
 - ii.iii. **Be aware that metabolism of drugs will decrease with age and lower starting doses may be warranted**
 - b. Pain in pediatric and newborn patients
 - i. Consider using pain faces (Wong-Baker scale)
 - ii. Consider using NPASS (Neonatal Pain, Agitation, and Sedation Scale)
 - iii. **Use NIPS scale neonatal-infant Pain Scale**
 - c. Pain in the non-English speaking or sensory impaired patient
 - i. Refer to Patient Care Services Policies II.H Communication with the Sensory Impaired (Blind//Deaf) and II.J Interpretation and Translation Services.
 - d. Denial of pain in the patient with known pathology or behavior indicating the existence of pain
 - i. Explore possible causes, attempt to find solutions or provide information to help patient choose better level of pain control
 - ii. Consider a trial dose of analgesic
 - e. Pain in patients with impaired communication (coma, severe emotional disturbance, dementia, or with end stage diseases)
 - i. Include family or close caregivers in making determination regarding patient's pain level, consider using Proxy Pain Rating.
 - ii. Consider a trial dose of analgesics, or other form of intervention if pain is suspected.
 - iii. Observe systematically for possible pain behaviors related to vocalizations, facial expressions, behavior changes, and autonomic responses
 - iv. Utilize presumptive treatment of pain for patients who cannot speak and who undergo painful treatments or procedures.
 - v. **Utilize a non-verbal pain scale (for example NVPS or CNPI or CPOT)**
 - f. **Opiate-induced sedation must be assessed and re-assessed in all of the above patient populations.**

2. Determine patient's ability to manage pain and/or appropriateness of treatment modality (e.g. Patient Controlled Analgesia (PCA)).

E. **SAFETY**

1. Discontinue PCA in patients with deteriorating level of consciousness and notify the ~~physician~~**physician/LIP**.
2. Instruct family/caregivers to report patient's pain or inability to use PCA to the nurse. Family/caregivers should not push PCA button for patient.
- ~~2-3.~~ **Inspect all of patient's medications and identify those with potential to cause sedation (e.g opiates, benzodiazepines, anticonvulsants etc.). Use all sedating medications with caution as their effect may be additive.**
- ~~3-4.~~ **In patients receiving intrathecal or epidural opioids, Clarify any supplemental pain medication ordered by ~~physician~~**physician/LIP** other than anesthesiologist with the anesthesiologist before administration in patients receiving intrathecal or epidural opioids.**
- ~~4-5.~~ Monitor the use of ice or heat therapy and the use of transcutaneous electrical nerve stimulation (TENS) patches at least every four hours for the development of burns and/or skin breakdown.
- ~~5-6.~~ Inspect site of fentanyl patches every shift for evidence of inflammation.
- ~~6-7.~~ **Observe patients who are receiving a narcotic/opioid for ~~their individual response~~ excessive sedation following administration. *Naloxone should be readily available to antagonize enough narcotic so that the patient is able to maintain adequate ventilation but leaves enough opioid available in the system to relieve pain.**
- ~~7-8.~~ Avoid abrupt discontinuation of an opioid in a known or suspected physically dependent patient.
- ~~8-9.~~ Regulate all continuous IV pain medications on an infusion pump.
- ~~9-10.~~ Notify ~~physician~~**physician/LIP** for any unrelieved pain.
- ~~10-11.~~ Report to the ~~physician~~**physician/LIP** any signs/symptoms of over sedation or any other unexpected physiological and behavioral outcomes:
 - a. Apnea
 - b. Respiratory rate less than 10 breaths per minute or less than 20 breaths per minute for children under 2 years of age
 - c. SpO₂ less than 92% or as ordered
 - d. Hypotension
 - e. Allergic reactions
 - f. Change in level of consciousness (e.g. unresponsive, somnolent, difficult to arouse)
 - g. Nausea/vomiting
 - h. Itching
 - i. Urinary retention
 - j. Absent bowel sounds

F. **ATTACHMENTS FORMS (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS FOLDER):**

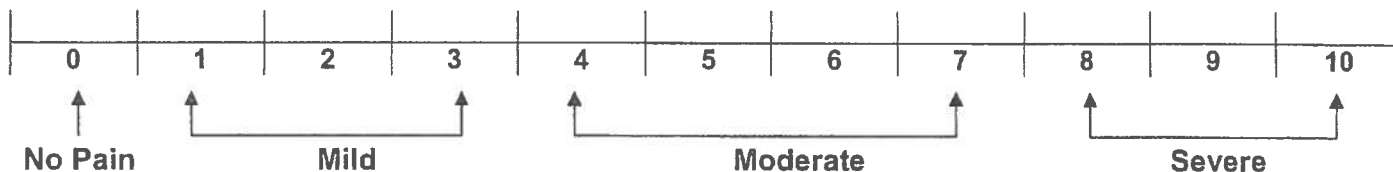
1. Adult Pain Evaluation Resource Guide
 - a. Numeric Scale
 - b. Wong-Baker Face Scale
 - c. Adult Non-Verbal Pain Scale (NVPS)
 - d. Ventilated Patient Non-Verbal Pain Scale (NVPS)
 - e. Proxy Pain Rating
2. Pediatric Pain Evaluation Resource Guide
 - a. Numeric Scale
 - b. Wong-Baker Face Scale
 - c. Behavioral Scales (FLACC)
 - i. FLACC
 - ii. Neonatal Pain, Agitation, and Sedation Scale (NPASS)
- ~~ii-3.~~ **Commonly Used Pain Medications Known to Cause Sedation List**
- ~~3-4.~~ **Sedation Evaluation Resource Guide (~~POSS~~)TCMC Medical Staff Recommended Pain Therapies**

G. **REFERENCES:**

1. California Healthcare Association Consent Manual Health and Safety Code Section 124960. (2005).
2. Odhner, M., Wegman, D., Freedland, N., and et al.. (2003). Assessing pain control in nonverbally critically ill adults. *Dimens Crit Care Nurs*, Volume 22/6
3. Amis, D. and Green, J. (2004). Assessment of effective coping during labor. *Lamaze International* Retrieved April 24, 2008. www.lamaze.org.
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7. **Pasero C, McCaffery M. (2011): *Pain Assessment and Pharmacologic Management*. St. Louis: Mosby/Elsevier.**

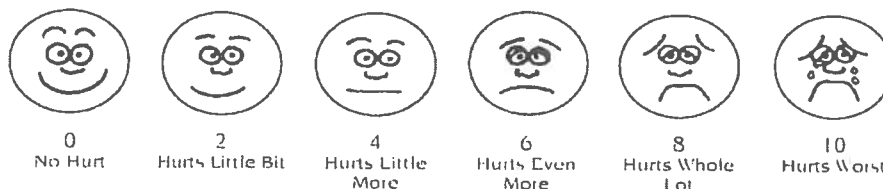
ADULT PAIN EVALUATION RESOURCE GUIDE

1. **NUMERIC SCALE (0 – 10):** For patients who can self-report



2. **WONG – BAKER FACES**

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



3. **ADULT NON-VERBAL PAIN SCALE (NVPS):** For patients who are unable to respond/determine the pain rating (0 – 10)

Subscales	0	1	2
FACE	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead.	Frequent grimace, tearing, frowning, wrinkled forehead.
ACTIVITY	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes.
GUARDING	Lying quietly, no positioning of hands over areas of body	Splinting areas of body, tense	Rigid, stiff
PHYSIOLOGIC I (Vital Signs)	Stable vital signs (no change in past 4 hours).	Change from baseline over past 4 hours in any of the following: SPB greater than 20mm HG HR greater than 20 beats/minute RR greater than 10 breaths/minute	Change from baseline over past 4 hours in any of the following: SPB greater than 30mm HG HR greater than 25 beats/minute RR greater than 20 breaths/minute
PHYSIOLOGIC II	Warm, dry skin	Dilated pupils, perspiring, flushing	Diaphoretic, pallor

4. **VENTILATED PATIENT NON-VERBAL PAIN SCALE (NVPS):** For patients who are unable to respond/determine the pain rating (Best used in critical care areas) (0 – 10)

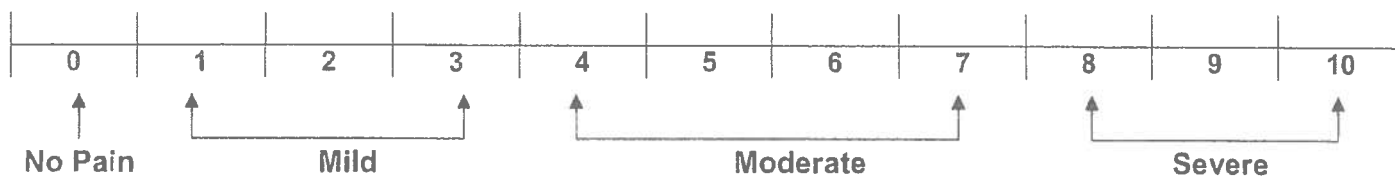
Subscales	0	1	2
FACE	No particular expression or smile.	Occasional grimace, tearing, frowning, wrinkled forehead.	Frequent grimace, tearing, frowning, wrinkled forehead.
ACTIVITY	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes.
GUARDING	Lying quietly, no positioning of hands over areas of body	Splinting areas of body, tense	Rigid, stiff
PHYSIOLOGY (Vital Signs)	Stable vital signs	Change from baseline in any of the following: SPB greater than 20mm HG HR greater than 20 beats /minute	Change from baseline in any of the following: SPB greater than 30mm HG HR greater than 25 beats/minute
RESPIRATORY	Baseline RR/SpO2 Compliant with ventilator	RR greater than 10 above baseline, or 5% ↓SpO2 Mild asynchrony with ventilator	RR greater than 20 above baseline, or 10% ↓SpO2 Severe asynchrony with ventilator

5. **PROXY PAIN RATING:** The family or caregiver thinks the patient is in pain.

Proxy Pain Rating: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

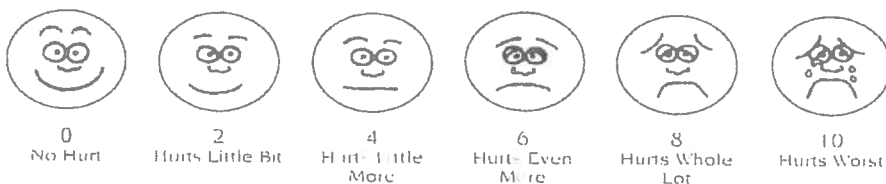
PEDIATRIC/NEONATAL PAIN EVALUATION RESOURCE GUIDE

1. **NUMERIC SCALE (0 – 10):** For patients who can self-report



2. **WONG- BAKER FACES**

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



3. **BEHAVIORAL SCALES:** For patients who cannot respond verbally

FLACC SCALE			
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown	Frequent to constant frown
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back & forth, tense	Arches, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steady, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by hugging touching, or "Talking to", distractible	Difficult to console or comfort

4. NEONATAL PAIN, AGITATION, & SEDATION SCALE (NPASS)

Criteria	Sedation		Normal	Pain/Agitation	
	-2	-1		1	2
Crying Irritability	No cry to painful stimuli	Briefly moans/cries to painful stimuli	Little crying Not irritable	Irritable/crying at intervals, consolable	Continuous high-pitched/ silent-cry. Inconsolable
Behavior State	No arousal to any stimuli, No spontaneous movement	Arouses minimally to stimuli. Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking. Constantly awake or arouses minimally to movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression to stimuli	Relaxed	Intermittent painful expression	Continual painful expression
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex. ↓ Muscle tone	Relaxed hands & feet Normal tone	Intermittent clenched toes, fists or finger splay, Body not tense	Continual clenched toes, fists or finger splay. Body is tense
Vital Signs HR, RR, BP SaO ₂	No variability to stimuli, Hypo-ventilation/apnea	Less than 10% variability from baseline with stimuli	Baseline/normal for gestational age	↑ 10-20% from base-line Sao ₂ 76-85% to stimulation – quick ↑	↑greater than 20% from baseline SaO ₂ less than 75% to stimulation – slow ↑ Out of sync with vent

Neonatal Infant Pain Scale (NIPS)

Parameter	Finding	Points
facial expression	relaxed	0
	grimace	1
cry	no cry	0
	whimper	1
	vigorous crying	2
breathing patterns	relaxed	0
	change in breathing	1
arms	restrained	0
	relaxed	0
	flexed	1
	extended	1
legs	restrained	0
	relaxed	0
	flexed	1
	extended	1
state of arousal	sleeping	0
	awake	0
	fussy	1

Attachment 3: Sedation Evaluation Resource Guide

Pasero Opioid-induced Sedation Scale (POSS) with Interventions

S = Sleep, easy to arouse

Acceptable; no action necessary; may increase opioid dose if needed

1 = Awake and alert

Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused

Acceptable; no action necessary; may increase opioid dose if needed

3 = Frequently drowsy, arousable, drifts off to sleep during conversation

Unacceptable;

Required Assessment:

- ☐ *RN full respiratory assessment including: rate, rhythm, depth, auscultation including, patient taking deep breaths.*
- ☐ *Review past 12-18 hours pain flowsheet.*
- ☐ *Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory*
- ☐ *Initiate ETCO₂ (required order TBD)*

1. Notify provider requesting a decreased dose of opioid

2. Administer a non-sedating, non-opioid such as acetaminophen or a NSAID, if ordered

Critical thinking

3. Increase stimulation such as:

- *Ask patient to take deep breaths every 5 – 10 min*
- *Ambulate patient, sit patient up in chair, walk to bathroom*

4 = Somnolent, minimal or no response to verbal and physical stimulation

Unacceptable;

☐ *stop opioid;*

☐ *consider administering naloxone*


☐ *stay with patient, stimulate, and support respiration as indicated by patient status;*

☐ *call Rapid Response Team (Code Blue) if indicated; notify primary or anesthesia provider; ☐ monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.*

Ramsey Scale

Level of sedation for adults using the Ramsey Scale:

- 1 = Patient anxious and agitated or restless or both
- 2 = Patient cooperative, oriented and tranquil
- 3 = Patient responds to commands only
- 4 = A brisk response to loud auditory stimulus
- 5 = A sluggish response to loud auditory stimulus
- 6 = No response to loud auditory stimulus

 Tri-City Medical Center		Distribution: Patient Care Services
PROCEDURE:	PATIENT CONTROLLED ANALGESIA (PCA)	
Purpose:	To outline the interdisciplinary responsibilities for effective pain management utilizing patient controlled analgesia pump methodology. To outline the nursing management of the adult/adolescent patient receiving self-administered analgesia via controller/pump.	
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 patient to actively participate in managing their pain
2. **Basal rate:** continuous infusion rate of medication
3. **PCA dose:** dose self-administered by the patient
4. **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. **Bolus dose:** is a dose administered by a licensed provider in response to pain not effectively controlled by PCA
6. **Multimodal analgesia:** use of more than one method for controlling pain. May be pharmacological or non-pharmacological
- 6-7. **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.
- 7-8. **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 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. **Opiate tolerant patient:** Patients with documented history of consuming prescription and non-prescription opiates at doses higher or equal to 60mg of morphine equivalents per day for at least 7 consecutive days.
10. **Standard PCA orders – method of pain management** allowing nurses to monitor and notify physician for further orders to adjust the PCA settings
- 8-11. **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 are 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 Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/93, 02/11; 05/14	03/11;06/14	03/11;06/14	07/14	04/11; 8/14	05/11	8/02, 7/03, 3/04, 2/06, 9/08, 05/11

- 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) Pain Management Policy
- 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. For patients receiving end tidal CO₂ (EtCO₂) monitoring, see PCS EtCO₂ Procedure

C. PROCEDURE STANDARD PCA:

- 1. Physician/Provider 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) 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/ provider orders timely
 - d. Label all medication with patient name, medical record (MR) number, medication name, concentration, dose and rate.
 - e. Assist with safe and effective medication administration
 - C.f. Detect and report medication-related adverse events
- 4.3. Nursing to complete the following prior to initiating PCA therapy for Ppain 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 ~~Ramsey Score~~ **Pasero Opiod-Induced Sedation Scale (POSS)**.
 - h. Initiate end tidal CO₂ (EtCO₂) monitoring - see PCS EtCO₂ Procedure

- i. If patient refuses EtCO₂ monitoring, initiate continuous pulse oximetry - see Patient Care Services (PCS) Pulse Oximetry Procedure
 - ii. Document refusal of EtCO₂ 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
 - 2-a. Administer ordered medication per PCS Medication Administration Policy. Follow PCA procedures to set the chosen pump/controller with the prescribed dosages and framework.
 - a-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, lockout interval or demand dose
 - ii. Lock PCA keys in designated area; 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
 - ii-e. Document initiation of medication and syringe change(s) in electronic medication administration record (eMAR)
 - b-f. Document initial assessment in the PCA section in the EHR. Complete and record all requested information on Narcotic Medication Administration/Assessment Record.
 - i. Include baseline data prior to initiating PCA
 - ii-g. Ensure Naloxone (Narcan) is available in Pyxis
5. Maintenance/Assessment
 - ~~c-a. The Oncoming shift will~~ 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** on the Narcotic Medication Administration/Assessment Record (only requires one RN signature). ~~Check and be familiar with any orders written by anesthesiologist and routine PCA orders written by physician.~~
 - 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. EtCO₂ 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 then
 - ii. Every two (2) hours times three 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 ~~4 on the Ramsey Score~~.)
 - 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
 - 3-e. Change the PCA tubing and syringe every 96 hours and label with date of next tubing change.
- ~~4. Assess vital signs every hour for 2 hours; then every 4 hours if 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 4 on the Ramsey Score.) and document in Medical Record~~

5. ~~Assess respiratory rate, sedation, and pain scores (0–10) every hour for 2 hours, then every 2 hours for 6 hours, then every 4 hours if stable (if unstable monitor every 2 hours) and document on the Narcotic Medication Administration/Assessment Record.~~
- 6.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 lability 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/provider will be notified**
 - 7.d. **Assess pain response, RN may decrease PCA dose but not the lockout interval, per PowerPlan after 2 consecutive pain assessments, if patients' pain is well controlled, to maintain goal pain level on lowest possible opioid dose.**
- 8.7. Report to physician immediately if:
 - a. Respiratory rate is less than 10 breaths per minute **or apneic**
 - b. **EtCO₂ alarms indicating hypercapnea or persistent hypoventilation**
 - a-c. **Hypotension (decrease in systolic blood pressure 20 mmHg from baseline)**
 - b-d. Anaphylactic reaction
 - e-e. Presence of **persistent** nausea, vomiting, rash, pruritus
 - d-f. Ineffective pain relief with current order
 - e-g. Patient level of consciousness unresponsive / ~~sedation~~ **POSS score is 3-4-5-6**
- 9.8. **Perform appropriate interverion(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 (narcan) IV push as ordered by physician **and call Rapid Response Team**
 - e-i. Observe for increased respiratory rate within 1-2 minutes of Narcan administration.
 - i. ~~If no response from Narcan, call a Rapid Response~~
 - f-e. Notify physician of patient's condition
 - g. ~~Apply pulse oximeter~~
 - h. ~~Monitor patient until stable~~
 - f. Monitor vital signs every 15 minutes until patient stable

D. **DOCUMENTATION:**

1. ~~Refer to Narcotic Medication Administration/Assessment Record form 8720-1017.~~
2. ~~Document start time of narcotic on Medication Administration Record.~~
3. **Document assessments in the PCA section in the EHR**
- 2-4. **Document initiation of medication and syringes changes on the (eMAR)**
- 3-5. Document all narcotic wasting in Pyxis.

E. **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](http://etcmc/alaris/medley(tm)_system_v7_cbt/menu.htm)
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Your Guide to Patient Controlled Analgesia (PCA)

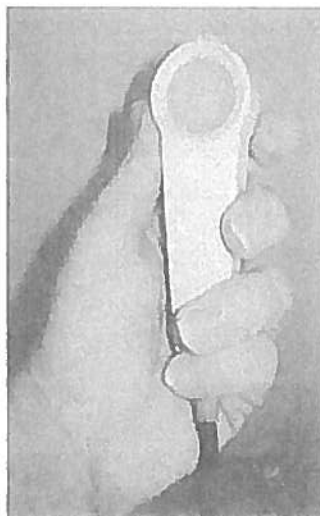
PCA

Patient Controlled Analgesia (PCA) is a way for patients to give themselves pain medication on an “as needed” basis. Your doctor determines the amount of pain medicine that will be given each time you push the button. This means that you have control over your own pain relief.

The PCA is simple to use. When you are feeling pain, push the button on the PCA handset and a dose of pain medication will be given to you automatically. Your nurse will show you how to use this handset. The medication goes directly into the vein through the IV (intravenous) tubing.

For your safety... ***YOU ARE THE ONLY ONE ALLOWED TO PUSH THE BUTTON ON THE HANDSET.***

PCA is very safe. Many patients find it easier to rest and recover more quickly with good pain control. A certain amount of pain medicine is given when you, the patient, push the button. You may find it helpful to push the button just before an activity that may cause you pain, such as dressing changes, walking, coughing, or going to therapy. We understand that your pain is real. If your pain is not relieved, let your nurse know. We want to help you control your pain. If you experience any side effects such as itching, hives, nausea, constipation, difficulty urinating, mental confusion, or excessive sleepiness let your nurse know. Our goal is to make you as comfortable as possible during your stay here at Tri-City Medical Center.



MEDICATIONS CURRENTLY USED FOR PCA				
Medication	Side Effects	Route	Total Dose*	Onset Duration
Opioids	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 <i>5X more potent than Morphine mg for mg.</i>	IV IM SQ	1-4 mg every 4-6 hours	5-10 minutes 3-4 hr
Meperidine (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

DRUG/ CONC.	BASAL RATE ORDER	BASAL RATE SETTING IN MLs	BASAL RATE SETTING IN MGs	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
<u>MORPHINE</u>	None	0	0	1	8	7.5	7.5
1mg/ml	None	0	0	1	10	6.0	6.0
60 ml syringe	1mg/hr	1	1	1	8	8.5	8.5
55mg in 55 mL	1mg/hr	1	1	1	10	7.0	7.0
	2mg/hr	2	2	1	8	9.5	9.5
	2mg/hr	2	2	1	10	8.0	8.0
<u>HYDROMORPHONE</u> (Dilaudid)	None	0	0	0.2	8	7.5	1.5
0.2mg/ml	None	0	0	0.2	10	6.0	1.2
60 ml syringe	0.2mg/hr	1.0	0.2	0.2	8	8.5	1.7
10mg in 50mL	0.2mg/hr	1.0	0.2	0.2	10	7.0	1.4
	0.4mg/hr	2	0.4	0.2	8	9.5	1.9
	0.4mg/hr	2	0.4	0.2	10	8.0	1.6
<u>MEPERIDINE</u> (Demerol)	None	0	0	10	20	3.0	30
10mg/ml	None	0	0	15	20	4.5	45
60 ml syringe	None	0	0	20	20	6.0	60
550 mg in 55 mL	10mg/hr	1	10	15	20	5.5	55

Delete -- converted to electronic health record (EHR) documentation

- ☐ Patient Co
☐ Continuous
☐ Epidural In

Date

Target Pain Level

- Ramsey Sedation Scale
1 = Anxious and agitated
2 = Cooperative, oriented, tranquil
3 = Awake but responds only to verbal commands
4 = Asleep, with brisk response to stimulation
5 = Asleep, with sluggish response to stimulation
6 = Asleep, with no response to stimulation

Initiation/Change - 2 RN Signatures Shift Verification - RN Signature	<input type="checkbox"/> Initiation <input type="checkbox"/> Shift Verification	<input type="checkbox"/> Dose Change <input type="checkbox"/> Shift Verification	<input type="checkbox"/> Dose Change <input type="checkbox"/> Shift Verification	<input type="checkbox"/> Dose Change <input type="checkbox"/> Shift Verification	<input type="checkbox"/> Dose Change <input type="checkbox"/> Shift Verification
Medication / Concentration					
Medication Dose					
Delay / Lockout Interval					
Basal / Continuous					
Bolus / Loading Dose					
RN Signature/Initials, time					
2nd RN Signature/Initials, time					

Assessment: Vital Signs: Q 1 hour x 2; then Q 4 hours if stable (if unstable monitor every 2 hours) and document in Medical Record (Initial / Dose Change) Respiratory Rate/Sedation/Pain: Q 1 hour x 2; then Q 2 hours x 6; then q 4 hours if stable (if unstable monitor Q 2 hours)

Respiratory Rate	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Sedation Level																								
Pain Level (0-10)																								
RN/LVN signature, title, time																								

Stable: Patient at or below target pain level; Respiratory rate greater than 12; Level of sedation less or equal to 4 per Ramsey Sedation Scale
Documentation: Q 4 hour. Clear history every 4 hours after data recorded.

RN only	0200	0600	1000	1400	1800	2200
Current Demand Dose						
Current Basal / Continuous Dose						
Patient History	0200	0600	1000	1400	1800	2200
Total Drug						
Total Demands						
Delivered						
Average Dose per Hour (Detail)						
Alaris History cleared						
RN Signature only, time						

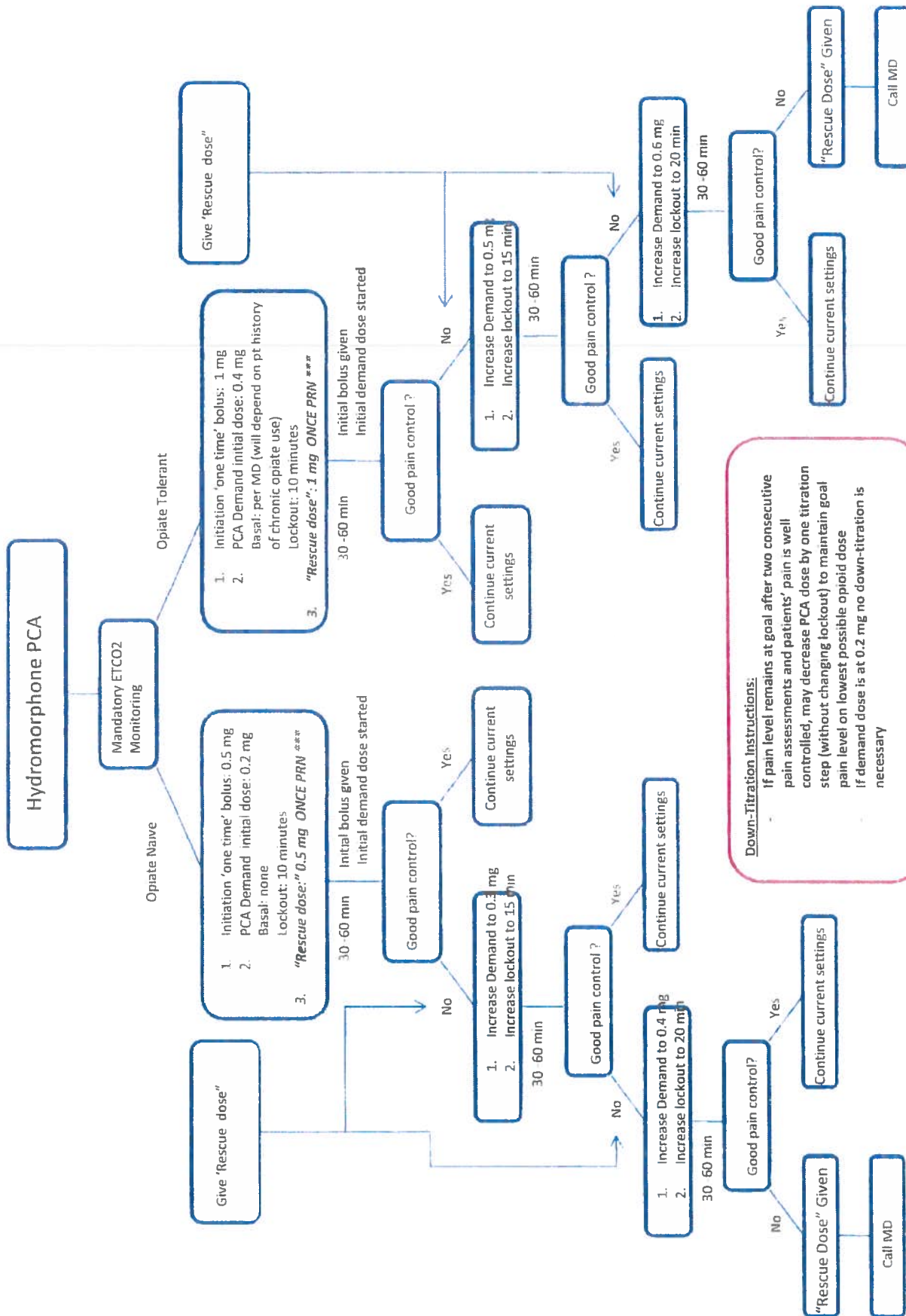
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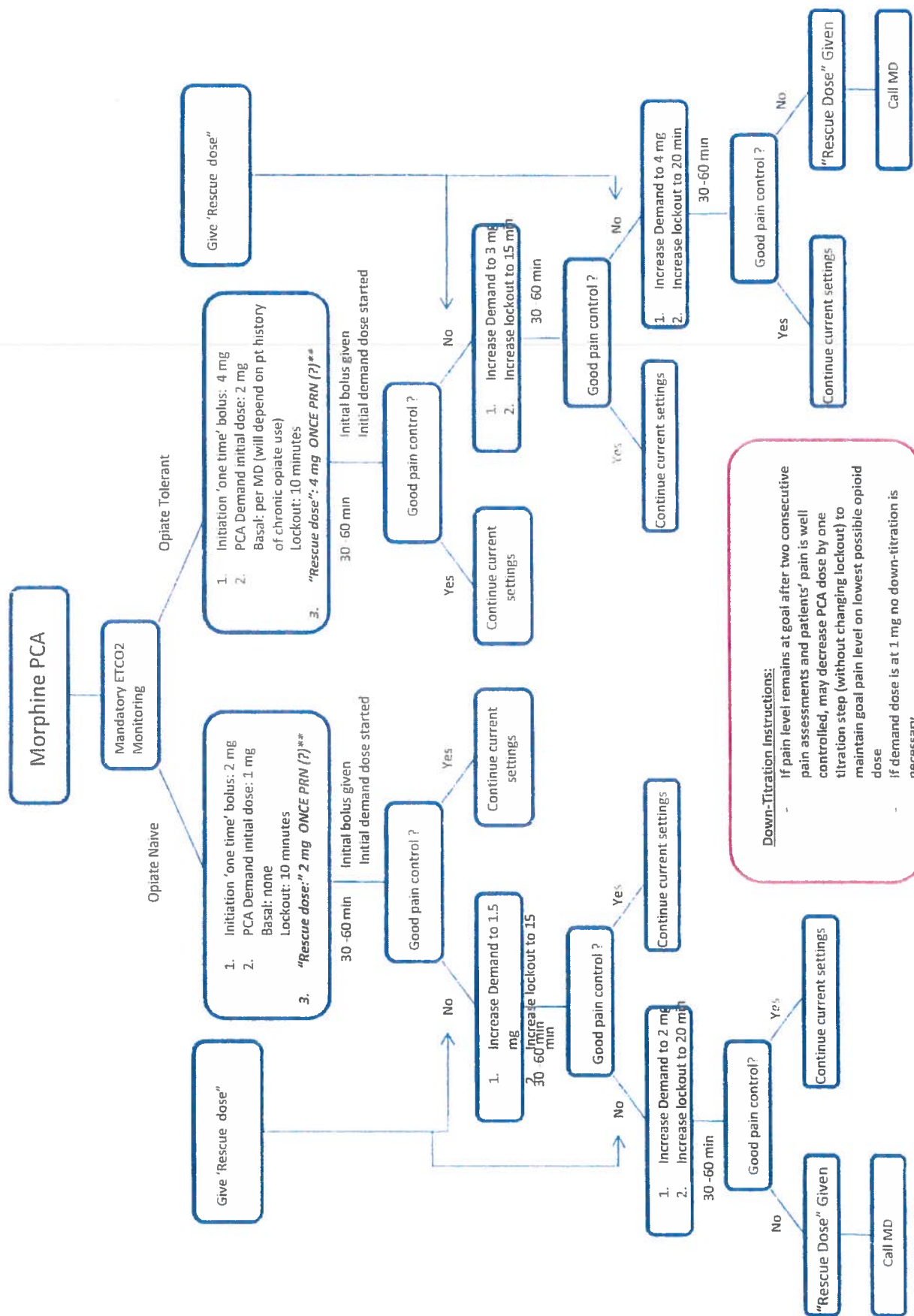


NARCOTIC MEDICATION ADMINISTRATION / ASSESSMENT RECORD


Attach Patient Label



*** "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



** "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

 Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE: POINT OF CARE TESTING COMPETENCY ASSESSMENT	
Purpose:	To outline the mandatory Point of Care testing personnel competency requirements.
Supportive Data:	To meet regulatory requirements, to include but not limited to College of American Pathology and Joint Commission
Equipment:	POC Competency Forms (located on Intranet)

A. **POLICY:**

1. Point of Care Testing (POCT) includes analytical patient tests performed outside the clinical facilities of the main laboratory. All POCT is covered under the Laboratory's **Clinical Lab Improvements AAmendments** license, and is subject to the same regulations. The College of American Pathologist (CAP) personnel competency requirements for POCT includes:
 - a. Evidence testing personnel have adequate, specific training to ensure competence.
 - b. A list delineating the specific tests each POCT personnel is authorized to perform.
 - c. A documented program ensuring each person performing POCT maintains satisfactory levels of competence.
2. Joint Commission requires competency to be assessed using at least two of the following methods per person per test:
 - a. Performance of a test on a blind specimen.
 - b. Periodic observation of routine work by the supervisor or qualified designee.
 - c. Monitoring of each user's quality control performance.
 - d. Use of written test specific to the test assessed.
3. **Competency for waived testing shall be evaluated upon hire and annually thereafter. Competency for non-waived testing shall be evaluated upon hire, semi-annually during the first year, and annually thereafter. Competency shall be reassessed at any time when problems are identified with employee performance. Competency must be reassessed at least annually. During the first year that an individual is performing patient testing, competency must be assessed every six months (i.e. there can be no more than 6 months between competency assessments during the first year of testing.)**
4. The records must make it possible for the Inspector to determine what skills were assessed and how those skills were measured. Some elements of competency include, but are not limited to:
 - a. Direct observations of routine patient test performance, including, as applicable, patient identification and preparation; and specimen collection, handling, processing and testing.
 - b. Monitoring the recording and reporting of test results, including, as applicable, reporting critical results.
 - c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventative maintenance records.
 - d. Direct observation of performance of instrument maintenance and function checks, as applicable.
 - e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples.
 - f. Evaluation of problem solving skills.
5. For non-waived (moderate-complexity) tests, all of the above six elements must be assessed annually. For waived tests, it is not necessary to assess all elements at each assessment. Ongoing supervisory review is an acceptable method of assessing competency.
6. Personnel will not be allowed to perform POC testing without completion of the competency requirements

B. **PROCEDURE:**

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Professional Affairs Committee	Board of Directors
06/10, 06/11;06/14	04/11;06/14	05/11;06/14	08/14	06/11	06/11

1. The Laboratory Medical Director authorizes personnel to perform testing. Authorization is determined by job description and is specific to nursing unit and job title. Refer to the Laboratory Point of Care Coordinator and Quality Management Manual for any clarification.
2. Evidence of training and competency shall be documented and records shall be maintained in the Employee file.
3. Management is responsible to ensure all testing personnel within their department have completed the required competencies.
4. If an individual fails to complete competency assessment by the due date, they will not be allowed to perform POC testing until the competency is completed.
5. Competency must be assessed:
 - a. ~~Upon hire (within 30 days)~~
 - b. ~~6 months after hire (by the last day of the month 6 months after the month of hire)~~
 - c. ~~12 months after hire (by the last day of the month 12 months after hire).~~
 - d. ~~Annually. After the first 12-month competency, skills lab may replace the annual competency.~~
- 6-5. Compliance will be tracked through ResQ. Return a POC testing: Competency Checklist with all completed competencies to the Education department.
 - a. ~~Blank F~~forms are found on the TCMC Intranet. ~~under Education Staff, POC Competencies.~~

C. **REFERENCES:**

1. [e-dition.icrinc.com WT.03.01.01](http://e-dition.icrinc.com/WT.03.01.01). Retrieved on May 11, 2011.
2. College of American Pathology. (20102014) Point of Care Testing Checklist.

2-

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 11/02 **SUBJECT:** Pre-Printed Orders

REVISION DATE: 12/02, 3/03, 2/04, 2/05, 11/06, 9/08 **POLICY NUMBER:** IV.M.1
06/11

Clinical Policies & Procedures Committee Approval: 04/11 08/14
Nursing Executive Council Approval: 04/11 08/14
Medical Executive Committee Approval: 05/11 09/14
Professional Affairs Committee Approval: 06/11
Board of Directors Approval: 06/11

A. PURPOSE:

1. To provide an approval process for Pre-Printed Orders (PPO).

B. DEFINITIONS:

1. ~~CPOE: Computerized Physician (or Provider) order entry.~~
2. **Powerplan: A grouping of orders that can be implemented together to facilitate the ordering process.**

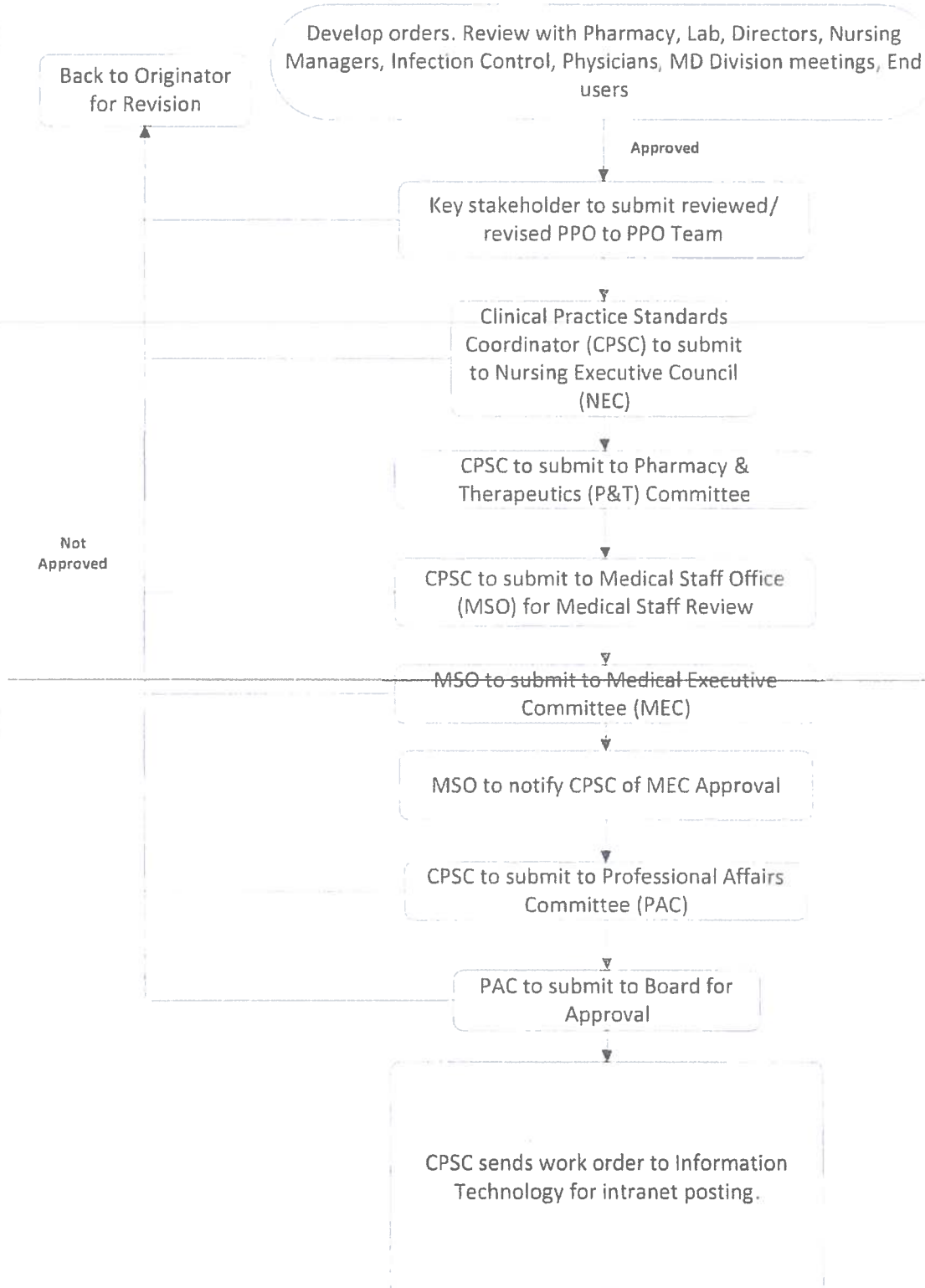
B.C. POLICY:

1. All pre-printed orders must be written in the approved Tri-City Medical Center (TCMC) format, include an approved barcode, and go through the approval process.
2. All new pre-printed orders and requests for modifications of existing pre-printed orders will be submitted to the **Clinical Documentation Coordinator** ~~Pre-Printed Orders Team~~ to facilitate the approval process.
3. The **Clinical Documentation Coordinator** ~~Pre-Printed Orders Team~~ will ensure all pre-printed orders are reviewed (and modified if necessary) to meet **organizational** ~~institutional~~ need and regulatory requirements (current requirement is once every three years).
4. Once approved by the Board, the pre-printed orders shall be available on the TCMC Intranet.
5. See attached flow chart of approval process (Attachment A)
6. **PPO's** ~~Pre-Printed orders shall not be created unless absolutely necessary~~ if an appropriate powerplan does not exist or is not appropriate to be created ~~at this time~~.
7. All PPOs must be reviewed and approved every 3 years.

D. FORMS (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS FOLDER):

- 5.1. Pre Printed Orders Approval Process

PRE-PRINTED ORDERS APPROVAL PROCESS



Delete

PRE-PRINTED ORDERS APPROVAL PROCESS

Back to Originator
for Revision

Develop orders. Review with Pharmacy, Lab, Directors, Nursing
Managers, Infection Control, Physicians, MD Division meetings, End
users

Key stakeholder to submit reviewed/
revised PPO to Clinical Documentation
Coordinator

Clinical Documentation Coordinator to
submit to Pharmacy & Therapeutics (P&T)
Committee


Clinical Documentation Coordinator to
submit to Medical Staff Office (MSO) for
Medical Department Division

Submit to Physician Information
Technology Committee (PITC)

MSO to submit to Medical Executive
Committee (MEC)

PAC to submit to Board for
Approval

Clinical Documentation Coordinator sends
to HIM Manager for barcoding and
ordering. Clinical Documentation
Coordinator post to the intranet.

 Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE: PULSE OXIMETRY	
Purpose:	Pulse oximetry is the noninvasive measurement of arterial blood oxygen saturation—the percent of to which hemoglobin bound to is filled with oxygen. A pulse oximeter is a probe with a light-emitting diode (LED) connected by a cable to an oximeter. Light waves emitted by the LED are absorbed and then reflected back by oxygenated and deoxygenated hemoglobin molecules. The reflected light is processed by the oximeter, which calculates pulse oxygen saturation (SpO ₂). This procedure applies to pediatric, adolescent and adult patient populations.
Supportive Data:	Masimo SET operator's manual, 2013 ⁹⁴ . Pulse Oximetry Mosby's Nursing Skills (2014 2006–2011) Elsevier.
Equipment:	Oximeter machine, oximeter probe appropriate for patient, record sheet

A. PROCEDURE:

1. Confirm physician order.
2. Identify patient **per the Patient Care Services Policy, Identification, Patient** ~~utilizing two patient identifiers.~~
3. Position patient comfortably.
4. Explain to patient the procedure and the reason for the monitoring.
 - a. If finger is to be used, you may need to remove fingernail polish with acetone from digit to be assessed.
5. Choose a site:
 - a. The site shall be well perfused and not restrictive of a patient's movements. The ring finger of the non-dominant hand is preferred.
 - b. Always choose a site that completely covers the sensor's detector window.
 - c. The site shall be cleaned of debris prior to sensor placement.
 - i. If patient has tremors, the ear lobe may be used.
6. Ensure the emitter (red light) and the photo detectors are properly aligned when using a single patient adhesive or disposable sensor.
 - a. When using a reusable sensor, ensure it opens and closes smoothly.
7. Connect the sensor to the patient cable.
 - 7.a. **Ensure** ~~Make sure~~ the connection is firm.
8. Turn on oximeter by activating power.
9. Ensure the display window is free of alarm and system failure messages.
10. Verify the following on the display:
 - a. High and low alarm limits for SpO₂ and pulse rate.
 - b. The reading for SpO₂ and pulse rate.
11. Wait 10-30 seconds for SpO₂ and pulse rate reading to stabilize.
 - 11.a. Motion artifact is the most common cause of inaccurate readings.
12. Inform the patient the oximeter will alarm if the sensor falls off or if the patient moves the sensor.
 - a. If continuous SpO₂ monitoring is planned, verify SpO₂ alarm limits and alarm volume, which are preset by the manufacturer:
 - i. SpO₂: low 90%, high 100%;
 - ii. preset pulse rate: low 50 bpm, high 140 bpm.
 - iii. Limits for SpO₂ and pulse rate shall be determined by patient's condition.
 - a-iv. ~~Pulse oximeter alarms shall be kept on at all times.~~
 - b. Adult SpO₂ sensor (Single Patient Use)
 - i. The site shall be checked at least every eight (8) hours to ensure proper adhesion, skin integrity, and proper alignment.
 - c. Reusable Tip Clip Sensor (**for example ear probe**)
 - i. The site must be changed every four (4) hours or every two (2) hours for patients with poor perfusion.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
4/06; 4/09; 07/14	07/11; 07/14	07/11;07/14	08/11;08/14	9/11	9/11

-

1. Document SpO₂ readings, oxygen flow & oxygen delivery device in the Medical Record.

- C

4.——Masimo Corporation. (2009). Retrieved from www.masimo.com.

- D

1. Patient Care Services Identification of Patient

-

**PROCEDURE: SPONGE, SHARPS & INSTRUMENT COUNTS, PREVENTION OF RETAINED SURGICAL OBJECTS**

Purpose:	To outline nursing responsibilities and accountability regarding sponge sharps, and instrument counts in the surgical areas.
Supportive Data:	Sponge, sharps, and instrument counts are done in the surgery to provide for safe patient care and as an avenue of accountability and legal responsibility. All items are to be counted except those used for storage or disposal of items.
Equipment:	White Board, White Board Marker, and Count Sheet(s), Sponge holders Items included in the count Countable items include , but are not limited to: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;">Blades</div> <div style="width: 33%;">Rubber shods</div> <div style="width: 33%;">Yankauer Tips</div> <div style="width: 33%;">Bulldogs</div> <div style="width: 33%;">Suture Needles</div> <div style="width: 33%;">Staple re-load cartridges</div> <div style="width: 33%;">Cotton balls</div> <div style="width: 33%;">Vessel loops</div> <div style="width: 33%;">Cottonoids</div> <div style="width: 33%;">Umbilical tape</div> <div style="width: 33%;">Detachable portions of equipment</div> <div style="width: 33%;">Wingnuts</div> <div style="width: 33%;">Instruments</div> <div style="width: 33%;">X-ray 4x4's</div> <div style="width: 33%;">Lap sponges</div> <div style="width: 33%;">Penrose drain</div> <div style="width: 33%;">Ligaclip boats</div> <div style="width: 33%;">Cautery tips</div> <div style="width: 33%;">Packing</div> <div style="width: 33%;">Hypodermic needles</div> <div style="width: 33%;">X-ray detectable towels</div> <div style="width: 33%;">Peanuts (Kittners /Dissectors)</div> <div style="width: 33%;">Defogger solution bottle, cap and sponge</div> </div>

A. POLICY:

1. Sponges, and sharps and miscellaneous items shall be counted on all procedures in which the possibility exists that **these items** ~~a sponge or sharp~~ can be retained.
 - a. **Sponge counts are exempt on eyes, minor ENT cases and cystoscopies.**
 - ~~1-b. Needle counts may be omitted on minor eye procedures.~~
2. Instruments shall be counted on all procedures in which the likelihood exists that an instrument can be retained.
 - a. **Instrument count is required for any procedure where the chest or peritoneum is entered and the incision is large enough for an instrument to pass through.**
 - b. **Instruments shall be counted at the start of all laparoscopy, thoracoscopy and robotic procedures since the possibility of converting to an open procedure exists.**
 - i. **If the procedure does not convert to an open procedure the instrument count does not need to be verified at the end of the case.**
 - ~~2-c. Instrument counts may be omitted in anterior, posterior, and lateral spine cases. At the end of the procedure, an X-ray is completed. The surgeon or radiologist may read the X-ray and the results of the reading, along with the name of the person who read the X-ray, are documented.~~
3. All counts shall be conducted audibly and visually.
 - a. Counted items shall be visualized by both the scrub person and the circulating Registered Nurse (RN) or designee (one of whom shall be an RN).
 - b. At time of permanent relief of either the scrub or circulating RN, direct visualization may not be possible.
4. A count may be initiated by any member of the ~~preoperative~~ **perioperative** team involved in the counting process.
5. Unnecessary activity and distractions should be omitted during the counting process.
- ~~6. Sponge counts are exempt on eyes, minor ENT cases and cystoscopies.~~
 - ~~a. Needle counts may be omitted on minor eye procedures.~~
- ~~7. Instrument counts may be omitted in anterior, posterior, and lateral spine cases. At the end of the procedure, an X-ray is completed. The surgeon or radiologist may read the X-ray and the results of the reading, along with the name of the person who read the X-ray, are documented.~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Operating Room Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/03, 4/06, 08/09; 05/12; 01/13; 05/134	06/12; 7/13; 5/14	06/12, 2/13; 5/14	6/14	07/12; 7/14	08/12	08/12

- ~~8-6.~~ Counts may be omitted in an extreme emergency.
- ~~9-7.~~ Counts shall be written on the white board.
- 8. Items added by a circulator other than the primary circulator, require the item to be initialed by the secondary circulator.
- ~~10-9.~~ **Sponges (laps, baby laps, raytex) are issued in groups of ten.**
- ~~11-10.~~ All sponges shall be X-ray detectable:
 - a. Never detach the sponge from its strings
 - i. Altering sponges invalidates the subsequent count and increases the risk of a portion being retained in the wound.
 - b. Never use the sponge for wound dressing
 - ~~b-c.~~ **At the conclusion of the case, all sponges (used and unused) shall be passed off the field, and separated into sponge holders.**
 - i. ~~Altering sponge counts invalidates the subsequent count and increases the risk of a portion being retained in the wound.~~
- ~~e-11.~~ Towels used in an open wound shall be x-ray detectable and shall be included in the count as miscellaneous items.
 - i.a. Scrub person to notify circulating RN when the towel has been removed from the abdomen
- 12. Sharps shall be documented as part of the count:
 - a. Multi-packed needles shall be counted according to the number marked on the outer package for counts until they are opened for use.
 - i. When opened for use, multi-packed needles shall be verified by the scrub person and the circulating RN.
 - ii. **Packaged needles containing an incorrect number shall be removed from the room.**
 - i.b. **Counting number of needle packages may not be used to reconcile an incorrect needle count.**
 - ~~b. Save all needle packages.~~
 - ~~c. Packaged needles containing an incorrect number shall be removed from the room.~~
- 13. The sponge, and sharps, and miscellaneous item count shall be performed as follows:
 - a. **Baseline count:** Before the procedure to establish the baseline **and identify manufacturer packaging errors.**
 - b. **New item count:** When new items are added to the field.
 - ~~a-c.~~ **Relief count:** At the time of permanent relief of the scrub or RN circulator.
 - ~~b-d.~~ **Cavity count:** Before closure of a cavity within a cavity (eg. Uterus, bladder, peritoneum)
 - ~~c-e.~~ **Closing count:** When Before wound closure begins
 - f. **Final count:** After skin closure or end of procedure, when surgical items are no longer in use and all sponges (used or unused) are passed off the field separated into sponge holders and confirmed by the surgical team. ~~At skin closure or end of procedure~~
 - ~~d.~~
- 14. Instruments shall be documented on the instrument count sheet:
 - a. Members of the surgical team shall account for broken or separated instruments within the surgical field
 - b. All instruments shall remain within the OR during the procedure until all counts are completed and resolved
 - i. Individual pieces of assembled instruments shall be accounted for within the instrument count, e.g., suction tips, wingnuts, blades, sheaths.
- 15. The instrument count shall be performed:
 - a. **Baseline count:** Before the procedure to establish a baseline
 - b. **New item count:** When new instruments are added to the field.
 - c. **Relief count:** At the time of permanent relief of the scrub or RN circulator.
 - d. **Cavity count:** Before closure of a cavity within a cavity.
 - i.e. **Closing count:** At wound closure or end of the procedure.

- ~~15.~~**16.** Items passed off or dropped from the sterile field shall be retrieved by the circulating nurse, isolated from the field and included in the final count.
- ~~16.~~ The instrument count shall be performed:
- ~~a.~~ Before the procedure to establish a baseline
 - ~~b.~~ Before wound closure
 - ~~c.~~ Laparoscopy or thoracoscopy shall require an instrument count in the event an incision is extended to allow for a more extensive procedure.
 - ~~d.~~ Instrument count is required for any procedure where the chest or peritoneum is entered and the incision is large enough for an instrument to pass through it.
- 17. Items added to the field need to be recorded at the time they are added.**
- a. Once the count has begun, recalled memory and/or counting packages cannot be used to reconcile a count.**
 - b. The number on the whiteboard/count sheets must match the number of items on the field at the time of the count, or the count is considered incorrect.**

B. PROCEDURE:

- 1. Pre-incision: RN Circulator and Scrub Person**
- a. Performs a baseline count of sponges, ~~and sharps and miscellaneous items~~. Use a marker to write the numbers per category on the white board. (Refer to policy statement).
 - b. Ensure the sponges included in the count have their x-ray detectable strings and/or markings.
 - i. Count each sponge and separate from other sponges during the count
 - ii. Remove all packing and wrapping materials
 - iii. Remove pre-packaged laps or 4 X 4's containing an incorrect count from the room
 - iv. X-ray detectable towels shall be included in the count
 - ~~c. Multi-packed Needles: RN Circulator and Scrub Person~~
 - ~~d-c.~~ Ensure multi-pack needles are counted according to the number marked on the outer package until they are opened for use.
 - ~~e. Save all needle packages~~
 - d. Remove packaged needles containing an incorrect number from the room
 - f. ~~Instruments: RN Circulator and Scrub Person~~
 - e. For cases requiring an instrument count, pPerform a baseline count of the instruments and document this number on the instrument count sheet.**
- ~~a. count sheet.~~
- ~~b-i.~~ Document extra instruments on the count sheet
- 1.2. Post-incision: RN Circulator and Scrub Person**
- ~~g-a.~~ Added Sponges, Needles, and Small Items: RN Circulator and Scrub Person
 - h-b. Count additional added sponges, needles and small miscellaneous items as they are added to the field. apart from the previously counted sponges.**
 - i. If items are added by a circulator other than the primary RN circulator, the item shall be initialed **on the count board**.
 - ~~i-c.~~ Count added instruments and the RN circulator shall document the number **and items** on the instrument count sheet.
 - ~~j-d.~~ Verify sponge, ~~needle/sharps, sharps, miscellaneous items~~, and instruments counts are completed prior to the relief of the primary RN circulator or primary scrub person.
 - i. The count shall be performed prior to the primary RN circulator or scrub person leaving the room.
- 2. Closure: RN Circulator and Scrub Person**
- a. Count the sponges, ~~sharps, miscellaneous items~~ needles and instruments at the beginning of closure of body cavities (such as uterus, bladder, pericardium, anterior/posterior vaginal mucosa).
 - ~~i. Body cavities.~~
 - 1) ~~Uterus~~

- 2) ~~Bladder~~
- 3) ~~Pericardium~~
- 4) ~~Anterior/posterior vaginal mucosa~~
- ii.b. Count in the following order
 - 1)i. Sponges
 - 2)ii. Needles
 - 3)iii. Other sharps and miscellaneous items
 - 4)iv. Instruments
- b.c. Count items in the following **sequence** order:
 - i. Operative field
 - ii. Mayo stand
 - iii. Back table
 - iv. Items off field
 - v. ~~Sponges must be visualized opened~~
- e.d. Count all sponges, ~~laps~~, needles and/or **other** sharps, and **small miscellaneous** items, followed by instruments at closure of the pleura or peritoneum.
 - i. ~~Broken sharps must be accounted for in their entirety~~
- d.e. ~~Begin final e~~ Count **at** with subcuticular closure of the wound.
 - i. All items except instruments are counted
 - ii. Inform primary surgeon of the **preliminary** ~~final~~ count outcome
 - 1) It is the legal responsibility of the RN circulator to ensure the primary surgeon is notified
- f. **All sponges must be opened and visualized during closing counts and separated into sponge holders.**
 - i. **At the end of skin closure ALL sponges are passed off the field, separated, opened to full length and placed in sponge holders.**
 - ii. **Use a separate sponge holder for each sponge type (i.e. one for laps, one for raytex).**
 - iii. **Only one sponge should be placed in each pocket of the sponge holder.**
 - iv. **Load the sponge holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards. This process will make visual determination of the filled holder easier to see from the OR table so empty pockets will be clearly visible to all in the room.**
 - v. **Place the sponge inside the pocket with the blue tag or blue stripe visible.**
 - vi. **Place one sponge per pocket, two sponges per pouch (or row), and 10 sponges per sponge holder.**
 - vii. **When a holder has 10 sponges, there will be no empty pockets.**
 - viii. **The final sponge count cannot be considered completed until ALL sponges opened during the case are bagged and visualized by the surgical team.**
 - ix. **The sponge holders are not disposed of until the patient leaves the OR.**
- g. **Broken sharps or instruments must be accounted for in their entirety during closing counts.**
 - 1) ~~_____~~
- e-h. Incorrect Counts:
 - i. Inform primary surgeon of any discrepancies
 - ii. Search the total room including **floor, trash and linen**:
 - 1) ~~Floor, trash, linen~~
 - a)1) If item is not found, an X-ray of the patient must be taken prior to patient leaving the OR suite
 - b)2) If item missing is micro or CV needle (C-1 or smaller), X-ray is not needed
 - e)3) A quality review report (QRR) must be **completed**. ~~filled out~~
- f.i. Ensure sterile field remains sterile until item is found or x-ray is read
- g-j. Inform Assistant Nurse Manager (ANM)/charge nurse/designee of any discrepancies
 - i. If counts were omitted due to extreme emergency, x-ray shall be performed per

primary surgeon prior to patient leaving the OR suite.

- 1) Ensure X-ray is read prior to patient leaving the OR suite
- 2) Document pre and post events regarding the nature of the emergency.
Documentation of the events is mandatory
- 3) Document the name of physician reading the x-ray and the x-ray results

C. **DOCUMENTATION:**

1. Document verification of all counts in the OR record.
 - a. Types of counts (sponges, sharps, and instruments)
 - b. Cavity count must be written as a count
 - c. The number of counts
 - d. Names and titles of persons performing counts
 - e. Results of counts
 - i. Notification of primary surgeon
 - ii. Actions taken if count discrepancies occur
 - iii. Rationale if counts are not performed or completed
 - iv. Complete **an incident report a QRR** for all incorrect counts.

D. **REFERENCES:**

1. **AORN** Perioperative Standards and Recommended Practices (2013⁴). "Recommended Practices for Prevention of Retained Surgical Items". Denver: Association of periOperative Registered Nurses, Inc.

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 6/06

SUBJECT: Wound V.A.C. (Vacuum Assisted Closure), Negative Pressure Therapy Policy

REVISION DATE: 12/08, 06/11; 4/14

POLICY NUMBER: IV.D.1

Clinical Policies & Procedures Committee Approval:	04/11 06/14
Nursing Executive Council Approval:	04/11 06/14
Department of Family Medicine:	07/14
Pharmacy and Therapeutics:	08//14
Medical Executive Committee Approval:	05/11 08/14
Professional Affairs Committee Approval:	06/11
Board of Directors Approval:	06/11

A. PURPOSE:

1. To define the appropriate procedure for initiation of Wound V.A.C. therapy **and Vacuum Assisted Closure (V.A.C.)**.
2. To define appropriate assessment, documentation, monitoring, and maintenance of Wound V.A.C. therapy **and V.A.C. Instillation Therapy Option**.

B. DEFINITIONS:

1. **Dehiscence:** the separation of a surgical incision or rupture of a wound closure.
2. **Diabetic Ulcer:** a wound that has failed to heal as a result of elevated glucose levels that have caused altered nerve function in the lower extremities, commonly located on pressure points of the foot such as the plantar surface and the metatarsal heads.
3. **Eschar:** black or brown, necrotic, devitalized tissue.
4. **Fistula:** an abnormal passage from an internal organ to the body surface or between two internal organs.
5. **Flap:** a layer of skin or other tissue surgically separated from deeper structures for transplantation or to cover an area that has been injured.
6. **Graft:** a tissue taken from a site and inserted into a new site to repair a defect in structure.
7. **Necrosis:** localized tissue death that occurs in groups of cells in response to disease or injury.
8. **Osteomyelitis:** local or generalized infection of bone and bone marrow.
9. **Partial-Thickness:** tissue damage to the epidermis and part of the dermis. Abrasions, skin tears, and blisters are examples of partial thickness wounds.
- 9-10. **Full Thickness:** Ulceration that extends through the dermis to involve the subcutaneous tissue and if Stage 4, the muscle and possibly down to the bone.
- ~~10-11.~~ **Pressure Ulcer:** localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
12. **Suction: dynamic pressure control**
- ~~11-13.~~ **Therapeutic Regulated Accurate Care (T.R.A.C.) Pad:** monitors and maintains target pressure at wound site ensuring consistent therapy is delivered.
- ~~12-14.~~ **Tunneling:** course or path of tissue damage occurring in any direction from the surface or edge of wound leading to dead space.
- ~~13-15.~~ **Undermining:** area of tissue destruction extending under intact skin along the periphery of a wound, commonly seen in shear injuries.
16. **Vacuum Assisted Closure (V.A.C.):** negative pressure device used to promote wound healing and stimulate granulation tissue.

- a. **V.A.C. Ulta with VeraFlo (Instillation Therapy System)** is indicated for patients who would benefit from negative pressure wound therapy, drainage and controlled delivery of topical wound treatment solutions over the wound bed.
- b. **V.A.C. Prevena - Incisional V.A.C. therapy** placed over an intact surgical incision, usually placed in surgery to help prevent dehiscence and infection. The V.A.C. is left in place x 7 days post operative and usually removed by surgeon. If patient is discharged, unit goes home with patient
- c. **V.A.C. Via - disposable home unit, sometimes used until patient can get traditional home wound V.A.C. authorized or for short term vac therapy at home**
- ~~14-17.~~ **V.A.C. GranuFoam:** hydrophobic, black foam. More effective at stimulating granulation tissue and should be used for a wound with drainage.
- ~~15-18.~~ **V.A.C. Vers-Foam:** hydrophilic, white foam, pre-moistened with sterile water. Used for extremely painful wounds, controlled growth of granulation tissue, and tunneling or undermining wounds. Minimum pressure setting is 125 mmHg.
- 19. **V.A.C. GranuFoam Silver:** Hydrophobic, black foam impregnated with silver, allows for continuous delivery of silver into wound protecting against many types of bacteria and fungus.
- ~~16-20.~~ **V.A.C. White Foam:** hydrophobic foam used for instillation therapy

C. **POLICY:**

- 1. When a patient has a wound that is difficult to heal and does not respond to therapy, or a complicated dressing change, a referral may be made per physician order to the Wound Nurse for Wound Evaluation and Treatment. The Skin/Wound Team is available for questions at extension 3793 or cell phone numbers 760-908-6488 and 760-802-9611.
- 2. Indications **for wound V.A.C.**
 - a. Acute, chronic, or traumatic wounds
 - b. Dehiscent Wounds
 - c. Diabetic Ulcers
 - d. Pressure Ulcers
 - e. Grafts
 - f. Flaps
 - g. Enteric Fistulas, in special circumstance
 - h. **Infected wounds**
 - g-i. **Venous ulcers**
- 3. Contraindications
 - a. Malignancy in wound – malignant cells should be removed prior to initiation of V.A.C. therapy.
 - b. Untreated osteomyelitis – wound should be free of osteomyelitis or receiving concurrent antibiotic therapy
 - c. Non-enteric and unexplored fistula
 - d. Necrotic tissue with eschar present – wound should be surgically debrided prior to initiation of V.A.C. therapy.
 - e. **Do not use V.A.C. Ulta with VeraFlo (instillation therapy) on wounds:**
 - i. **At risk of bleeding**
 - ii. **New flaps and grafts**
 - iii. **Acute enteric fistulas**
 - iv. **With unexplored tunnels or unexplored undermining as fluid may enter into unintended cavities**
 - v. **Requiring continuous therapy**
 - vi. **With unstable structures, such as unstable chest wall or non-Intact fascia**
 - vii. **With high exudates**
 - viii. **Closed incisions**
 - ix. **Where hemostatic agents have been used in the wound bed**
 - x. **With Granufoam silver because solutions may negatively impact the benefits of the silver dressing**

4. Precautions
 - a. Active Bleeding
 - b. Difficult wound hemostasis
 - c. Anticoagulant therapy
 - d. When **wound V.A.C.** therapy is initiated close to blood vessels or organs protective barriers will be used.
 - e. Wounds with enteric/non-enteric fistulas require special precautions, initiate dressing per specific physician order or make a referral to Wound Nurse for Wound Evaluation and Treatment
 - f. **For V.A.C. Ultra with VeraFlo (Instillation therapy):**
 - i. **Some irrigants/solutions utilized with instillation therapy may adversely affect bioengineered materials. Refer to manufacturer guidelines**
 - ii. **Use only solutions or suspensions indicated for topical wound treatment according to solution manufacturer guidelines.**
 - iii. **Use solutions that are compatible with V.A.C. dressings and disposable components.**
- ~~5. The Registered Nurse or Licensed Vocational Nurse is responsible for the management and maintenance of wound V.A.C. therapy.~~
5. A physician order is required to initiate wound V.A.C. and **V.A.C. Instillation** therapy.
 - a. **The primary nurse is responsible for ensuring appropriate orders for the wound V.A.C. are documented in the electronic health record (EHR).**
- ~~7. A physician order will include:
 - a. Exact location and type of wound to receive therapy.
 - b. Pre-Medication Instructions
 - c. Therapy settings (i.e. Continuous or Intermittent)
 - d. Pressure settings (i.e. 125 mmHg)
 - e. Dressing change interval~~
6. Orders should indicate:
 - a. **Type of wound V.A.C. therapy**
 - b. **Area of placement,**
 - c. **Therapy setting (continuous or intermittent), and**
 - d. **Pressure setting for suction (125 mmhg normal preset).**
 - e. **Frequency of dressing change and healthcare provider responsible for performing dressing change**
 - f. **For V.A.C. Ultra with VeraFlo (Instillation therapy) include:**
 - i. **Medication and dosage for irrigation,**
 - ii. **Instillation infusion time,**
 - iii. **Instillation hold and pressure suction cycles**
- ~~8.7. All supplies are latex free and obtained from the Sterile Processing Department (see Wound V.A.C. Supply List).~~
- ~~9. Dressing is to be changed every 48 to 72 hours, but no less than 3 times per week, or per physician order and be replaced with sterile V.A.C. disposables from unopened packages.~~
- ~~10. Foam, canister, tubing, and drape are latex free.~~
- ~~11.8.~~ Ensure Nutritional Consult has been made on each patient to optimize V.A.C. therapy. If no order exists the nursing staff will make the proper referral.
- ~~12.9.~~ Assessment
 - a. Assessment of dressing is done each shift or as needed and documented in the ~~medical record~~ **EHR**. Dressing should be monitored every 2 hours to ensure **dressing is intact and wound V.A.C is maintaining suction.**
 - a.b. **Assure proper functioning of wound V.A.C. machine. Check power cord, Sseal check light is on and battery is being charged.**
 - c. Photograph of wound will be taken upon initiation of wound V.A.C. **(except during surgery) and at least weekly (during a every wound V.A.C. dressing change)-week.**

D. **PROCEDURE:**

1. **Initiation:**

- a. **Wound V.A.C shall be initiated per physician order**
 - i. **V.A.C. Ulta with VeraFlo (instillation therapy) will be Initiated by Operating Room (OR), Post Anesthesia Care Unit (PACU), Wound/Ostomy registered nurses (RNs) or specially trained RN**
 - 1) **Instillation (Irrigation solutions) will be provided by Pharmacy**
 - 2) **V.A.C. Ulta with VeraFlo (Instillation therapy) set-up:**
 - a) **Adjust hanger arm on left side of unit and hang solution bottle**
 - b) **Prime tubing by spiking solution bottle using adapter with Veralink cassette spike. Clamp off tubing and insert Veralink cassette into left side of machine**
 - c) **After V.A. C. Veraflo foams applied, secure VeraFlo pad (cut 2.4 cm opening). Connect dressing tubing to canister tubing and VeraFlo tubing to Veralink connection**
 - d) **Configure therapy settings. Select V.A.C. VeraFlo therapy**
 - e) **Ensure fill assist is on, set soak time, V.A.C. therapy time, and target pressure/intensity. When complete press OK**
 - f) **Confirm settings and choose OK after unclamping VeraFlo tubing**
 - g) **Press start/stop fill assist and observe the wound bed fill with solution. Press stop/start again when volume is sufficient.**
 - h) **Select OK to confirm volume displayed and return to home screen**
 - i) **If the wound bed is overfilled with solution press “reset” to remove solution and return to fill assist to reset volume.**

2. **Suction:**

- a. Suction will be maintained for at least 22 hours of each 24-hour period. If suction is off for more than 2 hours in any 24-hour period (**verify by checking therapy history**), the dressing must be removed and replaced.
 - i. **If a VAC dressing is unable to be re- applied, a wet to dry dressing to the site is an alternative dressing until the VAC dressing can be applied. Do not leave a VAC dressing in place with the machine turned off for over 2 hours. Notify Physician.**
- b. Suction will be set at 125 mmHg continuous unless otherwise specified by physician. After the first 48 hours V.A.C. pressure settings may be titrated up or down by 25 mmHg in the following situations:
 - i. Titrate up (maximum setting is 175 mmHg) in a wound that has an excessive amount of drainage, a large wound, when V.A.C Vers-Foam is in wound, or difficulty maintaining seal.
 - ii. Titrate down (minimum setting is 50 mmHg) in wound that is very painful, or for a patient that is elderly, nutritionally compromised, on anticoagulants, has compromised circulation, or excessive granulation tissue growth.
- c. Intermittent suction therapy should be considered after the first 48 hours of therapy to stimulate granulation tissue quicker. It should not be used for patients who:
 - i. Are experiencing significant pain.
 - ii. Are experiencing difficulty maintaining seal.
 - iii. Have wounds where tunnels or undermining exists.
 - iv. Have a large or excessive amount of drainage.
 - d-v. **Are using the V.A.C. Ulta with VeraFlo (Instillation therapy) option.**

2-3. **Dressing change**

- a. Pre-medicate patient per physician's order (if indicated) 60 minutes prior to dressing change for oral medication or 5 - 15 minutes prior for IV medication.
- b. Ensure V.A.C. canister and machine are at bedside.
- c. Gather all supplies for dressing change including
 - i. Correct size and type of foam in unopened sterile package,
 - ii. Scissors,
 - iii. Sterile Normal Saline,
 - iv. Skin barrier,
 - v. Drape,
 - vi. Gloves, and
 - vii. Gown or eye protection if necessary-
 - viii. **Wound V.A.C dressing kit**
 - ~~vii-ix.~~ **Biohazard bag**
- d. Perform hand hygiene and don gloves
- e. Clamp tubing to T.R.A.C. pad and canister and remove old dressing and dispose of in biohazard bag along with gloves.
 - i. If there is difficulty removing dressing, use adhesive remover.
 - ii. If foam adheres to wound, use Normal Saline or sterile water to saturate the foam before removing.
 - iii. If wound is extremely painful and foam is difficult to remove, consider placing a single layer of non-adherent dressing (i.e. Adaptic, **mepiteleil** emulsion) in the wound bed prior to foam placement. Do not place Xeroform in bed of wound (petroleum based).
- f. Perform hand hygiene and don new gloves.
- g. Cleanse wound with Normal Saline or per physician order.
- h. Clean and dry skin surrounding wound.
- i. Apply barrier to intact skin surrounding wound. If a patient has fragile skin, is at risk for breakdown or if breakdown exists, place thin hydrocolloid (i.e. Duoderm) to that area.
- j. **Assess wound:**
 - i. **Location**
 - ii. **Type of wound**
 - iii. Measure wound margins and note and measure any tunneling or undermining. **including length, width and depth**
 - iv. **Drainage**
 - v. **Surrounding skin integrity**
 - vi. **Odor**
 - vii. **Appearance of wound (i.e., granulation), any tunneling or undermining**
 - ~~±viii.~~ Take photograph **at least weekly (during a dressing change) and upload to EHR at first post-op dressing change and weekly and if any changes in wound status is noted.**
- k. Ensure proper foam has been chosen and cut foam to fit gently into wound.
 - i. Do not cut foam directly over wound to ensure loose edges do not fall into wound.
 - ii. Rub edges after cutting to remove any loose pieces.
 - ~~±iii.~~ **If exposed internal organ or tendon, use a contact layer (i.e. Adaptic, mepitel) before foam application**
 - iii-iv. If the wound is larger than the largest piece of foam, use more than one piece of foam ensuring that edges of foam are in direct contact with each other for even distribution of negative pressure.
- l. Place foam gently into wound.
 - i. Do not force foam into wound.
 - ii. Foam should be slightly smaller than wound and should never lie on or touch intact skin.
 - iii. For a shallow wound, foam may be thinned to accommodate smaller dimensions.

- iv. Fill in all dead space.
- m. Cut drape larger than the wound allowing for a 3 - 5 cm border.
- n. Place drape over foam.
 - i. Save extra drape, excess drape can be used to reinforce difficult to seal areas.
 - ii. If hydrocolloid (i.e. Duoderm) has been placed ensure that the drape covers foam and the hydrocolloid (i.e. Duoderm).
- o. Cut a ~~3-cm~~ hole into the drape **the size of the T.R.A.C pad**, it is not necessary to cut into foam.
- p. Apply T.R.A.C. pad directly over the hole in the drape.
 - i. Do not cut the T.R.A.C. pad off or insert tubing into the foam, this will cause unit to alarm when turned on.
- q. Connect dressing tubing to canister tubing and open both clamps.
- r. Time, date, and sign dressing. Document properly.
- s. Remove gloves and perform hand hygiene.
- t. Place V.A.C. unit on a level surface, hang from the foot of the bed, or secure on an IV pole.
- u. Turn on green power switch on left side of V.A.C unit. Access V.A.C. settings under Therapy on main menu and set per physician order or on 125 mmHg continuous.
- v. Press therapy on/off button to activate V.A.C. therapy.
- w. In less than one minute the dressing should collapse into wound. If difficulty exists in maintaining vacuum or foam does not collapse, reinforce any air leaks with excess drape or gently press around foam with fingertips.

3.4. Canister Change

- a. V.A.C canister should be changed when full, on average 3 - 5 days (unit will alarm).
- b. Turn off therapy and close dressing clamp and canister clamp.
- c. Disconnect canister tubing from dressing tubing.
- d. Remove canister from unit by pressing blue button on front of unit and pulling. Dispose of old canister in biohazard bag.
- e. Insert new canister into slot and connect to dressing tubing. Open both clamps and resume therapy.
 - i. **V.A.C. Ulta with VeraFlo (Instillation therapy) requires more frequent changing of canisters due to the volume of wound irrigation solution and exudate removal.**

4.5. Disconnecting unit for brief periods

- a. If patient needs to be disconnected, ensure V.A.C therapy is not off for more than 2 hours total in a 24-hour period.
- b. Turn unit off.
- c. Clamp canister and dressing clamp.
- d. Disconnect canister tubing from dressing tubing and cover both ends with gauze or a glove and secure.
- e. To reconnect, remove gauze or glove from both ends and connect.
- f. Open both clamps and turn therapy on. Unit will default to previous settings.
- g. Reconnect V.A.C. unit to battery charger and wall plug. Check screen, battery symbol should be lighted green at all times.

E. **TROUBLESHOOTING:**

- 1. Audible Alarms
 - a. Therapy is not activated.
 - i. Machine will alarm every 15 minutes if on when therapy is not activated.
 - ii. Press therapy on main screen and turn on.
 - b. Canister is full
 - i. Change canister.
 - ii. **Even if canister does not appear to be full, or is new, and alarm goes off, check all connections then change canister, it may be faulty.**

- c. Leak or difficulty maintaining suction
 - i. Check for and listen for leaks in drape
 - ii. Reinforce as necessary
- d. Tubing blocked
 - i. **Ensure no kinks in tubing.**
 - ii. **Ensure clamps are open.**
 - iii. **Check that the canister is pushed fully in to that unit.**
 - iiii. **Ensure that T.R.A.C pad is not clogged. Cut out old T.R.A.C pad. Ensure hole in drape is cut the size of a quarter. Then, replace with new T.R.A.C pad.**
- e. Low battery
 - i. Check all connections to ensure battery charger is connected to wall plug and to the back of the V.A.C. unit.
 - ii. Battery symbol on screen should always be lighted and green.
- f. Keep unit on flat surface, unit will alarm if tilted greater than 45 degrees.
- g. Question mark at bottom left of main screen has an on-site user guide.
- h. A referral may also be made per physician order to Wound Nurse for Wound Evaluation and Treatment. For other troubleshooting tips, the Skin/Wound Team is available at extension 3793 or by cell phones 760-908-6488 and 760-802-9611. KCI is available 24 hours a day at 1-800-275-4524

F. DOCUMENTATION:

1. Document in the EHR:

- a. Wound V.A.C. therapy
 - i. Document wound output in the Intake and output section of the EHR per Standards of Care
 - ii. For V.A.C. Ultra with VeraFlo (instillation therapy):
 - 1) Document Instillation (Irrigation solution) in the electronic medication administration record (eMAR)
 - 2) Instillation (Irrigation solution) will not be calculated in the overall Intake
- b. Each dressing change **including:**
 - i. **Photograph of wound at least weekly**
 - ~~1. Wound assessment is to be documented as a clinical note in the electronic medical record and will include:~~
 - ~~a. Old dressing removal, including number of pieces of foam and adjunctive dressings removed~~
 - ~~b. Description of wound~~
 - ~~c. Cleansing of wound~~
 - ~~d. Size of wound (length, width, and depth in centimeters)~~
 - ~~e. Type of foam used~~
 - ~~f. Any adjunctive dressings used~~
 - ~~g. Skin barrier~~
 - ~~h. Therapy setting (i.e. 125 mmHg continuous)~~
 - ~~2. Documentation of wound assessment will include:~~
 - ~~a. Location~~
 - ~~b. Type of wound~~
 - ~~c. Age of wound~~
 - ~~d. Size (including length, width and depth)~~
 - ~~e. Drainage~~
 - ~~f. Surrounding skin integrity~~
 - ~~g. Oder~~
 - ~~Appearance of wound (i.e., granulation), any tunneling or undermining~~

Administrative Policy Manual

ISSUE DATE: 06/11

SUBJECT: Purpose & Responsibility of Risk
Management

REVISION DATE: 09/14

POLICY NUMBER: 8610-293

Administrative Policies & Procedures Committee Approval: 06/1109/14

~~Executive Council Approval:~~ 06/11

Professional Affairs Committee Approval: 07/11

Board of Directors Approval: 07/11

A. **SCOPE:**

1. Risk management is a hospital-wide integrated system that encompasses all areas of patient care, visitor, employee, property and medical staff safety.
2. All employees and members of the medical staff who have authority to influence patient care outcomes directly or indirectly are actively involved in the Risk Management Program. The Risk Management Program will pursue occurrences and circumstances that may present the potential for loss.

B. **AUTHORITY:**

1. The Director of Risk Management has been authorized by the Chief Executive Officer to provide the overall coordination of the Risk Management Program. It is the Chief Executive Officer, Chief of Staff, and Chief Nurse Executive, **and Chief Operating Officer**, who have the authority delegated by the Board of Directors to protect the interests of the hospital and patients by initiating necessary corrective action when the Risk Management Program has identified potentially adverse situations.

C. **GOALS:**

1. The major goal of the Risk Management Program is to establish a joint effort of the Board of Directors, Medical Staff and Administration, and all employees to provide a safe environment and quality patient care through the risk management principles of identifying exposure to loss, evaluating, analyzing, investigating, monitoring and **decreasing** improving the risks.
2. **To ensure t**The most advantageous method of correcting, reducing **and mitigating** or eliminating identifiable risks that may adversely affect our patients, visitors, employees and medical staff or the quality of care provided to patients will be selected.

D. **OBJECTIVES:**

1. To further improve the quality and safety of the care provided by the hospital.
2. To reduce patient and visitor injury to the lowest possible level.
3. To maintain and improve patient satisfaction with the organization.
4. To minimize adverse effects of loss through identification and assessment of actual and potential losses, loss prevention, risk reduction and claims control.
5. To minimize the occurrences of legal claims against the hospital.
6. The activity of risk management will contribute to the quality of care and a safer environment for patients, employees, visitors, medical staff and property, as well as reduce the cost of risk to the institution.

E. **RISK MANAGEMENT FUNCTIONS INCLUDE:**

1. **Identifying** ~~Identifies by through~~ ongoing assessment an annual plan to manage risk and evaluate the effectiveness of the Risk Management Program. Develops/modifies goals as indicated.
2. **Coordinating** ~~es the~~ development of corrective action plans to address identified risk exposures.

F. **RELATIONSHIP OF RISK MANAGEMENT TO THE ORGANIZATION:**

1. **Board of Directors:** Risk Management will report semi-annually to the Board of Directors. Will provide input on facility, department, and Medical Staff issues that address high-risk patient care issues, claims information, and regulatory/accreditation requirements. The Board will give input and guidance in the furtherance of Risk Management goals.
2. **Medical Staff Leadership: Risk Management works with** ~~Provides direction to~~ the Medical Staff in the identification and analysis of significant risk issues affecting the clinical operations of the facility. It is expected that physicians will cooperate in the Risk Management activities. The Risk Manager will interface with staff physicians to ensure communication and cooperation in Risk Management efforts.
3. **Bio-Ethics Committee:** The Risk Manager participates in this multidisciplinary committee **and** ~~Will~~ assists in the resolution and/or **advising** ~~e~~ as appropriate.
4. **Quality and Safety Committees:** The Risk Manager participates **on** ~~in~~ these committees and contributes expertise in risk reduction as a function of patient safety.
5. **Employees:** **The Risk Manager** ~~c~~ounselors clinical personnel on care issues/conflicts and responds to adverse patient outcomes. **The Risk Manager w**~~ill~~ act in a consulting capacity to all departments identifying and correcting unsafe conditions and practices whenever possible.

G. **ENVIRONMENTAL HEALTH AND SAFETY COMMITTEE:**

1. The Director of Risk Management is an active member of the Environmental Health and Safety Committee.
2. **Risk Management will aggregate data, specific to safety indicators for submission to the Committee on a quarterly basis.** ~~Aggregate data on safety indicators will be provided to the Committee quarterly.~~
3. **Risk Management w**~~ill~~ maintain risk data relating to patient or visitor occurrences and/or adverse outcomes and will present to committee members.
4. **The Director of Risk Management will refer potential and actual issues related to environmental functions to the Committee.** ~~The Director of Risk Management will refer to the Environmental Health and Safety Committee any issues that potentially or actually would be related to environmental functions.~~
5. **Risk Management will report safety issues identified by other departments / sources to the Committee for discussion, action and if possible, for resolution.** ~~Safety issues obtained from other sources will be brought to this committee for discussion, action, and resolution, if possible.~~

H. **REPORTING REQUIREMENTS OF RISK MANAGEMENT:**

1. **Internal:**
 - a. Incident Reporting and Analysis
 - i. Regular review and revision of policy and procedure.
 - ii. Analysis, investigation and trending of information in Quality Review Reports (QRR)/**RL Solutions**.
 - iii. Will review each incident report entered into the electronic QRR system for follow-up, risk identification, and trend analysis.
 - iv. Will compile data from the QRR and report to the appropriate committees.
 - b. Sentinel Events
 - i. Management and investigation of sentinel events will be according to hospital policies on mandatory reporting requirements.
2. **External:**
 - a. Provides Medwatch reports of medical device problems to the FDA and manufacturers as required under the Safe Medical Devices Act. Will maintain files for six years.

- b. Will assist State and Federal surveyors (i.e., The Joint Commission [TJC], California Department of Public Health [CDPH]) during scheduled and unannounced regulatory surveys.
- c. Reports to CDPH will be completed as needed after consultation with Administration.

I. **ANALYSIS OF RISK DATA BY RISK MANAGEMENT:**

1. Analyzing e loss data to determine appropriate loss prevention actions.
2. Analyzing es incidents/occurrences and identifies patterns as evidence for decision-making.
3. Providing es guidance for an evidence based risk management program for the facility.
4. Determining es the appropriate investigative technique and strategies to utilize with various types of potential claims.

J. **RISK MANAGEMENT EDUCATION RESPONSIBILITIES INCLUDE:**

1. Providing e an ongoing program to educate employees in risk management, safety and loss control matters, and incident reporting requirements.
2. Conducting ongoing in-service training and education with hospital personnel regarding specific and general risk management related issues.
3. Develops and implements educational programs for employees, Medical Staff and Board members based on analysis or risk assessments, historical and concurrent occurrence and claims data, and national trends.

K. **CLAIMS MANAGEMENT RESPONSIBILITIES INCLUDE:**

1. Oversees investigations of incidents that could lead to professional/general liability claims.
2. Works with patients/families and visitors where appropriate to resolve outstanding issues. Complaints and grievances will be handled in accordance with policy.
3. Identifies those occurrences that are potential compensable events and reports accordingly.
4. Protects confidentiality and access to Risk Management information and files.
5. Assists defense attorneys in preparation of defense.

L. **OPERATIONS/COMPLIANCE:**

1. Works closely with the Ethics & Compliance Officer to ensure compliance with statutory mandates, regulatory requirements and accreditation standards (i.e., TJC).
2. Disseminates information related to changes in regulatory requirements pertinent to potential liability exposures and risk issues.
3. Helps to ensure compliance with regulatory requirements, professional standards and guidelines.
4. Formulates and implements comprehensive Risk Management program, with full responsibility for operations of the program; may include an enterprise risk management approach.
5. Directs loss control/loss prevention activities and reports results to administration.
6. Responsible for identifying and communicating regulatory requirements relating to Risk Management activities.
7. Leads development of organization-wide approach on disclosure of medical errors and obtains physician support.
8. Analyzes the risk of loss versus cost of reducing risk.
9. Answers medical/legal inquiries of physicians, nurses, and administrators regarding emergent patient care issues and loss control.
10. Maintains awareness of legislative activities that may affect Risk Management programs and participates in the legislative process.

M. **LOSS PREVENTION / PATIENT SAFETY RESPONSIBILITIES INCLUDE:**

1. Planning developing and presents, develops, and presents educational material to administration, medical staff, nursing personnel, and other department personnel on topics related to risk management.
2. Developing s and implementing s programs designed to minimize the frequency and reduce the severity of actual and potential safety hazards throughout the facility.

3. **Leading** ~~s~~ or actively participating ~~es~~ in Root Cause Analyses; makes improvement recommendations.
4. **Supporting** ~~s~~ patient safety initiatives through leadership, direction, and involvement.
5. **Acting** ~~s~~ as resource, internal consultant, and educator for patient safety/risk management issues.
6. **Compling** ~~es~~ with various codes, laws, rules and regulations concerning patient care, including incident reporting and those mandated by state and federal agencies; also includes investigative activities with federal, state and local enforcement authorities.
7. **Leading** ~~s~~ investigations of adverse events and sentinel events.

N. **PROFESSIONAL DEVELOPMENT RESPONSIBILITIES INCLUDE:**

1. **Maintaining** ~~s~~ an exchange of information with professional organizations, peers and other resources to improve and update the program.
2. **Maintaining** ~~s~~ current knowledge and education in Risk Management.
3. **Maintaining** ~~s~~ membership in Risk Management societies.

O. **CONFIDENTIALITY OF INFORMATION:**

1. All Risk Management record reports and other documents are privileged and protected as confidential as applicable under California Evidence Code 1156 and 1157, as well as **under** attorney/client privilege.
2. ~~Patient identified medical~~ **Protected health** information is considered private and confidential and will be handled as such. This confidentiality extends to any form of disclosure, including information given over the telephone or in person. Protected privacy will include the medical record, identifiers in the record, financial statements, billing records and other information considered protected under the Health Insurance Portability and Accountability Act. Federal and State laws will be followed as applicable.

P. **REFERENCES:**

1. **Patient Care Services** Administrative Policy Incident Report – Quality Review Report (QRR), 8610-396
2. Administrative Policy Mandatory Reporting Requirements, 8610-236
3. Administrative Policy Disclosure of Unanticipated Adverse Outcomes to Patients, 8610-275
4. **Patient Care Services** Administrative Policy Patient Rights & Responsibilities, 8610-302
5. **Patient Care Services** Administrative Policy Patient Complaints & Grievances, 8610-318

EMERGENCY DEPARTMENT POLICY MANUAL

ISSUE DATE: NEW

**SUBJECT: Culture Follow Up Emergency
Department**

REVISION DATE:

Department Approval Date(s):	07/14
Department of Emergency Medicine Approval Date(s):	07/14
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	08/14
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. PURPOSE:

1. To define the procedure by which Emergency Department (ED) Nurses track, review, and follow up positive cultures in the Emergency Department on discharged patients.

B. DEFINITIONS:

1. Culture: Any urine, wound, cerebral spinal fluid (CSF), respiratory or other bodily fluid culture that is obtained in the Emergency Department on a discharged patient.
2. Positive Culture is defined as:
 - a. Urine: Any final positive report that indicates greater than 100,000 cfu/ml in patients greater than 36 months, or greater than 10,000 cfu/ml in patients less than 36 months old.
 - b. Wound/Stool: Any final positive report
 - c. Respiratory (including flu, RSV, pharyngeal): any preliminary or final positive report.
 - d. Other Cultures: Any final positive report
3. Negative Culture: Any culture that does not meet the above criteria.
4. Tracking Board: Emergency Department electronic tracking system.
5. "Positive Culture Results" Tab: The subset of the Tracking Board that filters for positive culture results.
6. Ad Hoc Charting: The section in Cerner utilized by Providers to document in "Forms."
 - a. ED Nurse Culture Results Review Form: The particular form that should be utilized by nurses to document culture follow up actions.
7. Antibiotic Sensitivities: These are listed on the 2nd page of a positive culture report and help to guide treatment.
 - a. "S"=Susceptible. The bacteria will be killed by the listed antibiotic
 - b. "R"=Resistant. The bacteria will NOT be killed by the listed antibiotic.
 - c. "I"=Intermediate. The bacteria might or might not be killed by the listed antibiotic
8. Common "equivalent" names for antibiotics
 - a. Septra or Bactrim = Trimethoprim/Sulfamethoxazole
 - b. Keflex = Cephalexin=Cefazolin (per Dr. Smith 2-27-14 for UTIs)
 - c. Cipro = Ciprofloxacin
 - d. Levaquin = Levofloxacin
 - e. Macrobid or Macrodantin = Nitrofurantoin

C. POLICY

1. The designated ED Nurse will review the Positive Culture Results Tab once per day
2. The designated ED Nurse will follow the procedure outlined below to eliminate all positive cultures that do NOT require MD/PA follow up action.

3. The designated ED nurse will document in the EHR any and all actions taken on each patient.


D. **FUNCTION OF THE "POSITIVE CULTURE RESULTS" TAB:**

1. Displays all Preliminary and Final culture results from the Microbiology lab at TCMC.
2. Completely negative cultures will not show up.
3. Positive cultures will automatically drop off list after 14 days.
 - a. All follow up must be completed within 14 days
4. The "Follow Up" column has a drop down menu attached to it
 - a. If this "Follow Up" column is EMPTY, no work has been done on this patient
 - b. If this "Follow Up" column shows START, that indicates that an RN or MD/PA has begun to work on this patient.
 - c. If one clicks COMPLETE in the "Follow Up" column, the patient will be permanently deleted from the tracking screen
 - i. COMPLETE should only be clicked when the patient requires no further action or follow up by ANY provider.
 - ii. Do not click COMPLETE until all necessary follow up has been completed.

E. **PROCEDURE**

1. Print Screen of "Positive Culture Results" tab on Tracking Screen
 - a. A printout **MUST** be made of the Culture Results Tracking screen **BEFORE** any action is taken for the day
 - b. This printout must be done on a daily basis and placed in the Culture Results binder located in the Emergency Department.
 - c. To print list click on the "print" button on right side of screen.
2. Positive Blood or CSF Culture
 - a. All positive Blood and CSF cultures (preliminary or final) will be addressed by the MD/PA on duty in Fast Track or Station D.
3. Positive Urine Culture
 - a. Open patient's chart and review the positive culture report
 - i. If it is a PRELIMINARY report, take no action
 - ii. If the FINAL REPORT shows **less than 100,000 cfu/ml** (or less than 10,000 cfu/ml for patients less than 36 months), Click COMPLETE in the Follow Up Column on the Tracking Screen to permanently remove the patient.
 - 1) Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not clinically significant. No further action warranted."
 - iii. If the FINAL REPORT shows **greater than 100,000 cfu/ml** (or greater than 10,000 cfu/ml for patients less than 36 months),
 - 1) Review Clin Notes and/or Medication List
 - b. If an antibiotic was not prescribed → Click START in the Follow Up Column on the Tracking Screen.
 - i. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. No antibiotic was prescribed. Referred for follow up by MD/PA."
 - c. If an antibiotic was prescribed
 - i. Compare the prescribed antibiotic to the list of "susceptible" antibiotics on the positive culture report
 - ii. If the prescribed antibiotic matches one of those listed as "susceptible," Click COMPLETE in the Follow Up Column on the Tracking Screen to remove the patient
 - iii. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Correct antibiotic already prescribed. No further action warranted."
 - d. If the prescribed antibiotic does NOT match one of those listed as "susceptible," click START in the Follow Up Column on the Tracking Screen to refer it to the MD/PA.

- i. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not sensitive to prescribed antibiotic. Referred for follow up by MD/PA."
 4. Positive Pharyngeal, Stool, Vaginal, Penile, Pleural Fluid, Ascitic Fluid, or Wound Culture
 - a. Review patient's chart (Clin Notes and/or Medication List)
 - b. If an antibiotic was not prescribed,
 - i. Click START in the Follow Up Column on the Tracking Screen.
 - 1) Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. No antibiotic prescribed. Referred for follow up by MD/PA."
 - c. If an antibiotic was prescribed
 - i. Compare the prescribed antibiotic to the list of "susceptible" antibiotics on the positive culture report
 - ii. If the prescribed antibiotic matches one of those listed as "susceptible," Click COMPLETE in the Follow Up Column on the Tracking Screen to remove the patient
 - 1) Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Correct antibiotic already prescribed. No further action warranted."
 - d. If the prescribed antibiotic does NOT match one of those listed as "susceptible," click START in the Follow Up Column on the Tracking Screen to refer it to the MD/PA.
 - i. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not sensitive to prescribed antibiotic. Referred for follow up by MD/PA."
 5. Positive Influenza or RSV
 - a. Click COMPLETE in the Follow Up Column on the Tracking Screen to remove the patient
 - i. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not clinically significant. No further action warranted."

 Tri-City Medical Center	EMERGENCY DEPARTMENT
PROCEDURE: TRIAGE OF EMERGENCY DEPARTMENT PATIENTS	
Purpose:	To provide a standardized system whereby patients presenting to the Emergency Department are treated in order of priority based upon acuity utilizing the Emergency Severity Index.
Supportive Data:	Agency for Health Quality Research, Emergency Severity Index, Version 4.
Issue Date: 8/09	Revision Date(s): 2/11

A. DEFINITIONS:

1. **Triage:** The purpose of triage in the emergency department (ED) is to prioritize incoming patients and to identify those who cannot wait to be seen.
2. **Emergency Severity Index:** The Emergency Severity Index (ESI) is a tool for use in emergency department (ED) triage. The ESI triage algorithm yields rapid, reproducible, and clinically relevant stratification of patients into five groups, from level 1 (most urgent) to level 5 (least urgent). The ESI provides a method for categorizing ED patients by both acuity and resource needs.
3. **Acuity:** Acuity is determined by the stability of vital functions and the potential threat to life, limb, or organ.
4. **Resource Needs:** The number of resources a patient is expected to consume in order for a disposition decision to be reached. The triage nurse estimates resource needs based on previous experience with patient presenting with similar injuries or complaints.

B. POLICY

1. All patients presenting to the Emergency Department will be triaged by a registered nurse (RN) who has demonstrated competency in triage utilizing the Emergency Severity Index.
2. All patients presenting to the Emergency Department requesting treatment shall be entered into the electronic medical record.
3. Triage in the emergency department occurs utilizing a two-tier triage process.
 - a. All patients presenting for treatment are assessed by a Registered Nurse, receive a first-tier triage assessment, and are assigned an acuity level based on the Emergency Severity Index.
 - b. When there are available beds in the Emergency Department, patients are immediately placed in a bed and receive a second-tier triage assessment by the Primary Nurse.
 - c. When there are no available beds, second-tier triage assessment occurs by a Registered Nurse in triage.
 - d. Patients arriving by ambulance will receive a first-tier triage by the first available Registered Nurse. This may include the Charge Nurse, Team Leader, or the patient's Primary Nurse. Patients arriving by ambulance will receive a second-tier triage assessment by the Primary Nurse.

C. PROCEDURE:

1. First-Tier Triage

- a. All patients presenting to the Emergency Department will be assessed by the First Nurse; a Registered Nurse responsible for the initial assessment of patients.
- b. The First Nurse will obtain the following information:
 - i. The patient's chief complaint.
 - ii. With the assistance of emergency technicians, the First Nurse will obtain a set of vital signs (including a height and weight on pediatric patients).
- c. The First Nurse will assign an acuity based on the patient's chief complaint, expected resource utilization, and vital signs.
- d. The First Nurse will ensure registration staff has entered the patient's information into the electronic medical record and that the patient has an appropriate name band placed.
 - i. **If there are available open emergency department beds:**
 - C.1.d.i.1 The First Nurse will assign the patient to an available bed.

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C.1.d.i.2 Patients who have stable vital signs and are not at risk for deterioration will be transported to the assigned bed by the Emergency Technician.

C.1.d.i.3 Patients who have unstable vital signs or who are at risk for deterioration will be transported by the First Nurse to the assigned bed.

C.1.d.i.4 Hand off will occur from triage personnel to the primary nurse.

2. **Second-Tier Triage**

a. **If there are no available emergency department beds:**

i. Patient's will receive a second-tier triage assessment and await bed availability in the Emergency Department waiting room.

ii. Information gathered during the second-tier triage process includes:

C.2.a.ii.1 Chief complaint

C.2.a.ii.2 Allergies

C.2.a.ii.3 Suicide Risk Assessment

C.2.a.ii.4 Fall Risk Assessment

iii. The First Nurse will communicate with the Emergency Department Charge Nurse regarding bed availability and assign patients to beds as they become available.

C.2.a.iii.1 Patients will be transported by the emergency technician and hand off communication will occur to the Primary Nurse.

iv. Reassessments (vital signs, including pain) will be documented in the ED record and any clinically significant changes will be communicated to the ED ANM/Charge RN.

C.2.a.iv.1 Patients waiting for placement in an Emergency Department bed will be reassessed as deemed appropriate by the Registered Nurse.

C.2.a.iv.2 These patients will have vital signs repeated every two hours while waiting.

3. **Vital Signs**

a. Vital signs will be obtained during the first-tier triage process.

b. Vital signs include:

i. Temperature

ii. Pulse

iii. Respirations

iv. Blood Pressure

C.3.b.iv.1 Blood pressure is obtained with other vital signs in all children 2 years old of age and older.

C.3.b.iv.2 Blood pressure is obtained in children under 2 years of age if indicated (i.e.; signs and symptoms of dehydration, shock, or sepsis).

v. Pain Assessment

vi. Weight

C.3.b.vi.1 Weight is obtained on all patients <under 18 years old.

4. **Emergency Severity Index**

a. The Emergency Severity Index is an algorithm in which the Registered Nurse assesses acuity level as well as expected resource utilization to categorize emergency department patients. Initially, the triage nurse assesses only the acuity level. If a patient does not meet high acuity level criteria (ESI level 1 or 2), the triage nurse then evaluates expected resource needs to help determine a triage level (ESI level 3, 4, or 5).

b. ESI level is a measure of acuity assessment at the time triage was completed. ESI level is not a measure of ongoing patient acuity and should not be changed as the patient's condition improves or deteriorates.

c. ESI level is determined utilizing an algorithm with 4 decision points:

i. Does the patient require lifesaving intervention?

ii. Is this a patient who shouldn't wait?

iii. How many resources will this patient need?

iv. What are the patient's vital signs?

5. **Emergency Severity Index Acuity Levels**

a. **Level 1**

- i. ESI acuity level 1 patients have emergency medical or surgical conditions that require immediate lifesaving interventions.
- ii. These patients typically require a team response where both medical and nursing care are initiated simultaneously to prevent deterioration in the patient's condition.
- iii. Examples of ESI level 1 patients include but are not limited to:
 - C.5.a.iii.1 Cardiac arrest or respiratory arrest
 - C.5.a.iii.2 Severe respiratory distress with SpO2 **<less than** 90, agonal or gasping type respirations
 - C.5.a.iii.3 Critically injured trauma patient who presents unresponsive
 - C.5.a.iii.4 Severe bradycardia or tachycardia with signs of hypoperfusion
 - C.5.a.iii.5 Hypotension with signs of hypoperfusion
 - C.5.a.iii.6 Chest pain, pale, diaphoretic, blood pressure 70/palp
 - C.5.a.iii.7 Anaphylactic shock,
 - C.5.a.iii.8 Baby that is flaccid
 - C.5.a.iii.9 Unresponsive patient with a strong odor of alcohol
 - C.5.a.iii.10 Hypoglycemia with a change in mental status

b. **Level 2**

- i. ESI acuity level 2 patients are high-risk patients. ESI level 2 patients present with symptoms that are suggestive of conditions that require time sensitive treatment, have conditions that may deteriorate, and have a potential threat to life, limb, or organ. This level of acuity also includes patients who have an acute alteration in the level of consciousness or neurological status.
- ii. Patients with severe pain or distress, as evidenced by a pain score of 7/10, **may** also be assigned to ESI acuity level 2.
- iii. Examples of ESI level 2 patients include but are not limited to:
 - C.5.b.iii.1 Active chest pain, suspicious for acute coronary syndrome but does not require an immediate life-saving intervention, stable
 - C.5.b.iii.2 A needle stick in a health care worker
 - C.5.b.iii.3 Signs of a stroke, but does not meet level-1 criteria
 - C.5.b.iii.4 A rule-out ectopic pregnancy, hemodynamically stable
 - C.5.b.iii.5 A patient on chemotherapy and therefore immunocompromised, with a fever
 - C.5.b.iii.6 A suicidal or homicidal patient or a patient experiencing delusions
 - C.5.b.iii.7 New onset of confusion in an elderly patient
 - C.5.b.iii.8 The 3-month-old whose mother reports the child is sleeping all the time
 - C.5.b.iii.9 The adolescent found confused and disoriented

c. **Level 3**

- i. ESI level 3 patients are patients with stable conditions that have been determined to not meet criteria to be classified as ESI level 1 or 2.
- ii. The Registered Nurse, after determining the patient's condition is stable, predicts the number of resources the patient will require is 2 or more.
- iii. Vital signs are required to assign an ESI level 3.
 - C.5.c.iii.1 Patients with abnormal vital signs may require a reassignment of ESI level 2.
- iv. Examples of ESI level 3 patients include but are not limited to:
 - C.5.c.iv.1 Assault
 - C.5.c.iv.2 Abdominal pain with stable vital signs
 - C.5.c.iv.3 Headache
 - C.5.c.iv.4 Mild/moderate difficulty breathing with stable vital signs
 - C.5.c.iv.5 Nausea, vomiting, diarrhea with stable vital signs
 - C.5.c.iv.6 Minor trauma
 - C.5.c.iv.7 Mild/moderate difficulty breathing (croup, bronchiolitis, pneumonia, known asthma with worsening symptoms)

a.C.5.c.iv.8 Seizure, alert on arrival

d. Level 4

- i. ESI level 4 patients are patients with stable conditions that have been determined to no meet criteria to be classified as ESI level 1 or 2.
- ii. The Registered Nurse, after determining the patient's condition is stable, predicts that the number of resources the patient will require is 1.
- iii. Vital signs are not required to assign an ESI level 4.
- iv. Examples of ESI level 4 patients include but are not limited to:
 - C.5.d.iv.1 Chronic back pain
 - C.5.d.iv.2 Isolated eye complaints
 - C.5.d.iv.3 Headache with normal vital signs and normal mental status
 - C.5.d.iv.4 Minor head injury
 - C.5.d.iv.5 Minor trauma (isolated extremity injury, minor MVA)
 - C.5.d.iv.6 Minor psychiatric complaints (depression/anxiety)
 - C.5.d.iv.7 Simple lacerations requiring sutures
 - C.5.d.iv.8 Uncomplicated URI symptoms

e. Level 5

- i. ESI level 5 patients are patients with stable conditions that have been determined to no meet criteria to be classified as ESI level 1 or 2.
- ii. The Registered Nurse, after determining the patient's condition is stable, predicts that the number of resources the patient will require is 0.
- iii. Vital signs are not required to assign an ESI level 5.
- iv. Examples of ESI level 5 patients include but are not limited to:
 - C.5.e.iv.1 Dressing changes
 - C.5.e.iv.2 Earache
 - C.5.e.iv.3 Minor Flu Symptoms
 - C.5.e.iv.4 Medication refills
 - C.5.e.iv.5 Minor trauma (superficial lacerations/abrasions)
 - C.5.e.iv.6 Isolated sore throat, no respiratory symptoms
 - C.5.e.iv.7 Wound rechecks

6. Special Considerations

a. Pediatric Fever

- i. The following guidelines should be used when evaluating pediatric patients who present with fever:
 - C.6.a.i.1 1-28 days of age and Temperature **>greater than 38.0 C (100.4 F)** assign ESI Level 2
 - C.6.a.i.2 1-3 months of age and Temperature **>greater than 38.0 C (100.4 F)** consider ESI Level 2
 - C.6.a.i.3 3 months – 3 years of age and Temperature **>greater than 39.0 C** and the patient has incomplete immunizations or no obvious source of fever consider ESI Level 3

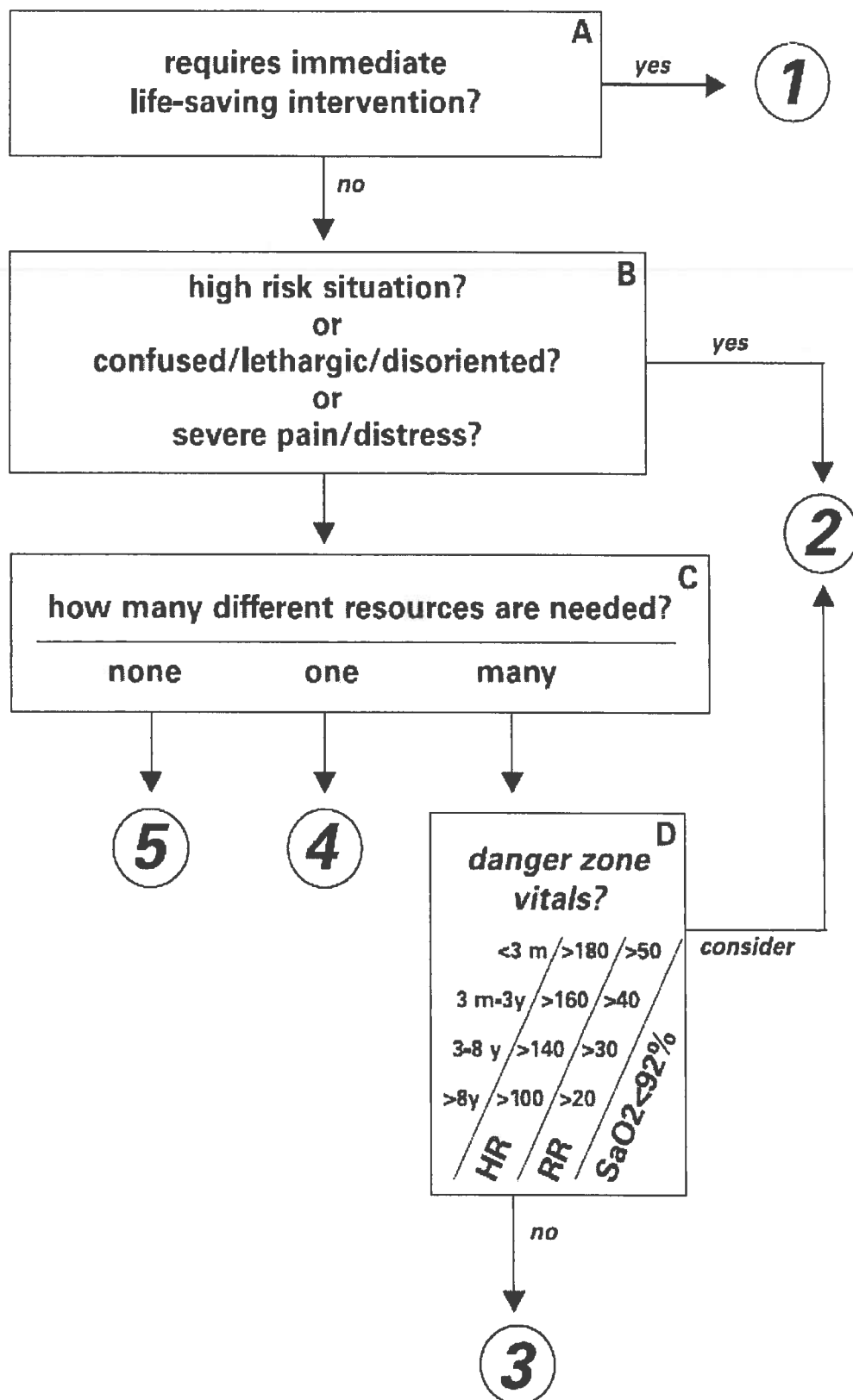
b. Emergency Department Standardized Procedures

- i. Emergency Department Standardized Procedures should be initiated when the physician is not readily available to assess and initiate care on patients.
- ii. ED Standardized Procedures may be initiated in any area of the emergency department by a Registered Nurse who has demonstrated competency.

D. RELATED DOCUMENTS

1. Appendix A: Emergency Severity Index Version 4 Algorithm
2. Appendix B: Lifesaving Interventions, Resources, Danger Zone Vital Signs
3. Agency for Healthcare Research and Quality (2012). "Emergency severity index: A triage tool for emergency department care, version 4."

Appendix A: ESI Algorithm



Appendix B: Lifesaving Interventions, Resources, and Danger Zone Vital Signs

- A. Immediate life-saving intervention required: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O₂, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SPO₂<90, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either:

- (1) nonverbal and not following commands (acutely); or
- (2) requires noxious stimulus (P or U on AVPU) scale.

- B. High risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.

- C. Resources: Count the number of different types of resources, not the individual tests or x-rays (examples: CBC, electrolytes and coags equals one resource; CBC plus chest x-ray equals two resources).

<i>Resources</i>	<i>Not Resources</i>
<ul style="list-style-type: none"> • Labs (blood, urine) • ECG, X-rays • CT-MRI-ultrasound-angiography 	<ul style="list-style-type: none"> • History & physical (including pelvic) • Point-of-care testing
<ul style="list-style-type: none"> • IV fluids (hydration) 	<ul style="list-style-type: none"> • Saline or heparin
<ul style="list-style-type: none"> • IV or IM or nebulized medications 	<ul style="list-style-type: none"> • PO medications • Tetanus immunization • Prescription refills
<ul style="list-style-type: none"> • Specialty consultation 	<ul style="list-style-type: none"> • Phone call to PCP
<ul style="list-style-type: none"> • Simple procedure =1 (lac repair, foley cath) • Complex procedure =2 (conscious sedation) 	<ul style="list-style-type: none"> • Simple wound care (dressings, recheck) • Crutches, splints, slings

- D. Danger Zone Vital Signs

Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric Fever Considerations

1 to 28 days of age: assign at least ESI 2 if temp >38.0 C (100.4F)

1-3 months of age: consider assigning ESI 2 if temp >38.0 C (100.4F)

3 months to 3 yrs of age: consider assigning ESI 3 if: temp >39.0 C (102.2 F), or incomplete immunizations, or no obvious source of fever

**PROCEDURE: CHEST TUBE, CARE OF INFANTS WITH PNEUMOTHORAX**

Purpose: For severely compromised infants who have an air leak syndrome, immediate treatment with needle aspiration may be required. Subsequent treatment consists of thoracotomy and placement in the infant's chest of a drainage tube connected to a draining device.

Equipment: Chest tubes: 8 Fr, 10 Fr, and 12 Fr-Pigtail Universal Catheter

~~Procedure tray~~

Povidone Iodine

Sterile saline wipes

Rubber-tipped-clamps

Mask, hat, sterile gown and gloves for physician

Wall suction equipment

~~Infant Chest Drainage Unit Underwater-drainage-system kit~~

5 in 1 Straight tubing connector

Vinyl connecting tube

Sterile water

Tape

Suture

Sterile 2 inch x 2 inch gauze

Tegaderm™ dressing

1% Xylocaine

Analgesic such as Morphine or Fentanyl

Sedative such as Midazolam or Ativan

Vaseline gauze

A. PROCEDURE:

1. Obtain informed consent from parent or legal guardian.
2. Assemble equipment and perform hand hygiene.
3. Perform "time out" to verify patient, and procedure, and correct side "**right side**" with physician.
4. Insertion of a chest tube is an invasive procedure that requires sterile technique. Each person assisting must wear a gown, gloves, a mask, and a cap.
5. A chest tube may only be inserted by a physician.
6. ~~Place~~ The infant ~~should be~~ on a heart rate-apnea monitor with an audible QRS; the pulse oximeter should be on and functioning during the procedure.
7. A blood-pressure cuff should be in place so blood pressure can be checked.
8. ~~Provide P~~ pain management medication ~~should be administered.~~
9. ~~Use a~~ A transilluminator ~~should be used to confirm the presence of a pneumothorax or perform a chest x-ray performed if time and patient's condition allow for diagnosis, if necessary.~~
10. ~~A chest X-ray should be performed before insertion of a chest tube, if possible.~~
11. **Position infant with the pneumothorax upright or flat. Elevate the head of bed. Immobilize the infant's extremities.** ~~The infant should be positioned so that the side with the pneumothorax is upright or flat, with the head of the bed elevated; the infant's extremities should be immobilized.~~
12. ~~The drainage system should be S~~ set up **drainage system** according to package-insert instructions. ~~Connect t~~ The **sterile** end of the tubing from the collection chamber ~~should be connected to a 5 in 1 straight tubing connector universal adapter and remain sterile. It will be connected to the vinyl connecting tube, which then will be connected to the chest tube when the chest tube is inserted. The suction tubing may be placed to wall suction with a regular suction adaptor.~~

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- ~~13-12.~~ **Suction can be set by dialing in the ordered amount of suction on the chest drain. Set the suction to the level ordered by the physician (usually between -5 to -20 mm Hg). Set the suction regulator (connected to a wall outlet) should be set at a minimum of 80 mm Hg.**
- ~~14-13.~~ **Rubber-tipped cKeep cClamps and Vaseline gauze should be kept at the bedside at all times while the chest tube is in place.**
- ~~15-14.~~ **Secure all connections with tape and position The tubing should be positioned so there are no dependent loops through which drainage would have to flow against gravity. The tubing should be stabilized and secure tubing to promote function and comfort and to prevent accidental removal. Connections should be taped.**
- ~~16-15.~~ If bubbling resumes after initially ceasing, it is important to troubleshoot the system. Check that all connections are secure, and check to see if the chest tube has become dislodged. It may be necessary to obtain a chest X ray to see whether the infant has accumulated a pneumothorax.
- ~~17-16.~~ **AnyMark drainage drainage in the drainage collection chamber should be marked on the drainage device. The amount should be documented the amount under output in the electronic on the patient medical record every 12 hours.**
- ~~18-17.~~ **Keep tThe dressing should remain airtight; any routine dressing changes are not recommended. The site should be Evaluated the site for signs of infection. and Cehanged the dressing if infection is suspected or if the dressing becomes wet and drainage occurs.**
- ~~19-18.~~ **The dressing should be Labelled dressing with the date and time it was placed.**
- ~~20-19.~~ **Avoid mMilking and stripping of the chest tube. should be avoided.**
- ~~21-20.~~ Clamping has minimal clinical value. Therefore, if it is necessary to transport an infant with a chest tube, the chest tube may be placed to water seal or Heimlich valve. Only clamp a chest tube to simulate tube removal to determine patient tolerance. This can also be achieved by turning the stopcock on the vinyl connector tubing, off to patient.
- ~~22-21.~~ Following the insertion of a chest tube, **obtain** a chest x-ray, blood gas, and vital signs. ~~should be obtained.~~ **Evaluate bBreath sounds should be evaluated before and after the procedure. To help drain air, Elevate the head of the bed should be inclined to a 30'- 45' angle after chest tube insertion.**
- ~~23-22.~~ The physician performs removal of chest tubes. After removal, **apply** an occlusive Vaseline pressure dressing. ~~should be applied.~~ **Dispose of tThe chest drain should be disposed of in the infectious waste container.**

B. DOCUMENTATION:

- ~~1.~~ **The RN should Document the procedure in the patient's medical record. Include tThe size of the chest tube and the infant's tolerance of the procedure. should be included.**
- ~~2.~~ **The RN should check and Rrecord vital signs and auscultate breath sounds every 2 hours.**
- ~~3.~~ Every shift, the RN ~~should records~~ the chest tube site, any bubbling in the water seal chamber, the amount of suction, and the amount of drainage, if any.

C. REFERENCES:

- ~~1.~~ Cotton, C. M., & Goldberg, R. N. (2005). Air leak syndromes. In A. R. Spitzer (Ed.), *Intensive care of the fetus and neonate, 2nd Ed.* Philadelphia: Elsevier.
- ~~2.~~ Don, S.M. (2005). Historical perspectives: neonatal transilluminations. *Neoreviews*, 6, e112-e114.
- ~~3-2.~~ Fletcher, M.A., & MacDonald, M., J. Ramasethu, and K. Rais-Bahrami. (1993). Atlas of procedures in neonatology (5th 2nd ed.). Philadelphia: Lippincott, Williams, & Wilkins.
3. Gomella, T.L., Cunningham, M.D., Eyal, F.G. & Zenk, K. E. (Eds.). (20132009). Neonatology: Management, procedures, on-call problems, diseases, and drugs (6th ed.). New York: McGraw-Hill.
4. Ikuta, Linda M., and Sandra S. Beauman, eds. (2011). **Policies, Procedures, and Competencies for Neonatal Nursing Care.** Glenview, IL: National Association of Neonatal Nursing Care.
5. Verklan, M.T., Walden, M. (Eds.). (2009). Core curriculum for neonatal intensive care nursing (4th ed.). St. Louis: Saunders.

**PROCEDURE: NASOGASTRIC (NG) AND OROGASTRIC (OG) TUBE INSERTION, MAINTENANCE, AND REMOVAL**

Purpose: To outline the nursing responsibilities in the placement, maintenance, and removal of enteral tubes.

Supportive Data: Nasogastric and orogastric tube placement is used for diagnostic and therapeutic purposes. Enteral tubes are placed to decompress the stomach and proximal small intestine, evacuate gastric contents, administer lavage, and instill medications, fluids and feedings. Enteral tube placement requires a physician's order. Once per shift and before use for diagnostic or therapeutic reasons, the enteral tube is observed to ensure that the system is intact, without leaks, kinks or clots. ~~Short-term enteral tubes (generally made of polyvinylchloride [PVC]) should be changed every 1 to 3 days or as recommended by manufacturer. Long-term enteral tubes (made of polyurethane) should be changed every four weeks or as recommended by manufacturer.~~

Equipment:

1. Enteral tube (type and size appropriate for intended purpose)
2. Non-sterile gloves
3. **Hydrocolloid dressing Duoderm or appropriate skin protective barrier**
- ~~3.4.~~ Transparent dressing
- ~~4.5.~~ 5-10 mL syringe
- ~~5.6.~~ Stethoscope
7. **Water-soluble lubricant or sterile water**
- ~~6.8.~~ **Syringe feeding pump and extension tubing as needed**

A. PROCEDURE:**1. INSERTION:**

- a. RN ~~will~~ collaborates with attending physician regarding placement of NG/OG tube for purpose of **gastric decompression or gavage feedings**.
- b. Perform hand hygiene and apply non-sterile gloves.
- c. Assemble appropriate equipment.
- d. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
- e. Position the patient:
 - i. Patients may be swaddled.
 - ii. A second person may assist with patient containment.
- f. Determine length of enteral tube to be inserted by measuring the tube from the **tip** bridge of the nose to the earlobe, and from the earlobe to a space halfway between the umbilicus and the termination of the xiphoid process.
- g. Mark the measured distance on the tube with a small piece of tape **or make note of the pre-printed centimeter measurement on the tubing**.
- h. **Place an appropriate sized piece of hydrocolloid dressing duoderm on skin where tube is to be secured**
- ~~h.i.~~ Lubricate the distal end of the tube with **sterile water or water-soluble lubricant**.
- ~~i.j.~~ Insert the tube gently through the mouth or nares, aiming down and back.
- k. If there appears to be resistance, do not force. Try rolling the enteral tube gently. If still unable –to pass the enteral tube, remove it and try the other nostril.
- l. Do not pass the enteral tube beyond the original mark until further assessment is made.
- ~~j-m.~~ Remove enteral tube at once if there are signs of distress, coughing, gasping, **apnea, bradycardia** or cyanosis.
- ~~k-n.~~ Allow the patient to **stabilize** ~~rest~~ and resume insertion procedure.
- ~~l-o.~~ Continue to pass enteral tube until marked position is at the tip of the nostril or at the lip.

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- ~~m-p.~~ Verify placement of the tube in stomach by
 - i. Aspirating gastric contents**
 - ~~m.ii.~~ Listening with a stethoscope over the epigastric area while injecting small amount (1-3 ml) of air ~~and/or aspirate gastric contents and then return.~~
- ~~n-q.~~ Secure the enteral tube in place **on top of hydrocolloid dressing duoderm** with transparent dressing.
- ~~o-r.~~ Place a small label (tape **or patient label**) with insertion date on enteral tubing just below the hub.
- ~~p-s.~~ Discard used supplies and gloves in appropriate receptacle.
- ~~q-t.~~ Perform hand hygiene.
- ~~r-u.~~ Document the following in the patient's medical record:
 - i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.
 - ii. Tolerance of procedure.

2. MAINTENANCE:

- a. Ongoing proper placement is verified by:
 - i. Measuring the distance from nares to the distal end of the NG/OG tube every shift.
 - ii. Verifying proper placement prior to use through auscultation **and/or** aspiration.
 - ~~ii-iii.~~ **Whenever an x-ray is obtained.**
- ~~ii-b.~~ **Evaluate color and amount of aspirate and notify physician for residuals containing blood, brown or dark green bilious fluid.**
- ~~ii-c.~~ **Short term (PVC) feeding tubes inserted for gastric decompression are ~~should be~~ changed every 72hrs. Long-term enteral only feeding tubes (polyurethane) are ~~should be~~ replaced every 30 days.**
- ~~ii-i.~~
- d. ~~Refer to physician orders for application of feeding, venting, and/or suctioning.~~

3. GAVAGE FEEDINGS:

- ~~3-a.~~ **Gavage feeds are ~~may be~~ given via gravity or by use of a feeding pump utilizing enteral only syringes and tubing.**
- b. **Verify proper tube placement prior to every feed.**
- ~~3-c.~~ **Check residual on preterm infants prior to feed making note of amount, color and consistency. Residuals > 20% of previous feed amount are ~~should be~~ reported to the physician unless a specific order regarding residual management has already been obtained. Do not check residuals of infants on continuous feeds unless ordered by the physician.**
- ~~3-d.~~ **For gravity gavage feeds attach barrel of syringe to feeding tube and pour prepared feed into barrel. Insert plunger into barrel to start fluid flow. Adjust the height of the barrel to control flow speed. Do not force feed in with plunger instead allow it to flow by gravity.**
- ~~3-e.~~ **For pump feeds attach syringe to extension tubing and prime tubing then attach to feeding tube. Place syringe into feeding pump and set pump infusion rate to infuse feed over the ordered time frame and volume. ~~Extention~~Extension tubing should be changed with each feed.**
- ~~3-f.~~ **If infant is on continuous feeds, prepare a syringe with up to 4 hours of breastmilk or formula and attach to infant as described above. A new extension tube is ~~should be~~ used with each new syringe. Program pump to deliver the feed at the ordered rate.**
- ~~3-g.~~ **Offer a pacifier with gavage feeds to allow infant to ~~assoiciate~~associate sucking with a full stomach.**
- ~~3-h.~~ **At the end of the feed, either remove the barrel or extension tubing and clamp feeding tube or leave a barrel attached for venting if necessary.**

8-i. **Keep head of bed elevated during gavage feeds**

4. **REMOVAL:**

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

B. **REFERENCES**

1. Merenstein, G.G. & Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th Ed. St. Louis, MO. Mosby.
2. Bowden, V.R. & Greenberg, C.S. (2011). Pediatric nursing procedures, 3rd Ed. Philadelphia. PA. Lippincott Williams and Wilkins.
- 2-3. Ikuta, Linda M., and Sandra S. Beauman, eds. (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care., 2011.

WOMEN'S AND CHILDREN'S SERVICES MANUAL - NICU

SUBJECT: PAIN MANAGEMENT, NEONATES AND INFANTS

ISSUE DATE: 10/03

REVISION DATE: 05/08, 4/09, 06/11, 8/12, 8/14

Department Approval Date(s):	12/13
Department of OB/GYN Approval Date(s):	01/14
Department of Pediatrics Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	04/14
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. POLICY:

1. All neonates and infants ~~should be~~ **are** assessed and reassessed on an ongoing basis for pain management. Healthcare providers ~~should~~ modify the NICU environment to alleviate periods of stress, minimize pain, and optimize growth and development.
2. Pain management ~~should be~~ **is** used to minimize the intensity, duration, and physiological cost of pain, and to maximize the infant's ability to cope with and recover from the painful experience.

B. EQUIPMENT:

1. NPASS
2. Sucrose
3. Blankets
4. Pacifier
5. Pain medication (per physician's order)
6. **Colostrum/Breast milk**


C. PROCEDURE:

1. Perform hand hygiene and put on gloves.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
3. Assess the neonate. ~~The Assessment should include:~~ **includes:** gestational or postmenstrual age, illness severity, sleep and wake states, ~~previous painful procedures, previous handling,~~ vital signs, percentage of oxygen, and oxygen saturation.
4. Assess pain using the Neonatal Pain, Agitation, and Sedation Scale (N-PASS)
 - a. The N-PASS tool utilizes behavioral state and physiological parameters to assess sedation, pain, and agitation. Scoring is done in association with vital signs. Pain is scored with every vital sign assessment.
5. Assess pain when pain is suspected, with every vital sign assessment, before handling and after a painful procedure, and 30 minutes after a pain medication is administered.
6. ~~When performing a procedure, determine~~ **Determine** if the procedure is painful or non-painful. Some examples of painful procedures include: needle insertion, heel stick, **nasal/oral** gavage tube placement, suctioning, tape removal, lumbar puncture, percutaneous line insertion, intubation and extubation, chest tube insertion and removal, intramuscular injection, circumcision, and eye examinations.
7. Provide non-pharmacologic interventions for all **painful** situations, if appropriate, such as swaddle, nonnutritive sucking, sucrose, facilitated tuck, decreased lights, decreased noise, skin-to-skin contact, breastfeeding, and breast milk.

8. Ensure that pharmacologic interventions have been provided for moderate to severe pain along with prolonged pain and that the neonate has obtained proper pain relief.
9. Remove gloves and perform hand hygiene.
10. Document the procedure and the pain score in the patient's medical record.

D. **REFERENCES:**

1. Altimier, L., Brown, B., & Tedeschi, L. (2011~~06~~). *Neonatal nursing policies, procedures, competencies, and clinical pathways*, 4~~th~~ ed. Glenview, IL: National Association of Neonatal Nurses.
2. **Gomella, T.L. (2013). Neonatology: management, procedures, on-call problems, diseases, and drugs, 7ed. New York, NY: McGraw Hill Education.**
3. Pain Assessment (Neonatal). (2013~~2~~). Mosby's Nursing Skills. Retrieved from <http://app44.webinservice.com/NursingSkills/Home.aspx>

 Tri-City Medical Center	Women's and Children's Services Manual - NICU
PROCEDURE: PATIENT ASSIGNMENT NICU	
Purpose:	To provide safe nursing care for all NICU patients based on patient needs and staff competency. To communicate and document patient assignments using consistent guidelines.
Supportive Data:	California Code of Regulations TITLE XXII, §70217. Joint Commission Comprehensive Accreditation Manual for Hospitals, Leadership Standards; LD 04.01.07, LD04.01.11,LD04.03.01,LD.01.03.07

A. POLICY

1. The Assistant Nurse Manager (ANM) or designee, who is a professional registered nurse, is responsible for patient care assignments at the beginning of each shift. A patient classification system is utilized. Nurse/patient ratios will be maintained to meet patient needs and TitleXXII Regulations. Staff floating from another unit or agency will have a TCMC NICU staff member assigned as a resource person for support. The NICU Manager, ANMs or designee are responsible for monitoring appropriate patient assignments.
2. The NICU Nurse Manager has accountability for staffing and work schedules.

B. PROCEDURE:

1. The ANM or designee utilizes the Cerner powerform for acuity tool to determine the number of nurses needed based on patient acuity as described in the Policy Patient classification in the NICU. Based upon the information obtained the number of professional registered nurses are determined for the NICU including personnel with the necessary competencies for the patient population.
2. The ANM or designee develops the patient assignment utilizing the following criteria
 - a. The complexity of the patient's condition and the required nursing care.
 - b. The dynamics of the patient's status.
 - c. The knowledge and the skill of the nursing staff member to effectively assess and care for the patient
 - d. The type of technology employed in providing nursing care with consideration given to the knowledge and skill required to effectively use the technology.
 - e. The degree of supervision required by each nursing staff member based on his/her previous assessed level and current level of competence in relation to the nursing care needs of the patient.
 - f. Relevant infection control and safety issues.
 - g. The patient's geographical location within the NICU
 - h. Continuity of care by reassigning staff to patients for whom they previously provided care.
 - i. Assigning patients to designated primary and associate nurses.
3. The assignment sheets include:
 - a. Date and shift
 - b. Location
 - c. Manager
 - d. ANM, or Designee
 - e. Licensed personnel
 - f. Unlicensed personnel used as support staff
 - g. Preceptees/orienteers
 - h. Agency/Float personnel
4. Document the Following on the assignment sheet:

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/14	06/14	n/a	n/a		09/10; 08/12

- a. Each patient assigned to an RN. The following positions may be utilized to assist the RN assigned to the patient and should be indicated on the assignment sheet:
 - i. An RN with a partial assignment
 - ii. **Assignment/Break Nurse**
 - iii. **Charge Nurse**
 - ii-iv. ANM
 - iii-v. NICU Manager
 - iv-vi. Clinical Educator
 - v-vii. Clinical Nurse Specialist
 - b. Indicate the name of the TCMC NICU nurse assigned as a resource nurse **for to float or agency nurses assigned to the unit for that shift.**
 - c. **Document** Break and meal times and coverage, and when necessary, in service/meeting times **on the break/meal log form.** Meal breaks are extended over enough hours to minimize the number of nurses out of the unit requiring coverage.
 - d. Document the name of the RN providing relief.
 - e-d. Orientees are not utilized as direct care providers without supervision by competent licensed TCMC NICU staff
 - f. ~~Assign additional responsibilities, such as disaster code, crash cart check, audits, etc.~~
 - g-e. Update the assignment sheet as new patients are admitted **or discharged**, when a patient's acuity changes, **and/or assignments** change.
 - f. The assignment sheets are archived by the TCMC NICU Nurse manager or designee. The archived sheets will be retained for the period of time as prescribed by the regulatory agencies.
5. **Staffing for Periods of High Census**
- a. The NICU will maintain a staffing strategy in order to accommodate staffing needs when census is high.
 - b. The manager and designee (e.g. assistant nurse manager (ANM)/relief charge nurse) will make all attempts to use NICU core staff in an effort to provide consistency of care. Only nurses who are NRP certified can float to NICU. RNs that are floated to the NICU will only take care of CCS defined continuing care patients that do not require higher levels of care or competencies, (i.e., ventilator support, NCPAP, central lines or impending invasive procedures). Competencies of care will be documented for patient assignment.
 - c. An RN who floats to NICU shall be assigned a resource nurse who may or may not be the ANM/relief charge nurse. On occasions when treatment modalities that the float RN does not feel competent performing arise unexpectedly, the resource nurse will perform the tasks for the float RN or the ANM/relief charge nurse will reassign the patient to ensure safe care.
 - d. NICU will typically only take floats when there are appropriate acuity patients that can be assigned to them. Pre-booking through registry can be done during times that normally require a higher number of staff.
 - e. Travelers are required to have the same competencies as the core staff in NICU. Attending high-risk deliveries is optional, especially for those who are only committed for a short time. Travelers may be given the opportunity to orient to high-risk deliveries, if requested.

C. **REFERENCES:**

1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.
- 4-2. **California Children's Service Manual of Procedures, Section 3.25.2.A2C**

**PROCEDURE:****PATIENT CLASSIFICATION (ACUITY) IN THE NICU****Purpose:**

The purpose of the Patient Classification System and tools is to determine the nursing care needs of the individual NICU patients that reflect the assessment by the professional registered nurse. The framework for the Patient Classification system is the AACN Synergy Model for Patient Care—that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. Synergy results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse's competencies.

Supportive Data:

California Code of Regulations TITLE XXII, Section 70053.2
Joint Commission Comprehensive Accreditation Manual for Hospitals,
Leadership Standards

A. CARE PROVISION:

1. Synergy Model for Patient Care: The TCMC model for nursing care that links clinical practice with patient outcomes:
2. Levels of Care: Categories that define the intensity of care requirements for individual patients based on the profession registered nurse's assessment. The levels of care follow a decreasing level of intensity:
 - a. Level 10 -1 RN to 1 patient
 - i. Care Intensity 1:1 High ADL Needs
 - ii. Care Intensity 1:1 Moderate ADL Needs
 - iii. Care Intensity 1:1 Minimum ADL Needs
 - b. Level 9 - 1 RN to 2 patients
 - i. Care Intensity :High Care Needs High ADL Needs
 - c. Level 8 -1 RN to 2 patients
 - i. Care Intensity High Care Needs Moderate ADL Needs
 - d. Level 7 -1 RN to 2 patients
 - i. Care Intensity High Care Needs Minimum ADL needs
 - e. Level 6 – 1 RN to 3 patients
 - i. Care Intensity Moderate Care Needs High ADL needs
 - f. Level 5-1 RN to 3 patients
 - i. Care Intensity Moderate Care Needs Moderate ADL needs
 - g. Level 4– 1 RN to 3 patients
 - i. Care Intensity Moderate Care Needs Minimum ADL needs
 - h. Level 3– 1 RN to 3 patients
 - i. Care Intensity Minimum Care Needs High ADL needs
 - i. Level 2– 1 RN to 3 patients
 - i. Care Intensity Minimum Care Needs Moderate ADL needs
 - j. Level 1– 1 RN to 3 patients
 - i. Care Intensity Minimum Care Needs High ADL needs
 - k. Please see Appendix A and B for additional information concerning Levels of care

B. RESPONSIBILITIES:

1. The NICU Manager, Assistant nurse managers (ANMs) or designees are responsible to ensure that the professional registered nurse complete the Patient Classification for their patient(s) each shift.
2. The NICU Manager and/or the ANMs will ensure that the Patient Classification system for the NICU is utilized accurately.
3. Nursing is responsible for Patient Classification utilizing the Cerner Acuity Powerform.

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/14	3/14	n/a	n/a		09/10; 08/12

C. **PROCEDURE:**

1. The professional registered nurse determines each patient's care intensity and activity of daily living (ADLs) indicators based on the RN knowledge of the patient status, the plan of care for the patient and the nursing assessment.
 - a. The Care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels
 - b. The ADL indicator is defined by minimal, moderate and high
 - c. Each care intensity and ADL indicator is specific to the NICU and has a weight associated to it that assists in determining the acuity of the patient.
2. A task will be triggered at each **shift** to the professional registered nurse for each patient assigned. **It is the responsibility of the professional registered nurse to complete the acuity of their assigned patients.**
3. ~~The professional registered nurse is required to complete the acuity on assigned patient(s) by 1100 and 2300 or the task will be noted as overdue.~~
4. The ANM or designee is responsible to verify that the Acuity Powerform is completed for each patient each shift.
5. The ANM or designee will complete the Staffing Calculator by 1500 and 0300 which reflects the acuity of the patient(s) as completed by the professional registered nurse(s) and the minimum number of staff required based on acuity and minimum staffing ratios
6. This information is submitted electronically to Staffing Resource Center if completed by the time previously specified.
 - a. If the information is late in being completed the ANM or their designee is responsible for faxing a copy of their daily summary reports to the Staffing Resource Center as soon as possible.
7. The Manager, ANM or designee reviews the required staffing based on the Patient Classification tool and the actual staffing used.
8. Trends and patterns are analyzed by the NICU Manager. Problems related to balancing ratios will be brought to the Director and CNE attention. Information will be used to plan future staffing needs.

D. **INTER-RATER RELIABILITY PROCESS:**

1. Inter-rater reliability is defined as the degree to which two observers, operating separately and independently, assign the same care level rating to the patient
2. The purpose of this process is to ensure consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) powerform.
3. Each shift a task will be triggered by Cerner to the ANM or designee to complete an Acuity Validation on patients in the NICU.
 - a. The task is set to randomly pick 2 NICU patients
4. The information is monitored on a monthly basis and reported as appropriate
5. The NICU manager is responsible for ensuring completion of the validation tasks.

E. **REFERENCES:**

1. Hardin, S.R., & Kaplow, R., (2005). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care*. Jones and Bartlett. Sudbury, Ma.

F. **Appendix A:**

NICU Neonatal - Test, Mary

NICU Neonatal Intensive Care Needs Intensity

	Minimal	Moderate	High	1:1 RN	Comment
Stability (Condition Stability & Assessment/VS)	<input type="text"/>				
Complexity (Procedures & Respiratory)					
Vulnerability (Education)					
Resiliency (Level of Supervision)					
Predictability					
Resource Availability (Psychosocial)					
Participation in Decision Making (Communication)					

Care Needs Intensity

☐ Minimal Care Needs

☐ Moderate Care Needs

☐ High Care Needs

☐ 1 Patient to 1 RN (ICU, NICU & BHU only)

☐ 1 Patient to 2 RN's (ICU only)

ADL Dependency

☐ Minimal ADL Needs

☐ Moderate ADL Needs


☐ High ADL Needs

NICU NEONATAL INTENSIVE CARE NEEDS INTENSITY DEFINITIONS

PATIENT CHARACTERISTICS	MINIMAL	MODERATE	HIGH	1:1 RN
STABILITY (CONDITION STABILITY & ASSESSMENT/VS) The ability to maintain a steady-state equilibrium	Assessment/VS q 3-4 hrs VS stable	Maybe at risk for deterioration of condition, Assessment/VS q 2 hrs May or may not be Hemodynamically stable	At risk for deterioration of condition, Assessment/VS q 1 hr or more frequent, Hemodynamically unstable/labile vitals	At risk for deterioration of condition, Continuous monitoring of the critically ill patient, Hemodynamically unstable, condition worsening
COMPLEXITY (PROCEDURES & RESPIRATORY) The intricate entanglement of 2 or more systems (body, family, therapy)	Patient with non-complex medications/therapies/family dynamics	Patient with moderately complex medications Ex: amphotericin, calcium, patient with multi-system support/therapies Ex: feedings, glucose monitoring, patient with minor family issues	Patient with complex medication Ex: dopamine, indocin, blood, patient with multi-system support/therapies Ex: transportation, communication, emotional	Patient with complex medication Ex: epinephrine, gtt, patients with multi-system support Ex: ventilatory, hemodynamic; patients with numerous family issues Ex: not visiting, non-compliance

G. **Appendix B**

CARE NEEDS	ADL	ACUITY	CHARGE CODE
minimum	minimum	1	NICU 3 Level 1
minimum	moderate	2	NICU 3 Level 1
minimum	high	3	NICU 3 Level 1
moderate	minimum	4	NICU 5 Level 1
moderate	moderate	5	NICU 5 Level 1
moderate	high	6	NICU 7 Level 1
high	minimum	7	NICU 7 Level 1
high	moderate	8	NICU 9 Level 2
high	high	9	NICU 9 Level 2
1:1	minimum	10	NICU 10 Level 3
1:1	moderate	10	NICU 10 Level 3
1:1	high	10	NICU 10 Level 3

 Tri-City Medical Center	Women's and Children's Services - NICU
PROCEDURE: PRE/POST WEIGHTS FOR BREASTFED INFANTS IN THE NICU	
Purpose: To use the weight scale as a means of quantifying intake at the breast in order to ensure optimal nutrition and support the mother/infant breastfeeding dyad.	
Equipment: Breastfeeding scale	

A. **POLICY:**

1. The use of a breastfeeding scale to approximate an infant's intake at breast can be a valuable tool in assessing an infant's progress towards discharge. Its use, however, should be limited to those infants whose intake may be less than optimal due to their disease process, such as prematurity or infant of a diabetic mother. The primary goal is to encourage the breastfeeding mother and establish a long-term breastfeeding dyad. Regardless of the intake amount, the mother will be encouraged with the message that every time her baby is at the breast is a "successful" feeding.


B. **PROCEDURE:**

1. Pre/Post weights are **not** necessary for the following infants:
 - a. Infants less than 3 days of life unless MOB is consistently pumping volumes of at least 10ml, when lactogenesis II has occurred.
 - b. Infants greater than 36 weeks gestation without feeding problem (ie not on OT service)
2. Indications for obtaining pre and post breastfeeding weights once milk supply has been established:
 - a. Infants less than 36 weeks gestation
 - b. Term infants with identified feeding problems
 - c. As ordered by the neonatologist
3. Pre/Post weights shall continue until the baby is no longer requiring gavage feeds **AND** demonstrates the ability to take full feedings at the breast.
4. **Before feed weight (pre-weight)**
 - a. Weights are to be measured in grams only
 - b. Turn scale on and verify it is "zeroed"
 - c. Swaddle infant and disconnect leads from monitor. Place monitor on "Standby"
 - d. Place swaddled baby on scale. All leads and feeding tubes should be placed on top of bundled baby. Any leads or tubing unable to be disconnect (ie, running IV) should be held up and off scale by RN.
 - e. RN to keep one hand just above baby for safety.
 - f. Wait until scale determines weight. "Set" weight in scale per manufacturer's instructions. Remove baby from scale, hand to mother, reconnect leads and resume monitoring.
 - g. Record set pre-weight.
 - h. Diaper, clothing and blanket should not be changed between the "before" and "after" weights.
5. **After-feed Weight (post-weight)**
 - a. Ensure scale is on and either has retained previous weight or is "zeroed"
 - b. Weigh baby again using exact same technique as previous weight. Ensure no changes have been made in diaper, clothing, etc. and infant is swaddled in same blanket.
 - c. RN to keep one hand hovering above infant at all times.
 - d. Wait until scale determines weight and value locks into scale. Remove infant and place in a safe location. Reattach leads and resume monitoring.
 - e. Record the post weight and calculate amount fed.
 - f. Chart the amount fed in the infant's EMR as mls of 20 cal BM intake.

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/14	3/14	3/14	n/a	5/14		

C. **REFERENCE LIST**

1. Meir PP, Engstrom JL, Test weighing for term and preterm infants is an accurate procedure, Arch Dis Child Fetal Neonatal Ed. 2007 March; 92(2): F155-F156
 2. Spatz, DL. Innovations in the Provision of Human Milk and Breastfeeding for Infants Requiring Intensive Care.JOGNN. 2011; 41, 138-143
 3. Spatz, DL. Ten Steps for Promoting and Protecting Breastfeeding for Vulnerable Infants. Journal of Perinatal and Neonatal Nursing. 2004; 18(4) 385-396.
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 Tri-City Medical Center		Women's and Children's Services Manual - NICU
PROCEDURE:	REPLOGLE TUBE INSERTION AND MANAGEMENT	
Purpose:	To provide gastric decompression and prevent vomiting and aspiration	
Supportive Data:	Replogle tube insertion is used to treat a variety of gastrointestinal and multisystem disorders with gastrointestinal involvement. The largest drainage tube that can be comfortably inserted should be used to provide proper drainage and decompression of the stomach; 8-fr tube for infants <1,500 gms and a 10-fr tube for infants > 1,500 gms. Decreasing the risk of emesis and the potential for aspiration helps to prevent further complications.	
Equipment:	1. Dual lumen Replogle tube (8-fr or 10-fr) 2. Suction canister and tubing 3. Drainage trap 4. Hydrocolloid dressing 5. Transparent dressing 6. Sterile water or water-based lubricant	

A. **PROCEDURE:**

1. **INSERTION:**

- a. RN will collaborate with attending physician regarding placement of replogle tube for purpose of gastric decompression.
- b. Perform hand hygiene and apply non-sterile gloves.
- c. Assemble appropriate equipment.
- d. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
- e. Position the patient:
 - i. Patients may be swaddled.
 - ii. A second person may assist with patient containment.
- f. Determine length of replogle tube to be inserted by measuring the tube from the tip -of the nose to the earlobe, and from the earlobe to a space halfway between the umbilicus and the termination of the xiphoid process.
- g. Mark the measured distance on the tube with a small piece of tape or make note of the pre-printed centimeter measurement on the tubing.
- h. Place an appropriate sized piece of hydrocolloid dressing on skin where tube is to be secured
- i. Lubricate the distal end of the tube with sterile water or water-soluble lubricant.
- j. Slowly and gently insert the tube through the mouth or nares, aiming down and back and advance until the pre-measured length is at the tip of the nostril or at the lip.
- k. If there appears to be resistance, **do not force**. Try rolling the tube gently. If still unable to pass the tube, remove it and try the other nostril. Remove tube at once if there are signs of distress, coughing, gasping, apnea, bradycardia or cyanosis.
- l. Allow the patient to stabilize and resume insertion procedure.
- m. Verify placement of the tube in stomach by listening with a stethoscope over the epigastric area while injecting small amount (1-3 ml) of air and/or aspirate gastric contents.
- n. Secure the replogle tube in place on top of hydrocolloid dressing with transparent dressing.
- o. Connect the replogle tube to the drainage trap then connect the drainage trap to suction as ordered. Continuous or low intermittent suction should be set to 40-60mm Hg unless specified differently by the physician.

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
7/14	7/14	7/14	n/a	8/14		

- p. Place a small label (tape or patient label) with insertion date on replegle tubing just below the hub.
- q. Discard used supplies and gloves in appropriate receptacle.
- r. Perform hand hygiene.
- s. Document the following in the patient's medical record:
 - i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.
 - ii. Tolerance of procedure.

2. **MANAGEMENT:**

- a. Ongoing proper placement is verified by:
 - i. Measuring the distance from nares to the distal end of the gastrostomy tube every shift.
 - ii. Verifying proper placement through auscultation or aspiration
 - iii. Whenever an x-ray is obtained.
- b. Evaluate and document color and amount of aspirate and notify physician of any change in drainage color or quantity.
- c. Replegle tubes should be changed every 72hrs.
- d. If secretions are extremely thick and drainage has stopped, the replegle may be irrigated to prevent or clear plugging. Consult with the physician prior to irrigating the replegle tube. Irrigate with 1-5ml of normal saline. If the tube cannot be irrigated, discontinue it and insert a new tube.
- e. When charting output, subtract the amount of normal saline used as irrigant from the total output.

3. **REMOVAL:**

- a. Disconnect suction (if attached) and drainage trap.
- b. Remove transparent dressing.
- c. Pinch replegle tube closed as the tube is slowly withdrawn to prevent aspiration of contents into the pharynx.
- d. Discard in appropriate receptacle.
- e. Document the procedure in the patient's medical record.

B. **REFERENCE LIST**

- 1. Ikuta, Linda M., and Sandra S. Beauman, eds. Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care, 2011.
- 2. Merenstein, G.G. & Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th. St. Louis, MO: Mosby.
- 3. Gomella, Tricia Lacy, M. Douglas Cunningham, and Fabien G. Eyal, eds. Neonatology: management, procedures, on-call problems, diseases, and drugs. 7th. New York: McGraw Hill Education Lange, 2013.

WOMEN'S AND CHILDREN'S SERVICES MANUAL – NICU

SUBJECT: STAFFING POLICY FOR HIGH CENSUS

The contents of this policy were combined into the Patient Assignment NICU policy

ISSUE DATE: 09/06 REVISION DATE: 05/08, 04/09, 06/11, 8/12

A. PURPOSE:

1. To provide a guideline on staffing the neonatal intensive care unit (NICU) adequately and safely in times of high census.

B. POLICY:


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

C. EXTERNAL LINKS:

D. REFERENCES:

E. APPROVAL PROCESS:

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

 Tri-City Medical Center		Women's and Newborn's Services Procedure Manual
PROCEDURE:	NEONATAL RESUSCITATION TEAM FOR SCHEDULED CESAREAN SECTIONS	
Purpose:	To provide guidelines and role responsibilities for the neonatal resuscitation team make up attending scheduled, lower risk Cesarean Section (C-Section) deliveries. Neonatal Resuscitation for any delivery is guided by the Neonatal Resuscitation Program (NRP) developed by the American Academy of Pediatrics and the American Heart Association.	

A. POLICY:

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

B. PROCEDURE:

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/14	5/14	n/a	n/a	8/14		

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

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

1. Please see Women and Children's Policy: Neonatal Team Attendance at Deliveries
2. Reasons to involve the Neonatologist during an infant resuscitation include but are not limited to these considerations:
 - a. **Anytime the need for intubation is anticipated or required, as the anesthesiologist's primary responsibility is caring for the mother.**
 - a-b. Unexpected meconium stained fluid with a non-vigorous infant
 - i. The RN shall bulb suction any visible meconium from the infant's mouth and nose and begin resuscitation per NRP guidelines until the Neonatologist arrives.
 - b-c. Infant receiving PPV for 30-60 seconds without clinical improvement (Continued Apnea, Heart Rate less than 100)
 - e-d. Infant with an APGAR score less than 7

- ~~d.e.~~ Infants with pulse oximetry saturation values (in 5 minutes of life) lower than NRP guidelines
 - e.f. Any time chest compressions are initiated
 - f.g. Anytime the resuscitation team feels further evaluation of the infant is needed
 - ~~g.~~ ~~Anytime the need for intubation is anticipated or required~~
- 3. The primary, direct method for contacting the Neonatologist will be the responsibility of the Circulating Nurse by using the WHITE PHONE in the OR.
 - a. A back up measure can included paging the Neonatologist.
- 4. If the Neonatal Crash Cart is needed the OR Circulating Nurse shall bring it to the room
- 5. A "Code ~~Caleb~~ Pink" can also be initiated as indicated, please see the Standardized Procedure: Code ~~Pink-Caleb~~ in Women's and Children's Services.

D. **REFERENCES**

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

Tri-City Medical Center
Oceanside, California

WOMEN'S AND CHILDREN'S SERVICES POLICY MANUAL

ISSUE DATE: NEW

**SUBJECT: PLACENTA RELEASE TO
PATIENT/FAMILY**

REVISION DATE:

Department of OB/GYN Approval: 6/2013

Medical Executive Committee Approval: 5/2014

Professional Affairs Committee Approval:

Board of Directors Approval:

A. PURPOSE:

1. In an effort to be culturally sensitive to our patient population's desires and requests, a placenta that **has not been sent to pathology for evaluation**, may be sent home with the patient if requested.
2. Maternal, fetal/neonatal, and placental indications for the placenta to be sent to pathology for examination can include, but are not limited to:
 - a. Premature infant
 - b. Prolonged rupture of membranes
 - c. Maternal infection (suspect chorioamnionitis, GBS +, etc.)
 - d. Intrapartum temperature > 100.4°F (38°C)
 - e. Low birth weight or IUGR
 - f. Congenital anomalies
 - g. Abruptio placenta
 - h. Post term infant
 - i. Fetal demise
 - j. Maternal medical problems
 - k. Maternal drug use
 - l. Multiple gestation
 - m. Placentas which appear abnormal (velamentous insertion of the cord, battledore, succenturiate, circumvallate, etc.)
 - n. 2 vessel umbilical cords
 - o. Abnormal blood gases
 - p. Meconium-stained placentas
3. The placenta will not be released to the patient if she has a known blood borne illness to include, but not limited to: HIV, Hepatitis, and Syphilis.
4. If the patient desires to take her placenta home after discussion with her provider and there is NOT an indication for examination, the patient will be given the "Consent for Placenta Removal from the Hospital" to read and sign.
 - a. The signed form will be scanned into the patient's electronic medical record
 - b. A copy of the form will be given to the patient.

B. PROCEDURE:

1. Notify the provider if the patient requests to take her placenta home.
2. The provider will determine if there is an indication to send the placenta to pathology for examination and if not, write an order indicating **the release of the placenta to the patient**, as appropriate. If the placenta will be released to the patient, the patient will be given the "Consent for Placenta Removal from the Hospital" form to read and sign.

- a. The form will be scanned into the patient's electronic medical record and a copy of the form will be given to the patient.
3. Immediately after delivery:
 - a. Place the placenta in a clear plastic zip lock bag and then into another plastic zip lock bag (double bag). Put the double bagged placenta into a leak-proof, covered container and label it with the patient name and delivery time. Please also indicate on the container: "HOLD ON UNIT, FOR PATIENT RELEASE".
 - b. Put the labeled container into the unit's lab specimen refrigerator in the Biohazard room to keep it refrigerated until the patient or designated transporter can take it home. (DO NOT SEND THE PLACENTA HOME WITH A BIOHAZARD LABEL OR IN A RED BIOHAZARD BAG)
 - c. The patient/family must take possession of the placenta and remove it from the hospital premises within 6-12 hours after delivery.
4. A placenta that has been removed from the delivery room or sent to pathology **will not** be released to the patient.
5. ~~The California Department of Health Services has given hospitals permission to release a patient's own placenta to her when requested. Medical waste requires that it be "waste" and without intrinsic value. Because the placenta is of intrinsic value to the patient and or/her family, it never becomes waste and is not subject to regulation by the Medical Waste Management Act (Part 12, California Health and Safety Code, Section 117360 et seq.)~~ **The California Department of Public Health has reported that a placenta is not a biohazardous waste as defined in Section 117655 of the California Health and Safety Code, if it has not been suspected of being contaminated with infectious agents.**

C. **FORMS**

1. Consent for Placenta Removal from the Hospital

D. **REFERENCES:**

1. "Practice Guideline for Examination of the Placenta" developed by the Placental Pathology Practice Guideline Development Task Force of the College of American Pathologists; (Arch Pathol Lab Med, 1997; Vol 121, 449-476)
2. Hester, D. M. (2008) Ethics by committee: consultations, organization and education for hospital ethics committees. New York, Rowmann & Littlefield.

Staffing Resource Center Policy Manual

ISSUE DATE: 4/03 **SUBJECT:** Disaster Call Back List

REVISION DATE: 1/05, 12/05
REVIEW DATE: 6/03, 4/07, 4/10

Department Approval Date(s):	04/14
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. POLICY:

1. The Staffing Resource Center will maintain an up-to-date Disaster Call Back List for all Tri-City Healthcare District Departments.
2. This book will be kept in the Staffing Resource Center.
3. Quarterly, a designated Staffing Resource Representative will contact each TCHD Department and request a current phone list from the Director/designee.
 - a. This will be done via e-mail or interoffice mail.
 - b. It is the responsibility of the Manager/their designee to update these lists and return to Staffing within 1 month of receipt.
 - c. Once the updated lists are turned in, they will be placed in the Disaster Call Back Book and the older version will be destroyed.
4. Any Department that has several staffing changes prior to the quarterly update is encouraged to send an updated phone list to Staffing Resource Center.

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
October 7, 2014

Members Present: Larry Schallock, Chairperson; Director Ramona Finnila; Eric Burch, Community Member; Blake Kern, Community Member; Al Memmolo, Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member

Non-Voting Members: Greg Moser, General Counsel; Tim Moran, CEO; Casey Fatch, Chief Operating Officer

Others Present: Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Colleen Thompson, Director Medical Records; Donna Dempster, Director Medical Staff Services; David Bennett, Chief Marketing Officer

Absent: Director Paul V. L. Campo

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m. in Assembly Room 3 at Tri-City Medical Center by Director Schallock, Committee Chairman.		
2. Introduction and Welcome of New Members	Chairman Schallock welcomed new committee members, Ms. Blake Kern, Mr. Al Memmolo and Dr. Henry Showah. Committee members introduced themselves and provided brief background information.	None.	
3. Approval of Agenda	It was moved by Director Finnila to approve today's agenda as presented. Dr. Henry Showah seconded the motion. The motion passed unanimously.	Agenda approved.	
4. Comments from members of the public	Chairman Schallock read the Public Comments announcement as listed on today's Agenda.	There were no public comments.	
5. Ratification of prior Minutes	It was moved by Director Finnila and seconded by Dr. Showah to ratify the minutes of the May 6, 2014 Governance & Legislative Committee. The minutes were approved with Ms. Blake Kern, Mr. Al Memmolo, Mr. Eric Burch and Dr. Marcus Contardo abstaining from the vote.	Minutes ratified.	Ms. Donnellan
5. Old Business - None			

Governance & Legislative Committee Meeting

-1-

May 6, 2014

20 (4) F.

Topic	Discussion	Action Follow-up	Person(s) Responsible
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6. New Business a. Annual review of Committee Charters – > Community Healthcare & Alliance Committee	<p>Chairman Schallock explained the Community Healthcare & Alliance Committee has reviewed their Charter and the Charter is coming forward today for review to be followed by approval of the Board of Directors.</p> <p>The committee did not have any additional recommended changes.</p> <p>It was moved by Dr. Contardo to recommend the Community Healthcare & Alliance Committee Charter be brought forward for Board approval. Mr. Burch seconded the motion. The motion passed unanimously.</p>	Recommendation to be sent to the Board of Directors to approve the Community Healthcare & Alliance Committee Charter as presented; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
b. Medical Staff Rules and Regulations Review	<p>Chairman Schallock explained the Board of Directors is tasked with approving the Rules and Regulations of the Medical Staff that are adopted by other Medical Staff Committees. General Counsel recently observed the revisions to Rules and Regulations were not coming forward to a Board Committee prior to Board approval.</p> <p>Dr. Contardo provided perspective on the process, explaining the Rules and Regulations contained in today's meeting packet are Department and Division specific and there is also a set of policies and procedures that are Medical Staff specific. Dr. Contardo did not recommend making any changes to the Rules and Regulations contained in today's meeting packet.</p> <p>Mr. Moser stated Title 22 is being followed, however the current process does not allow the opportunity for organizational or governance oriented changes.</p> <p>Ms. Donna Dempster, Director of Medical Staff Services stated review by the Governance Committee would delay the approval process by one month. Mr. Moran, CEO explained in an urgent situation, the Medical Executive Committee does have authority to act on</p>	Recommendation to be sent to the Board of Directors that Medical Staff Policy and procedure changes, as well as Departmental Rules and Regulations and Procedures go to the Governance Committee prior to Board approval; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	<p>behalf of the Medical Staff.</p> <p>Discussion was held regarding whether the Committee's Charter requires a revision to reflect the Committee oversees Medical Staff Rules and Regulations. Mr. Moser did not recommend a change to the Charter but requested a motion on direction. Director Finnilla suggested the Rules and Regulations reflect the dates reviewed by the respective Division and Board.</p> <p>It was moved by Ms. Kern that the Medical Staff be directed to refer all Medical Staff Policy and procedure changes, as well as Departmental Rules and Regulations and Procedures to the Governance Committee prior to Board approval. Director Contardo seconded the motion. The motion passed unanimously.</p>		
c. Review of TCHD Bylaws -	<p>Agenda items c. Review of TCHD Bylaws – Article IV, Section 3 and d. Review of Board Policy 14-028 were discussed concurrently. Chairman Schallcock explained the Board Chair or his designee attends the monthly Medical Executive Committee, Auxiliary and Foundation Board meetings without compensation and does so to discuss the Board's business, rather than their own personal agenda. Mr. Moser explained there is a Board policy on compensation and these meetings do not qualify for compensation.</p> <p>Discussion was held regarding Section 9. Removal, Resignation or Vacancy and consequences of not adhering to Board business when attending meetings such as the MEC, Auxiliary and Foundation Board meetings. The committee directed General Counsel to draft revisions to Bylaws Section 9. Removal, Resignation or Vacancy as well as Board Policy #14-028 Authorizing Directors to Represent the District in Advocacy.</p>	<p>General Counsel to draft revisions to TCHD Bylaws Article IV, Section 9 and Board Policy 14-028 – Authorizing Directors to Represent the District in Advocacy. Item to appear on next month's agenda.</p>	General Counsel

Topic	Discussion	Action Follow-up	Person(s) Responsible
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d. Review of Board Policy 14-028	Agenda item discussed in conjunction with c. above.	See above.	
e. Review of policies related to gifts:	Mr. Moser stated at the request of the Compliance Officer, Tri-City Healthcare District's various gift policies were reviewed for consistency.	Recommendation to be sent to the Board of Directors to approve Board Policy 14-044 as presented; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
➤ Board Policy 14-044	With regard to Board Policy 14-044 Mr. Moser referred to section III. Distribution of Gifts, F. 2. Mr. Moser recommended the statement be included to reflect <i>"Officials receiving such tickets shall return any unused tickets to the District, preferably in time for reallocation by the CEO"</i> . It was moved by Director Finnila to recommend the Board approve the addition to Section III. F. 2. above as presented. Dr. Contardo seconded the motion. The motion passed unanimously. Mr. Moser explained California Form 801 has been newly adopted by the FPPC and is a new form for reporting travel expenses paid by a party other than the District. Mr. Moser provided clarification with regard to California FPPC Form 802 – Agency Report of Events and Ticket/Pass Distributions. It was suggested Mr. Moran meet with Mr. David Bennett, CMO and Ms. Donnellan to ensure compliance with the FPPC. Mr. Moser explained AP&P 8610-483 reflects gifts such as flowers or food that can be consumed or shared by the employee's coworkers, may be accepted provided the total cost is not greater than \$50 per person however, the Pharmaceutical Vendors Policy 8390-10025 prohibits gifts of any denomination. Mr. Moser stated the revisions to AP&P 8610-483 make it clear there is another policy for Pharmacy. Likewise Pharmacy Services Policy 8390-10025 was revised to reflect that the policy does not address gifts to TCMC	Mr. Moran, Mr. Bennett and Ms. Donnellan to meet and develop mechanism to comply with FPPC Form 802. Recommendation to be sent to the Board of Directors to approve AP&P 8610-483 as presented and Pharmacy Services Policy 8390-10025 as presented and modified; item to appear on next Board agenda and included in Board Agenda packet.	Mr. Moran, Mr. Bennett and Ms. Donnellan Ms. Donnellan
➤ AP&P 8610-483			
➤ Pharmacy Services Policy 8390-10025			

Topic	Discussion	Action Follow-up	Person(s) Responsible
DRAFT			
	<p>employees and their immediate family members from other vendors doing business with TCMC and refers to AP&P 8610-483.</p> <p>It was moved by Director Finnila to recommend approval of revisions to AP&P 8610-483 and Pharmacy Services Policy 8390-10025 as presented. Ms. Kern seconded the motion. The motion passed unanimously.</p> <p>Mr. Burke suggested minor grammar and typographical changes to Pharmacy Services Policy 8390-10025.</p> <p>Extensive discussion ensued regarding the \$50 limit on gifts related to physician holiday parties and other such events. Mr. Moser clarified the value of a given event cannot be more than \$50 to each individual and the \$50 limit applies not only to officials who file Form 700 but other employees as well.</p>		
f. Review of Board Policy 14-031	<p>Chairman Schallock stated an HR Committee Community Member has requested committee community members be given a badge to avoid being stopped at the entrance to the hospital. The committee supported providing committee community members with a badge as desired.</p>	<p>Committee members interested in obtaining a badge will be directed to Employee Health. Employee Health will be instructed to provide badges for committee community members and remove key code access from badges prior to distribution. Badges will not be mandatory for committee members.</p>	Ms. Donnellan
g. Review and discussion of "litigation hold" procedure	<p>Mr. Moser briefly explained when a litigation hold may be necessary and questioned whether the District would like to implement a formal policy related to a litigation hold. Discussion was held as to the different types of cases that may be subject to a litigation hold and the fact that a variety of cases may need to be preserved but in a different manner.</p> <p>It was recommended discussion of this agenda item be tabled pending the hiring of a new Chief Compliance Officer.</p>	<p>Litigation hold to be discussed at committee meeting following hiring of Chief Compliance Officer; place on future agenda.</p>	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
DRAFT			
h. Review of Board Policy 14-008 – Records Retention and Destruction for consistency with Administrative Policy 8610-237 – Hospital Records Retention	Mr. Moser explained there is a comprehensive Board Policy on Records Retention as well as a hospital policy on retention which are inconsistent. Chairman Schallack invited Ms. Colleen Thompson, Director of Medical Records to engage in discussion. Ms. Thompson distributed a memorandum in which she identified inconsistencies between the current Board policy and the Administrative Policy. She explained the Administrative Policy references the retention period for documents to conform with CHA's recommended retention period. Ms. Thompson further explained when in doubt staff would refer to the Administrative Policy rather than the Board's policy. Mr. Moser explained the Board's policy provides the legally required retention timeframes where CHA lists the recommended retention timeframes. Ms. Thompson stated she prefers the more stringent guidelines which are statewide and adopted by most state agencies. Ms. Thompson also explained the use of the Iron Mountain for off-site storage site as well as electronic record storage. Dr. Contardo stated the Lab is highly regulated and not mentioned in either policy. He stated the Lab utilizes the most stringent guidelines and applies it across the board. The Committee directed Mr. Moser to collapse the Board policy into CHA recommendation guidelines and bring forward to next month's meeting.	General Counsel to draft revisions to Board Policy 14-088 to provide consistency with Administrative Policy 8610-237. Revised policy to be discussed at November committee meeting.	General Counsel
7. Discussion regarding Current Legislation	Chairman Schallack reported the legislature is out of session however he reported on three bills which were passed by the Legislature and later vetoed by the Governor including SB1094 related to the Attorney General's right to amend the sale or transfer of transactions of non-profit hospitals up to five years after the sale is completed, AB2616 would create a workers' compensation presumption for MSRA infection claims for specific hospital employees and SB455 related to nurse-patient ratios.	Information only.	
8 Review of FY2015 Committee Work Plan	The FY2015 Committee Work Plan was included in today's meeting packet for reference. Chairman Schallack explained the Governance Committee Work	Information only.	

Governance & Legislative Committee Meeting

-6-

October 7, 2014

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	Plan does overlap with the Board of Directors Work Plan.		
9. Committee Communications	Director Finnila welcomed the new members to the committee.	Information only.	
10. Community Openings – One	There is currently one opening on the committee.	Vacant seat is currently being advertised.	Ms. Donnellan
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, November 4, 2014 at 12:30 p.m.	None.	
12. Adjournment	Chairman Schalloock adjourned the meeting at 2:09 p.m.		

TRI-CITY HEALTHCARE DISTRICT

COMMUNITY HEALTHCARE ALLIANCE COMMITTEE (CHAC) COMMITTEE CHARTER

The Community Healthcare Alliance Committee (the “CHAC”) of the Tri-City Healthcare District (“District”) has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

CHAC is to provide governance oversight and to make recommendations to the District’s Board of Directors (“Board”) in four key areas:

1. Outreach opportunities to District residents with services, programs, or facilities that meet demonstrated health-related needs and result in measurable improvement in the health of the community;
2. Establishment of a strategic alliance between the District and the community by discussing the community’s concerns, healthcare needs, and short- and long-range planning of services;
3. Grant-funding opportunities to help healthcare-related non-profit organizations that benefit District residents and further the District’s Mission of “advancing the health and wellness of those we serve”;
4. Allocation of discretionary funds, in addition to the grant funds listed above, to meet demonstrated community healthcare needs if determined by the Board to be vital and necessary.

II. Guiding Principles

The CHAC operates under the following guiding principles:

1. Healthcare-related needs are defined broadly and are not limited to those addressed only by traditional healthcare facilities and providers;
2. The District should drive its outreach efforts based on the needs of those who reside within the boundaries of the District;
3. There are limited human and capital resources with which to meet the healthcare needs of the population of the District;
4. An annual plan and budget shall be established, within the District’s Strategic Plan and budget, that prioritizes the needs to be addressed;
5. Targeted activities shall be measurable and regularly reported;

6. The District may act alone or may collaborate at times with others to address community needs within the District;
7. The CHAC shall effectively interface between the TCHD Board of Directors and Administration.

III. Membership

CHAC shall have 25 voting members: three Directors; three community members representing residents of Carlsbad, Oceanside and Vista; one representative appointed by the Mayors of Carlsbad, Oceanside and Vista (three in all) notwithstanding Board Policy 10-031; one representative appointed by the Chambers of Commerce of Carlsbad, Oceanside and Vista (three in all); one representative appointed by the Superintendents of the Carlsbad, Oceanside and Vista Unified School Districts (three in all); one representative appointed by the Senior Commissions of Carlsbad, Oceanside and Vista (three in all); one public safety representative appointed by the City Managers of Carlsbad, Oceanside and Vista (three in all); one representative of the Medical Staff appointed by the Medical Staff; and three community member residents of Carlsbad, Oceanside, and/or Vista with multicultural expertise including African American, Asian, and Hispanic experience selected by the Board of Directors.

In addition, community healthcare organizations shall be represented by three non-voting members, one each appointed by the Vista Community Clinic, North County Health Services, and County of San Diego Health and Human Services Agency.

Members representing key constituencies shall be selected by the organizations they represent and serve at the pleasure of the appointing authority, subject to the authority of the Chairperson in Section 1, Article V of the District's Bylaws. Such representatives shall not be considered "community members" as described in Board Policy No. 14-031. Term limits and district residency requirements shall not apply to members representing key constituencies. In each instance, a letter of appointment from the appointing authority shall be transmitted to the District in order for the representative to be seated.

Community members shall be selected by the Board, and meet all requirements prescribed in Board Policy No. 14-031.

A quorum of CHAC shall consist of a minimum of 13 members.

IV. Meetings

The Committee may establish its own meeting schedule annually.

V. Minutes

CHAC will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

VI. Reports

CHAC will report regularly to the Board regarding (i) all determinations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations submitted to the Board for action.

VII. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at <http://www.tricitymed.org/about-us/code-of-conduct/> and shall comply with all provisions thereof while a member of this Committee.

Approved: BOD 11/6/14

Topic	Discussion	Action Follow-up	Person(s) Responsible
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DRAFT

6. New Business a. Annual review of Committee Charters – ➤ Community Healthcare & Alliance Committee	<p>Chairman Schallock explained the Community Healthcare & Alliance Committee has reviewed their Charter and the Charter is coming forward today for review to be followed by approval of the Board of Directors.</p> <p>The committee did not have any additional recommended changes.</p> <p>It was moved by Dr. Contardo to recommend the Community Healthcare & Alliance Committee Charter be brought forward for Board approval. Mr. Burch seconded the motion. The motion passed unanimously.</p>	<p>Recommendation to be sent to the Board of Directors to approve the Community Healthcare & Alliance Committee Charter as presented; item to appear on next Board agenda and included in Board Agenda packet.</p>	Ms. Donnellan
b. Medical Staff Rules and Regulations Review	<p>Chairman Schallock explained the Board of Directors is tasked with approving the Rules and Regulations of the Medical Staff that are adopted by other Medical Staff Committees. General Counsel recently observed the revisions to Rules and Regulations were not coming forward to a Board Committee prior to Board approval.</p> <p>Dr. Contardo provided perspective on the process, explaining the Rules and Regulations contained in today's meeting packet are Department and Division specific and there is also a set of policies and procedures that are Medical Staff specific. Dr. Contardo did not recommend making any changes to the Rules and Regulations contained in today's meeting packet.</p> <p>Mr. Moser stated Title 22 is being followed, however the current process does not allow the opportunity for organizational or governance oriented changes.</p> <p>Ms. Donna Dempster, Director of Medical Staff Services stated review by the Governance Committee would delay the approval process by one month. Mr. Moran, CEO explained in an urgent situation, the Medical Executive Committee does have authority to act on</p>	<p>Recommendation to be sent to the Board of Directors that Medical Staff Policy and procedure changes, as well as Departmental Rules and Regulations and Procedures go to the Governance Committee prior to Board approval; item to appear on next Board agenda and included in Board Agenda packet.</p>	Ms. Donnellan

20 (4) F.2.

Topic	Discussion	Action Follow-up	Person(s) Responsible
	<p>behalf of the Medical Staff.</p> <p>Discussion was held regarding whether the Committee's Charter requires a revision to reflect the Committee oversees Medical Staff Rules and Regulations. Mr. Moser did not recommend a change to the Charter but requested a motion on direction. Director Finnilla suggested the Rules and Regulations reflect the dates reviewed by the respective Division and Board.</p> <p>It was moved by Ms. Kern that the Medical Staff be directed to refer all Medical Staff Policy and procedure changes, as well as Departmental Rules and Regulations and Procedures to the Governance Committee prior to Board approval. Director Contardo seconded the motion. The motion passed unanimously.</p>		DRAFT
c. Review of TCHD Bylaws –	<p>Agenda items c. Review of TCHD Bylaws – Article IV, Section 3 and d. Review of Board Policy 14-028 were discussed concurrently. Chairman Schallcock explained the Board Chair or his designee attends the monthly Medical Executive Committee, Auxiliary and Foundation Board meetings without compensation and does so to discuss the Board's business, rather than their own personal agenda. Mr. Moser explained there is a Board policy on compensation and these meetings do not qualify for compensation.</p> <p>Discussion was held regarding Section 9. Removal, Resignation or Vacancy and consequences of not adhering to Board business when attending meetings such as the MEC, Auxiliary and Foundation Board meetings. The committee directed General Counsel to draft revisions to Bylaws Section 9. Removal, Resignation or Vacancy as well as Board Policy #14-028 Authorizing Directors to Represent the District in Advocacy.</p>	General Counsel to draft revisions to TCHD Bylaws Article IV, Section 9 and Board Policy 14-028 – Authorizing Directors to Represent the District in Advocacy. Item to appear on next month's agenda.	

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San Diego, CA 92101
T. 619.238.1900
F. 619.235.0398

TO: Governance & Legislative Committee
Tri-City Healthcare District

FROM: Gregory V. Moser
Natalie V. Mueller

DATE: October 1, 2014

RE: Review of Tri-City Gift Policies

At the request of the Compliance Officer, we reviewed Tri-City Healthcare District's various gift policies for consistency, and to see if we could make the policies more efficient. We examined the following policies: (1) "Distribution of Ticket and Passes to District-Sponsored or Controlled Events and Donated Tickets and Passes," which is Board Policy No. 14-044; (2) the administrative policy "Conflicts of Interest and Acceptance of Gifts;" (3) Compliance Program Manual Policy No. 8610-483; and (4) "Pharmaceutical Vendors," Pharmacy Services Policy Manual Policy No. 8390-10025. These have passed through different committees at different times. We recommend that the Committee consider requesting review by those committees.

Currently, the "Pharmaceutical Vendors" policy, recommended to the Board by the Medical Staff, restricts an employee's acceptance of *any* gift from a pharmaceutical vendor, while the general "Conflicts of Interest and Acceptance of Gifts" policy (which originated in the Ethics, Audit and Compliance Committee) allows employees to accept non-monetary gifts from a vendor up to \$50.00. We recommend at least cross-referencing the policies to make it clear that an employee cannot accept any gift from a pharmaceutical vendor, but that non-monetary gifts from other vendors up to \$50.00 are acceptable. You may also want to ask the Medical Staff to review the pharmacy policy for consistency.

Finally, we note that in May 2014 the Fair Political Practices Commission amended its regulations on travel paid for by third parties for officials to carry out District business, allowing such travel expenses *not to be considered a gift* to the public official if the agency discloses those payments on Form 801, which we provide here. No amendment to any policy is required to take advantage of this regulation.

1. "Distribution of Ticket and Passes to District-Sponsored or Controlled Events and Donated Tickets and Passes," Board Policy No. 14-044.

We recommend updating the code section reference in Section IV "Disclosure Requirements" to accurately reflect the appropriate section. We also suggest addressing disposition of unused tickets distributed to officials under the policy.

2. "Conflicts of Interest and Acceptance of Gifts," Compliance Program Manual Policy No. 8610-483.

We recommend clarifying that Administrative Policy No. 8610-483 is a combination of former policies 8610-462 and 8610-425. We also recommend at least adding a statement to the "Purpose" section of the policy explaining that the policy does not apply to Pharmaceutical Vendors, and directing employees to the Pharmacy Services Policy Manual, Policy No. 8390-10025: "Pharmaceutical Vendors," if the gift is from a pharmaceutical vendor. Lastly, we recommend adding the option of calling the Values Line as a means of reporting a potential conflict of interest under the "Procedures" Section. This is an option for employees in Tri-City's "Code of Conduct" and we recommend providing employees with the same option in your policy. Alternatively, you may consider asking the Board to refer this policy to the Ethics, Audit and Compliance Committee for further review.

3. "Pharmaceutical Vendors," Pharmacy Services Policy Manual Policy No. 8390-10025.

We recommend considering whether to refer this policy to the Medical Staff for review. This policy appears to have gone directly to the Board for approval without consideration by any Board committee. If the Governance Committee reviews this policy, we recommend proposing a disclaimer that the policy only addresses gifts from pharmaceutical vendors, and directing employees to the "Conflicts of Interest and Acceptance of Gifts" policy. We also recommend adding a "Procedures" section to mirror the "Conflicts of Interest and Acceptance of Gifts" policy. Currently, the policy does not offer any guidance to employees on how to report violations of the policy. The procedures should direct employees to the Compliance Officer or Values Line if they have questions about a gift, and instruct employees on reporting receipt of a gift.

4. Tri-City Healthcare District's Compliance "Code of Conduct"

We also recommend revising the Compliance Code of Conduct to reference the correct Conflicts of Interest and Acceptance of Gifts Policy, Policy No. 8610-483. Currently, the Code of Conduct references former Tri-City policies 8610-462 and 8610-425. Again, this policy did not pass through the Governance Committee before. Consequently, a referral to the Board suggesting review by the Ethics, Audit and Compliance Committee may be appropriate.

Attached to this memorandum are copies of the policies with our suggested revisions.

GVM

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

BOARD POLICY #14-044

**POLICY TITLE: Distribution of Tickets and Passes to District-Sponsored or
Controlled Events and Donated Tickets and Passes**

This Policy provides a framework for the District's distribution of tickets or passes to District officials and others to attend District-sponsored or controlled events, as well as distribution of tickets or passes which are donated to the District. This Policy is authorized by 2 Cal. Code Regs. § 18944.1. This Policy is intended to be consistent with the Fair Political Practices Commission's regulations regarding gifts and behested payments, but this Policy does not supplant or replace those regulations.

I. DEFINITIONS

- A. "Official" includes members of the Board of Directors, officers, employees and consultants of the District, as defined under the Political Reform Act and its regulations. "Official" also any person required to file an annual Statement of Economic Interests (Form 700) under the District's conflict of interest code.
- B. "Immediate family" means the spouse or registered domestic partner and dependent children, of an Official.

II. APPLICATION

- A. This Policy applies to tickets or passes provided to an Official by the District when:
 - 1. The ticket or pass is to a facility, event, show or performance for an entertainment, amusement, recreational, or other similar purpose, such as a ticket or pass to a tennis tournament, marathon or theater production. This Policy does not apply to a ticket or pass if the only benefit received at the event is food and beverages, such as a dinner or luncheon; and
 - 2. If the ticket is donated to the District by an outside source,
 - a. the ticket or pass is not earmarked by that source for use by a particular Official, and
 - b. the District determines, in its sole discretion, which official may use the ticket or pass; or
 - 3. If the ticket is not donated by an outside source, it is obtained by the District (i) pursuant to the terms of a contract for use of public property,

(ii) because the District controls the event, or (iii) by purchase of the District at fair market value; and

4. The District distributes the ticket or pass in accordance with this Policy, including the disclosure requirements.
- B. Officials who receive a ticket may elect to treat the ticket as income consistent with applicable state and federal income tax laws. In such event, the District shall report the distribution of the ticket as income to the official by posting it on FPPC Form 802 on the District's website within 30 days after the distribution.
- C. This Policy does not apply to tickets or passes provided directly to an Official from source other than the District, or tickets for which the Official elects to pay to the District the value of the tickets.
1. In the case of a ticket that provides one-time admission or access, when the Official elects to pay for the ticket, the "value" is the price that was or would have been offered to the general public for the ticket. This will usually be the face value of the ticket.
 2. In the case of a ticket that provides repeated admission or access, such as a season ticket, the "value" to the Official is the fair market value of the actual use of the ticket, taking into account the use by any guests who may be admitted with the ticket, or if the ticket is transferred to another person, the fair market value of possible use by that person.
- D. Benefits received by the Official at the event which are not included in admission, such as food, beverages or any other item presented to the Official at the event, must be reported as gifts by the Official if they exceed the reporting threshold.

III. DISTRIBUTION OF TICKETS

- A. The District's Chief Executive Officer (or his or her designee provided such designation is documented in writing) shall act on behalf of the District under this Policy. The CEO shall manage the receipt, distribution and accounting for all tickets and passes subject to this Policy. The CEO shall determine the value of tickets.
- B. The distribution of any ticket to, or at the behest of, an Official shall accomplish one or more of the following public purposes of the District:
1. Category 1 Public Purposes
 - a. Performance of a ceremonial role or function representing the District at an event.
 - b. The job duties of the Official require his or her attendance at the event.

- c. Promotion of District-controlled or sponsored events, activities or programs.
- d. Promotion of the District on a local, state or national scale.
- e. Encouraging or rewarding District employees.

2. Category 2 Public Purposes

- a. Promotion of healthcare related community programs and resources available to residents within the District's service area.
- b. Attracting or rewarding volunteers at the District's facilities.

- C. The CEO shall give priority in the distribution of tickets or passes for the public purposes in Category 1 Public Purposes, as first priority and Category 2 Public Purposes, as second priority.
- D. The CEO may establish procedures governing the timing and form of requests for tickets consistent with this Policy, provided all such requests shall be required to be in writing.
- E. The CEO may, in his or her discretion, announce the availability of tickets or passes and invite written requests for such tickets or passes. The CEO may make such announcements to any individuals or group of individuals he or she deems appropriate given the public purpose(s) to be accomplished by such distribution.
- F. The CEO shall evaluate any written requests and distribute tickets or passes in his or her discretion provided such evaluation and distribution is consistent with this Policy.
 - 1. The CEO may distribute tickets or passes at the behest of a member of the District's Board of Directors if such behest is for one or more of the public purposes stated in this Policy. No other District official may behest tickets or passes.
 - 2. The CEO may distribute tickets or passes for personal use by an Official's immediate family, or no more than one guest, if such distribution is for one or more of the public purposes stated in this Policy. Officials receiving such tickets shall return any unused tickets to the District, preferably in time for reallocation by the CEO.
 - 3. The CEO may also distribute tickets or passes to individuals, entities or organizations who are not Officials if such distribution is consistent with one or more of the public purposes stated in this Policy.
 - 4. The CEO shall not distribute any tickets or passes to a physician unless such distribution is approved by the Compliance Officer of the District.

- G. In the event there are tickets or passes that have not been distributed in response to written requests, the CEO may donate such tickets to a nonprofit, tax-exempt or governmental organization provided such donation accomplishes one or more of the public purposes stated in this Policy.
- H. An Official who receives a ticket or pass pursuant to this Policy shall not transfer or distribute such ticket or pass to any other person, except to members of the official's immediate family, or no more than one guest, solely for their personal use.
- I. In all circumstances, the CEO may decline to distribute tickets or passes if he or she determines such distribution would not be consistent with one of the public purposes stated herein.

IV. DISCLOSURE REQUIREMENTS

- A. The CEO or his or her designee shall cause a record of the distribution of a ticket or pass to be posted, on FPPC Form 802, in a prominent fashion on the District's website within thirty (30) days after the distribution. The posting shall include all of the information required by 2 Cal. Code Regs. §18944.1(ed). This requirement is satisfied by completing FPPC Form 802. In completing FPPC Form 802, the CEO or his designee shall identify at least one of the applicable public purposes described in Section 3(b) of this Policy.
- B. A copy of this Policy shall be posted in a prominent fashion and maintained on the District's website.

Reviewed by the Gov/Leg Committee: 7/13/11
Approved by the Board of Directors: 7/28/11
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name

Division, Department, or Region (if applicable)

Street Address

Area Code/Phone Number

Email

Agency Contact (name and title)

Date Stamp

California **801**
Form

For Official Use Only

☐ Amendment (explain in comment section)

Date of Original Filing: _____
(month, day, year)

2. Donor Name and Address

☐ Individual

Last Name

First Name

☐ Other

Name

Address

City

State

Zip Code

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

Name \$ Amount Name \$ Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Location of Travel

Dates (month, day, year)

Transportation Provider

☐ Rail

☐ Air

☐ Bus

☐ Auto

☐ Other

Check Applicable Boxes

Name of Lodging Facility

\$ _____
Lodging Expenses

\$ _____
Meal Expenses

\$ _____
Transportation Expenses

\$ _____
Other Expenses

\$ _____
Total Expenses

3.1 (b) Payment(s) not related to travel:

Dates (month, day, year)

\$ _____
Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name

First Name

Position/Title

Department/Division

Last Name

First Name

Position/Title

Department/Division

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature

Print Name

Title

(month, day, year)

Comment:

(Use this space or an attachment for any additional information)

FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

Clear Page

Payment to Agency Report Instructions

A Public Document

California
Form **801**

This form is used to report certain payments received by state and local government agencies. It includes:

- a payment for an official's travel expenses for the purpose of facilitating the public's business in lieu of a payment using agency funds; and
- a payment that would otherwise be considered a gift or income to the benefiting official, but is instead accepted on behalf of the agency.

FPPC Regulations 18944 and 18950.1 provide a procedure that state and local agencies may use to disclose payments used for agency purposes and paid by a third party. The regulations' reporting procedures provide an alternative means to disclose a payment that may otherwise be considered income or a gift to a benefitting employee and subject to reporting on a Statement of Economic Interest, Form 700.

When and Where to File

An agency accepting a payment pursuant to Regulation 18944 and 18950.1 must complete Form 801 for each payment received regardless of the amount. The form must be maintained as a public document. If payments aggregate \$2,500 or more in a calendar quarter, website posting is required.

Website Posting:

State Agencies

Within 30 days after the end of a calendar quarter if aggregated reported payments, for travel and non-travel purposes, total \$2,500 or more:

- the agency must post the reports (or a report summary) on the agency website; and
- forward the information to the FPPC which will also post the information.

Local Agencies

The website posting rules differ for travel and non-travel payments.

Travel

Within 30 days after the end of a calendar quarter if aggregated reported payments total \$2,500 or more:

- the agency must post the reports (or a report summary) on the agency website; and
- forward the information to the FPPC.

Payments Not Related to Travel

The agency's filing officer for Statement of Economic Interests, Form 700, must receive the report. Within 30 days after the end of a calendar quarter if aggregated reported payments total \$2,500 or more, the local agency must post the information on the local agency website. A report is not sent to the FPPC unless the agency does not have a website.

Postings must be displayed in a prominent manner and easily accessible. Reports may be posted earlier.

FPPC: Statements should be emailed to form801@fppc.ca.gov. Statements may also be mailed to 428 J Street, Suite 620, Sacramento, CA, 95814 or faxed to (916) 322-3711.

Part 1. Agency Identification

List the agency's name and address and the name of an agency contact. Mark the amendment box if changing any information on a previously filed form and include the date of the original filing.

Part 2. Donor Information

Disclose the name and address of the donor. If the donor is not an individual, identify the business activity or nature and interests of the entity.

If the donor received funds from other sources that were used in connection with the payment, disclose the name and payment information for each source.

Part 3. Payment Information

Expenses may be rounded to whole dollars.

Section 3.1.a. Itemize travel payments including departure and return dates. Complete all fields, use "n/a" appropriately. Total the expenses for items such as taxi rides, gratuities, and rental cars in the "other" field and describe in the comments section.

Section 3.1.b. Report agency payments that are not travel related.

Section 3.2. Description

All payments must include a specific description of the use of the payment and the intended purpose for agency business. For example, a travel payment may read: Travel to attend an EPA co-sponsored solar energy seminar in Washington D.C.

Section 3.3. Identify Officials

Travel Payments: The name of the position/title and department of each official who used the payment is required. List the official's name if he/she is an elected or appointed official. It is not required to list the names of other officials, rather insert "n/a." Do not leave blank.

Non-Travel Payments: The name, position/title and department of the agency official who used the payment must be identified. All officials' names are required.

Part 4. Verification

Verification of travel payments must be signed by an authorized agency official. Such individuals are those who have the authority to approve similar travel payments when made with agency funds.

Verification of non-travel payments must be signed by the agency head.

Agency Report of:
Ceremonial Role Events and Ticket/Pass Distributions

A Public Document

Agency Name		Date Stamp	California Form 802 For Official Use Only
Division, Department, or Region (If Applicable)			
Designated Agency Contact (Name, Title)			
Area Code/Phone Number	E-mail	<input type="checkbox"/> Amendment (Must provide explanation in Part 3) Date of Original Filing: _____ (Month, Day, Year)	

2. Function or Event Information

Does the agency have a ticket policy? Yes ☐ No ☐ Face Value of Each Ticket/Pass \$ _____

Event Description _____ Date(s) ____/____/____
Provide Title/Explanation

Ticket(s)/Pass(es) provided by agency? Yes ☐ No ☐ If no: _____
Name of Source

Was ticket distribution made at the behest of agency official? No ☐ Yes ☐ If yes: _____
Official's Name (Last, First)

3. Recipients

• Use Section A to identify the agency's department or unit. • Use Section B to identify an individual. • Use Section C to identify an outside organization.

A. Name of Agency, Department or Unit	Number of Ticket(s)/Pass(es)	Describe the public purpose made pursuant to the agency's policy
B. Name of Individual (Last First)	Number of Ticket(s)/Pass(es)	Identify one of the following:
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <i>If checking "Ceremonial Role" or "Other" describe below</i>
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <i>If checking "Ceremonial Role" or "Other" describe below</i>
C. Name of Outside Organization (include address and description)	Number of Ticket(s)/Pass(es)	Describe the public purpose made pursuant to the agency's policy

4. Verification

I have read and understand FPPC Regulations 18944.1 and 18942. I have verified that the distribution set forth above is in accordance with the requirements.

Signature of Agency Head or Designee

Print Name

Title

(Month Day Year)

Comment: _____

Agency Report of: Ceremonial Role Events and Ticket/Pass Distributions

California **802**
Form

A Public Document

This form is for use by all state and local government agencies. The form identifies persons that receive admission tickets and passes and describes the public purpose for the distribution. This form was prepared by the Fair Political Practices Commission (FPPC) and is available at www.fppc.ca.gov.

General Information

FPPC Regulation 18944.1 sets out the circumstances under which an agency's distribution of tickets to entertainment events, sporting events, and like occasions would not result in a gift to individuals that attend the function. In general, the agency must adopt a policy which identifies the public purpose served in distributing the admissions. The Form 802 serves to detail each event and the public purpose of each ticket distribution. FPPC Regulation 18942 lists exceptions to reportable gifts, including ceremonial events, when listed on this form.

When the regulation procedures are followed, persons, organizations, or agencies who receive admissions are listed on a Form 802. Agency officials do not report the admissions on the official's Statement of Economic Interests, Form 700, and the value of the admission is not subject to the gift limit.

The Form 802 also informs the public as to whether the admissions were made at the behest of an agency official and whether the behested tickets were provided to an organization or to specific individuals.

Exception

This form is not required for admission provided to a school or university district official, coach, athletic director, or employee to attend an amateur event performed by students of that school or university.

Public Posting

This form must be maintained as a public document. A copy of all forms must be forwarded to the FPPC for posting on its website. E-mail delivery is preferred. E-mail: Form802@fppc.ca.gov; Fax: 916.322.0886; 428 J Street, Suite 620, Sacramento, CA 95814.

Forms must be sent to the FPPC as soon as possible. General business practice is no later than 45 days from the distribution.

A local agency may also post the forms on its website, but it is not required to do so.

Privacy Information Notice

Information requested by the FPPC is used to administer and enforce the Political Reform Act. Failure to provide

information may be a violation subject to administrative, criminal, or civil penalties. All reports are public records available for inspection and reproduction. Direct questions to FPPC's General Counsel.

Instructions

Part 1. Agency Identification:

List the agency's name. Provide a designated agency contact person, their phone number, and e-mail address. Mark the amendment box if changing any information on a previously filed form and include the date of the original filing.

Part 2. Function or Event Information:

Confirm that your agency has a policy for ticket distribution. Unless the ceremonial role or income box in Part 3, Section B, is marked, this form is only applicable if your agency has a policy.

Complete all of the other required fields that identify the ticket value, description of event, date(s) and whether the ticket was provided by the agency or an outside source. If an agency official behests the tickets, the official's name is also required. Use the comment field or an attachment to explain in full.

Part 3. Ticket Recipients:

This part identifies who uses the tickets. The identification requirements vary depending upon who received the tickets and are categorized into three sections. Each section must list the number of tickets received. Use the comment field or an attachment to explain in full.

Section A. Report tickets distributed to agency staff, other than an elected official or governing board member, pursuant to the agency's policy. It is not necessary to list each employee's name, but identify the unit/department for which the employee works. The agency must describe the public purpose associated with the ticket distribution. A reference to the policy is permissible.

Section B. Report: 1) any agency official who performs a ceremonial role; 2) any agency official who reports the value as income; or 3) tickets used by elected officials and governing board members (including those distributed pursuant to the agency's policy).

Section C. Report tickets provided to an organization. The organization's name, an address (website url is permissible), and a brief description of the public purpose are required.



Tri-City Health Care District
Oceanside, California

Compliance Program Manual

ISSUE DATE: 08/12 SUBJECT: Conflicts of Interest and Acceptance of Gifts

REVISION DATE: 08/12 POLICY NUMBER: 8610-483
(Former Policies 8610-462 & 8610-425)

Human Resources Committee Approval: 08/12
Board of Directors Approval: 08/12

A. PURPOSE:

1. This policy (1) helps policy-making managers and other employees avoid actual, potential, and perceived conflicts of interest; (2) establishes procedures designed to ensure conflicts are properly disclosed and resolved; and (3) provides guidance regarding the acceptability of gifts and gratuities.

2. This policy does not apply to acceptance of gifts from pharmaceutical vendors. Employees and their Immediate Family Members are prohibited from accepting gifts from pharmaceutical vendors. For TCHD's pharmaceutical vendor policy, see Pharmacy Services Policy Manual, Policy No. 8390-10025: "Pharmaceutical Vendors".

B. GENERAL POLICIES:

1. TCHD's policy-making managers and other employees must devote their best efforts and attention to the performance of their duties and obligations at TCHD, and must avoid and promptly disclose conflicts of interest.
2. Employees shall not use TCHD information, property, or labor for personal gain, or disclose or use TCHD's confidential information for any purpose inconsistent with their official duties.
3. Employees and their Immediate Family Members, are prohibited from accepting monetary gifts or gratuities, or non-monetary gifts costing more than \$50, for their own personal benefit, from anyone doing business with, or seeking to do business with, the District.
4. Employees are prohibited from soliciting gifts for their own personal benefit, of any amount or kind, from anyone doing business with, or seeking to do business with, the District.
5. Employees who receive honoraria (money) for speaking on behalf of the District or for participating in surveys in the course of their duties on behalf of the District must give the money to Tri-City Hospital Foundation to the extent they exceed

associated travel expenses.

6. At the discretion of a department manager or director, gifts such as flowers or food that can be consumed or shared by the employee's coworkers, may be accepted provided the total cost is not greater than \$50 per person. This policy does not preclude employees from sending flowers or modest gifts to one another for the condolence of a death or to celebrate a special occasion.
7. Vendors, patients, visitors, physicians, and employees who wish to show their appreciation or support of TCHD and its employees by means of a substantial gift should be referred to the Tri-City Hospital Foundation.

C. DEFINITIONS:

1. Conflict of Interest. A conflict of interest occurs when an individual is in a position to control or influence a business decision and has a personal, financial, or other competing interest in the outcome of the decision.
2. A competing interest arises when an individual, or his/her immediate family member, stands to gain or lose - directly or indirectly - as a result of the outcome of the matter or decision.
3. Immediate Family Member. This term means a spouse or civil union partner, natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and the spouse of a grandparent or grandchild.

D. EXAMPLES:

The following is a non-exhaustive list of examples of Conflicts of Interest:

1. An employee is a partner in an entity seeking to do business with TCHD.
2. A manager provides confidential information to a patient to encourage a lawsuit against TCHD.
3. An employee suggests TCHD hire a firm owned by her spouse to create hospital signage.
4. An employee purchases property for the purpose of selling it to TCHD.
5. A manager pressures a subordinate to hire a friend or relative.
6. An employee commits TCHD to contract with a bank in exchange for a decreased interest rate on her car loan.

E. PROCEDURES:

1. All employees who believe they may have a Conflict of Interest, as described in this policy with respect to any District matter or decision must bring this concern to the

immediate attention of the Compliance Officer, or the Values Line (800) 273-8452.

2. ~~_____~~ The Compliance Officer will review all Conflict of Interest disclosures and provide a written determination and instruction with respect to compliance with this policy.
3. The failure to fully, accurately, and promptly disclose actual, potential, or perceived Conflicts of Interest may result in disciplinary action, up to and including termination.

F. SCOPE OF POLICY:

2. This policy establishes rules for employee conduct that supplement and do not replace or excuse non-compliance with conflict of interest laws applicable to policy-making management and other employees of the District under California or Federal laws.
3. Review of a disclosure by and receipt of instructions from the Compliance Officer do not relieve any employee from adherence to other applicable laws and policies governing local healthcare district employees, including but not limited to:
 - a. Limits on positions and ownership interests in competing hospitals (Health & Safety Code section 32110);
 - b. Disclosure and disqualification from participating in governmental decisions as a designated person under the District's conflict of interest code under the Political Reform Act;
 - c. Prohibitions on making contracts which may affect personal finances under Government Code section 1090;
 - d. Use of confidential information for personal gain under Government Code section 1098;
 - e. Engaging in inconsistent, incompatible, or conflicting employment activities or enterprises, as proscribed by Government Code section 1126.

TRI-CITY MEDICAL CENTER
Oceanside, California

PHARMACY SERVICES POLICY MANUAL

ISSUE DATE: 11/11

SUBJECT: Pharmaceutical Vendors

REVISION DATE:

POLICY NUMBER: 8390-10025

REVIEW DATE:

APPROVAL:

Pharmacy and Therapeutics Committee:

3/20/12 Medical Executive Committee: 3/26/12

Board of Directors: 3/30/12

A. Purpose

1. Interactions between medical centers and industry are vital to public health, but they must be conducted in a way that is principled and upholds the public trust.

2. The purpose of this policy is to address the specific interactions between Tri City Medical Center ("TCMC") personnel and the pharmaceutical vendor industry.

3. This policy does not address gifts to TCMC employees and their immediate family members from other vendors doing business with, or seeking to do business with TCMC. For TCMC's general gift policy, see Compliance Program Manual, Policy No. 8610-483: "Conflicts of Interest and Acceptance of Gifts Policy".

B. Definitions of Gifts

1. A gift is defined as anything of value that is given by a business or individual that does or seeks to do business with TCMC and for which the recipient neither paid nor provided services.
2. Gifts may include but are not limited to:
 - a. Cash in any amount
 - b. Any product or service, or discounts on products or services
 - c. Prizes
 - d. Gift certificates
 - e. Tickets
 - f. Loans
 - g. Meals, Food or Beverages
 - h. Transportation
 - i. Hotel accommodations
 - j. Use of company vehicles or vacation facilities
 - k. Stocks or other securities, participation in stock offerings
 - l. De minimis items, e.g. trade show trinkets distributed to large numbers of people by vendor representatives. This does not include materials of de minimis value which have a clear educational value, such as patient-friendly booklets.
 - m. Group items or services from vendors meant to be shared by all members of the staff, (e.g. flowers or chocolates)

- n. Vendor invitations to be their guest at charitable events whether or not sponsored by Tri City Medical Center
- o. Promotional items such as pens, pads or other office supplies featuring product or company names

C. Special Examples

1. Food provided by a pharmaceutical representative during an in-service is considered a gift and is prohibited.
 - a. This standard applies to events held on TCMC campus.
 - b. Exception to this section would include food provided in connection with a Continuing Medical Education ("CME") accredited program.
2. Textbooks and items of educational value may be provided to the institution if approved by the Department of Pharmacy and may only be give to the Department of Pharmacy for distribution to the clinical staff.
3. Free pharmaceutical samples, supplies, or equipment designated are considered a gift and are prohibited.
 - a. Pharmaceutical samples are not permitted at Tri-City Medical Center for personal use or for distribution to patients or family members. Distributing drug samples would place the individual in a drug dispensing role, subject to applicable laws and regulations.
 - b. The Department of Pharmacy may not receive or dispense any pharmaceutical samples.

D. Act

1. All gifts from vendors, regardless of value are strictly prohibited.
2. Vendors may offer a hospital incentive if a buyer agrees to purchase the vendor's company goods or services. Personal incentives (e.g., merchandise, tickets to special events, vacation trips, etc.) are considered gifts and cannot be accepted under any circumstances.
3. Employees may not accept gifts, gratuities, or compensation in exchange for listening to a sales talk by an industry representative, for prescribing or changing a patient's prescription, or for attending a CME or non-CME activity (unless the individual is a speaker or is otherwise actively participating or presenting at the event).

E. Site Access by Pharmaceutical and Device Manufacturer Representatives

1. In general, industry representative may not interact with TCMC employees on campus. Interactions are allowed in limited circumstances, when the expertise of representatives is required for instruction in the use of a device and a TCMC supervisor, manager, or educator is present to supervise the interaction.
 - a. Under these circumstance representatives must comply with all patient care requirements and wear appropriate clothing and identification that distinguishes them from employed staff.
2. Pharmaceutical representatives may only visit the Department of Pharmacy to discuss and demonstrate their new products. While generally acceptable as straightforward sales visits, an appointment is always required.

3. Representatives are not permitted on campus on a drop-in basis.
4. Representative must use the RepTrax system and may not come onto campus if the Rep Trax system alerts them to unresolved items.
5. Sales representative are not permitted in any patient care areas and may not access any patient - specific information.
6. The Department of Pharmacy shall provide pharmaceutical in-services to physicians and nurses at TCMC
7. Sales representative are not permitted to conduct any in-services at Tri City Medical Center except as outlined below.
 - a. The in-service topic relates to a medication not adequately known by pharmacy services (such as devices and inhaled anesthetics, and radiopharmaceuticals).
 - b. The industry representative providing the in-service must either be a Medical Science Liaison for the product or a registered nurse or medical doctor (MD or DO only).

F. Participation in Industry Sponsored Programs, Speaker's Bureaus, and Consulting

1. Employees may accept only fair market compensation for specific, legitimate services provided by them to industry. The terms of the arrangements, services provided, and compensation must be set forth in writing and signed by both parties.
2. Employees may not accept compensation for listening to a sales presentation (e.g. detailing) by an industry representative.
3. Employees who are simply attending a CME or other instructional activity, and are not speaking or otherwise actively participating or presenting at the meeting, may not accept compensation from companies either for attending or defraying costs related to attending the meeting.
4. Employees must disclose any honorarium or payment received for all industry sources when requesting medication be added to the formulary or before presenting at Pharmacy and Therapeutics Committee meetings.

G. Industry Sponsored Scholarships and Other Educational Funds for Trainees

1. TCMC staff and trainees may not accept scholarships or other special funding directly from a vendor.
2. Vendors may make donations to the Education Department fund through the Foundation; the department will use its own criteria to select trainees to receive support for participation in educational events.
3. Under no circumstance can a trainee be paid by a commercial sponsor to attend an educational event where the trainee is not speaking.
4. For CME/non-CME-certified activities, reimbursement for travel, lodging, honoraria, or personal expense may not come directly from industry.
 - a. Exception to this rule applies only if the attendee is speaking at the event.
5. The policy is not intended to preclude industry support for staff to travel to evaluate major clinical equipment for prospective acquisition by TCMC.

H. Purchasing

1. Staff who are involved in institutional decisions concerning the purchase of or approval of medications or equipment, or the negotiation of other contractual relationships with industry must not have any financial interest (e.g., equity ownership, compensated positions on advisory boards, a paid consultancy or other forms of compensation) in the vendor that might benefit from the institutional decision.
2. This provision is not intended to preclude indirect ownership, through mutual funds or other investment vehicles, of equities in publicly traded companies.
3. Staff must disclose their actual and potential conflicts of interest related to any institutional deliberations and generally may not participate in deliberations in which he or she has an actual or potential conflict of interest.

I. Procedures

1. If an employee has doubts or concerns about whether a gift is acceptable, he or she should contact the Compliance Officer, or the Values Line (800) 273-8452 for a determination.
2. All employees who believe they may have received a gift as described in this policy must bring this concern to the immediate attention of the Compliance Officer, or the Values Line (800) 273-8452.
3. Violation of this policy may result in a disciplinary action against the employee, up to and including termination and/or cessation of business with any vendor in question.



4002 Vista Way, Oceanside, CA 92056-4506 • (760) 940-3001

TO: Larry Schallock, Chairperson
FROM: Scott Worman, M.D., Chief of Staff
DATE: November 6, 2014
SUBJECT: Medical Executive Committee Recommendations

The following documents were reviewed and approved by the Governance Committee on November 3, 2014. These documents are forwarded to the Board of Directors with recommendations for approval.

Department/Divisions Rules & Regulations:

1. Division of Cardiology Rules & Regulations
2. Division of Neonatology Rules & Regulations
3. Department of Ob/Gyn Rules & Regulations
4. Department of Radiology Rules & Regulations

Medical Staff Policies:

1. Name Tags for Health Care Practitioners, 8710-521
2. Physician Surgical Assistant, 8710-536
3. Suspension for Delinquent Medical Record 8710-519

Standardized Procedures:

1. NICU Nurse Practitioner Standardized Procedures

The above recommendations are presented to the Board of Directors for final review and disposition.

SUBMITTED BY:

Scott Worman, M.D., Chief of Staff

Date

GOVERNING BOARD DISPOSITION:

Approved: ☐

Denied: ☐

Julie Nygaard, Secretary
For and on behalf of the TCHD Board of Directors

Date



MEMO

TO: Medical Executive Committee
FROM: Department of Medicine
DATE: October 27, 2014
SUBJECT: Cardiology Rules and Regulations Modification

The following modification to the Cardiology Rules and Regulations is recommended for approval:

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Electrophysiologic Testing and Ablation, right-side only excluding mapping	Completion of subspecialty fellowship training or one-hundred (100) cases, with documentation of forty (40) cases within two (2) years prior to application.	Five (5)	Forty (40)

Approved:

Division of Cardiology: 10/1/14
 Department of Medicine: 10/21/14
 Medical Executive Committee:
 Governance Committee:
 Board of Directors:

TRI-CITY HOSPITAL DISTRICT

Rules & Regulations

Section: Medical Staff

Subject: Division of Neonatology

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I. MEMBERSHIP

- A. The Division of Neonatology consists of physicians who are board certified in Neonatal-Perinatal Medicine by the American Board of Pediatrics or are progressing toward certification.
- B. Applicants who are progressing toward board certification must complete formal training prior to applying for medical staff membership in the Division of Neonatology and must become board certified within four (4) years of the initial granting of medical staff membership, unless extended for good cause by the Pediatrics Department.
- C. Board certified members who were issued certificates in Neonatology after 1989 are required to become re-certified prior to their expiration date to keep their certification current.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Neonatology are:

- A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;
- B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
- C. Conduct, participate in and make recommendation regarding continuing medical education programs pertinent to Division clinical practice;
- D. Review and evaluate Division member adherence to:
 - 1. Medical Staff policies and procedures;
 - 2. Sound principles of clinical practice.
- E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
 - 1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
 - 2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
- F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
- G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
- H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
- I. Approve of On-Going Professional Practice Evaluation Indicators; and
- J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DIVISION MEETINGS

- A. The Division of Neonatology shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Committee, and then to the Medical Executive Committee. .
- B. Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DIVISION OFFICERS

- A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be board certified in Neonatal-Perinatal Medicine.

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- B. The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election.
- C. The Chief shall be elected by a simple majority of the members of the Division.
- D. The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

- A. Be accountable for all professional and administrative activities of the Division;
- B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
- C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
- D. Recommend to the Department of Pediatrics and the Medical Executive Committee the criteria for clinical privileges in the Division;
- E. Recommend clinical privileges for each member of the Division;
- F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
- G. Other duties as recommended from the Department of Pediatrics or the Medical Executive Committee.

VI. MEDICAL DIRECTOR DUTIES

- A. Participate in the development, review, and assurance of the implementation of NICU policies;
- B. Supervise NICU quality control and quality assessment activities, including morbidity and mortality reviews as demonstrated by participating in the bi-monthly M&M conferences for NICU and the quarterly Quality Review Committee for Pediatrics.
- C. Assure NICU staff competency in resuscitation techniques and proficiency in needle aspiration for pneumothorax per Needle Aspiration of Chest for Pneumothorax Standardized Procedure.
- D. Assure ongoing NICU staff education as evidenced by attending, skills labs, monthly education for NICU, attendance at the National NICU Conferences, and attending the Pediatric Ground Rounds on a quarterly basis.
- E. Participate in the NICU budget process.
- F. Provide oversight of neonatal/infant transport to and from NICU and;
- G. Assure maintenance of the NICU database and vital statistics.

VII. ALLIED HEALTH PROFESSIONALS

- A. **Nurse Practitioners: A registered nurse who has specialized advanced skills in diagnosis, assessment, and patient management and is permitted to prescribe certain medications. The nurse practitioner shall function according to standardized procedures developed in collaboration with the supervising physician, who shall be a member of the Department of Pediatrics, and approved by the Department of Pediatrics, Interdisciplinary Practice Committee, Medical Executive Committee and Board of Directors.**

~~VII.~~VIII. PRIVILEGES

- A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

TRI-CITY HOSPITAL DISTRICT

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Section: Medical Staff

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- B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
- C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
- D. ~~Documentation Neonatal Resuscitation Program (NRP) certification is required for all Division members who request privileges within the Division of Neonatology.~~
- E. Requests for privileges in the Division of Neonatology are evaluated based on the physician's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on Division specified criteria. Practitioner's practice only within the scope of their privileges as defined within these Rules and Regulations.
- F. Classification of Newborns:
1. Level 3: Newborns needing intensive care and other infants who have potentially life-threatening illnesses, are otherwise unstable, including those needing ventilator support. Admission criteria per the NICU unit-specific "Admission and Discharge Criteria for the NICU" policy.
 2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
 - i Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
 - ii Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
 - iii Hypoglycemia (without other risk factors, such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
 - iv Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
 - v Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

Neonatology Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients	Training and evidence of current Neonatal Resuscitation Program (NRP) certification	Six (6) admissions and/or consultations	Evidence of current NRP certification
Consultation, including via telemedicine (F)			
Perform medical history and physical examination, including via telemedicine (F)			
Attendance at C-sections and vaginal deliveries, including newborn resuscitation			
Newborn care, Level 2 and Level 3			
Invasive Procedures			
Arterial puncture	Training and evidence of current Neonatal Resuscitation Program (NRP)	Five (5) cases from Invasive Procedures category	One (1) case and evidence of current NRP certification
Bone marrow aspiration or biopsy			Evidence of current NRP certification

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Neonatology Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Central vessel catheterization	certification		One (1) case and evidence of current NRP certification
Endoscopic procedures			Evidence of current NRP certification
Exchange transfusion of neonates			
Interosseous needle insertion			
Intubation/ Infant Thoracentesis/Thoracostomy, Infant			Two (2) cases and evidence of current NRP certification
Lumbar puncture			One (1) case and evidence of current NRP certification
Manometrics – esophageal and colonic			Current NRP evidence of certification
Peripheral arterial catheterization, and umbilical catheterization - artery			FourTwo (24) cases and evidence of current NRP certification
Peripheral IV cutdown			Current NRP evidence of certification
Percutaneous liver biopsy			Current NRP evidence of certification
Suprapubic aspiration			One (1) case and evidence of current NRP certification
Thoracentesis			One (1) case and evidence of current NRP certification
Thoracostomy			One (1) case and evidence of current NRP certification
Umbilical catheterization – artery			Four (4) cases and evidence of current NRP certification
Umbilical catheterization – vein	Four (4) cases and evidence of current NRP certification		
Non-Invasive Procedures			
Care of ventilated patients	Evidence of current Neonatal Resuscitation Program (NRP) certification	Three (3) cases from Non-Invasive Procedures category	Evidence of current NRP certification
Cardiac defibrillation			
Delivery room newborn resuscitation			
Echocardiography			
Elective cardioversion			
Electrocardiography (EKG/ECG)			

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Neonatology Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Pneumogram interpretation			Three (3) cases and evidence of current NRP certification
Parenteral hyperalimentation			Ten (10) cases and evidence of current NRP certification
Pericardiocentesis			Evidence of current NRP certification
Pediatric Cardiology Procedures			
Cardiac defibrillation	Successful completion of a fellowship training program in Neonatology or Pediatric Cardiology	Two (2) cases from this category	Ten (10) cases from this category
Consultation, Pediatric Cardiology			
Echocardiography			
Elective cardioversion			
Electrocardiography (EKG/ECG)			
Pericardiocentesis			
Other			
Moderate sedation	See Policy 8710-517 and evidence of current NRP certification	See Policy 8710-517	See Policy 8710-517 and evidence of current NRP certification

VIII.X. REAPPOINTMENT

- A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

IX.X. PROCTORING OF PRIVILEGES

- A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.
- B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s).
- C. **THE MONITOR MUST BE PRESENT FOR THE PROCEDURE FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.**

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- D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
- E. The member shall have free choice of suitable consultants and assistants.
- F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
- G. A form shall be completed by the proctor, and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e. qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.
- H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.
- I. Responsibility of New Medical Staff Member:
 - 1. The applicant must notify the Division Chief (or his designee) at the time a procedure is scheduled. If the Division Chief is not available to observe the procedure, he/she should appoint a designee to observe the procedure.
 - 2. If the procedure must be done as an emergency without proctoring the Division Chief must be informed at the earliest appropriate time following the procedure.

X.XI. UNASSIGNED NEWBORN CALL

- A. Medical Staff members of the Neonatal Division will participate in the Unassigned Newborn call roster.
- B. To participate in the Unassigned Call Roster, the Division members must consistently exhibit timely response. Once notified by Obstetrics Department, the Division member is expected to respond in person to an emergent situation within thirty (30) minutes.
- C. Provisional or Courtesy Staff can be on the unassigned call panel at the discretion of the Division Chair.
- D. When it is discovered that a patient has been previously treated by a Neonatology Division staff member, that member should be given the opportunity to provide further care unless the patient or primary care physician request otherwise.
- E. The physician on-call or his designee, who provides care for an unassigned patient is responsible for the disposition of that patient until discharge.

APPROVALS:

Division of Neonatology: 8/19/14

Department of Pediatrics: 8/19/14

Interdisciplinary Practice Committee: 9/29/14

Medical Executive Committee:

Board of Directors:

TRI-CITY HOSPITAL DISTRICT

Rules & Regulations

Section: Medical Staff

Subject: Department of
Obstetrics/Gynecology

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I. MEMBERSHIP

- A. The Department of Obstetrics and Gynecology consists of physicians who are ~~B~~board ~~C~~certified or actively ~~progressing towards in the process of obtaining board~~ certification by the American Board of Obstetrics and Gynecology and have successfully completed an ACGME/AOA-~~accredited~~~~approved~~ residency training program in Obstetrics and Gynecology. [tp1]

II. GENERAL FUNCTION

The general functions of the Department of Obstetrics and Gynecology shall include:

- A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;
- B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
- C. Conduct, participate in and make recommendations regarding continuing medical education ~~programs~~ pertinent to Department clinical practice;
- D. Review and evaluate Department member adherence to:
1. Medical Staff policies and procedures;
 2. Sound principles of clinical practice.
- E. Submit ~~written~~ minutes to the QA/PI/~~PS~~ Committee and Medical Executive Committee concerning:
1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
 2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
- F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
- G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified.
- H. Recommend-/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
- I. Approve~~al~~ of On-Going Professional Practice Evaluation Indicators; and
- J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DEPARTMENT MEETINGS

- A. The Department of Obstetrics and Gynecology shall meet ~~at the discretion of the Chair, but at least quarterly every other month and in no event shall they meet less than quarterly.~~ [tp2] The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI/~~PS~~ Committee, and then to the Medical Executive Committee.
- B. Twenty-five percent (25%) of the Active Department members, but not less than two (2) members shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

- A. The Department shall have a Chair and Vice-Chair who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department.

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- B. The Department Chair and Vice-Chair shall be elected every year by the Active members of the Department who are eligible to vote. The Chair and Vice-Chair shall be elected by a simple majority of the members of the Department. Vacancies of any officer for any reason shall be filled for the un-expired term through a special election.
- C. The Department Chair and Vice-Chair shall serve a one-year term, which coincides with the Medical Staff year unless ~~they~~ **he/she** resigns, ~~is~~ **are** removed from office, or loses ~~his/her~~ **their** Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIRMAN

- A. The Department Chair~~man~~, and the Vice-Chair~~man~~, in the absence of the Chair~~man~~, shall assume the following responsibilities:
1. Be accountable for all professional and administrative activities of the Department;
 2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.
 3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
 4. Recommend to the ~~Department of Obstetrics and Gynecology and~~ Medical Executive Committee the criteria for clinical privileges in the Department.
 5. Recommend clinical privileges for each member of the Department.
 6. Assure that the quality, safety, and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
 7. Other duties as recommended from the Medical Executive Committee.

B. Initial Criteria Obstetrics and Gynecology:

VI. RENEWAL OF PRIVILEGES

- A. ~~Procedural privileges may be renewed if the minimum number of cases is met over a two-year reappointment cycle from any and all locations where the practitioner has privileges. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. If proctoring requirements are met, the physician may have his/her privileges renewed for a two-year period. If not, the physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).~~

[tp3]

VII. CLASSIFICATIONS

A. PHYSICIAN

1. Members of Department of Obstetrics and Gynecology are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:
 - a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.
 - b. Unexpected complications arise which are outside this level of competence.
 - c. Specialized treatment or procedures are contemplated with which they are not familiar.

B. PHYSICIAN ASSISTANTS (PA)

TRI-CITY HOSPITAL DISTRICT

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1. Physician Assistants may only provide those medical services for which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, ~~and~~ which are delegated in writing by a ~~Supervising~~ physician who is responsible for the patients cared for by that physician assistant, ~~and as~~ **privileges granted.** [tp4]
 - a. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.
 - b. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition, (e.g., surgical assisting).
 - c. A supervising physician shall observe or review evidence of the physician assistant performance of all tasks and procedures as delegated to the physician assistant until assured of competency.
 - d. A physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care.
 - e. Refer to the AHP rules and regulations for further delineation of sponsoring physician's supervision requirements.
 - f. A physician assistant may not admit or discharge patients.
2. The Department of Obstetrics and Gynecology requires a physician co-signature as delineated in the AHPs Rules and Regulations:
 - i. ~~Order(s) and telephone Order(s) may be immediately implemented and physician co-signature required within 24 hours of AHPs order.~~
 - ii. ~~Any medical record of any patient cared for by a physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed, countersigned and dated by the supervising physician within 24 hours.~~
 - iii. ~~The sponsoring physician must review and authenticate any progress note within the medical record of any patient(s) documented by a physician assistant within 24 hours.~~

[tp5]

C. **REGISTERED NURSE FIRST ASSISTANT (RNFA)**

1. A registered nurse first assistant is a healthcare provider who, under the supervision of a physician, performs a variety of pre, intra, and postoperative services for patients undergoing a surgical procedure in the surgical suites. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks **in accordance with privileges granted.** [tp6] The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. The RN first assistant functions under standardized procedures and must adhere to the AHP's rules and regulations.

D. **CERTIFIED NURSE MIDWIFE (CNM)**

1. The midwife (CNM), a dependent allied health professional (AHP), functions under standardized procedures and must adhere to the AHPs rules and regulations. Refer to CNM standardized procedures for specific criteria.

~~VIII.~~ VII.

PRIVILEGES

- A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

TRI-CITY HOSPITAL DISTRICT

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- B.** By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
- C.** **All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.**^[1p7]
- B-D.** The categories and applicable privileges are as follows:
1. Obstetrical
 - i FERN testing and other associated testing within their scope of practice, or for any emergency procedure, which, in the physician's judgment, is deemed indicated.
 2. Gynecological
 3. Maternal-Fetal Medicine
 4. Gynecological-Oncology

Privileges: Obstetrical	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients, including via telemedicine	Training/experience	N/A	N/A
Consultation, including via telemedicine			
Perform H&P (includes pelvic exam and cultures) , including via telemedicine			
Obstetrical Category:			
Amniocentesis	Training/experience 1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN. 2. Documentation of fifty (50) cases reflective of the scope of privileges requested within the previous twenty-four months.	N/A Ten (10) cases, including five (5) concurrent vaginal deliveries, two (2) C-sections	N/A Fifty (50) cases to include: two (2) - C-sections and ten (10) vaginal deliveries.
Basic obstetrical ultrasound			
Breech vaginal delivery			
Cesarean hysterectomy			
Cesarean Section		Two (2) cases	Two (2) cases
Episiotomy, vaginal repair, sphincter repair		N/A	N/A
Evacuation of hydatidiform mole			
Evacuation of pelvic hematoma			
External cephalic version			
Forceps/low forceps/vacuum delivery			
Hemorrhoid excision			
Hypogastric Artery Ligation			
Induction of labor			
Management of intra-uterine fetal demise			
Management of medical complications of pregnancy, preterm labor, pregnancy induced hypertension / eclampsia, pre-eclampsia, and			

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multiple gestation			
Manual removal of placenta			
Operative vaginal delivery - <u>forceps/low-forceps/vacuum delivery</u>			
Perineal laceration, first (fourchette) & second degree lacerations			
Perineal laceration, third & fourth degree			
Postpartum hemorrhage			
<u>Resuscitation of infant</u> [tp8]	Training/experience	N/A	N/A
Suction D&C for termination of pregnancy	Training/experience	N/A	N/A
Transvaginal cervical cerclage			
<u>Tubal ligation, postpartum bilateral</u> [tp9]			
Vaginal Deliveries (Spontaneous, uncomplicated and precipitous term deliveries), and vaginal birth after previous C-section [tp10]		Fifteen (15) cases Five (5) must be concurrent	Ten (10) cases
Privileges: Gynecological Category: Vaginal/Vulvar Surgery			
Anterior/posterior repair with or without placement of mesh	<ol style="list-style-type: none"> 1. Successful completion of an ACGME- or AOA- accredited residency in OB/GYN. 2. Documentation of twenty-five (25) cases from the Gynecological Category (including at least five (5) major abdominal cases) reflective of the scope of privileges requested within the previous twenty-four months. 	N/A Ten cases (10) from the Gynecological Category, including two (2) total vaginal hysterectomies, two (2) total abdominal hysterectomies, and two (2) diagnostic laparoscopies	Twenty-five (25) cases from the Gynecological Category, including two (2) total vaginal hysterectomies, two (2) total abdominal hysterectomies, and two (2) diagnostic laparoscopies reflective of the scope of privileges requested. N/A [tp11]
Biopsy of cervix, vulva, vagina			
Bladder neck suspension			
Cervical cryotherapy			
Closure of vaginal fistula			
Conization of cervix			
Culdocentesis			
Cystoscopy			
Dilation and curettage (D&C)			
Dilation and evacuation (D&E)			
Endometrial ablation			
Hymenectomy			
Hymenotomy			
Hysterosalpingogram (HSG)			
I&D – Bartholin's gland cyst/abscess/marsupialization			
Incision and drainage wound abscess/hematoma			
IUD Insertion/Removal			
Loop electrical excision procedure (LEEP)			
Perineoplasty			
Repair incidental cystostomy			
Repair of recto-vaginal fistula			

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Repair vesico-vaginal fistula			
Sacrospinous ligament fixation			
Simple vulvectomy			
Total vaginal hysterectomy		Two (2) cases	Two (2) cases
Trachelectomy		N/A	N/A
Transvaginal enterocele repair			
Urethral dilation			
Urethral sling (e.g. TVT, TVOT)			
Urethroscopy			
Vaginal bilateral tubal ligation			
Vaginectomy			
Gynecological Privileges Category:			
Abdominal Surgery			
Abdominal sacrocolpopexy	Training/experience	N/A	N/A
Adhesiolysis			
Bilateral tubal ligation			
Bladder neck suspension ^(p 12)			
Evacuation of pelvic abscess			
Evisceration repair			
Exploratory laparotomy			
Incisional hernia repair, concomitant			
Micro tubal surgery			
Myomectomy and metroplasty			
Oophorectomy			
Ovarian cystectomy			
Paravaginal repair			
Pelvic and/or para-aortic lymphadenectomy			
Pelvic lymph-node sampling			
Pre-sacral neurectomy			
Repair of Enterocoele			
Repair surgical rent of bladder/bowel			
Retropubic urethropexy			
Salpingo-oophorectomy			
Salpingostomy/salpingectomy			
Suprapubic cystotomy			
Total Abdominal Hysterectomy		Two (2) cases	Two (2) cases
Tumor Debulking		N/A	N/A
Wedge Resection of Ovaries			
Gynecological Category Privileges:			
Endoscopy/Hysteroscopy-Laparoscopy Surgery			
Appendectomy (incidental)	Training/experience	N/A	N/A
Aspiration of cyst			
Bladder Neck Suspension			
Colposuspension			

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Diagnostic Laparoscopy		Two (2) cases	Two (2) cases
Endometrial ablation		N/A	N/A
Fulguration of lesions			
Laparoscopic Assisted Vaginal Hysterectomy (LAVH)			
Laparoscopic Supracervical Hysterectomy (LSH)			
Laparoscopic treatment of ectopic pregnancy			
Laparoscopic Tubal Ligation			
Lysis of Adhesions			
Myomectomy			
Ovarian Cystectomy			
Removal of Adnexal Structure			
Removal of Meckel's diverticulum (w/consultation)			
Repair of Cystotomy/Enterotomy			
Resection of other uterine masses			
Surgical with or without D&C			
Thermal balloon Ablation			
Total Laparoscopic Hysterectomy (TLH)			
Treatment of Ectopic Pregnancy			
Tubal occlusion for sterilization			
Gynecological Privileges:			
Endoscopy-Hysteroscopy			
Surgery [ip13]			
Endoscopy/Hysteroscopy, diagnostic	Training/experience	N/A	N/A
Endoscopy/Hysteroscopy, endometrial ablation		N/A	N/A
Endoscopy/Hysteroscopy, Resection of other uterine masses			
Endoscopy/Hysteroscopy, surgical with or without D&C			
Endoscopy/Hysteroscopy, thermal balloon ablation			
Endoscopy/Hysteroscopy, tubal occlusion for sterilization			
Gynecologic-Oncology Surgery Category:			
Diagnostic			
Cystoscopy with biopsy	1. Successful completion of an ABOG- or AOA-approved fellowship in Gynecologic Oncology.	N/A Ten cases (10) from the Gynecologic-Oncology Surgery Category, including at	Twelve (12) representative blend of cases from Diagnostic and Therapeutic categories.
Liver Biopsy	2. Board certification in Gynecologic Oncology		
Proctoscopy with biopsy	3. Documentation of twenty-		
Staging laparotomy			

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	five (25) cases current experience either from fellowship (if within previous twenty-four (24) months past 2 years) or another acute care facility.	least two (2) Diagnostic and four (4) Therapeutic procedures. [tp14]	
Therapeutic			
Bladder/ureter/urethra surgery, concomitant		Two (2)	
Chemotherapy administration		N/A	
Colpectomy			
Cystectomy, concomitant			
Cytoreduction for cancer			
Exenteration		One (1)	
Flap closure of perineal defects, myocutaneous flaps, skin grafting		N/A	
Gastrostomy, concomitant			
Ileostomy, concomitant			
Insertion of suprapubic tube			
Intestinal surgery, concomitant			
Lymphadenectomy; pelvic, aortic, inguinal, femoral,, scalene node)		Two (2)	
Medical Management of the cancer patient		N/A	
Radical hysterectomy		Two (2)	
Radical vaginectomy		N/A	
Radical vulvectomy		One (1)	
Repair of vascular injury		N/A	
Salpingoplasty			
Splenectomy, concomitant			
Urinary diversion, concomitant			
Ventral hernia repair, concomitant			
Privileges:			
Maternal-Fetal Medicine (Perinatology)			
Admit patients	Training/experience	N/A Proctoring fulfilled by completion of categorical proctoring. [tp15]	N/A
Consultation	1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN, and;		
Genetic Amniocentesis	2. Successful completion of an ABOG- or AOA-approved fellowship in Maternal-Fetal Medicine	Two (2) cases from this category	Two (2) cases from this category
Chorionic villus sampling			
Cordocentesis			
Intrauterine fetal transfusion			
Criteria to apply for Laser Surgery Privileges:			
Intra-Abdominal Laser Surgery	Initial Appointment	Proctoring	Reappointment

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CO2-Laser	1. Documentation of completion of laser training for each wavelength requested. 2. Documentation of clinical experience with specialized laser surgery or hands-on laboratory experience for each wavelength requested.	One (1)	(every 2 years)
Nd Yag Laser			One (1)
Other:	Initial Appointment	Proctoring	Reappointment (every 2 years)
Sedation: Moderate	Per MS policy #517	Per MS policy #517	Per MS policy #517
Forensic Outpatient Clinic Site-Specific Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Perform history and physical examination (includes pelvic exam and cultures)	Training/experience	N/A Proctoring fulfilled by completion of categorical proctoring [tp16]	N/A
Biopsy: cervical, vulvar, vaginal			
Biopsy: Endometrial			

VIII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Procedural privileges will ~~may be renewed if the minimum number of cases is met over a two-year reappointment cycle from any and all locations where the practitioner has privileges. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. If proctoring requirements are met, the physician may have his/her privileges renewed for a two-year period. If not, The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).~~ [tp17]

IX. PROCTORING

- Each new ~~m~~Medical ~~s~~Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department to the Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors.
- All Active members of the Department will act as proctors. An associate may ~~monitor~~proctor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.
- THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR**

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MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.

- D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
- E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.
- F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
- G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.
- H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case.
- I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

X. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

- A. The Department of OB/GYN will have a Quality Review Committee (Q.R.C.) comprised of no less than four (4) department members. The committee Chairman is the department's representative to the Medical Staff QA/PI/PS Committee. The Department Chairperson shall appoint the remaining members for a two (2)-year term. Committee members are able to succeed themselves. At least one (1) member from each OB/GYN "group" will be on the Q.R.C. if possible. The Q.R.C. will meet at least four (4) times per year.
- B. General Function:
 - 1. The Q.R.C. provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members to OB/GYN patients in the hospital.
- C. Specific Functions. The Q.R.C. is established to:
 - 1. Identify important elements of OB/GYN care in all areas in which it is provided.
 - 2. Establish performance monitoring indicators and standards that are related to these elements of care.
 - 3. Select and approve their performance monitoring indicators.
 - 4. Integrate relevant information for these indicators and review them quarterly.
 - 5. Formulate thresholds for evaluation related to these performance monitoring indicators.
 - 6. Review and evaluate physician practice when specific thresholds are triggered.
 - 7. Identify areas of concern and opportunities to improve care and safety, and provide education to department members based on these reviews.
 - 8. Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate department member in accordance with Medical Staff Bylaws.
 - 9. If needed, request Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice.
 - 10. Monitor and review the effectiveness of any intervention and document any change.
- D. Other functions:
 - 1. Assist in the reappointment process through retrospective review of charts.
 - 2. Review any issues related to OB/GYN that are forwarded for review by other departments.

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3. Assist in the collection, organization, review, and presentation of data related to OB/GYN care, safety, and department clinical pathways.

4. Review cases involving any OB/GYN deaths in the hospital.

E. Reports:

1. Minutes are submitted to the Medical Staff QA/PI/PS Committee and the M.E.C. The Q.R.C. will provide minutes and, as needed, verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to the department members and to QA/PI/PS Committee.

XI. EMERGENCY ROOM CALL

A. Medical Staff Department members within the Department of OB/GYN who have been successfully removed from proctoring for **Obstetrical Category Privileges** (p18) ~~(15) Vaginal Deliveries, (2) Cesarean Section cases~~ and have had (1) Laparoscopic case and (1) Abdominal Hysterectomy case proctored may participate in the Emergency Department call roster or consultation panel as determined by the medical staff or Department Chair or their designee. This does not preclude complying with proctoring requirements as outlined above.

B. Refer to Medical Staff Policy, #8710-520 Emergency Room Call: Duties of the On-Call Physician.

C. When a patient indicates that he or she has been previously treated by a staff member, that member will be given the opportunity to provide further care.

~~C-D.~~ **A patient, including obstetrical patients, who are under 13 weeks pregnant and who has been seen within the last two years by a community clinic primary care provider of the clinic, except for vaccination clinics, must be seen by that clinic provider OB physician on call. Any obstetrical patients greater than 13 weeks with the above-referenced criteria are unassigned patients.** (p19)

~~D-E.~~ The members of the Department of OB/GYN will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, any necessary emergency special care will be provided by the on-call physician.

~~E-F.~~ The care provided by an on-call physician will not create an obligation to provide further care.

~~F-G.~~ The exception to the aforementioned Emergency Department On-Call requirements is North County Health Services call panel.

Approvals:

Department of Ob/Gyn: 10/6/14

Medical Executive Committee:

Board of Directors:

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I. MEMBERSHIP

- A. The Department of Radiology consists of physicians who have a contractual relationship with the hospital to practice Radiology and are board certified **or board eligible and actively progressing towards certification**^(p.1) in Diagnostic Radiology and/or Nuclear Medicine by the American Board of Radiology.
- B. The Department of Radiology, at its sole discretion, may also admit physician assistants (PAs) upon a majority vote of the physician members. These PAs must be certified by their certifying body (National Commission on Certification of Physician Assistants (NCCPA)) or be board eligible and achieve such status within two (2) years of appointment. Each PA must hold a current valid California PA license issued by the Physician Assistant Examination Committee of the Medical Board of California.

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Radiology shall include:

- A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;
- B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
- C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;
- D. Review and evaluate Department member adherence to:
 - 1. Medical Staff policies and procedures;
 - 2. Sound principles of clinical practice.
- E. Submit written minutes to the QA/PI/PS Committee and Medical Executive Committee concerning:
 - 1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
 - 2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
- F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
- G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
- H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
- I. Approve On-Going Professional Practice Evaluation Indicators; and
- J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.
- K. Establish protocols for the supervision of Physician Assistants.

III. DEPARTMENT MEETINGS

The Department of Radiology shall meet at least quarterly or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI/PS Committee, and then to the Medical Executive Committee.

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Twenty-five percent (25%) of the Active Department members, exclusive of teleradiology providers, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

The Department shall have a Chair who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department.

The Department Chair shall be elected every year by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department.

The Department Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

- A. Be accountable for all professional and administrative activities of the Department;
- B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
- C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
- D. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
- E. Recommend clinical privileges for each member of the Department;
- F. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
- G. Other duties as recommended from the Medical Executive Committee.

VI. CLASSIFICATION: Privileges in the Department of Radiology are divided into the following categories:

- A. Diagnostic Radiology - Diagnostic radiologists use x-rays, radionuclides, ultrasound, and electromagnetic radiation to diagnose and treat disease. Physicians are eligible for privileges in all routine radiographic and fluoroscopic procedures, and minor procedural components attendant to them as outlined in the Physician Privilege Table. All Diagnostic Radiologists may remotely interpret (teleradiology) diagnostic images.
- B. Nuclear Medicine - Specialists in nuclear radiology use the administration of trace amounts of radioactive substances (radionuclides) to provide images and information for making a diagnosis. Members trained and certified only in Nuclear Medicine are eligible for only Nuclear Medicine privileges.
- C. Interventional Radiology – Specialists in vascular and interventional radiology diagnoses who treat diseases with use of various radiologic imaging technologies, including fluoroscopy, digital radiography, computed tomography (CT), sonography, and magnetic resonance imaging (MRI). Physicians are eligible for interventional radiology procedures if they meet the credentialing criteria as outlined in the applicable Medical Staff policies/rules (see Interventional Privileges section of the Physician Privilege Table).
- D. Teleradiology – Remote interpretation of diagnostic images for emergency, after hours and consultation purposes. Teleradiology only privileges are identified in the Physician Privilege Table.

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- E. Physician Assistants (PA) - A PA may provide medical services that are consistent with his/her education, training, and experience, and PA regulations as outlined in the PA's Delegation of Services Agreement. PAs are also subject to the Allied Health Professional Rules and Regulations. The Physician Supervision requirement (defined by Business and Professions Code Section 3502) is met by the use of protocols as designated in their Delegation of Service Agreement.
- F. Nurse Practitioner (NP) - Nurse practitioners may provide medical services that are consistent with their education, training, and experience, and are outlined in the Standardized Procedures for a NP in the Radiology Department. Nurse practitioners are also subject to the Allied Health Professional Rules and Regulations.

VII. PRIVILEGES

- A. Request for privileges in the Department of Radiology shall be evaluated on the bases of the member's education, training, experience, demonstrated professional competence and judgement, clinical performance and documented results of patient care and monitoring.
- B. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
- C. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
- ~~C-D.~~ **All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.**^[tp2]
- ~~D-E.~~ Sites:
 1. All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
 2. Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside, CA 92056.

Physician Privilege Table

Physician Privilege Table			
Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients	Board certification or board eligible and actively progressing towards certification ^[tp3] None None None	Proctoring satisfied upon completion of proctoring for History and physical examination. ^[tp4] None None	None None None
Consultation, including via telemedicine (F)			
History and physical examination ^[tp5] , including via telemedicine (F)		None None	
General Diagnostic Radiology and Fluoroscopy			
Arthrography/arthrocentesis/injection	Board certification or board eligible and actively progressing	Twenty-five (25) representative blend of cases	Fifty (50) representative blend of cases
Breast biopsy			
Computed tomography			
General diagnostic/fluoroscopy			
Hysterosalpingography			

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Lumbar or C1-2 puncture/myelography	towards certification ^[tp6]		
Lymphocintigraphy			
Magnetic resonance imaging/spectroscopy			
Mammography			
Nuclear medicine (all routine)			
Positron emission tomography (PET)			
Radionuclide cysternography and shunt studies			
Sialography			
Ultrasonography/hysterosonography			
Vascular duplex ultrasound			
Venography			
Special Nuclear Medicine Procedures – Members of the Department trained and board certified only in Nuclear Medicine are eligible for Nuclear Medicine privileges only.			
Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
I-131 therapy for thyroid cancer or for hyperthyroidism	Board certification or board eligible and actively progressing towards certification ^[tp7]	Three (3) cases representative blend	Five (5) representative blend of cases
Radionuclide therapy low dose < 33 mCi			
Radionuclide therapy high dose > 33 mCi			
P-32 intravenous or intracavitary			
Immune imaging (Zevalin, etc.)			
Teleradiology (for Stat-Rad only; all non-Stat-Rad practitioners use General Diagnostic Radiology and Fluoroscopy privileges)			
Computed tomography	25 cases General Radiology and 10 Ultrasound, 10 Tomography, 10 MRI, and 10 Nuclear Medicine	Twenty-five (25) representative blend of cases	Fifty (50) representative blend of cases
General radiology			
General nuclear medicine			
Magnetic resonance imaging			
Ultrasonography			
Peripheral Vascular Interventional Procedures			
Peripheral angiography (extremity, visceral, thoracic, pulmonary, carotid, cerebral)	Refer to Policy 8710-504	Refer to Policy 8710-504	Refer to Policy 8710-504
Peripheral intervention (angioplasty, stent placement, thrombolysis, embolization, drug infusion, stent graft, chemoembolization, etc.)			
Venography and venous intervention (venous thrombolysis, tPA, stent, IVC filter, venous sampling, transjugular intrahepatic portosystemic shunt (TIPS), venous access procedures (Ports, Midline catheters, Tunneled lines))			

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Interventional Procedures			
Endovascular AAA repair	Refer to Policy 8710-503	Refer to Policy 8710-503	Refer to Policy 8710-503
Vertebral Augmentation	Refer to Policy 8710-534	Refer to Policy 8710-534	Refer to Policy 8710-534
GI/Biliary Intervention (includes Gastrostomy/Enterostomy, GI Stent, Biliary Drain/Stone removal, Dilation, Stent, etc.	Completed fellowship training in interventional radiology or diagnostic radiology with appropriate experience and acceptable outcomes	Two (2) cases	Twenty (20) representative blend of cases
Genito-Urinary Intervention (includes Nephrostomy, Ureteral Stent, Stone Removal, Tract Dilation, Endopyelotomy, etc.		Two (2) cases	
Biopsy/Drainage Intervention (includes all biopsy, aspiration and drainage procedures		Two (2) cases	
Tumor Ablation Intervention (includes ablation by injection or Radiofrequency probe, Brachytherapy with implantable seeds			
Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders (including: Coil Occlusion of intracranial aneurysms, treatment of AV Malformation or Fistulas)	Refer to Policy 8710-530	Refer to Policy 8710-530	Refer to Policy 8710-530
Pain Management PrivilegesSpecial Procedures	Refer to Policy 8710-541		
Discogram	Refer to Policy 8710-541	Refer to Policy 8710-541	Refer to Policy 8710-541
Radiofrequency Thermocoagulation lesion ablation (RFTC)			
Intradiscal electrothermal annuloplasty			
Implantables^[tp8]			
Sedation Privileges			
Moderate sedation	Refer to Policy 8710-517	Refer to Policy 8710-517	Refer to Policy 8710-517
Deep sedation			

Physician Assistant Privilege Table			
General Patient Care Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Perform history and physical examination	Per AHP Rules and Regulations	Ten (10) cases to include therapeutic procedures	Satisfactory evaluation by supervising physician
Furnish drugs consistent with the TCMC formulary and as outlined in the standardized procedures and protocols			
Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained			

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prior to furnishing medication			
General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)			
Recommend therapeutic diets and exercise			
Provide patient education and counseling			
Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the practitioner's knowledge and/or skills, or for those conditions that require consultation			
Therapeutic Procedures – A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.			
Bone Marrow Biopsy, image guided	Per AHP Rules and Regulations. Competency in these procedures will be determined by the Division of Radiology, taking into account training, experience and other post-graduate training.	Five (5) cases	Satisfactory evaluation by supervising physician
Central line insertion: femoral lines		Three (3) cases	
Central line insertion: PICC lines		Three (3) cases	
Lumbar Puncture, image guided		Three (3) cases	
Paracentesis		Three (3) cases	
Abscess drainage tube manipulation/resuturing		Proctoring satisfied upon completion of General Patient Care Privileges proctoring. ^[tp9] N/A	
Chest tube removal			
Keo feeding tube insertion/nasogastric tube insertion			
Liver biopsy, image guided			
Peripheral IV line insertion			
Removal of drains and/or tubes			
Removal of tunneled catheters			
Removal of venous port (Mediport)			
Subcutaneous local anesthesia			
Suturing and suture removal			
Moderate Sedation	Refer to Policy 8710-517	Refer to Policy 8710-517	Refer to Policy 8710-517

Nurse Practitioner Privilege Table

General Patient Care Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Perform history and physical examination	Per AHP Rules and Regulations	Ten (10) cases to include therapeutic procedures	Satisfactory evaluation by supervising
Furnish drugs consistent with the TCMC formulary and as outlined in the			

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standardized procedures and protocols			physician
Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication			
General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)			
Recommend therapeutic diets and exercise			
Provide patient education and counseling			
Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the practitioner's knowledge and/or skills, or for those conditions that require consultation			
Therapeutic Procedures – A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.			
Central IV access: femoral line insertion	Per AHP Rules and Regulations. [tp10] Competency in these procedures will be determined by the Division of Radiology, taking into account training, experience and other post-graduate training.	Three (3) cases	Satisfactory evaluation by supervising physician
Central IV access: PICC line insertion		Three (3) cases	
Lumbar Puncture		Three (3) cases	
Paracentesis		Three (3) cases	
Abscess drainage tube manipulation/resuturing		Proctoring satisfied upon completion of General Patient Care Privileges proctoring. [tp11] N/A	
Chest tube removal		N/A	
Keo feeding tube insertion/nasogastric tube insertion		N/A	
Peripheral IV line insertion		N/A	
Removal of drains and tubes		N/A	
Removal of tunneled catheters		N/A	
Removal of venous port (Mediport)		N/A	
Suturing and suture removal		N/A	
Subcutaneous local anesthesia		N/A	

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

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VII. PROCTORING OF PRIVILEGES

- A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.
- B. All Active members of the Department will act as proctors.
- C. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.
- D. **THE MONITOR MUST BE PRESENT IN THE PROCEDURE ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACITIONER'S COMPETENCE.**
- E. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
- F. The member shall have free choice of suitable consultants and assistants. The proctor may assist the member.
- G. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
- H. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.
- I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

VIII. EMERGENCY DEPARTMENT CALL

Active department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. The Department Chair will be responsible for maintaining adequate coverage of the Emergency Department. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional or Courtesy staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Department.

APPROVALS:

Department of Radiology: 10/7/14
| **Interdisciplinary Practice Committee: 10/20/14**
Medical Executive Committee:
Board of Directors:

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/01

SUBJECT: Name Tags for Health Care
Practitioners

POLICY NUMBER: 8710 – 521

A. PURPOSE:

1. ~~To outline the requirements for name badges for Medical Staff members and Allied Health Professionals (AHP) in accordance with the provisions of California Business & Professions Code Section 680., this policy is to identify guidelines for health care practitioner to disclose his or her name and license status, as granted by the State, on a name badge in at least 18-point type and wear the badge while in the hospital.~~
To outline the requirements for name badges for Medical Staff members and Allied Health Professionals (AHP) in accordance with the provisions of California Business & Professions Code Section 680., this policy is to identify guidelines for health care practitioner to disclose his or her name and license status, as granted by the State, on a name badge in at least 18-point type and wear the badge while in the hospital.

B. DEFINITION:

1. ~~A health care practitioner is an individual licensed by the State of California to provide health care to patients in any setting.~~
A health care practitioner is an individual licensed by the State of California to provide health care to patients in any setting.

C. B. GUIDELINES/REQUIREMENTS:

1. ~~Any~~**All** health care practitioners who ~~has~~**have** been granted membership ~~and~~**and/or** clinical privileges ~~to the Medical Staff~~ must wear ~~a~~**a** name badges.
- 1.2. The name badge must disclose his/her name ~~per license/credential~~**per license/credential**, licensure status ~~as~~**as granted by the State**, and photo.
- 2.3. This name badge must be in at least 18-point type font.
- 3.4. The name badge must be worn and visible while providing care in the hospital.

Approvals:

Medical Executive Committee Approval: 09/11
Board of Directors Approval: 09/11

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 10/05

SUBJECT: Physician/**Podiatrist** Surgical
Assistant

REVISION DATE: ~~3/08; 5/13~~

POLICY NUMBER: 8710 – 536

A. **PURPOSE:**

1. To provide credentialing criteria for **non surgeon physicians and podiatrists in non-podiatric cases MD, DO, and Podiatrist, who are not surgeons**, to act as surgical first assistants.
- ~~1. Physicians and podiatrists may act as a surgical first assistant on any procedure in which they have been granted.~~

B. **DEFINITIONSCOPE OF PRIVILEGES:**

1. ~~Physician Surgical First Assistant:~~ Provides aid in exposure, hemostasis, use of surgical instruments on tissues, and other technical functions to help the surgeon carry out a safe operation.

C. **CREDENTIALING CRITERIA:**

1. Letter(s) of reference from individual responsible for formal training and/or a surgeon who is familiar with the physician's experience as a surgical first assistant; **and**
 - ~~2.a.~~ Completion of a surgical residency from a program accredited by the Accreditation Council for Graduate Medical Education (**ACGME**); **or**
 - ~~3.b.~~ Completion of a surgical rotation during internship training of at least (six weeks) in duration; **or**
 - ~~4.c.~~ A licensed Doctor of Podiatric Medicine, (~~licensed after 1984~~).

D. **PROCTORING:**

1. A minimum of **three** (3) cases in which the physician acts as the surgical first assistant shall be proctored by the primary surgeon. There should be at least **two** (2) different primary surgeons.

E. **REAPPOINTMENT:**

1. A minimum of **three** (3) cases as a surgical first assistant ~~should~~**shall** be performed ~~during the per~~ two-year reappointment cycle. Quality assurance mechanisms ~~should~~**will** be applied and considered in the reappointment process.

~~F. REFERENCES:~~

- ~~1. Clinical Privilege White Paper: Practice Area 180 – Surgical First Assistant~~

Approvals:

~~Medicine Division~~**Credentials Committee** Approval: 10/8/14

Medical Executive Committee Approval:

Board of Directors Approval: 03/08



Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 7/01

SUBJECT: **Delinquency Status Suspension for Delinquent Medical Records**

REVISION DATE: 3/05, 4/06, 3/07, 7/07, 3/08, 9/09,
10/14

POLICY NUMBER: 8710 – 519

Medical Division Approval: 09/09

Medical Executive Committee Approval: 09/09

Governance Committee:

Board of Directors Approval: 03/08; 09/09

A. PURPOSE:

1. This statement outlines the steps taken to obtain completion of a medical record and follow-up mechanisms that have been established to ensure timely completion of the deficiency.

B.A. POLICY:

1. It is the policy of Tri-City Medical Center **and its Medical Staff** to ensure that all medical records are completed in a timely manner, **and reflects the care provided to the patient in accordance with Medical Staff Policy 8710-518, Medical Record Documentation Requirements, applicable laws, and accreditation standards.**
2. Dictations not completed within 14 days of notification are identified as Delinquent
3. Signatures not completed within 30 days of notification are identified as Delinquent

C. RESPONSIBILITIES:

1. **Medical Records Department**
 - a. The Medical Records department is responsible for reviewing medical records and identifying the deficiencies that exist on the record. These deficiencies are based upon the Medical Record Documentation Requirements Policy and Procedure. Deficiencies that require completion are assigned to the physician by the Medical Record Technicians in the Processing section.
 - b. The Medical Records department will monitor physician compliance with completion of records and make appropriate notifications to ensure completion. Ongoing reporting of physician completion activity will be reported to the Medical Records Committee of the Medical Staff.
2. **Medical Staff**
 - a. It is the responsibility of the members of the Medical Staff to ensure that a complete and accurate record is recorded for all patients treated in the facility and to respond to notifications regarding records having documentation deficiencies.
 - i. Physician use of the Inbox application in the Corner system is required for documents filed in the Compass system (e.g. transcribed reports, scanned documents, etc.).
 - ii. Physician authentication of paper-based documents requires signature on the hard copy document maintained in the Medical Records department.

PROCEDURE:

1. Applicable TCMC departments shall enforce pre-procedure requirements for History and Physical exam, as outlined in Medical Staff Policy 8710-518, **Medical Record Documentation Requirements.**

2. In order to facilitate timely medical record completion and appropriate practitioner notification, the TCMC IT Department shall develop and implement such automated notification mechanisms as requested by the Medical Records/HIM Department.
3. The Medical Records/HIM Department is responsible for reviewing medical records and identifying deficiencies of dictations and signatures, as outlined in *Medical Record Documentation Requirements*.
4. The practitioner is responsible for identifying any error(s) in assigned dictations/signatures by “refusing” the item within the Cerner Message Center, and indicating the appropriate practitioner if possible.
5. The Medical Records/HIM Department will run a weekly report to identify dictations and signatures that are not complete following patient discharge.
 - a. A letter will be initiated to each practitioner weekly when the practitioner has any deficiencies aged 7 days from discharge. A second communication will be sent at 10 days post discharge.
6. Each week the Medical Records/HIM Department will submit to the Chief of Staff (via the Medical Staff Office) a list of verified deficiencies that have reached the point of 14 days post discharge, and thus are delinquent.
7. As directed by the Chief of Staff, the Medical Staff Office shall prepare and send Notice of Automatic Limited Suspension; the suspended practitioner shall also be called by the Medical Staff Office and advised of the limited suspension.
8. Limited suspension shall apply to the practitioner’s right to admit, treat or to provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the practitioner has already admitted or has scheduled to treat or to perform any invasive procedure. Obligations to fulfill ED On-Call duties as per existing schedule shall remain in effect.
9. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available.
10. The suspension shall continue until the medical records are completed or suspension lifted by the Chief of Staff or his designee.
11. Bona fide vacation or illness may constitute an excuse, subject to the approval of the Medical Executive Committee.
12. The Medical Staff Office shall notify Medical Records/HIM, IT, Surgery, Administration, Admitting, Cardiology and Radiology of the automatic suspension.
 - a. Each of these departments is responsible for enforcing the suspension.
 - b. Any questions shall be directed to the Chief of Staff via the Medical Staff Office.
13. The Medical Records/HIM Department shall notify the Medical Staff Office as a suspended practitioner has completed all deficiencies.
14. The Medical Staff Office shall notify the practitioner and applicable departments that the suspension has been lifted.
- D-15. Days on suspension shall be tracked in the Medical Staff’s credentialing database and considered at the time of OPPE and reappointment.

~~1. Record Completion/Notification~~

- ~~a. The following steps are to be followed by the Medical Records Department in order to ensure compliance with the Documentation Requirements Policy.~~
- ~~b. The patient’s medical record shall be completed at the time of discharge, including, history and physical, operative report, emergency department report, physician orders and discharge summary. A record is considered delinquent 14 days after it has been assigned to the physician for completion except as otherwise specified.~~
- ~~c. Physicians will be notified of documentation deficiencies (Dictations and Signatures) through the Inbox application in Compass and via letters sent twice per month by Medical Records. The letter will be accompanied by a list of incomplete records that require intervention by the physician.~~
 - ~~i. The Inbox application contains folders that identify for the physician those documents that need to be Signed/Reviewed and those requiring dictation.~~

- ii. ~~The deficiency populates the physician's Inbox the day that a dictated report is transcribed and the date paper-based deficiencies are assigned by Medical Records.~~
 - iii. ~~Signature of transcribed documents in the Inbox supports the electronic signature requirements outlined in policy.~~
- d. ~~In cases where the physician is away from the Medical Center for 14 days or longer, the delinquency status may be delayed until the physician has had sufficient time to complete the delinquent charts. Medical Records will be advised of a physician's absence by receipt of the Vacation Notification form from the physician prior to the scheduled absence.~~

Note: ~~Letters regarding incomplete records will still be forwarded to a physician who is on vacation. The intent of this letter is to serve as a reminder/notification that incomplete records exist.~~
- e. ~~Physicians having an outstanding History and Physical, Operative Report, Cardiac Cath, Interventional Radiology, Wound Care, or Occupational Health dictation will be reminded to complete the report.~~
 - i. ~~Post-discharge, a Medical Record representative will contact the physician's office notifying the physician/office staff that the physician has 7 days to complete the report or the physician will be placed on delinquency status and fined \$250 for the outstanding report.~~
 - ii. ~~The notification conversation between the Medical Records department and the physician/representative will be documented with a copy of the document forwarded to the physician's office and the Medical Staff Office.~~
 - iii. ~~A physician who has not completed the outstanding History and Physical, OP report, Cardiac Cath, Interventional Radiology, Wound Care, or Occupational Health report by the date required will be placed on delinquency status until the report has been completed.~~
 - 1) ~~The Operations Manager will communicate the Physician's Delinquency Status to the Director of Medical Staff Services for follow-up.~~
- f. ~~Physicians having a Discharge Summary that requires dictation will be notified via the incomplete chart letter that is mailed twice each month (the first and fifteenth day of each month). This letter serves as notification to the physician of the charts that need to be completed by the date specified on the letter. All physicians will be provided with a minimum of 14 days to complete their Discharge Summaries.~~
- g. ~~On the first and fifteenth day of each month, the Medical Records Department will generate a listing of all Discharge Summaries that have not been completed.~~
 - i. ~~A letter will be sent to the physicians on the list identifying their need to complete the outstanding Summary (ies) before the date reflected on the letter (1st or 15th). (July 1st letter will require completion by the 15th, July 15th letter will require completion by August 1st).~~

Note: ~~if the physician determines that the report for the identified patient does not belong to him/her, the physician must resolve assignment of the deficient report with the Medical Records Team by the due date on the letter.~~
 - ii. ~~If the physician has not dictated and/or resolved the outstanding Summary (ies) by the due date, a \$25 fine per chart will be assessed and the physician will be placed on delinquency status until the report has been completed. The assessment (\$25) for a delinquent Discharge Summary is applied per month until the report is dictated.~~
 - 1) ~~The Operations Manager will communicate the Physician's Delinquency Status to the Director of Medical Staff Services for follow-up.~~
- h. **Completion of Signatures**
 - i. ~~Physicians are notified of signatures to be completed via the Physician Inbox application and a Notification Letter from Medical Records.~~
 - ii. ~~Once a month (15th) the physician is notified of outstanding signatures.~~
 - iii. ~~Signatures are to be completed within 30 days of notification~~

- iv. ~~When signatures are NOT completed within the 30 days, the physician is placed on Delinquency Status and this information is forwarded to the Director of Medical Staff Services for follow-up with the physicians.~~
- v. ~~Vacation days (less than 7 days) during the period between notification and required completion date. Physicians will need to ensure that their deficiencies are current by the established due date (1st or 15th) of each month regardless of the day of the week).~~

E. DELINQUENCY STATUS

1. ~~Assignment to delinquency status will occur if physicians have not completed the dictation of History and Physical, Operative, and Cardiac Catheterization reports within the required 14 days and signatures have not been completed within 30 days. Dictation will be verified through the standard dictation system.~~
2. ~~Delinquency Status is assigned to a physician who has not completed the dictation of a report by the 1st or 15th day of the month when he/she has been notified that a report has been assigned to him/her for completion.~~
 - a. ~~Physicians who have been assigned to Delinquency Status will receive a letter from the Chief of Staff requiring that the outstanding documents be dictated within 14 days or the Medical Staff member will be suspended and fines will be assessed pursuant to Article VI, § 6.3-4, Medical Records;~~
 - b. ~~Limited suspension shall apply to the Medical Staff member's right to admit, treat or to provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the medical staff member has already admitted or has scheduled to treat or to perform any invasive procedure.~~
 - c. ~~Members whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available.~~
 - d. ~~The suspension shall continue until the medical records are completed or suspension lifted by the Chief of Staff or his designee.~~
 - e. ~~Bona fide vacation or illness may constitute an excuse subject to the approval of the Medical Executive Committee.~~
3. ~~The physician will remain on delinquency status until all available delinquent reports have been completed and verified on the standard dictation system.
Vacation days taken when a physician is on delinquency status will not count in the total number of delinquency days (communication via the Vacation Notification form is required).~~

F. MONITORING

1. ~~The Operations Manager of Medical Records is responsible for the follow-up and monitoring of delinquent documentation deficiencies.~~
 - a. ~~Physicians having outstanding H&P, OP/CATH, and Discharge Summaries as of the first and fifteenth day of each month will be identified.~~
 - b. ~~A summary report of delinquent medical records will be compiled and forwarded to the Director of Medical Staff Services by the 5th and 20th of each month.~~
 - c. ~~Physician specific information relating to delinquency status is compiled monthly and reported to the Chief of Staff via the Medical Staff Office.~~
2. ~~The Medical Records Department will provide information monthly to the Medical Staff Office regarding delinquent reports that subject the physician to follow-up by the Chief of Staff and assessment of a fine. The Medical Staff Office will follow-up with the responsible physician(s).~~
3. ~~Physicians may be fined and/or suspended per Medical Staff Policy #519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.3-4(a).~~
4. ~~If the physician reaches 180 days delinquency status, he or she is eligible for administrative suspension at the discretion of the Chief of Staff or their designee.~~
16. The Medical **Records Executive** Committee will serve as the intermediary in resolving suspension/delinquency status questions from physicians and will assist the Medical Records

Department in communications with ~~members of the Medical Staff~~ **practitioners** who have disputes regarding the actions of this policy.

- 5.17. Practitioners indicating an intent to resign will be advised to complete all outstanding dictations and signatures before departure, as failure to do so will make them ineligible for “good standing” affiliation verifications. The Chief of Staff has the discretion to make exceptions where there are extenuating circumstances**

G.C. REFERENCES:

- ~~1. Medical Staff P&P 533: Electronic Signature~~
 - 2.1. Medical Staff P&P 8710-518: Medical Record Documentation Requirements**
 - 3.2. Medical Staff Bylaws: Article VI, § 6.34-4**
-

Tri-City Medical Center
Allied Health Professional
Nurse Practitioner – Neonatal Intensive Care Unit
Standardized Procedures

Approvals

Division of Neonatology:	8/19/14
Department of Pediatrics:	8/19/14
Pharmacy and Therapeutics Committee:	9/18/14
Interdisciplinary Practice Committee:	9/29/14
Credentials Committee:	10/8/14
Medical Executive Committee:	
Board of Directors:	

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**California Standardized Procedures
Tri-City Medical Center
Neonatal Intensive Care Unit
4002 Vista Way
Oceanside, CA 92056**

Introduction:

The purpose of these standardized procedures is to define the scope of practice of the Neonatal Nurse Practitioner at Tri-City Medical Center in order to meet the legal requirements for the provision of health care by nurse practitioners. The standardized procedures for the nurse practitioner are established to assist all health care providers with an understanding of the role and scope of practice of the nurse practitioner. It shall be understood that because a nurse practitioner's practice is directed by a supervising physician, and he/she acts for that physician, the orders and tasks performed shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified, orders may be initiated without the prior patient-specific order of the supervising physician. (See also AHP Rules and Regulations)

The standardized procedures consist of the following:

General Policies: Gives authorization to the nurse practitioner, and defines the general conditions for implementation of the standardized procedures in this document.

Standardized Procedure Procedures: Delineates the functions requiring a standardized procedure, and using policies and protocols, defines the circumstances and requirements of their implementation by the nurse practitioner.

General Policy Component

It is the intent of this document to authorize the Neonatal Nurse Practitioner to implement the standardized procedures without the immediate supervision or approval of a physician at Tri-City Medical Center. The standardized procedures, including all the policies and protocols under which they are to be implemented, are defined in this document and will be referred to generally as standardized procedures. It is not the intent to have the nurse practitioner independently diagnosing, treating, or managing various patient conditions potentially encountered, but rather to utilize assessment and health care management skills in conjunction with the standardized procedures and the collegial physician-nurse practitioner relationship to meet the health care needs of the patient.

I. Development, Revision, and Review:

- A. The standardized procedures have been developed collaboratively and approved by the Interdisciplinary Practice Committee (IDPC) whose membership consists of nurses, physicians, and administrators.
- B. The Standardized Procedures are to be kept in the Medical Staff Office which includes dated, signed approval sheets of persons covered by the standardized procedures.
- C. Standardized procedures are to be reviewed by the IDPC every three (3) years and as practice changes.
- D. All changes or additions to the standardized procedures are to be approved by the IDPC accompanied by a dated and signed approval sheet.

- E. Standardized Procedures must be approved by the applicable Medical Staff Department/Division(s), Committees, and Board of Directors before they are effective.

II. Qualifications and Evaluations:

A. Education and Training:

The nurse practitioner performing the standardized procedures must have:

1. Possession of a current California Registered Nursing license;
2. Successfully completed a Board of Registered Nursing approved nurse practitioner program;
3. Certification as a nurse practitioner by the California Board of Registered Nursing (Title 16, Article 8, Section 1482, Business and Professions Code); Successful completion of the Neonatal Nurse Practitioner National Certification Examination within one year of initial credentialing;
4. If furnishing drugs and devices, the nurse practitioner must possess a furnishing license;
5. Nurse practitioners wishing to furnish Schedule II through V controlled substances are required to complete a Board of Registered Nursing approved 3 hour continuing education course as well as possess a DEA certificate to prescribe Schedule II-V drugs.

III. Scope and Setting of Practice:

Nurse practitioners function under the sponsorship of a member of the Medical Staff, and upon application approval through the Medical Staff credentialing process may perform the following patient care services.

- A. Nurse practitioners may perform the following functions within their training specialty area and consistent with their experience and credentialing:
- Assessment (including performing the history and physical examination)
 - Management, and treatment of episodic illnesses
 - Chronic illnesses
 - Common nursing functions of health promotion
 - General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)
 - Recommendation of diets
 - Refer to Specialty Clinics and appropriate health facilities, agencies, and resources in the community when indicated
 - Initiate admissions (all admissions must be on order of physician)
 - Write patient summaries and record/present data in a manner meaningful to the physician and collaborating team members
 - Furnish medications as further described herein, if the nurse practitioner possesses a furnishing license; for Schedule II-V controlled substances must also have completed a BRN approved 3-hour continuing education course and possess a valid DEA certificate.
 - Make daily rounds with or without the physician
- B. Standardized procedure functions are to be performed in the hospital. Consulting physicians are available to the nurse practitioner at all times in person, by electronic means, or by telephone.
- C. Consultation:

The nurse practitioner may seek physician consultation as specified in the individual protocols and under the following circumstances:

1. Whenever situations arise which go beyond the intent of the standardized procedures or the competence, scope of practice, or experience of the nurse practitioner.
2. Acute decompensation of the patient situation.
3. Whenever patient conditions fail to respond to the management plan within an appropriate time frame.
4. Uncommon or unstable patient conditions.
5. Unexplained historical, physical, diagnostic or laboratory findings.
6. All emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.
7. Upon request of patient, family, nurse, or supervising physician.

Whenever a physician is consulted, a notation to that effect, including the physician's name, must be documented in the medical record.

D. Setting/Practice Privileges:

The nurse practitioner is granted practice privileges for the care of patients at Tri-City Medical Center.

E. Education/Counseling:

The nurse practitioner may instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as:

1. Medications
2. Diets
3. Social Habits
4. Normal growth and development
5. Understanding of and long-term management of a patient's diseases

F. Evaluation of Clinical Care:

Following approval, the evaluation of the nurse practitioners' competence in performance of standardized procedure functions will be completed in the following manner:

1. Initial: At 3 months by supervising physician, through feedback from colleagues, physicians, and/or chart review during performance period being evaluated.
2. Routine: Annually after the first year by the supervising physician, through feedback from colleagues, physicians, and/or chart review.
3. Follow-up: Areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, (e.g. direct supervision).
4. Additionally, the nurse practitioner is subject to such evaluation, monitoring, proctoring and other review as required by the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures.

IV. Authorized Nurse Practitioners:

The Statement of Approval signed by the credentialed/privileged nurse practitioner will serve as formal authorization to implement the Standardized Procedures at Tri-City Medical Center.

V. Procedures:

The standardized procedures developed for use by the nurse practitioner are designed to describe the steps of medical care for given patient situations. They are to be used in the

following circumstances: management of acute/episodic conditions, trauma, chronic conditions, routine/high risk deliveries, infectious disease contacts, and ordering medications and durable medical equipment.

A. Patient Records:

The nurse practitioner will be held responsible for the preparation of a complete medical record for each patient contact. The problem-oriented medical records system is used for documenting findings and observations according to the established procedure for use of this system.

B. Supervision:

The nurse practitioner is authorized to implement the standardized procedures in this document without direct or immediate observation, supervision or approval of a physician, except as may be specified on the Standardized Procedure(s). Physician consultation is available at all times, either onsite, by electronic means, or via telephone. Please also refer to the AHP Rules and Regulations for requirements regarding co-signatures.

STANDARDIZED PROCEDURE: Patient Management in the Neonatal Intensive Care Unit

I. POLICY: As described in the General Policy Component.

- A. Function: To allow Neonatal Nurse Practitioners (NNP) to collaborate with attending physician staff in the Division of Neonatology in the assessment, diagnosis, and management of neonates requiring care at Tri City Medical Center (TCMC).
- B. Circumstances under which the nurse practitioner may perform function:
 - 1. Setting:
 - a. Neonates admitted to TCMC or being transferred to the Neonatal Intensive Care Unit (NICU) by a neonatologist attending physician who has neonatal admitting privileges.
 - 2. Supervision:
 - a. The Neonatal Nurse Practitioner (NNP) shall at all times be under the supervision of a member of the neonatology medical staff who has been authorized to supervise allied health professionals through these standardized procedures. The NNP shall be able to identify the supervising medical staff member by name.
 - 3. Patient conditions requiring immediate communication with the supervising physician:
 - a. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been initiated e.g. adverse medication responses, development of complications.
 - b. Acute deterioration of patient condition
 - c. When the situation exceeds the NNP's level of expertise and/or comfort
 - d. Upon request of the infant's family, nurse, or other staff physician.
 - 4. The supervising physician shall:
 - a. Be physically present or immediately available by telecommunication at all times.
 - b. Identify an alternate authorized supervising physician to support the NNP function in his or her absence.
 - c. Participate in the orientation of the new NNP to the neonatology service, provide on-going mentoring and evaluation during the 90-day introductory period, annually, and as indicated thereafter
 - d. Develop a collaborative relationship with the NNP by establishing the plan of care for each patient and communicating expectations for the course of treatment.

II. PROTOCOL/PROCEDURE:

- A. Database:
 - 1. Subjective Data – The NP may obtain:
 - a. Maternal history from interviews with family members and/or maternal medical team.
 - b. Applicable family medical and psychosocial history.
 - 2. Objective Data –
 - a. Using medical records from mother and infant (when available), obtain past medical history, which may include the maternal, perinatal, and neonatal history, e.g. gestational age, pregnancy/labor and delivery complications, post-delivery status and treatment.
 - 3. Assessment – The NP may perform physical examination to include:

- a. General appearance and skin
 - b. Head/scalp/neck
 - c. Eyes, ears, nose and oropharynx
 - d. Chest, cardio, and respiratory systems
 - e. Abdomen
 - f. Genitalia
 - g. Back and extremities
 - h. Any other examination relevant to the neonatal evaluation
- B. Plan:
- 1. The NNP may develop a work-up plan based on information obtained from the history and physical examination.
 - a. The NNP may order, evaluate results, and provide follow-up for laboratory and diagnostic tests pursuant to established NICU protocols.
 - b. The NNP may order specialty consultations in collaboration with supervising physician as needed.
 - 2. The NNP may develop working diagnoses based on above data (history, physical exam, vital signs, laboratory and other diagnostic results). This set of working diagnoses will be discussed by the NNP with the attending neonatology staff.
 - 3. The NNP may develop a treatment plan, which may include admission, discharge, perinatal consults, and daily management orders, in direct collaboration with the supervising physician. The plan shall be appropriate to the working diagnoses and pursuant to established NICU protocols/Power Plans.
 - a. Pharmacologic therapy: only NNPs possessing a furnishing number issued by the California Board of Registered Nursing may order pharmacologic therapy.
 - b. Drugs and devices are furnished (ordered) only in accordance with these standardized procedures and TCMC policy.
 - c. Furnishing shall be limited to those drugs agreed upon by the neonatology medical staff.
 - d. Patient specific protocol for ordering controlled substances: The NNP may, with DEA registration appropriate to order controlled substance, order controlled substances for the following categories of NICU patients:
 - i. Ventilator dependent infants
 - ii. Pain uncontrolled by non-scheduled medications
 - iii. Infants treated for substance abuse withdrawal.
 - 4. The NNP may order blood and blood products following informed consent and pursuant to established NICU protocols.
 - 5. The NNP may triage and/or accept requests for admissions or transport to the NICU in collaboration with the supervising physician.
- C. Record Keeping:
- 1. Documentation is performed in the medical record on designated forms or in the electronic medical record.
 - 2. The NNP shall document the collaborative communication when complex diagnostic studies (MRI, CT) and non-formulary medications are ordered.

Resources

1. California Board of Registered Nursing, "An Explanation of Standardized Procedure Requirements for Nurse Practitioner Practice". December 1998. CA Department of Consumer Affairs. Sacramento.
2. Heiss-Harris, G.M., Bailey, T. (2010). Common invasive procedures. In M.T. Verklan, M. Walden (Eds.), *Core curriculum for neonatal intensive care nursing* (4th ed., pp. 328-331). Maryland Heights, MO: Saunders.
3. Kattwinkel, J. (Ed.). (2011). *Textbook of Neonatal resuscitation* (6th ed.). Elk Grove Village, IL: American Academy of Pediatrics and American Heart Association.
4. MacDonald, M.G., & Ramasethu, J. (Eds.). (2007). *Atlas of procedures in neonatology* (4th ed.). Philadelphia: Lippincott, Williams & Wilkins.
5. Verklan, M.T., Walden, M. (Eds.). (2009). *Core curriculum for neonatal intensive care nursing* (4th ed.). St. Louis, MO: Saunders.
6. Walden, M., Gibbins, S. (2012). *Newborn pain assessment and management: Guideline for practice* (3rd ed., pp. 5-25). Glenview, IL: NANN. (Level VII)

Acknowledgement Statements:

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

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

Nurse Practitioner Signature

Date

Sponsoring Physician Signature

Date

Sponsoring Physician Signature

Date

Sponsoring Physician Signature

Date

Sponsoring Physician Signature

Date

Sponsoring Physician Signature

Date

Tri-City Medical Center
Audit, Compliance & Ethics Committee
October 16, 2014
Assembly Room 3
8:30am-10:30am

Members Present:	Director Ramona Finnilla (Chair); Director Larry W. Schallock; Director Julie Nygaard, Jack Cumming, Community Member
Non-Voting Members:	Tim Moran (CEO); Casey Fatch (COO); Steve Dietlin (CFO)
Others Present:	Teri Donnellan, Executive Assistant; Nellie Brown, Senior Administrative Assistant
Absent:	Carlo Marcuzzi, Community Member; Dr. Frank Corona, Physician Member; Casey Fatch, COO

	Discussion	Action Recommendations/Conclusions	Person(s) Responsible
1. Call to Order.	The meeting was called to order at 8:35 a.m. in Assembly Room 3 at Tri-City Medical Center by Director Finnilla, Chairperson. Committee members introduced themselves to the applicants.		
2. Approval of Agenda	Chairperson Finnilla requested flexibility in the order of interviews for the six candidates, due to the fact that one candidate would be participating via teleconference due to recent surgery. The committee was supportive of Chairperson Finnilla's request.	Agenda approved with flexibility in order of interviews.	
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item.	Chairperson Finnilla reported the committee will be interviewing applicants for two vacant seats today due to the fact that Mr. Robert Pearlman recently completed his allotted four year term.		
4. Ratification of minutes-September 18, 2014.	It was moved by Director Nygaard and seconded by Director Schallock to approve the minutes of the September 18, 2014 meeting. The motion passed unanimously.	Minutes ratified	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
<p>5. New Business</p> <p>A) Committee Interviews:</p> <ol style="list-style-type: none"> 1. Kathryn Fitzwilliam 2. Mary Regan 3. Guy Roney 4. Irwin Schenker 5. Barton Sharp 6. Paul T. Lowik D.P.M 	<p>Chairperson Finnila reported there are six candidates who will be interviewing today for the two open seats on the Audit, Compliance & Ethics Committee including:</p> <ol style="list-style-type: none"> (1) Kathryn Fitzwilliam (2) Mary Regan (3) Guy Roney (4) Irwin Schenker (5) Barton Sharp (6) Paul T. SLOWIK, D.P.M. <p>Chairperson Finnila explained the interview process and noted candidates will be asked to step outside of the room while the Committee interviews each candidate individually. Candidates will be allowed to remain in the room following their interview to observe the remainder of the meeting if they so desire.</p> <p>The first candidate interviewed was Kathryn Fitzwilliam. Ms. Fitzwilliam presented an impressive resume with over 20 years experience in audit. Ms. Fitzwilliam provided background information noting experience with both a Public Accounting firm and in industry as well as experience with process improvement and business systems design and implementation. Committee members asked questions of Ms. Fitzwilliam. Ms. Fitzwilliam was given the opportunity to ask questions of the committee and thanked the committee for the opportunity to interview.</p> <p>The second candidate interviewed was Mary Regan. Ms. Regan provided background information noting she has been self-employed for almost 30 years as a Mortgage Broker and also serves as a HUD counselor. Committee members asked questions of Ms. Regan. Ms. Regan was</p>	<p>Committee's recommendation to appoint Kathryn Fitzwilliam and Barton Sharp to the vacant seats to be sent to the Board of Directors for approval at their November 6, 2014 Regular Meeting; item to appear on next Board agenda and included in Board Agenda packet.</p> <p>Applicants that were not present and not selected will be notified of the committee's recommendation.</p>	<p>Ms. Donnellan</p> <p>Ms. Donnellan</p>

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>given the opportunity to ask questions of the committee. She stated she is also quite interested in serving on the Governance and Legislative Committee or Finance, Operating & Planning Committee should she not be selected for the Audit Committee.</p> <p>The third candidate interviewed was Guy Roney who presented with expertise in the brokerage, development and the financial structuring of real estate assets as well as related experience with debt restructuring and bankruptcy. The committee asked questions of Mr. Roney. Mr. Roney was given the opportunity to ask questions of the committee and Mr. Roney stated he has the time and willingness to contribute to the committee and would be honored to be selected.</p> <p>The fourth candidate interviewed was Dr. Paul Slowik, a retired Podiatrist and member of Tri-City Medical Center's Medical Staff for 14 years and Chief of Podiatry for many years. Dr. Slowik was interviewed by teleconference due to recent surgery. Committee members asked questions of Dr. Slowik. Dr. Slowik was given the opportunity to ask questions of the committee. Dr. Slowik stated he is a man of high integrity and Tri-City has done a lot for him and he would like to give back by serving on the committee.</p> <p>The fifth candidate interviewed was Irwin Schenker who presented with extensive experience in hospital administration and healthcare consulting. Committee members asked questions of Mr. Schenker. Mr. Schenker was given the opportunity to ask questions of the committee. Mr. Schenker stated he previously served on the Finance, Operations & Planning Committee and enjoys participating and providing his expertise to the committee.</p> <p>The final candidate interviewed was Barton Sharp who presented with management experience at JC Penney and Walt Disney, as well as a past member of the Grand Jury Association of San Diego County and Board Member of the</p>		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	<p>United States Selective Service System. Committee members asked questions of Mr. Sharp. Mr. Sharp was given the opportunity to ask questions of the committee. Mr. Sharp stated he has seen some remarkable changes in the last two years and would like to be involved in moving the organization forward.</p> <p>At the conclusion of the interviews all candidates were asked to leave the room while the committee deliberated. Committee members provided comments on each candidate and discussed their individual strengths and weaknesses. Each committee member conveyed their two top choices. Based on the votes, Chairperson Finnila announced the committee would recommend Ms. Kathryn Fitzpatrick and Mr. Barton Sharp be appointed to fill the two vacant seats on the committee.</p> <p>Applicants were invited back to the meeting where the results were announced.</p>		
6. Old Business A) Chief Compliance Officer Update	Chairperson Finnila reported the Board will be interviewing candidates for the Chief Compliance Officer position on Tuesday evening.	None	
7. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7)	Director Finnila made an oral announcement of the item listed on the closed session.		
8. Motion to go into Closed Session.	It was moved by Jack Cumming and seconded by Director Nygaard to go into Closed Session at 10:09 a.m. The motion passed unanimously.		
10. Open Session	The committee returned to open session at 10:10 a.m. with attendance as noted above.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
11. Report from Chairperson on any action taken in closed session (Government Code, Section b54957.1)	Chairperson Finnila reported no action was taken in closed session.		
12. Date of Next Meeting	The date of the committee's next meeting is November 20, 2014.		
13. Adjournment	Chairperson Finnila adjourned the meeting at 10:10 a.m.		Chair

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

**September 25, 2014 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056**

A Regular Meeting of Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:45 p.m. on September 25, 2014.

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

Director Paul Campo
Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, M.D.
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Casey Fatch, Chief Operating Officer
Steven L. Dietlin, Chief Financial Officer
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:45 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.
2. Approval of Agenda

**It was moved by Director Dagostino to approve the agenda as presented.
Director Campo seconded the motion. The motion passed unanimously (7-0).**

Chairman Schallock noted a revised agenda was distributed to reflect the removal of item 19. 4. D. 1. related to Dr. Willard.

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the September 25, 2014 Regular Board of Directors Meeting Agenda.

There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of items listed on the September 25, 2014 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of potential litigation, three matters of existing litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, approval of closed session minutes and two reports involving Trade Secrets.

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:48 p.m.

8. At 3:38 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

Director Paul Campo
Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, M.D.
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Casey Fatch, Chief Operating Officer
Steven Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Schallock reported the Board took no action in closed session.

(The numbering sequence below follows that of the Board Agenda)

10. Chairman Schallock noted all Board members were present. Director Nygaard led the Pledge of Allegiance.
11. Chairman Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 23. Chairman Schallock commented on the Board Policy regarding total time allotted for

public comments and stated the Board will adhere stringently to the three (3) minute rule.

12. Special Presentation – Efficiency and Effectiveness Initiative – Presentation by Daniel Martinez, VP of IT, Greg Felix (Airstrip), Kevin Harris (CureMatrix), David Lucas (Vivify), Dr. Scott Worman, Chief of Staff.

Mr. Daniel Martinez, SVP of Informational Technology gave a brief overview of the IT Roadmap to improve the District's outcome for the future and improved patient care. He explained presentations given today by Greg Felix (Airstrip), David Lucas (Vivify Health) and Kevin Harris (CureMatrix) and Dr. Scott Worman, Chief of Staff will reflect the following:

- Physician will be able to access live patient data in real time and update remotely.
- Patients will be able to take home a remote care management system.
- Create a culture of coordinated care with data driven decision making.

Mr. Martinez introduced Mr. Scott Livingstone, Senior Director of Clinical Effectiveness who spoke regarding the clinical measures to impact which include the following:

- Outcome Measures – 30 day Readmission Rates for Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease, Heart Failure, Pneumonia, Total Knee/Hip Arthroplasty and all cause readmission
- SD County Transition Partnership reduced 30-day readmission by 65%.

Mr. Greg Felix presented on behalf of Airstrip, the Mobility Solution which will allow a centrally located telemetric monitoring system providing live-time wave forms to physicians securely and remotely via mobile device (Smart phone, table, office PC) to enhance patient care, patient satisfaction, physician satisfaction and improve patient safety.

Mr. David Lucas presented on behalf of Vivify Health. He explained Vivify will provide after care, in-home remote monitoring, on-going best practice, evidence-based disease specific educational information, and video communication solutions for TCMC patients at high risk for readmission. Monitoring will include blood glucose, pulse oximetry, blood pressure and weight. Vivify will be able to support TCMC After Care Management efforts through a clinical call center 24/7.

Mr. Kevin Harris presented on behalf of CureMatrix. He explained TCMC is looking to create a culture of coordinated care and data-driven decision making by using stored data as an enterprise asset to help improve outcomes at the hospital. He stated CureMatrix will help develop the analytics tools within this Center for Clinical Effectiveness.

Dr. Scott Worman explained how these initiatives will do the following:

- Enhance patient safety and outcomes while driving out care deliver costs.
- Streamline Physician care collaboration.
- Enhance patient satisfaction and market share.
- Reduce readmissions.

- Telehealth expansion – Stroke, CV, ICU, Psych, enhance specialist consults to the ED.
- Early detection and intervention of high risk patients (OB, Critical Care, Ortho).
- Operationalize analytics for clinical decision support and population health management.

Several members of the audience made comments and asked questions including Mr. Frank Gould, Mr. Louis Montulli, Ms. Jane Mitchell, Mr. Michael Slavinski and an unidentified nurse.

Directors also asked questions of the presenters and expressed their appreciation for the informative presentations.

No action was taken.

13. Report from TCHD Foundation – Glen Newhart, Executive Director

Mr. Glen Newhart, TCHD Foundation Executive Director discussed Foundation activities past and present. Mr. Newhart stated the TCHD Foundation is a partner in the mission of the Healthcare District and they are honored to support the initiatives that are brought forward. Mr. Newhart stated the Foundation funded a \$41,000 grant this past week to assist in the renovation of the Emergency Department lobby.

Mr. Newhart introduced Mrs. Ellen Stotmeister, Chair of this year's Diamond Ball. Mrs. Stotmeister stated the Diamond Ball is the annual fundraiser for the Foundation and one of the premier events in North County. In addition, it is also our 50th anniversary and will be held on Saturday, November 15th at Park Hyatt Aviara Resort in Carlsbad with a live auction, opportunity drawing and fabulous menu. The guest Master of Ceremonies will be newscaster, Kimberly Hunt and her sportscaster husband Billy Ray Smith. Coincidentally the event will be held on National Philanthropy Day.

Director Campo expressed his appreciation to the Procopio firm for their corporate sponsorship. He also encouraged other vendors including those featured in the previous presentation to consider sponsorship at the Diamond Ball.

Mr. Newhart announced this year's Legacy Award winner is Bob and Sandee Carter who are involved in numerous charitable events. Mr. Newhart encouraged everyone to come out and honor their legacy of giving in our communities.

No action was taken.

14. Report from Chief Executive Officer

Mr. Moran gave a brief report. He reported some very positive improvements in HCAPS scores.

With regard to strategy for partnering with physicians, Mr. Moran stated we have made numerous connections with physicians in the community. He is extremely pleased that we now have possession of the campus Medical Office Building and the leadership team will work in earnest to pull together both primary care and specialist

physicians to occupy the building and those physicians will be critical to helping us plan for our future.

Mr. Moran stated we are also re-examining our Service Line strategies, a number of which were approved in the budget this year. He noted the Joint Conference Committee recently met to reassess how we are doing with Women's Services, Orthopedics, Oncology, Cardiac Services and that was an excellent start to see how we are doing and will help him to work with the leadership team and the Board as we develop strategies going forward.

Mr. Moran stated we are working on the Crisis Stabilization Unit which was one of our key strategies.

Mr. Moran explained the Tri-City Emergency Room is an area of concern and is the third busiest in the county. He stated this is an area where we have seen an increase in recent months in mental health activity which adversely affects the Emergency Room. Mr. Moran stated 20% of patients who come to the Emergency Room at Tri-City do not live in the District and he hopes to work with the county and advance some creative strategies that will address these needs for patients in an area other than the emergency room setting and utilize our resources more effectively. Mr. Moran noted this is not an issue unique to Tri-City.

With respect to communication, Mr. Moran stated we continue to provide community breakfasts and reach out to physicians. Physicians have pointed out that English is not the first language for many of their patients and they had had difficulty getting access to care. As a result the Marketing Department has put together a quick reference guide that outlines the many languages,

Director Reno spoke regarding the multicultural program that Mr. Francisco Valle has been involved with in the past. Ms. Sharon Schultz, CNE explained Mr. Valle provides training for staff who are interested in being interpreters. She noted we currently have one interpreter on days on one on nights as well as the NexTalk for video interpretation.

An unidentified staff member stated she is not aware of a live interpreter on nights. Mr. Francisco Valle explained we have two full time Spanish interpreters who work 6:00 a.m. to 7:00 p.m., however we do not have 24 hour coverage, although we do utilize other adjuncts as described by Sharon Schultz.

No action was taken.

15. Report from Chief Financial Officer

Mr. Dietlin reported on the August YTD financial results as follows (dollars in Thousands):

- Net Operating Revenue – \$53,965
- Operating Expense – \$54,593
- EROE - \$20
- EBITDA – \$2.749

Other Key Indicators for the current year included the following:

- Average Daily Census - 193
- Adjusted Patient Days – 19,547
- Surgery Cases – 1,129
- Deliveries – 509
- ED Visits – 11,970

- Net Patient Accounts Receivable – \$40.1 (dollars in millions)
- Days in Net Account Receivable – 48.2

Discussion was held regarding the quality of care of outpatient vs. inpatient surgery. Dr. Worman explained there are national standards and each patient is assessed individually for inpatient vs. outpatient surgery.

Mr. Dietlin presented graphs which reflected Paid Full Time Equivalents per Adjusted Occupied Bed, Emergency Department Visits, EROE and EBITDA.

Mr. Dietlin also reviewed the highlights of Fiscal 2014 Financial Results which were brought to the Audit Committee this past week and presented by Moss Adams.

Mr. Dietlin reported the following for FY2014 (dollars in millions):

- Cash Flows Provided by Operating & Non-Capital Financing Activities - \$24.4 compared to \$9.4 in FY 2013.
- Cash and Cash Equivalents - \$13.9
- Unused Available Revolving Credit Facility - \$18.7

From an operating performance perspective, Mr. Dietlin reported the following:

- Operating Revenue - \$319,743
- Operating Expense - \$325,398
- EBITDA - \$21,917
- EROE - \$4,385

Director Reno requested clarification with regard to the monies received through a legal settlement with Citibank. Mr. Dietlin explained there was an approximate \$5.5 million legal settlement that was included in the results and reflected as non-operating income and noted in the footnotes as such. He further explained Net Patient Revenue is broken out in the financials and anything that is material would be broken out in the financial statements as a footnote.

Directors expressed appreciation to Mr. Dietlin for his efforts. Mr. Dietlin explained a financial turnaround is a collaborative effort. He noted there is continual pressure on reimbursement.

No action was taken.

16. New Business

- a. Consideration to accept the FY2014 Financial Audit – presentation by Devon Wiens, Moss Adams

Mr. Devon Wiens reported Moss Adams completed their audit and presented those results to the Audit Committee on September 18, 2014 where they spent a significant amount of time going over the result with the committee. Mr. Wiens explained Moss Adams issued our report on Monday, September 22nd and it is referred to as an unmodified or unqualified opinion that states the financial statements are fairly stated and there were no adjustments and no material weaknesses that were identified in the audit process. Mr. Wiens spoke regarding Accounts Receivable and he explained Accounts Receivable is our largest non-cash asset that is not a building and is the most volatile. He further explained \$42 million is an estimate of cash collections and the auditors spend a great deal of time looking at the internal control environment and booking of cash collections.

Chairman Schallock questioned if Mr. Wiens expressed any area of concern related to the finances when management were asked to leave the room at the Audit Committee for discussion by the Committee. Director Finnila stated when management left the room the committee had ample time to ask questions and Mr. Wiens indicated no problems whatsoever. She stated the Committee felt strongly that the management team should get a good report card for doing the audit in such a timely fashion. Director Nygaard, also an Audit Committee Member stated she was very pleased with how careful and thorough this audit was and felt it was one of the best audits she has ever seen. Chairman Schallock also confirmed no issues were raised by the auditors and is extremely comfortable with the report. He noted the community members who sit on the Audit Committee asked a variety of questions and were very satisfied with the answers provided by auditors.

It was moved by Director Campo that the TCHD Board of Directors accept the FY2014 Financial Statement Audit as recommended by the Audit, Compliance & Ethics Committee. Director Dagostino seconded the motion.

Director Kellett expressed his appreciation to Mr. Dietlin for a clean audit. Director Reno also commended Mr. Dietlin and his staff for a job well done.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- b. Consideration to approve the renewal of 2015 Employee Benefits – presentation by Denise Hujing and Kandace McCrae, BB&T

Ms. Denise Hujing and Ms. Kandace McCrae stated BB&T was appointed as the District's brokerage and consulting firm as of April 1, 2014. She stated the results presented today have been vetted to the Executive Team as well as the Human Resource Committee. Ms. Hujing explained the primary focus surrounded cost containment to minimize financial impact to employees and to maintain or improve the core networks with as little disruption as possible. In addition, potential plan design changes were considered to enhance the wellness program already in existence. Ms. Hujing stated that through negotiations and market leverage, BB&T was able to achieve \$1,112,009 in premium savings (over the initial renewals). In addition, UHC has committed \$75,000 towards TCMC's wellness program.

Ms. McCrae provided an overview of the benefits including Medical (HMO and PPO), Pharmacy (Self-Funded), Dental (DHMO and ASO/Self-Funded PPO), Vision (PPO) Basic Life, Supplemental Life, Survivor Income, Long Term Disability, Employee Assistance Program and Executive Reimbursement Benefit and their respective recommendations.

With respect to the EAP program, Ms. McCrae stated BB&T's recommendation has changed since this presentation was distributed and BB&T now recommends TCHD remain with Magellan due to no price or benefit advantage of moving to United.

It was moved by Director Finnila to approve the renewal of the 2015 Employee Benefits as recommended by the Human Resources Committee with the exception of the EAP Plan whose recommendation has been changed to remain with Magellan. Director Dagostino seconded the motion.

Chairman Schallock recognized Mr. Frank Gould, community member. Mr. Gould questioned if the benefits as presented will increase employee contribution next year. Ms. Hujing stated it is her understanding that contributions by employees should increase by less than 5%.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- c. Recommendation to appoint Ms. Xiomara Arroyo to a two-year term on the Community Healthcare & Alliance Committee – Multicultural Seat

It was moved by Director Nygaard that the TCHD Board of Directors appoint Ms. Xiomara Arroyo to a two year term on the Community Healthcare & Alliance Committee – Multicultural Seat, as recommended by the Community Healthcare & Alliance Committee. Director Dagostino seconded the motion.

Ms. Xiomara introduced herself to the Board and thanked the Board for the opportunity to serve on the committee.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- d. Approval to appoint Ms. Linda Ledesma to a two-year term on the Community Healthcare & Alliance Committee – Carlsbad Resident Seat

It was moved by Director Nygaard that the TCHD Board of Directors appoint Ms. Linda Ledesma to a two year term on the Community Healthcare & Alliance Committee – Carlsbad Resident Seat, as recommended by the Community Healthcare & Alliance Committee. Director Finnila seconded the motion.

Director Nygaard stated Ms. Ledesma was not able to attend today's meeting, however the committee unanimously supports the appointment of Ms. Ledesma.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- e. Approval to reappoint Ms. Marilou dela Rosa Hruby to a second two-year term on the Community Healthcare & Alliance Committee.

It was moved by Director Nygaard that the TCHD Board of Directors appoint Ms. Marilou dela Rosa Hruby to a second two-year term on the Community Healthcare & Alliance Committee, as recommended by the Community Healthcare & Alliance Committee. Director Dagostino seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

- f. Consideration to cast ballot for Jo MacKenzie as a Regular Special District member and Ed Sprague, Special District Alternate Member on LAFCO's Board of Directors.

Chairman Schallock explained this motion is brought forward today to designate someone to cast the vote for the open LAFCO positions. He noted Ms. Joe MacKenzie has been very active both locally and on a state-wide effort.

It was moved by Director Nygaard that the TCHD Board of Directors appoint Chairman Schallock to cast the vote for Jo MacKenzie, Regular Special District Member and Ed Sprague, Special District Alternate Member on LAFCO's Board of Directors. Director Dagostino seconded the motion.

Chairman Schallock recognized Mr. Michael Slavinski, Vista Resident, noting Mr. Slavinski has 50 seconds remaining of his four minutes for public comment. Mr. Slavinski voiced his support of Ms. Jo MacKenzie, Regular Special District Member on LAFCO's Board of Directors.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

17. Old Business - None

18. Chief of Staff

- a. Consideration of September 2014 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 22, 2014.

Dr. Worman stated on behalf of the Medical Staff he appreciates the close working relationship that the Medical Staff has with Administration and the Board.

With regard to the Emergency Department, Dr. Worman stated we have a very busy Emergency Department with top quality nurses and physicians who staff it. He noted our Emergency Department physicians are very highly regarded in the county.

Dr. Worman further stated that providing high quality care under the changing referral and financial pressures is an ongoing challenge and the Medical Staff looks forward to working with Administration and the Board to meet those challenges.

It was moved by Director Campo to approve the September 2014 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 22, 2014. Director Finnila seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

19. Consent Calendar

Chairman Schallock noted item 19. 4. D. 1. was removed from the agenda originally posted related to Dr. Willard. Chairman Schallock noted the revised agenda did not reflect this agenda item.

It was moved by Director Campo to approve the Consent Calendar. Director Finnila seconded the motion.

It was moved by Director Reno to pull item 19(4) G. 1. Consideration to approve Committee Operating Principles. Director Kellett seconded the motion.

Director Nygaard stated for the record she would be abstaining from the minutes of August 28, 2014.

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

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

The vote on the main motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

20. Discussion of items pulled from Consent Agenda.

Director Reno who pulled item 19(4) G. 1 Consideration to approve Committee Operating Principles requested clarification as to why the Operating Principles were not reviewed by the Compliance Officer. Director Finnila explained the Audit Committee has been reviewing the Operating Principles for several months, took a fresh look and cleaned them up a bit, however there were no substantial changes.

It was moved by Director Nygaard to approve the Audit Committee Operating Principles as presented. Director Dagostino seconded the motion.

The vote on the motion is as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard and Schallock
NOES:	Directors:	Reno
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

21. Reports (Discussion by exception only)

22. Legislative Update —.

Chairman Schallock reported everything at the state level is awaiting the Governors decision.

23. Comments by members of the Public

Chairman Schallock reminded speakers their allotted time is three minutes.

Chairman Schallock recognized the following individuals:

- Mr. Steve Matthews - Mr. Matthews stated he is here today to represent the nurses here at Tri-City Medical Center who are concerned about what is going on in the Emergency Room. He spoke regarding a press conference that was recently held on these issues. He spoke regarding Assignment to Objection Forms and urged administration to deal with the issues promptly. Time was called. Mr. Matthews continued to speak. Chairman Schallock politely asked that Mr. Matthews leave the podium.
- Ms. Lori Rachac, Registered Nurse, Emergency Department - Ms. Lori Rachac spoke regarding disturbing changes she has witnessed in the Emergency Room that impact patient care. She expressed concern with patient ratios and psychiatric patients that pose a threat to their safety. As a registered nurse and patient advocate, Ms. Rachac urged the Board to address these issues.
- Ms. Phyllis Fry – Ms. Fry urged the board to reconsider the cancellation of the Scribe America contract, noting triage time will likely increase.
- Ms. Sandy Oswald, Registered Nurse, Emergency Department - Ms. Oswald stated she is disappointed and discouraged with management's failure to support herself and coworkers with their legitimate concerns which were brought forward as early as 2013. She stated she will continue to advocate for the safety of our patients.
- Ms. Chris Hart, Registered Nurse, Emergency Department - Ms. Hart spoke regarding her experience with the Studer Group and referred to it as a very humiliating point in her nursing career. She stated she believes Studer's goal is to turn well seasoned staff into robots. She urged the Board and Administration to give the staff the support they need and the hospital will flourish.
- Ms. Jane Mitchell – Ms. Mitchell spoke regarding issues in the Emergency Department. She stated it is time to listen to nurses and employees who speak about concerns that affect the quality of patient care without fear of retaliation or losing their jobs.
- Mr. Frank Gould, Vista Resident – Mr. Gould spoke on behalf of the nurses who are here with sincere concerns that have gone unheard and are trying to correct a system that is rapidly deteriorating.

Mr. Gould also spoke regarding the Medical Office Building and establishing fair market value for suites. Time was called.
- Mr. Louis Montulli – Chairman Schallock reminded Mr. Montulli he had two minutes remaining to speak. Mr. Montulli spoke regarding his personal background and experience and the upcoming election.
- Ms. Gigi Gleason – Ms. Gleason stated she has served on the TCHD Foundation Board and has supported the hospital financially for many years. She expressed her unwavering support for the incumbent members of the District Board who have restored TCMC as a successful, sustainable entity. She noted respect for

the hospital has been restored as well as fiscal responsibility. Ms. Gleason encouraged the public to vote for the community and incumbent Board.

- Ms. Shirley Armstrong, Registered Nurse, Emergency Department – Ms. Armstrong stated she has been a nurse in the Emergency Department for 15 years and is here today in support of our management team who do an excellent job.
- Ms. Lori Graham, Registered Nurse, Emergency Department – Ms. Graham stated Emergency Rooms today are facing insurmountable problems, however she remains confident in our leadership team and nurses and these challenges must be faced together.
- Ms. Gretel Kovak, Registered Nurse, Emergency Department – Ms. Kovak stated she is extremely proud to be a nurse at Tri-City, noting staff provide the best compassionate care and treat all patients with dignity and respect. She believes it is important that nurses are united and a public forum is not the appropriate venue to air their problems. Ms. Kovak stated she is here today in support of our leadership team and she takes offense to staff who are publicly criticizing leadership and blowing things out of proportion. Time was called.
- Dr. Henry Showah, Emergency Department Medical Director – As the Medical Director of the Emergency Department Dr. Showah assured everyone that our patients get excellent care and the physicians and staff work tirelessly to ensure that. Dr. Showah spoke regarding the increase in patient volume and acuity and that it is important to stay the course and remain united to meet these challenges. He stated Tri-City has provided outstanding care to our community for the past 50 years and is very proud of our Gold Plus certification in Stroke. Time was called.
- Ms. Ellen Stotmeister, District voter - Mrs. Stotmeister stated she is here today in support of the Board incumbents, noting this Board has managed to turn the ship around into a safe harbor. She stressed that it is imperative to keep this team intact and allow them to complete the job they started. Mrs. Stotmeister stated the Board has brought TCMC back to fiscal good health and brought civility to the Dais. Mrs. Stotmeister noted the Medical Staff here at Tri-City have unanimously endorsed the five incumbents.
- Don Reedy, Community Healthcare & Alliance Committee member – Mr. Reedy spoke on behalf of the incumbents and suggested the voters put their faith in the foundation that has been created.

Chairman Schallock thanked all the speakers for coming to today's meeting and expressing their opinions.

24. Additional Comments by Chief Executive Officer

Mr. Moran did not have any further comments.

25. Board Communications

Director Reno read a letter into the record from a community member in reference to her positive experience with radiology screening.

Director Reno read a second letter into the record from a staff member regarding the termination of the Scribe America contract. Director Reno stated she is disturbed that money is spent on consultants while services such as the scribes are being terminated.

Director Reno spoke regarding the hiring process of former CEO, Mr. Larry Anderson. She expressed concern regarding the validity of information given to the public and is shocked to think any member of this Board would tear down an individual's integrity.

Director Finnila stated she is extremely proud to be a member of the Board majority and how they have come to unite with all the different silos including the physicians, nurses Labor Unions and C-Suite and all parties are working toward the same goal -- the best patient care and a source of pride for our community. She reiterated that there is no truth to the rumor that this Board plans to sell the hospital.

Director Dagostino stated he is extremely proud of our Administration and the manner in which the hospital is run. He explained the Board's role is to oversee and holds fiduciary responsibility but the C-Suite is the real nuts and bolts of the organization.

Director Campo stated this Board is extremely concerned about patient care and it is the number one reason he is here. He stated he is very disheartened by the negative comments made by some of the nursing staff.

Director Kellett expressed his appreciation to Mr. Steve Dietlin, his staff and Administration for a prompt clean audit and a profitable year.

Director Nygaard reminded everyone it is time for Open Enrollment and Tri-City is offering workshops to educate patients on their health plans. In addition, in October Tri-City will be offering free flu shot clinics at the Wellness Center and here at the hospital.

Director Nygaard reported the Community Healthcare & Alliance Committee has been very interested in mental health and the mental health of our younger children and the impact on our society. She stated the committee has set up a series of workshops with individuals who work in the mental health field in the Tri-City area and a report will be forthcoming to the Community Healthcare & Alliance Committee and the Board for evaluation.

Director Nygaard also commented on the upcoming election and the fine work the current Board has done. She reiterated that there is no truth in the rumor that this Board is selling the hospital and further, the Medical Staff have recently given unanimous support for the incumbents.

Director Reno questioned the appropriateness of the perception of campaigning from the Dais. Mr. Moser stated Board members may make general statement but should not campaign from the Dais.

26. Report from Chairperson

Chairman Schallock requested clarification on the flu shot. Ms. Sharon Schultz confirmed the elderly will receive a stronger concentration.

Chairman Schallock reminded everyone that Saturday is Prescription Take Back Day and Tri-City is a designated drop off facility.

Chairman Schallock stated the hospital in San Clemente is experiencing problems similar to Fallbrook Hospital and may also lose their Emergency Room. He stated it has become increasingly difficult for these institutions to survive financially.

Lastly, Chairman Schallock spoke regarding the passing of Mr. Robert Folcaner, past President of the Auxiliary and the first male to hold that position.

27. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business.

28. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 6:53 p.m.

29. Open Session

At 7:36 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

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

Chairperson Schallock reported no action had been taken in closed session.

31. There being no further business Chairman Schallock adjourned the meeting at 7:36 p.m.

Larry Schallock, Chairman

ATTEST:

Julie Nygaard, Secretary

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

**September 23, 2014 – 6:00 o'clock p.m.
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 5:00 p.m. on September 23, 2014.

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

Director Paul V. L. Campo
Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Jody Root, General Legal Counsel
Tim Moran, Chief Executive Officer
Steven Dietlin, Chief Financial Officer
Esther Beverly, VP of Human Resources
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 6:04 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of Agenda

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

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Root, made an oral announcement of item listed on the September 23, 2014 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter, Consideration of Appointment of Public Employee: Chief Compliance Officer.

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Campo to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 6:05 p.m.
7. The Board returned to Open Session at 6:56 p.m. All Board members were present.
8. Report from Chairperson on any action taken in Closed Session.

Chairman Schallock reported today's meeting has been adjourned to September 25, 2014 at 1:30 p.m. in classroom 6.

-
9. There being no further business, Chairman Schallock adjourned the meeting at 6:57 p.m.

Larry W. Schallock
Chairman

ATTEST:

Julie Nygaard
Secretary

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

**October 21, 2014 – 4:00 o'clock p.m. (postponed to 5:00 o'clock p.m.)
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way, Oceanside, CA at 5:00 p.m. on October 21, 2014.

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

Director Paul V. L. Campo
Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Jody Root, General Legal Counsel
Steve Dietlin, CFO
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

Julie moved to approve agenda. Jim seconded. All approved.

1. The Board Chairman, Director Schallock, called the meeting to order at 5:00 p.m. in Assembly 3 of the Eugene L. Geil Pavilion with attendance as listed above.
2. Approval of Agenda

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

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Root, made an oral announcement of item listed on the October 21, 2014 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Consideration of Appointment of Public Employee: Chief Compliance Officer.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Dagostino to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 5:05 p.m.
7. The Board returned to Open Session at 7:24 p.m. All Board members were present.
8. Report from Chairperson on any action taken in Closed Session.

Chairman Schallock reported no action was taken in closed session.
9. There being no further business, Chairman Schallock adjourned the meeting at 7:24 p.m.

Larry W. Schallock
Chairman

ATTEST:

Julie Nygaard
Secretary

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

**October 28, 2014 – 10:00 o'clock a.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on October 28, 2014.

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

Director Paul V. L. Campo
Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Gretta Proctor, General Legal Counsel
Tim Moran, Chief Executive Officer
Casey Fatch, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Esther Beverly, Vice President of Human Resources
Dr. Scott Worman, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.
2. Approval of agenda.

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

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Ms. Gretta Proctor, made an oral announcement of items listed on the October 28, 2014 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, Reports Involving Trade Secrets, Consideration of Appointment of Public Employee: Chief Compliance Officer and one matter of existing litigation.

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

6. Chairman Schallock adjourned the meeting to Closed Session at 10:07 a.m.
7. The Board returned to Open Session at 4:10 p.m. with attendance as listed above.
8. Report from Chairperson on any action taken in Closed Session.

Chairman Schallock reported no action had been taken in closed session.

9. Open Session

- a. Ratification of finding of emergency circumstances requiring waiver of bidding per Health & Safety Code 32136.

Mr. Greg Moser, General Counsel reported Administration is requesting the Board approve the waiver of bid requirements related to the repair of medical gas leaks that have been identified due to health and safety requirements. Mr. Moran stated it is imperative the repairs to the medical gas leaks be made immediately.

It was moved by Director Dagostino to ratify the finding of emergency circumstances requiring waiver of bidding per Health & Safety Code 32136. Director Campo seconded the motion.

The vote on the motion was as follows:

AYES:	Directors:	Campo, Dagostino, Finnila, Kellett, Nygaard, Reno and Schallock
NOES:	Directors:	None
ABSTAIN:	Directors:	None
ABSENT:	Directors:	None

10. Motion to return to Closed Session

At 4:10 p.m. Director Dagostino moved that the Board return to Closed Session. Director Campo seconded the motion. The motion passed unanimously (7-0).

11. The Board returned to Open Session at 5:04 p.m. with all Directors present with the exception of Director Reno.
12. Report from Chairperson on any action taken in Closed Session.

Chairman Schallock reported no action had been taken in closed session.

13. There being no further business, Chairman Schallock adjourned the meeting at 5:04 p.m.

Larry W. Schallock
Chairman

ATTEST:

Julie Nygaard
Secretary



Financial Information Foundation

Funds Raised		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	\$	7,507	\$ 41,024	\$ 87,154										\$ 135,685
FY14	\$	18,153	\$ 8,490	\$ 20,751	\$ 243,582	\$ 199,040	\$ 141,909	\$ 20,016	\$ 12,697	\$ 50,627	\$ 45,735	\$ 120,625	\$ 52,731	\$ 934,357

Endowment Portfolio Value*

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	\$	775,459	\$ 795,002	\$ 776,207									\$ 776,207
FY14	\$	717,484	\$ 704,609	\$ 733,341	\$ 751,741	\$ 764,377	\$ 776,902	\$ 758,698	\$ 788,703	\$ 786,194	\$ 777,913	\$ 791,841	\$ 791,841

*Fully restricted and subject to market fluctuations

Covered California / Healthcare Reform

Number of Covered California Patients Treated

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	173	209	228										610
FY14			N/A				60	66	54	78	114	171	543

Covered California Patient Charges

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	\$	2,232,644	\$ 1,661,397	\$ 1,976,644									\$ 5,870,685
FY14			N/A				\$ 421,882	\$ 1,278,266	\$ 852,155	\$ 1,442,508	\$ 1,397,561	\$ 2,295,174	\$ 7,687,546

Covered California Expected Net Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	\$	647,467	\$ 481,805	\$ 573,227									\$ 1,702,499
FY14			N/A				\$ 77,204	\$ 233,923	\$ 155,944	\$ 263,979	\$ 313,054	\$ 514,174	\$ 1,558,278

Performance compared to prior year:

Better	Same	Worse
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Tri-City Medical Center

ADVANCED HEALTH CARE
FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
FY15	46.3	48.8	48.5										47.9	48-52
FY14	49.0	48.7	48.0	49.9	51.3	57.5	53.2	50.3	48.2	48.1	49.1	48.3	49.7	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD Avg	Range
FY15	78.1	77.1	81.2										78.8	75-100
FY14	78.0	87.4	90.8	90.5	91.5	89.8	82.8	73.4	87.4	83.3	81.1	75.2	84.3	75-100

TCHD EROE \$ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Range
FY15	\$368	(\$348)	\$112										\$132	(\$790)
FY14	(\$467)	(\$406)	\$845	\$83	\$4,171	\$214	(\$45)	(\$279)	(\$511)	\$788	(\$264)	\$257	\$4,385	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD Range
FY15	1.33%	1.32%	0.41%										0.16%	-0.98%
FY14	-1.77%	-1.55%	3.23%	0.30%	16.29%	0.81%	-0.16%	-1.05%	-1.99%	2.82%	-0.96%	1.00%	1.37%	



Tri-City Medical Center

ADVANCED HEALTH CARE
FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD %
FY15	\$1,761	\$988	\$1,456										\$4,205	\$3,505
FY14	\$1,160	\$1,081	\$2,278	\$1,620	\$5,653	\$1,717	\$1,655	\$1,188	\$1,012	\$2,307	\$1,124	\$1,121	\$21,917	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD %
FY15	6.38%	3.75%	5.37%										5.18%	4.35%
FY14	4.40%	4.11%	8.71%	5.95%	22.08%	6.49%	5.89%	4.45%	3.94%	8.25%	4.10%	4.34%	6.85%	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD %
FY15	5.93	5.89	6.01										5.94	6.11
FY14	6.03	6.00	6.05	6.06	6.22	5.93	5.75	5.86	6.09	6.04	5.95	5.99	6.01	

TCHD Fixed Charge Coverage Covenant Calculation

	YTD Jul	YTD Aug	YTD Sep	YTD Oct	YTD Nov	YTD Dec	YTD Jan	YTD Feb	YTD Mar	YTD Apr	YTD May	YTD Jun	YTD	YTD %
FY15	1.55	1.60	1.52											1.10
FY14			1.45	1.69	2.50	2.37	2.08	1.94	1.78	1.78	1.50	1.45		1.05

TCHD Liquidity \$ in Millions (Cash + Available Revolving Line, in Excess of Covenant Requirement)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD %
FY15	\$27.7	\$21.4	\$19.9											
FY14	\$17.7	\$21.6	\$20.2	\$19.3	\$27.1	\$27.3	\$22.0	\$21.9	\$23.6	\$24.5	\$30.7	\$32.6		



Employee Satisfaction



National 90th Mean Scores
Partnership 79.9
Satisfaction 77.1
Engagement 83.6

Voluntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY14
FY15													
FY14			12.1%			12.2%			11.7%			11.4%	11.4%

Involuntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY14
FY15													
FY14			6.9%			8.0%			6.8%			3.2%	3.2%

HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

Source: Hospital Compare
Benchmark Period: 10/1/2012-9/30/2013

"Overall Rating of Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	66%	60%																	
FY14	60%	63%	58%	71%	65%	75%	61%	64%	64%	63%	65%	59%	64%	71%	76%	70%	76%	68%	71%

"Recommend The Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	73%	69%																	
FY14	65%	67%	67%	78%	65%	77%	65%	69%	65%	61%	72%	64%	68%	77%	79%	78%	80%	70%	71%

"Communication with Nurses"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	79%	77%																	
FY14	76%	72%	74%	84%	73%	81%	74%	76%	68%	69%	73%	75%	74%	78%	75%	76%	81%	74%	79%

Performance compared to prior year: Better Same Worse

"Communication with Doctors"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	80%	71%											78%	79%	78%	80%	82%	78%	82%
FY14	75%	75%	78%	79%	80%	85%	73%	77%	73%	75%	80%	81%							

"Response of Hospital Staff"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	63%	76%											65%	63%	63%	64%	65%	62%	64%
FY14	63%	65%	66%	72%	69%	73%	64%	62%	61%	64%	68%	56%							

"Hospital Environment"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	60%	57%											58%	61%	66%	64%	62%	61%	67%
FY14	54%	53%	56%	59%	58%	59%	62%	62%	55%	56%	62%	64%							

"Pain Management"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	74%	68%											68%	71%	68%	70%	76%	68%	71%
FY14	75%	60%	73%	76%	71%	76%	75%	70%	63%	60%	66%	64%							

"Communication about Medicines"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	65%	63%											60%	62%	62%	62%	65%	61%	64%
FY14	65%	64%	61%	62%	56%	69%	65%	53%	55%	52%	62%	62%							

"Discharge Information"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	88%	81%											83%	84%	81%	86%	83%	83%	85%
FY14	85%	80%	76%	84%	79%	88%	80%	77%	86%	80%	89%	86%							

Performance compared to prior year

Better Same Worse



Core Measures

Center for Medicare & Medicaid Services (CMS)

AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	100%												100%
FY14	88%	100%	100%	100%	100%	88%	86%	100%	100%	100%	100%	100%	95%

California (Apr. 2013 - Mar. 2014): 95%

SCIP-Inf-1: Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	100%												100%
FY14	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

California (Apr. 2013 - Mar. 2014): 99%

SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	100%												100%
FY14	96%	100%	100%	100%	96%	100%	100%	100%	100%	100%	97%	100%	99%

California (Apr. 2013 - Mar. 2014): 99%

SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hrs After Surgery End Time

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	100%												100%
FY14	95%	100%	100%	100%	100%	96%	100%	94%	100%	100%	96%	100%	98%

California (Apr. 2013 - Mar. 2014): 98%

SCIP-Inf-4: Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	100%												100%
FY14	100%	100%	100%	92%	88%	86%	75%	100%	83%	100%	88%	100%	93%

California (Apr. 2013 - Mar. 2014): 94%

Performance compared to prior year:

Better	Same	Worse
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SCIP-Inf-9: Urinary Catheter Removed on POD 1 (Post-Op Day) or POD 2

California (Apr. 2013 - Mar. 2014): 98%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	94%												94%
FY14	100%	100%	95%	95%	95%	92%	88%	93%	100%	96%	92%	95%	95%

SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Arrival

California (Apr. 2013 - Mar. 2014): 97%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	92%												92%
FY14	100%	100%	100%	100%	89%	100%	100%	82%	100%	100%	100%	100%	98%

SCIP-VTE-2: Surgery Patients Who Received Appropriate VTE Prophylaxis after Surgery

California (Apr. 2013 - Mar. 2014): 98%

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	100%												100%
FY14	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Emergency Department (ED)

Left without Treatment (LWOT)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	5.2%	4.5%											4.9%
FY14	2.6%	3.3%	3.3%	3.0%	2.7%	3.6%	4.8%	2.4%	4.0%	3.8%	5.8%	3.5%	3.6%

Transfers out of the ED

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	1.83%	2.36%											2.09%
FY14	2.68%	2.75%	2.58%	2.09%	2.44%	2.93%	2.61%	2.53%	2.15%	2.57%	2.16%	2.48%	2.49%

Door to Bed Assignment - Median Time in min.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	31	32											31
FY14	16	17	21	18	18	20	31	24	26	26	36	22	22

Performance compared to prior year:

Better	Same	Worse
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Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	35	32	45										112
FY14	28	27	28	32	38	25	25	40	31	34	34	41	383

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	14	9	22										45
FY14	14	7	13	17	16	16	12	18	19	19	16	14	181

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	6	10	8										24
FY14	5	8	8	9	9	13	9	7	9	8	7	11	103

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	7	11										28
FY14	14	10	15	4	16	16	10	10	12	7	14	9	137

Performance compared to prior year:

Better	Same	Worse
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Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	45	51	32										128
FY14	20	41	27	35	44	32	50	33	29	38	35	35	419

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	23.3	26.5	27.1										25.6
FY14	19.3	21.7	22.0	17.6	19.8	19.9	18.1	22.4	24.3	21.3	21.9	24.9	21.1

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	5.2	3.5	4.3										4.3
FY14	4.7	4.8	4.0	3.5	4.6	3.8	3.7	6.1	5.7	4.0	4.2	5.0	4.5

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	13.2	18.2	19.7										17.0
FY14	12.4	13.5	16.7	19.3	16.0	16.8	17.2	18.6	10.1	11.0	12.1	14.0	14.8

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	190.8	195.0	195.1										193.6
FY14	181.9	179.2	184.2	197.9	188.6	196.4	202.2	210.9	187.7	193.1	198.1	199.0	193.1

Performance compared to prior year:

Better	Same	Worse
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Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	246	263	244										753
FY14	226	223	237	229	224	220	229	188	177	208	218	197	2576

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	16	19	12										47
FY14	22	15	18	18	15	18	27	11	20	14	12	16	206

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	4	6	2										12
FY14	7	10	8	12	13	5	12	7	13	8	9	2	106

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	10	9	10										29
FY14	6	9	12	11	9	6	10	15	10	7	12	16	123

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY15	1.64	1.63	1.58										1.62
FY14	1.65	1.69	1.63	1.53	1.57	1.56	1.58	1.49	1.60	1.58	1.59	1.58	1.59

Performance compared to prior year:

Better	Same	Worse
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Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Construction Report
As of September 2014

Project	CEO, Capital Committee, or Board Approval Date	Bid Close Date	Design/ Construction	% of Design Complete	Project Start or Estimated Project Start Date	Estimated Construction Completion Date	% of Construction Complete	OSHDP Fee's /Other AHJ Fee's	Design Budget	Construction Budget - 1.64% OSHDP Fee's	Equipment Budget - 0.164% OSHDP Fee's	Total Budget	Actual Expenditures *	Remaining Budget	Total Amount Committed	Total Budget less Amount Committed	Status / Comments
Nurse Call System - Phase 1 (Design Only)	January 17, 2012 FOP	June 1, 2012	No Bids Solicited at this time	100%	Unknown	Unknown	0%	4,100	HDR Architects	No Contractor Selected	N/A	\$ 300,000.00	\$ 97,097.33	\$ 202,902.67	\$ 97,097.33	\$ 202,902.67	OSHDP approval received April 2014. Waiting on direction from the C-Suite on when we want to proceed with a public bid.
		May 3, 2013						Sun Engineering	No Contractor Selected								
									20,000	\$112,305.00	\$ 60,000.00	\$ 194,305.00	\$ 88,275.78	\$ 106,029.22	\$ 96,457.00	\$ 97,848.00	Histology portion is complete. Working on pre-design for Cytology.
Histology Grading Stations/Cytology Renovation	January 11, 2013 capital committee Annual Budget approval FY 2014		TCHD employees installing Professional services	100%	May 1, 2014	June 14	100%	2,000	Mascari Warner Arch	Multiple Trade Contractors							Waiting on Legal and Siemens to Negotiate the contract for leasing the new equipment.
									143,231	\$338,846.40	\$ 513,951.40	\$ 154,776.00	\$ 359,075.40	\$ 129,777.00	\$ 384,074.40	Design is approved by OSHDP. Will send out for a public bid once Angio & CT are complete.	
Angio Lab Renovation	September 3, 2012 Capital Committee	January 8, 2014	Professional services	100%	Unknown	Unknown	0%	11,771	Mascari Warner Arch	No Contractor Selected							Waiting on drawings and specs from GE to finish the design.
Nuclear Equip & Radiopharm Room Remodel	November 9, 2012 Capital Committee		No Bids Solicited at this time	100%	Unknown	Unknown	0%	6,802	101,200	No Contractor Selected							
		May 2, 2013							Dayr Architecture	No Contractor Selected							
CT Scan Remodel	June 27, 2013 (Board)		No Bids Solicited at this time	95%	Unknown	Unknown	0%	3,362	50,600	No Contractor Selected							
Cardiac MOB Design (next to wellness ctr)	January 2, 2014 (Capital Committee)	August 2, 2013							Sifer Architects	No Contractor Selected	N/A						
									141,173	Spooners	N/A	\$ 141,173.02	\$ 96,932.61	\$ 44,240.41	\$ 106,698.50	\$ 34,474.52	Design is approved. Waiting on direction from the C-Suite on when we want to send this out for Public Bid.
		May 1, 2014	No Bids Solicited at this time	100%	Unknown	Unknown	0%	N/A	0	\$652,191.00	N/A	\$ 652,191.00	\$ 456,533.70	\$ 195,657.30	\$ 622,451.45	\$ 29,739.55	Construction is about 50% complete. The Physicians hired the contractor to do the construction.
Joint Commission Plans for Improvement 74 Fire Doors	June 1, 2014		Professional Services SFEIR	100%	July 1, 2014	August 14	100%	0	Sifer Architects	NA							
C-13 Clinic Design Build out	September 2, 2014							2,000	57,790	Multiple Trade Contractors							
									N/A	\$38,363.00	N/A	\$ 612,752.00	\$ 5,684.82	\$ 607,067.18	\$ 56,818.00	\$ 555,934.00	Project is 100% Complete.
Renovation of Cardiac Wellness Center	September 2, 2014		No Public Bid Required	NA	August 11, 2014	August 14	100%	0									
Total Construction Projects																	

* Actual Expenditures* excludes capitalized interest

** Estimated completion is based on actual physical project progress and not on amounts invoiced to the District

Building Operating Leases
Month Ending September 30, 2014

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month (a)	LeaseTerm		Services & Location	Cost Center
					Beginning	Ending		
Gary A. Colner & Kathryn Ainsworth-Colner Family Trust 4913 Colusa Dr. Oceanside, Ca 92056 V#79235	1,650	\$1.85	(a)	\$ 4,149.39	8/1/12	7/31/15	Dr Dhruvil Gandhi 2095 West Vista Way, Ste.106 Vista, Ca 92083	8460
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87000	\$4.08	(a)	\$225,517.00	7/1/13	6/30/28	Wellness Center 6250 El Camino Real Carlsbad, CA 92009	7760
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	\$1.50	(a)	\$ 3,398.15	1/1/13	12/31/14	Performance Improvement 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	\$0.95		\$ 5,566.11	5/1/13	4/30/18	Nifty After Fifty 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	\$1.65	(a)	\$ 8,861.09	9/1/12	8/31/17	OP Physical Therapy, OP OT & OP Speech Therapy 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	\$1.22	(a)	\$ 9,811.17	7/1/11	7/1/16	Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083	7320
Medical Acquisition Co., Inc. Gateway Rd. Carlsbad, Ca 92009 V#80390	3,527	\$2.00	(a)	\$ 7,054.00	4/1/11	3/30/15	Human Resources Office 1211 West Vista Way Vista, Ca 92083	8650
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 V#81250	4,760	\$3.55	(a)	\$ 22,377.00	10/1/12	10/1/22	Chemotherapy/Infusion Oncology Office 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	\$1.10		\$ 4,857.46	10/28/13	3/3/18	Nifty after Fifty 510 Hacienda Drive Suite 108-A Vista, CA 92081	9550
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	\$1.37	(b)	\$ 7,933.59	12/19/11	12/18/16	Vacant Medical Office Building 4120 Waring Rd Oceanside, Ca 92056	8462 Until operational
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	\$3.13	(b)	\$ 12,912.04	1/1/12	12/31/16	Vacant Bank Building 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				\$ 312,437.00				

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

(b) Rate per Square Foot is computed based on the initial base rent at inception of lease. The current rent payment is based on the related outstanding debt, therefore the rent payment declines over time.


Tri-City Medical Center
**ADVANCED HEALTH CARE
FOR YOU**
Education & Travel Expense
Month Ending September 30, 2014

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8723	ACHSA CONF	62614	450.00	78664	TJ GRUNNAN RN
8740	ACLS COURSE	92214	190.00	81295	LORRAINE BULLA
8764	AM HEART FAILURE SEMINAR	71114	904.67	60897	LYDIA SERRIN
7400	PEDIATRIC CONFERENCE	91514	330.00	81771	MEGGAN MCGRAW
8740	AORN PERIOP 101-WEBINAR	91014	2,687.90	9999	SHARON VIRGEN, GRECIA GONZALES
8510	API FUND FOR PAYROLL	81314	429.00	8021	CIELO CAYABYAB
6183	CALNOC CONFERENCE	72314	675.00	79284	JENESSA FRENCH
8756	CALNOC CONFERENCE	72314	675.00	77414	MICHELLE DODSON
7770	CCPB TRAINING	717142	250.00	78953	KARYN QURASHY
7010	CHA DISASTER PL	72814	793.78	81463	SUE KIRK
8754	HEALTH LAW	849006	750.00	31992	MARCIA CAVANAUGH
8740	CHEMO CLASS	92214	200.00	81762	JAYSON REMIGIO
7400	CHF CONFERENCE	62314	1,361.52	81041	SHARON DAVIES
8740	COURSE-EVERYTHI	90914	200.00	80179	JUDY C. DENAGA
7770	CRANIO SACRAL SEMINAR	71714	200.00	78953	KARYN QURASHY
7010	ESI WEB COURSE	82214	1,275.00	82174	ED DEPT- 75 PARTICIPANTS
8620	GOVERNOR FORUM	82714	343.11	78591	LARRY W. SCHALLOCK
8614	HEALTHCARE MGMT SEMINAR	80814	2,450.00	77376	JEREMY RAIMO
7084	INCARERATED PATIENT CONF	90214	220.00	77773	VICTOR L. SOUZA, M.D.
8700	MINORS HEALTH-WEBINAR	80714	185.00	14365	COLLEEN M THOMPSON
8740	PALS	70814	100.00	81736	TRINA ROBINSON
8740	PCCN CONFERENCE	92214	160.00	81825	MARIA CARLOS
8740	PCCN CONFERENCE	92214	200.00	80175	JOYCE J. FERRER
8700	PRIVACY TRAINING	62514	216.96	71807	COLLEEN M THOMPSON
8340	SERVSAFE CLASS	5910549	135.00	68056	J PEREZ
8758	STROKE MEETING	42114	600.00	82057	JACK SCHIM
8740	TUITION REIMB	71514	5,000.00	82165	ROSEMARIE FINONES
8740	TUITION REIMB	90914	2,500.00	78192	JOY LITTLE
8740	TUITION REIMB	82614	139.00	82180	MARIA R THOMAS
8740	TUITION REIMB	82614	150.00	82179	RYAN RABOLD
8740	TUITION REIMB	80514	159.00	81735	ANDREA HANSON
8740	TUITION REIMB	72914	199.00	44103	RAUL A MERIDA
8740	TUITION REIMB	72914	199.00	77624	ARIEL BASAEZ
8740	TUITION REIMB	81214	200.00	77784	HAMID WALEH
8740	TUITION REIMB	80514	200.00	78548	STEVE SIMS
8740	TUITION REIMB	90914	1,273.43	80084	COURTNEY NELSON
8740	TUITION REIMB	72314	2,500.00	79494	DIANNE MONTIJO
8756	VHA FORUM	50514	903.94	82086	RICK SANCHEZ
8720	VHA LEADERSHIP CONF	63014	201.88	59683	SHARON SCHULTZ
7633	VMWARE TRAINING	70214	281.84	82186	LILLIAN LEE

**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.