**TRI-CITY HEALTHCARE DISTRICT**
**AGENDA FOR A REGULAR MEETING**
**June 21, 2024 – 3:30 o'clock p.m.**
**Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion**
**4002 Vista Way, Oceanside, CA 92056**

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

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 1 | Call to Order | 3 min. | Standard |
| 2 | Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) | 2 min. | Chair |
| 3 | Roll Call / Pledge of Allegiance | | |
| 4 | Approval of Agenda | 2 min | Standard |
| 5 | Public Comments – Announcement<br>Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors.<br><br>NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications. | 2 min. | Standard |
| 6 | May 2024 Financial Statement Results | 10 min. | CFO |
| 7 | New Business –<br><br>a) Review, discussion and action regarding the Operating and Capital Budgets for FY2025.<br><br>b) Review, discussion and consideration to extend the MidCap Financial Services Capital Management Credit Agreement for an additional two years. | <br><br>10 min.<br><br>5 min. | <br><br>CFO<br><br>CFO |
| 8 | Old Business – None | | |

*Note: This certifies that a copy of this agenda was posted in the entrance to the Tri-City Medical Center at 4002 Vista Way, Oceanside, CA 92056 at least 72 hours in advance of the meeting. Any writings or documents provided to the Board members of Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Department located at the Tri-City Medical Center during normal business hours.*

*Note: If you have a disability, please notify us at 760-940-3348 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.*

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| 9 | Chief of Staff -<br><br>a) Consideration of June 2024 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals, **pending** recommendation from the Medical Executive Committee on June 24, 2024. | 5 min. | COS |
| 10 | Consent Calendar<br><br>(1) Board Committee<br><br>**(a) Finance, Operations & Planning Committee**<br>**Director Younger, Committee Chair**<br>*No meeting held*<br>(2) Consideration to approve Resolution No. 826, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2024 and ending June 30, 2025, in Accordance with Article XIII B of the Constitution of the State of California; Code of the State of California.<br><br>(3) Consideration to approve the agreement with Medline Industries, LP for general laboratory supplies for a term of 17 months, beginning June 1, 2024 and ending October 31, 2025, for an annual cost of $604,236. And a total cost for the term of $856,001.<br><br>(4) Consideration to approve an agreement with Beckman Coulter, Inc. for Urinalysis Instrumentation, Service and Consumables for a term of 60 months, beginning July 1, 2024 and ending June 30, 2029, for an annual cost of $66,396 and a total cost for the term of $331,980.<br><br>(5) Consideration to approve the renewal of the agreement with South Coast Perfusion, Inc. for a term of 24 months, beginning July 1, 2024 and ending July 30, 2026, for an estimated annual cost of $466,200 and a total term cost of $932,400.<br><br>(6) Consideration to approve the renewal of the agreement with Brian Mudd, DDS for Emergency Department On-Call Coverage Panel for Oral-Maxillofacial for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, with an annual and total term cost of $182,500.<br><br>(7) Consideration of the renewal of an agreement with Andrew R. Deemer, M.D. and Mohammad Jamshidi-Nezhad, D.O, as the Vascular Surgery ED on-Call physicians for a term of 24 months, beginning July 1, 2024 and ending June 30, 2026, for a total term cost of $730,000.<br><br>(8) Consideration to approve the renewal of the agreement for the Emergency Department Call Coverage Panel for Spine Surgery, to include Payam Moazzaz, M.D., Tyrone Hardy, M.D. Mark Stern M.D., Kevin Yoo. M.D., Sunil Jeswani, M.D. for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, with an annual and total term cost of $162,250.<br><br>(9) Consideration to approve the renewal of an agreement with Michael J. Ammar, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Vincent Q. Nguyen, M.D. and Maulik Zaveri M.D., as the Ophthalmology ED Call coverage | | Chair |

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|

physicians for a term of 24 months, beginning July 1, 2024 and ending June 30, 2026, for a total term cost of $310,250.

(10) Consideration to approve the Medical Staff Leadership Agreement for Chief of Staff, Henry Showah, M.D. for a term of 11 months, beginning August 1, 2024 and ending on June 20, 2025, for an annual cost not to exceed $72,000, plus an additional educational allowance for the 11-month term of $5,000, for a total term cost not to exceed $77,000.

(11) Consideration to approve an agreement with Frank Corona, M.D., Medical Director for Pulmonary Rehab, for a term of 24 months, beginning July 1, 2024 and ending June 30, 2026, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual cost of $42,000 and a total cost for the term of $84,000.

(12) Consideration to approve an agreement with Barton & Associates to provide Locum Tenem's Pathology services for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, with a term cost not to exceed $300,000.

(13) **Administrative Policies & Procedures**

**A. Patient Care Services**

1. Admixture, Intravenous Procedure
2. Census Zones, Managing of Policy
3. STEMI Transfer from Non-PCI Capable Facility

**B. Administrative**

1. Consent for Photograph/Videotape 372
2. Disclosure of Unanticipated Adverse Outcomes to Patients, Families, Surrogates and Agents 275

**C. Cardiac Cath Lab**

1. Implant Tray Setup Procedure
2. Percutaneous Transmittal Coronary Angioplasty Setup (PTCA) Procedure
3. Set Up and Insertion of Intra-Aortic Balloon IAB) Catheter Procedure
4. Stenting Procedure

**D. Emergency Department**

1. EZ-IO Intraosseous (IO) Infusion System Procedure

**E. Medical Staff**

1. Credentialing Policy, da Vinci Robotic Assisted Surgery 8710-563
2. Medical Staff Standards of Conduct 8710-552
3. Quality Review Process for Teleradiologists 8710-525

**F. Pulmonary Rehab**

1. Contraindication to Pulmonary Rehab Exercise
2. Exercise Program
3. Home Exercise Program
4. Scope of Services
5. Strength Training

**G. Surgical Services**

1. Cell Saver Set-Up, Use and Monitoring Procedure

| | Agenda Item | Time Allotted | Requestor |
|---|---|---|---|
| | 2. Medications in Surgery Policy<br>3. Surgery Blood in Ice Chests Procedure<br>4. Visitors in the OR Policy<br><br>(14) Minutes<br>a) Special Meeting – May 30, 2024<br>b) Regular Meeting – May 30, 2024<br><br>(15) Reports – (Discussion by exception only)<br><br>a) Building Lease Report – (April, 2024)<br>b) Reimbursement Disclosure Report – (April 2024) | | |
| 11 | Discussion of Items Pulled from Consent Agenda | 10 min. | Standard |
| 12 | Comments by Members of the Public<br>NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda. | 5-10 minutes | Standard |
| 13 | Comments by Chief Executive Officer | 5 min. | Standard |
| 14 | Board Communications | 18 min. | Standard |
| 15 | Total Time Budgeted for Open Session | 1.5 hour | |
| 16 | Adjournment | | |

Tri-City Medical Center

**To:** **TCHD Board of Directors**

**From:** **Janice Gurley, CFO**

**Re:** **Extension to Mid-Cap Financial Services Capital Management Credit Agreement**

**Date:** **June 14, 2024**

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**Line of credit** – The current revolving line of credit with Mid Cap, LLC is due 8/31/24.

Asking:

Approval for 2 years extension: extending the term maturity date to August 31, 2026 with the same term: The amount available is $15.4 million, the interest rate is the London Interbank Offered Rate (LIBOR) plus 3.0% subject to a LIBOR floor of 1%. The amount available under this revolving line of credit is fully collateralized by certain assets of the District.

Purpose: Additional liquidity available to the district when needed.

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT
# June 12, 2024

*Attachment A*

## Initial Appointments

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

***Medical Staff:***

| Practitioner Name | Group | Specialty | Staff Status | Initial Appointment Term |
|---|---|---|---|---|
| AVILA, Jailyn MD | TeamHealth | Emergency Medicine | Provisional | 6/25/2024 – 6/25/2026 |
| CHEN, Anna MD | Gamma Neuro Network Inc. | Medicine / Teleneurology | Provisional | 6/25/2024 – 6/25/2026 |
| PARK, Sung-Min MD | Gamma Neuro Network Inc. | Medicine / Teleneurology | Provisional | 6/25/2024 – 6/25/2026 |
| PULIDO, Richard MD | Sound/ECHO | Medicine / Internal Medicine | Provisional | 6/25/2024 – 6/25/2026 |
| RIAD, Shareef MD | StatRad | Radiology / Teleradiology | Provisional | 6/25/2024 – 6/25/2026 |
| ROMAN, Jordan MD | TeamHealth | Emergency Medicine | Provisional | 6/25/2024 – 6/25/2026 |

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
# June 12, 2024

*Attachment B*

## Reappointments:

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

***Medical Staff***

**Department of Emergency Medicine:**

| Practitioner Name | Specialty | Staff Status: | Reappointment Term | Comments |
|---|---|---|---|---|
| CHIANG, Pengta A., MD | Emergency Medicine | Active | 6/25/2024-6/25/2026 | |
| FAIQ, Nadia, MD | Emergency Medicine | Active | 6/25/2024-6/25/2026 | - Change in staff status from Provisional to Active. |
| POLLACK, Melanie A., DO | Emergency Medicine | Active | 6/25/2024-6/25/2026 | |
| ZAWADA, Nicole T., MD | Emergency Medicine | Active | 6/25/2024-6/25/2026 | |

**Department of Medicine:**

| Practitioner Name | Specialty | Staff Status: | Reappointment Term | Comments |
|---|---|---|---|---|
| BHARNE, Anjali A, MD | Oncology | Active | 6/25/2024-6/25/2026 | |
| CLANCY, Tara L | Internal Medicine | Refer and Follow | 6/25/2024-6/25/2026 | |
| EL-SHERIEF- Karim H., MD | Cardiology | Active | 6/25/2024-6/25/2026 | |
| EVTIMOV, Stoimen S., MD | Internal Medicine | Active | 6/25/2024-6/25/2026 | |
| PARKER, John A., MD | Teleneurology | Active | 6/25/2024-6/25/2026 | Change in staff status from Provisional to Active. |
| SCHWERKOSKE, John, MD | Oncology | Refer and Follow | 6/25/2024-6/25/2026 | Change in staff status from Provisional to Refer and Follow. |
| SHIRKA, Romina, DO | Teleneurology | Active | 6/25/2024-6/25/2026 | Change in staff status from |

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
# June 12, 2024

*Attachment B*

| | | | | |
|---|---|---|---|---|
| | | | | Provisional to Active. |
| SOUZA, Victor L., MD | Internal Medicine | Active | 6/25/2024-6/25/2026 | |
| SHETH, Manish | Psychiatry | Refer and Follow | 6/25/2024-6/25/2026 | |

**Department of Pediatrics:**

| Practitioner Name | Specialty | Staff Status: | Reappointment Term | Comments |
|---|---|---|---|---|
| MOVAHHEDIAN, Hamid R., MD | Neonatology | Active | 6/25/2024-6/25/2026 | |
| NAUDIN, Veronica L., MD | Pediatrics | Active | 6/25/2024-6/25/2026 | |
| PERKINS, Rachel E., MD | Pediatrics | Active | 6/25/2024-6/25/2026 | - Provider does not have a current NRP/NALS or PALS. |

**Department of Radiology:**

| Practitioner Name | Specialty | Staff Status: | Reappointment Term | Comments |
|---|---|---|---|---|
| MILLER, Jeffrey S., MD | Diagnostic Radiology | Refer and Follow | 6/25/2024-6/25/2026 | - Provider requesting to go to Refer and Follow with no clinical privileges.<br>- Provider has a claim from 2023 that he did not disclose on application. |
| NASIRI, Arian K., MD | Interventional Radiology | Active | 6/25/2024-6/25/2026 | |

**Department of Surgery:**

| Practitioner Name | Specialty | Staff Status: | Reappointment Term | Comments |
|---|---|---|---|---|
| FOSTER, Alexander S., MD | Ophthalmology | Active Affiliate | 6/25/2024-6/25/2026 | |
| GOLD, Evan S., DMD | Oral & Maxillofacial Surgery | Refer and Follow | 6/25/2024-6/25/2026 | |
| LIU, Richard., MD | Otolaryngology | Active | 6/25/2024-6/25/2026 | |
| BOONJINDASUP,Aaron G., MD | Urology | Active | 6/25/2024-6/25/2026 | |
| PHAM, Martin H., MD | Neurological Surgery | Active Affiliate | 6/25/2024-6/25/2026 | Change in staff status from |

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
# June 12, 2024

*Attachment B*

| | | | | |
|---|---|---|---|---|
| | | | | Active to Active Affiliate based on activity. |
| NASSERY, Kristen M., MD | General Surgery | Active | 6/25/2024-6/25/2026 | |
| WADHWA, Ashish K., MD | Otolaryngology | Active Affiliate | 6/25/2024-6/25/2026 | |

**Resignations *Medical Staff and AHP*:**

| Practitioner Name | Department/Specialty | Reason for Resignation |
|---|---|---|
| AHMED, Mohammed M., MD | Psychiatric/ Medicine | Voluntary Resignation effective 6/30/2024. |
| ARAMIN, Hermineh MD | Pathology | Voluntary Resignation effective 6/10/2024 submitted by MD. |
| BERRY, Julie MD | Surgery/Otolaryngology | Voluntary Resignation- Per practitioner's letter: effective 6/30/24. |
| CAVIN, Lillian MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| CHU, James MD | Pediatrics/Peds Cardiology | Voluntary Resignation – Did not return reappointment app. |
| DUNN, William MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 11/14/23. |
| FRIEDMAN, Sidney MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| HAYS, Johnathan MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| HERGESHEIMER, Charles E., MD | Internal Medicine/ Medicine | Voluntary Resignation effective 6/30/2024. |
| MCCLAY, Edward F., MD | Medicine/ Internal Medicine | Voluntarily Resignation- Per practitioner will not move forward with Reappointment. |
| MYERS, Timothy MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| NISSIM, Lahav MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| RUFFOLO, Aldo MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| SHIRLEY, James MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| LIU, Jiajing MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| STUPIN, Jeremy MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| VELEZ, Erik MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| GOOTNICK, Susan MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| PIAMPIANO, Peter MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
# June 12, 2024

*Attachment B*

| | | |
|---|---|---|
| SANGHI, Amit MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| SILVA, Patricia MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |
| SUBRAMANIAN, Rupa MD | Medicine/Oncology | Voluntary Resignation – Did not return reappointment app. |
| WILLIAMS, Solomon MD | Telepsychiatry | Voluntary Resignation- Per group, resignation effective 5/28/24. |
| ZINN, William MD | Radiology/Teleradiology | Voluntary Resignation- Per group, resignation effective 5/24/24. |

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

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

Tri-City Medical Center
MEDICAL STAFF

# TRI-CITY MEDICAL CENTER
# CREDENTIALS COMMITTEE REPORT – Part 3 of 3
# June 12, 2024

## Proctoring Recommendations

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

| Practitioner Name | Department/Specialty | Privilege(s) |
|---|---|---|
| Yomiyyu Gammada, MD | Medicine/Internal Medicine | Admit patients, Internal Medicine, Consultations, Internal Medicine, including via telemedicine (F), History and physical examination, Internal Medicine, including via telemedicine (F). |
| Joseph Gehrz, MD | Emergency Medicine | General Patient Care |
| Eric Kim, MD | Medicine/Teleneurology | Intraoperative Neurophysiological Monitoring and Interpretation |

**RESOLUTION NO. 826**

**A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2024 AND ENDING JUNE 30, 2025 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA**

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

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

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

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

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

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2024 and ending June 30, 2025 is not to exceed $19,610,142.

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

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

ADOPTED, SIGNED AND APPROVED this 21st day of June, 2024.

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

ATTEST:

Gigi S. Gleason, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

**STATE OF CALIFORNIA** )
)
**COUNTY OF SAN DIEGO** )

**ss.**

I, Gigi Gleason, Secretary of TRI-CITY HEALTHCARE DISTRICT and of the Board of Directors thereof, do hereby certify that the foregoing Resolution was duly adopted by the Board of Directors of said District at a Regular Meeting of said Board held on the 21st day of June, 2024, and that it was adopted by the following vote:

| | |
|---|---|
| **AYES:** | **DIRECTORS:** |
| **NOES:** | **DIRECTORS:** |
| **ABSTAIN:** | **DIRECTORS:** |
| **ABSENT:** | **DIRECTORS**: |

Gigi S. Gleason, Secretary
of the TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: June 21, 2024**
**Medline Industries Prime Vendor for Laboratory Supplies PROPOSAL**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Type of Agreement** | | Medical Director | | Panel | X | Other: Vendor |
| **Status of Agreement** | X | New Agreement | | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Medline Industries, LP

**Area of Service:** Laboratory

**Term of Agreement:** 17 months, Beginning, June 01, 2024 – Ending, October 31, 2025

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $50,353 | $604,236 | $856,001 |

**Description of Services/Supplies:**

- This is a 17-month amendment to the master distribution agreement with Medline Industries in order to make Medline a prime vendor for laboratory supplies.
- Prime vendor status provides an additional 6% savings on total lab spend for supplies purchased through Medline. This 6% savings is estimated at $50K over the term of the contract.

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

**Person responsible for oversight of agreement:** Tara Eagle & Thomas Moore / Eva England & Janice Gurley

**Motion:**
I move that the TCHD Board of Directors authorize the agreement with Medline Industries, LP for general laboratory supplies for a term of 17 months, beginning June 01, 2024 and ending October 31, 2025 for an annual cost of $604,236 and a total cost for the term of $856,001.

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: June 21, 2024**
**Urinalysis Instrumentation, Service, and Consumables PROPOSAL**

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

**Vendor's Name:** Beckman Coulter, Inc.

**Area of Service:** Laboratory - Urinalysis

**Term of Agreement:** 60 months, Beginning, July 01, 2024 – Ending, June 30, 2029

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $5,533 | $66,396 | $331,980 |

**Description of Services/Supplies:**

- This is a reagent rental agreement to include instrumentation for urine chemistry and urine microscopy, associated instrument maintenance for 5 years, and consumables. The pricing is consistent with Vizient GPO usage tier that is based upon annual test volumes.
- Current annual spend is $58,958 for instrument maintenance and consumables.
- Current instrumentation uses Windows XP software, which reflects an IT security risk to the organization. By upgrading the new instrumentation, the software runs on Windows 10.

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

**Person responsible for oversight of agreement:** Tara Eagle, Assistant Director, Laboratory Services/ Eva England, Senior Director, Ancillary Services.

**Motion:**
I move that the TCHD Board of Directors authorize the agreement with Beckman Coulter, Inc. for Urinalysis Instrumentation, Service, and Consumables for a term of 60 months, beginning July 01, 2024 and ending June 30, 2029, for an annual cost of $66,396 and a total cost for the term of $331,980.

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: June 21, 2024**
**PERFUSION SERVICES AGREEMENT RENEWAL**

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

**Vendor's Name:** South Coast Perfusion Associates, Inc.

**Area of Service:** Surgery – Operating Room

**Term of Agreement:** 24 months, Beginning, July 1, 2024 – Ending, June 30, 2026

**Maximum Totals:**

| Monthly Cost | Annual Cost | Total Term Cost |
|---|---|---|
| $38,850 | $466,200 | $932,400 |

**Description of Services/Supplies:**

- Perform perfusion services at TCMC Hospital to include: Cardiopulmonary Perfusion, Intra-Aortic Balloon Pump, Ventricular Assist Device, Extracorporeal Membrane Oxygenation, and Auto-Transfusion. Contractor shall provide such services within 30 minutes from the time of call from the Hospital to contractor.
- Contractor shall provide quarterly QA/QI reports, in conjunction with Hospital Medical Staff (cardiac surgeons), attend and participate in Division meetings at least quarterly, designate a lead perfusionist assigned to Hospital, complete all required reporting forms, including STS forms relating to cardiac surgeries.

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

**Person responsible for oversight of agreement:** Hillary Lindberg, Manager-Surgical Services / Donald Dawkins, Chief Nurse Executive

**Motion:**
I move that the TCHD Board of Directors authorize the renewal of the agreement with South Coast Perfusion, Inc. for a term of 24 months, beginning July 1, 2024 and ending June 30, 2026, for an estimated annual cost of $466,200 and a total term cost of $932,400.

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: June 21, 2024**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ORAL/MAXILLOFACIAL SURGERY**

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

**Vendor's Name:** Brian Mudd, D.D.S.

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

**Term of Agreement:** 12 months, Beginning, July 1, 2024 - Ending, June 30, 2025

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

| Rate/Day | Term | Annual Cost |
|---|---|---|
| $500 | FY2025 | $182,500 |
| | **Total Term Cost** | **$182,500** |

**Description of Services/Supplies:**

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

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

**Person responsible for oversight of agreement:** Jeremy Raimo, COO / Bert Lawson, Director-Emergency Dept.

**Motion:**

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call Coverage Panel for Oral-Maxillofacial Surgery with Brian Mudd, D.D.S., for a term of 12 months, beginning July 1, 2024 and ending, June 30, 2025, with an annual and total term cost of $182,500.

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: JUNE 21, 2024**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: VASCULAR SURGERY**

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

**Physician's Names:** Andrew R. Deemer, M.D., Mohammad Jamshidi-Nezhad, D.O.

**Area of Service:** Emergency Department On-Call: Vascular Surgery

**Term of Agreement:** 24 months, Beginning, July 1, 2024 – Ending, June 30, 2026

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

| Rate/Day | Term | Term Cost |
|---|---|---|
| $1,000 | FY2025 (365 days) | $365,000 |
| | FY2026 (365 days) | $365,000 |
| | | **$730,000** |

**Position Responsibilities:**

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

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

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

**Motion:**
I move that the TCHD Board of Directors authorize Andrew R. Deemer, M.D. and Mohammad Jamshidi-Nezhad, D.O., as the Vascular Surgery ED On-Call Coverage Physicians for a term of 24 months, beginning July 1, 2024 and ending June 30, 2026, for a total term cost of $730,000.

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: June 21, 2024**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – SPINE SURGERY**

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

**Vendor's Name:** Payam Moazzaz, M.D., Tyrone Hardy, M.D., Mark Stern, M.D., Kevin Yoo, M.D., Sunil Jeswani, M.D.

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

**Term of Agreement:** 12 months, Beginning, July 1, 2024 - Ending, June 30, 2025

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

| Rate/Day | Term | Annual Cost |
|---|---|---|
| $450 | FY2025 | $164,250 |
| | **Total Term Cost** | **$164,250** |

**Description of Services/Supplies:**

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

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

**Person responsible for oversight of agreement:** Jeremy Raimo, COO / Bert Lawson, Director-Emergency Dept.

**Motion:**

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department Call Coverage Panel for Spine surgery to include Payam Moazzaz, M.D., Tyrone Hardy, M.D., Mark Stern, M.D., Kevin Yoo, M.D., and Sunil Jeswani, M.D. for a term of 12 months, beginning July 1, 2024 and ending, June 30, 2025, with an annual and total term cost of $164,250.

Tri-City Medical Center

**TCHD BOARD OF DIRECTORS**
**DATE OF MEETING: June 21, 2024**
**PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - OPHTHALMOLOGY**

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

**Physician's Names:** Michael J. Ammar, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Vincent Q. Nguyen, M.D., and Maulik Zaveri, M.D.

**Area of Service:** Emergency Department On-Call: Ophthalmology

**Term of Agreement:** 24 months, Beginning, July 1, 2024 – Ending, June 30, 2026

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

| Rate/Day | Term | Total Term Cost |
|---|---|---|
| $400 | FY2025 | **$146,000** |
| $450 | FY2026 | **$164,250** |
| | TOTAL TERM COST | **$310,250** |

**Position Responsibilities:**

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

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

**Person responsible for oversight of agreement:** Jeremy Raimo, COO / Bert Lawson, Director-Emergency Dept.

**Motion:**
I move that the TCHD Board of Directors authorize the renewal of Michael J. Ammar, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Vincent Q. Nguyen, M.D., and Maulik Zaveri, M.D., as the Ophthalmology ED Call-Coverage physicians for a term of 24 months, beginning July 1, 2024 and ending June 30, 2026, for a total term cost of $310,250.

# Tri-City Medical Center

**TCHD Board of Directors**
**DATE OF MEETING: June 21, 2024**
**Medical Staff Leadership Agreement – CHIEF OF STAFF, Henry Showah, M.D.**

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

**Physician's Name:** Henry Showah, M.D.

**Area of Service:** Medical Staff Leadership: Chief of Staff

**Term of Agreement:** 11 months, Beginning, August 1, 2024 – Ending, June 30, 2025

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

| Rate/Hr | Hrs/Month | Max Monthly Cost(TCHD) | Max Annual Cost(TCHD) | Education Expense for Term | Total Term Cost(TCHD) |
|---|---|---|---|---|---|
| $150 | NTE 40 hrs | NTE $6,000 | NTE $72,000 | $5,000 | NTE $77,000 |

**Position Responsibilities:**

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

| | | | | |
|---|---|---|---|---|
| Document Submitted to Legal for Review: | X | Yes | | No |
| Approved by Chief Compliance Officer: Roger Cortez CCPO /LC | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | X | Yes | | No |
| Budgeted Item: | X | Yes | | No |

**Person responsible for oversight of agreement:** Jonathan Gonzalez, Director-Medical Staff Services / Gene Ma, M.D., Chief Executive Officer

**Motion:** I move that the TCHD Board of Directors authorize the Medical Staff Leadership agreement for Chief of Staff, Henry Showah, M.D., for a term of 11 months beginning August 1, 2024, and ending on June 30, 2025, for an annual cost not to exceed $72,000, plus an additional educational allowance for the 11-month term of $5,000, for a total term cost not to exceed $77,000.

Tri-City Medical Center

**TCHD BOARD OF DIRCTORS**
**DATE OF MEETING: June 21, 2024**
**PHYSICIAN AGREEMENT – MEDICAL DIRECTOR, PULMONARY REHAB**

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

**Vendor's Name:** Frank E. Corona, M.D., dba Tri-City Pulmonary Medical Group, a Professional Corporation

**Area of Service:** Pulmonary Services Department

**Term of Agreement:** 24 months, Beginning, July 1, 2024 – Ending, June 30, 2026

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: YES
No increase in expense

| Rate/Hour | Hours per Month | Hours per Year | Monthly Cost | Annual Cost | 24 Month (Term) Cost |
|---|---|---|---|---|---|
| $175 | 20 | 240 | $3,500 | $42,000 | **$84,000** |

**Description of Services/Supplies:**

- Medical director leadership support of the Pulmonary Rehabilitation service line.
- Medical leadership oversight of the respiratory care department (Pulmonary Services) and the respiratory care practitioners.
- Review and make recommendations regarding clinical applications of respiratory care. Assistance in developing policies, procedures, clinical protocols, forms, reports and records by TCMC in connection with the department.
- Assist with the provision and design of educational services to the respiratory care staff members.

| | | | | |
|---|---|---|---|---|
| Document Submitted to Legal for Review: | X | Yes | | No |
| Approved by Chief Compliance Officer: Roger Cortez CCPO/MD | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | X | Yes | | No |
| Budgeted Item: | X | Yes | | No |

**Person responsible for oversight of agreement:** Eva England, Sr. Director-Ancillary Services / Dr. Gene Ma, Chief Executive Officer

**Motion:**

I move that the TCHD Board of Directors approve Dr. Frank Corona as the Medical Director for Pulmonary Rehab for a term of 24 months beginning July 1, 2024 and ending June 30, 2025. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175 for an annual cost of $42,000 and a total cost for the term of $84,000.

Tri-City Medical Center

**TCHD BOARD OF DIRCTORS**
**DATE OF MEETING: June 21,2024**
**BARTON & ASSOCIATES**

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

**Vendor's Name:** Barton Associates

**Area of Service:** Locum Tenem's Pathology Coverage

**Term of Agreement:** 12 months, Beginning, July 1, 2024 - Ending, June 30, 2025

**Maximum Totals:** Within Hourly and/or Annualized Fair Market Value: No (With Justification)

| **Daily Stipend** | **Annual Cost Not To Exceed** | **Contract Cost** |
|---|---|---|
| $4,000 | $300,000 | $4,000/Day +Lodging/Travel NTE $300,000 |

**Description of Services/Supplies:**

- Pathology Coverage 8am-5pm Monday - Friday

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

**Person responsible for oversight of agreement:** Gene Ma, CEO / Eva England, Sr. Director

**Motion:**

I move that the TCHD Board of Directors approve the agreement with Barton & Associates to provide Locum Tenem's Pathology services for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, with a term cost not to exceed $300,000.

Tri-City Medical Center

# ADMINISTRATION CONSENT AGENDA

**June 10th, 2024**

**CONTACT: Donald Dawkins, CNE**

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Patient Care Services** | | |
| 1. Admixture, Intravenous Procedure | Practice Change | Forward to BOD for Approval |
| 2. Census Zones, Managing of Policy | Practice Change | Forward to BOD for Approval |
| 3. STEMI Transfer from Non-PCI Capable Facility | 3 year review | Forward to BOD for Approval |
| **Administrative** | | |
| 1. Consent for Photograph/Videotape 372 | 3 year review, practice change | Forward to BOD for Approval |
| 2. Disclosure of Unanticipated Adverse Outcomes to Patients, Families, Surrogates, and Agents 275 | 3 year review, practice change | Forward to BOD for Approval |
| **Cardiac Cath Lab** | | |
| 1. Implant Tray Setup Procedure | 3 year review, practice change | Forward to BOD for Approval |
| 2. Percutaneous Transluminal Coronary Angioplasty Setup (PTCA) Setup Procedure | 3 year review, practice change | Forward to BOD for Approval |
| 3. Set Up and Insertion of Intra-Aortic Balloon (IAB) Catheter Procedure | 3 year review | Forward to BOD for Approval |
| 4. Stenting Procedure | 3 year review, practice change | Forward to BOD for Approval |
| **Emergency Department** | | |
| 1. EZ-IO Intraosseous (IO) Infusion System-Procedure | 3 year review, practice change | Forward to BOD for Approval |
| **Medical Staff** | | |
| 1. Credentialing Policy, da Vinci Robotic-Assisted Surgery 8710-563 | 3 year review, practice change | Forward to BOD for Approval |
| 2. Medical Staff Standards of Conduct 8710-552 | RETIRE | Forward to BOD for Approval |
| 3. Quality Review Process for Teleradiologists 8710-525 | RETIRE | Forward to BOD for Approval |
| **Pulmonary Rehab** | | |
| 1. Contraindication to Pulmonary Rehab Exercise | 3 year review | Forward to BOD for Approval |
| 2. Exercise Prescription | 3 year review | Forward to BOD for Approval |
| 3. Home Exercise Program | 3 year review | Forward to BOD for Approval |
| 4. Scope of Services | 3 year review | Forward to BOD for Approval |
| 5. Strength Training | 3 year review | Forward to BOD for Approval |

# ADMINISTRATION CONSENT AGENDA

**June 10th, 2024**

**CONTACT: Donald Dawkins, CNE**

| Policies and Procedures | Reason | Recommendations |
|---|---|---|
| **Surgical Services** | | Forward to BOD for Approval |
| 1. Cell Saver Set-Up, Use and Monitoring Procedure | 3 year review | Forward to BOD for Approval |
| 2. Medications in Surgery Policy | 3 year review | Forward to BOD for Approval |
| 3. Surgery Blood in Ice Chests Procedure | 3 year review | Forward to BOD for Approval |
| 4. Visitors in the OR Policy | 3 year review | Forward to BOD for Approval |

| Tri-City Medical Center | Distribution: Patient Care Services |
|---|---|
| **PROCEDURE:** | **ADMIXTURE, INTRAVENOUS** |
| Purpose: | To outline the responsibilities and technique for Registered Nurses (RNs) in compounding sterile intravenous admixture preparations in patient care areas to prevent harm that could result from microbial contamination (non-sterility), excessive bacterial endotoxins, ~~and~~ large content errors in strength of correct ingredients, and incorrect ingredients in compounded sterile preparations (CSP). |
| Supportive Data: | Aseptic technique refers to performing a procedure in a manner that minimizes the chance of contamination caused by the introduction of microorganisms. Because contaminants may be introduced from the environment, equipment, supplies, or personnel, it is essential to control these different sources of contamination at the time an aseptic procedure is performed. Touch contamination by the person performing a procedure is the most frequent cause of contamination, occurring when proper control over manipulation is not maintained. Good technique in the preparation of intravenous (IV) admixtures is critical to producing a sterile product.<br>All objects that come in contact with the drug additive or IV solution must be sterile, or contamination will result. |
| Equipment: | 1. Admixture (medication)<br>2. IV solution<br>3. Sterile syringe: appropriate size based on the volume of solution to be measured and the graduation marks on the syringe. (The smallest size syringe should be selected, but should not be filled to capacity or the plunger may become dislodged). Selecting the smallest size syringe allows the volume of solution to be measured most accurately.<br>4. Sterile needles for transfer; not less than 19 gauge recommended (*filtered needles or filter straws are needed to draw any medication from ampules)*<br>5. 70% alcohol swabs/wipes |

A. **POLICY:**

1. Pre-mixed standard concentration infusions shall be utilized whenever possible.
2. Intravenous admixture of pharmaceutical products which require the measured addition of a medication to a 50 mL or greater bag or bottle of IV fluid must be compounded in the pharmacy except:
   a. Emergencies when nursing staff may need to prepare a dose of a sterile product for immediate use.
      i. Medications for immediate use shall have administration started within ~~one hour~~ **four (4) hours** of preparation. If administration is not started within ~~one hour~~ **four (4) hours,** the dose must be discarded.
   **b.** Product stability is of short duration.
   ~~b.~~**c. Use of proprietary bag and vial system**
3. Compounding personnel must visually confirm that ingredients measured in syringes match the written order.
   a. All admixtures shall be visually examined for the presence of particulate matter and not administered or dispensed when such matter is observed.
4. All IV solutions mixed by nursing must be discarded within 24 hours of spiking.
5. All CSP labels shall include:
   a. Patient name
   b. Correct names and amounts or concentrations of ingredients
   c. Total volume
   d. Date and time of preparation

| Revision Dates | Clinical Policies & Procedures | Nursing Leadership | Medical Staff Department or Division | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 3/06, 9/08, 6/11, 4/12, 09/16, 10/21, **02/24** | 4/12, 10/16, 10/21, **03/24** | 4/12, 01/17, 11/21, **04/24** | n/a | 11/16, 02/17, 11/21, **04/24** | 5/12, 03/17, 01/22, **05/24** | 02/22, **06/24** | 06/12, 04/17, n/a | 06/12, 04/17, 02/22 |

e. Beyond use date (BUD) and time is ~~1 hour~~ **four (4) hours** from time of preparation. ~~If~~ **If the admixture is stable less than four (4) hours, then the BUD time will be limited by stability.**
~~i. Medication must be administered or have infusion initiated prior to BUD time.~~
f. Initials of the compounding nurse

B. **DEFINITION(S):**
1. Admixture: One or more drugs are commonly added to the intravenous solution to prepare the final sterile product. The drug is referred to as the additive and the final product is referred to as the admixture. This does not include the drawing up of medication into a syringe and/or adding medication to a buretrol or intravenous line.

C. **PROCEDURE:**
1. Assess designated preparation area for cleanliness and gather all appropriate supplies prior to beginning admixture procedure. If admixture area is visibly soiled, clean with hospital-approved disinfectant.
2. Perform hand hygiene.
3. Use of Needle and Syringe for Transfer:
   a. Open the syringe and needle using proper aseptic technique, do not allow syringe package to come in contact with the syringe, since the outside surface is contaminated.
   b. Remove the protective cover over the syringe tip by twisting.
      i. When a needle is to be added to a syringe, the needle package must be opened before removing the protective cap.
   c. Remove the protective cover over the syringe tip by twisting.
   d. Insert the tip of the syringe into the hub of the needle. The needle may be held on by friction or by a locking mechanism. The finger should be held well back from the point of attachment of the needle to the syringe.
   e. Leave needle guard in place until just before use. To remove the guard, pull it straight off or twist very gently.
4. Use of Ampules: When preparing sterile products contained within an ampule container, special precautions should be taken to avoid glass fragments from entering the final sterile product. Even tiny glass fragments entering the circulatory system can cause great damage to vital organs or carry contaminants that cause infection.
   a. Tap or shake all the liquid into the bottom half of the ampule.
   b. Wipe the ampule neck with an alcohol swab and break it at a horizontal angle away from you. Discard the wipe and the ampule neck immediately to prevent accumulation of glass particles in the CSP area.
   c. Choose an appropriate size syringe and attach a *filter straw or filter needle*.
   d. Hold the ampule at a nearly horizontal angle to ensure proper airflow around the neck area. Tip the ampule downward as necessary to keep the tip of the straw below fluid level.
   e. Withdraw the contents of the ampule with the syringe. When pulling back the plunger of the syringe, the fingers should not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand. Contamination of the medication can occur in some procedures if the plunger is touched with the fingers.
   f. Remove the filter needle or filter straw and replace it with a needle.
   g. Tap the air bubbles from the syringe barrel, bring the liquid to the correct volume, squirt any excess liquid into the ampule, and deliver the liquid.
5. Use of Vials:
   a. Remove the protective cap from the vial and scrub the diaphragm with alcohol swab, and allow to air dry before piercing the vial.
   b. Draw the volume of air equivalent to the volume of solution that will be withdrawn from the vial into the syringe. When pulling back the plunger of the syringe, the fingers should not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand.

c. Hold the vial and insert the needle at 45–degree angle with bevel up into the vial, taking care to prevent coring of the closure.
d. Hold the vial in a vertical position (inverted) and force air into the vial, withdraw slightly more than the required amount of fluid.
e. With the vial in the vertical (inverted) position and the needle in the diaphragm, tap the barrel of the syringe to remove air bubbles and bring the syringe to the proper volume. Read the volume of solution by aligning the rubber end of the plunger with the graduation marks on the barrel of the syringe. Squirt excess liquid back into the vial.

**6. Use of Proprietary Bag and Vial Systems (e.g., MINI-BAG Plus containers): The instructions below are for MINI-BAG Plus containers. Please follow assembly and reconstitution instructions included in the package insert if using a different system.**

**a. Assembly**

**i. Remove the drug vial cover, disinfect the rubber stopper with an alcohol swab, and allow to air dry before docking to the bag.**
**ii. Peel off the foil cover from the adaptor of the MINI-BAG Plus container. Inspect the adaptor for moisture and discard if found.**
**iii. Place the drug vial upright and hold firmly. Place the adaptor over the drug vial and push the adaptor down until the vial snaps in place. DO NOT TWIST. Pull vial gently to ensure it is fully seated in the adaptor.**
**iv. Note: When assembled outside of the sterile compounding suite in the pharmacy, BUD time is calculated from the time the vial is connected to the bag, not when the drug is reconstituted and mixed with the fluid in the bag.**

**b. Reconstitution: If the drug in vial is in liquid form, step iii of Reconstitution may be omitted.**

**i. Squeeze bag and check vial. Use only if the vial remains fully seated and dry.**
**ii. Bend the port tube up then down to snap the breakaway seal.**
**iii. Hold bag with vial down. Squeeze solution into vial until half full. Shake to suspend drug in solution unless shaking is not recommended.**
**iv. Hold bag with vial upside down. Squeeze bag to force air into vial. Release to drain suspended drug from vial.**
**v. Repeat Reconstitution steps iii and iv until vial is empty of drug and solution is thoroughly mixed. Ensure drug is completely dissolved if in powder form. Do not remove drug vial.**
**vi. Remove port protector just before use.**

~~6.~~**7.** To Reconstitute and Transfer a Drug from a Vial: Some drugs inside a vial may be in powder or liquid form. If the drug is in powder form, an extra step – reconstitution - must be performed before it can be added to the IV solution. Diluents such as sterile water for injection, bacteriostatic water for injection, or bacteriostatic 0.9% sodium chloride injection are usually used to reconstitute powdered drugs. The volume of a suitable diluent is specified in the package insert and frequently on the vial itself.

a. Remove the protective tab and swab the top surface of the rubber closure of each vial with alcohol swab, and allow to air dry before piercing the vial.
b. Determine the correct volume of suitable diluent to reconstitute the powdered drug.
c. Inject a volume of air equal to the volume of solution to be removed from the diluent vial using a needle and syringe, and then remove the diluent from the vial. (Hold the diluent vial in an inverted position).
d. Inject the diluent into the medication vial.
e. Remove the needle and shake the vial until the drug is dissolved unless shaking is not recommended.
f. Reinsert the needle and remove the proper volume of drug solution. Do not inject air before withdrawing the drug solution unless air was withdrawn before the needle was removed.
g. Remove all air bubbles from the syringe so the volume can be read accurately.

~~7.~~**8.** Drug Transfer into a Plastic Bag: A syringe and needle are generally used to transfer a drug additive from a vial or ampule to a plastic bag. It is recommended the needle gauge be not less

than 19 to ensure resealing of the protective rubber cover. The needle must be at least ½ inch long to penetrate the inner diaphragm.

a. Remove the plastic IV from the outer wrap.
b. Assemble the needle and syringe.
c. Swab the medication vial or ampule with alcohol swab and withdraw the necessary amount of drug solution. If the drug is in powder form, reconstitute it with the recommended diluent. (See previous section of procedure).
d. Swab the medication port of the plastic IV bag with an alcohol swab, and allow to air dry before piercing the port.
e. Insert the needle into the medication port and through the inner diaphragm. The medication port should be fully extended to minimize the chance of going through the side of the port.
f. Remove the needle and dispose of in appropriate sharps container.
g. Shake and inspect the admixture.

~~8.~~**9.** In Emergency Situations:

a. The RN may prepare the first infusion bag using aseptic technique for the following but not limited to: phenylephrine, nitroprusside, norepinephrine, epinephrine, epinephrine/calcium, diltiazem, aminocaproic acid, and labetaolol.
b. Label the compounded product appropriately

D. **REFERENCES:**

~~1. USP General Chapter. Pharmaceutical Compounding-Sterile Preparations. 797th ed: USP/NF,2004. Print~~

**1. United States Pharmacopeial Convention. General chapter pharmaceutical compounding—sterile preparations. USP-NF 2023, Issue 1, November 1, 2022, official as of November 1, 2023.**

~~2. Buchanan, C.E., and P.J. Schneider. Compounding Sterile Preparations 2nd Ed.: American Society of Health-System Pharmacists, 2005. Print~~
~~Contianment Technologies Group, Pharmacopeal Form, August 2003. <http://www.mic4.com/regulations/USP-797.pdf>~~

~~3.~~ **2. Lambert A., Smith J., Horkan L. USP Understanding Final Chapter Requirements & How to Start Implementation. Wolter Kluwer; November 30, 2022.**

Tri-City Medical Center
Oceanside, California

**PATIENT CARE SERVICES**

| | | | |
|---|---|---|---|
| **ISSUE DATE:** | **4/06** | **SUBJECT:** | **~~Census Zones, Managing of~~Code Surge: Patient Capacity Management** |
| **REVISION DATE:** | **6/06, 8/08, 4/11, 01/15, 08/18, 05/22** | | |

| | |
|---|---|
| **Patient Care Services Content Expert:** | **~~02/22~~01/24** |
| **Clinical Policies & Procedures Committee Approval:** | **~~03/22~~04/24** |
| **Nursing Leadership~~Executive Committee~~ Approval:** | **~~05/22~~06/24** |
| **Medical Staff Department or Division Approval:** | **n/a** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **n/a** |
| **Administration Approval:** | **~~05/22~~06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **05/22** |

A. **PURPOSE**:-

1. To provide a management plan for Tri-City Medical Center that shall ensure appropriate and consistent inpatient access which ensures patients have access to appropriate and consistent care during periods of high census. –

B. **POLICY:**-

1. The management of patient volume is essential in order to minimize delay and/or diversion of patients into Tri-City Medical Center.
2. In order to initiate the appropriate census management activities, the census **capacity**~~zone~~ status shall be ~~reviewed daily be the Administrative Supervisor (AS) and communicated as needed for timely patient throughput and problem solving based on census~~**communicated to nursing each day at the daily bed meetings**.
   ~~a.~~**i.** Daily bed meetings occur 7 days a week at a designated time each shift.
3. ~~**3.**~~ **The Administrative Supervisor (AS)** ~~**shall document census zone status on the Staffing, Patient Flow worksheet and daily census.**~~will communicate the census capacity at the bed meeting
4. ~~**3.**~~**4.** Daily bed census information is communicated to ~~nursing leadership shift supervisors~~ **nurse leaders** or designees supporting patient care in the ~~shift~~**daily** census report that is sent out via email.
5. ~~**4.**~~**5.** All bed requests will be entered into ~~the electronic patient placement program (for example Aionex)~~ patient placement program to facilitate tracking and patient placement.
6. ~~**5.**~~**6.** The number of available beds/staff determines the census management level

C. **DEFINITIONS:**

1. **Code ~~Triage~~** Surge: **The Emergency Department (ED) is experiencing capacity and/or is unable to accommodate incoming patients due to flow of patients through the hospital continuum.**
2. ~~**6.**~~**2.** Available Bed:
   a. Staffed
   b. Empty- clean or dirty and available for use
   ~~c. Empty and dirty~~
   ~~**d.**~~**c.** Occupied – pending discharge, transfer or downgrade
   ~~e. Occupied – pending transfers~~
3. ~~**7.**~~**3.** Census ~~-~~Capacity Green ~~Census Zone:~~
   ~~a.~~ ~~Availability of beds is adequate~~ Staffed open beds in the nursing units
   ~~b. Staffing is adequate~~

~~c.~~**b.** Emergency Department (ED) has available beds
~~d.~~**c.** ~~Many~~ **Multiple** discharges/transfers anticipated
~~e.~~**d.** Inpatient beds available to accommodate surgery and procedure admissions

~~8.~~**4.** Census Capacity Yellow ~~Census Zone~~:
a. Availability of **inpatient** beds is limited due to staff or capacity
~~a. Staffing limited, premium, and/or incentive pay has been offered to staff and agencies~~
b. ED is full, no admissions holding **> 2 hours**
~~b.~~**c.** Limited discharges/transfers or downgrades anticipated
~~c.~~**d.** Inpatient beds are limited to accommodate surgery and procedure admissions

~~9.~~**5.** Census Capacity Red ~~Census Zone:~~
a. No availability of beds due to staffing or capacity
~~b. Premium and/or incentive pay has been offered to staff and agencies with insufficient response~~
~~c.~~**b.** House-wide resources are limited
~~d.~~**c.** ED is full and/or on diversion and patients are being held for admission **greater thand (>) 2 hours**
~~e.~~**d.** Census is at capacity in all inpatient care areas ~~(excluding OB Couplets)~~
~~f.~~**e.** Inpatient beds not available to accommodate surgery schedule
~~g.~~**f.** ~~Postanesthesia~~**Post Anesthesia** Care Unit (PACU), Emergency Department (ED), Cath Lab, and Outpatient PACU have patients delayed for inpatient bed placement

~~10.~~**6.** Leadership Team:
a. The leadership team consists of the Chief Nurse Executive (CNE), **Chief Medical Officer (CMO),** Administrative Supervisor **(AS), ~~Assistant Clinical~~** Nurse **Leader/designee** ~~Directors and Managers and Supervisors, Administrative Supervisor,~~**(ANM),** Case Manager/Discharge Planner, ~~Ancillary~~**all** Managers~~/~~, Directors ~~for Laboratory and Radiology~~, ~~Medical Staff Office,~~ Environmental Services (EVS) **manager or designee,** ~~Delegate,~~ and Educators. ~~Other departments will be included based on patient need. Based on the current "zone", not all members of the leadership team will be included in meetings to discuss patient flow.~~

## ~~C.~~D. PROCEDURE:

1. During the **Census Capacity: Green ~~Census Zone~~":**
a. The ~~Charge ANM/~~Nurse~~/~~ **Leader or** designee for each inpatient care unit shall ensure appropriate assignments of patients to staff.
~~b. Patients waiting for admission will be assigned a staffed ready bed in Aionex~~
~~c.~~**b.** Potential discharges **and level of care downgrades** shall be identified ~~and~~**at** the ~~RN should collaborate as needed with~~**beginning of** the ~~physician, case manager~~**shift** and~~/or family for timely discharge~~ **throughout the day.**
~~d.c.~~ Patient **throughput** ~~Flow~~ shall be **continually** evaluated by the leadership team ~~on a continual basis~~**and during bed meetings.**

~~2.~~ During the **Census Capacity**: **Yellow ~~Census Zone":~~**
~~a. The AS may call an emergency bed meeting to discuss patient flow and action plan to improve patient throughput~~
~~b.~~**a.** The leadership team shall assess staffing; confirm resources for overflow capacity, beds, surgery schedule, and ED census to prepare for possible Census Capacity Red
**i. The AS may activate a "Code Surge" to decompress the Emergency Department**
**ii. The AS may call an emergency bed meeting for planning and action items**
~~c.~~**b.** Clinical Directors/Managers shall assist the ~~Charge Nurses~~**charge nurse** ~~ANMs~~ and staff with patient placement and acuity by contacting physicians to downgrade or discharge patients as appropriate.
~~d.~~**c.** Utilize all non direct care RNs to assist with patient flow
~~d.~~ **Clinical Directors/Mmanagers to follow up with case management on patient discharges or transfers to other facilities and patients waiting for durable medical equipment (DME)** ~~prior to discharge~~**.**

**e. Case Managers/Discharge Planners shall:**
- **i. Assess for potential discharges**
- **ii. Contact medical directors to triage patients out of area**

~~c.~~**f.** Hospitalists shall be contacted to assist with physician communication regarding ~~discharges~~**patient downgrades and/or discharges. The CMO may also be contacted for assistance with physician notification**.

**g. Prepare and ~~U~~tilize current open beds/unit for census increase.**

**h. Communicate to EVS all dirty beds are a STAT clean and based on admission needs**

~~e.~~**i.** ~~Vacant~~ **Overflow** or closed patient unit shall be prepared for use. ~~This includes contacting Patient Accounting to advise that patients may be admitted to the following overflow areas:~~
- ~~i. PACU/ICU Overflow~~ **Outpatient PACU** ~~– Primarily ICU, Telemetry Designated approved unit~~
- ~~ii. Acute Rehabilitation Unit (ARU) – any~~**1 North/Rehab** ~~– Med/Surg admission to the ARU would, need California Department of Public Health (CDPH) approval for Rehab.~~
- ~~3 Pavilion and 3 East~~
- **i. Ancillary departments are to be notified of the opening of an overflow** or closed **unit**
- ~~iii. Station D~~

~~d. Same nursing department standards shall be followed in the areas accepting overflow patients.~~

**j. Ancillary departments will be notified of increase in census or opening of overflow areas to ensure adequate patient care supplies,**
- **i. The Leadership of Supply Chain Management and Sterile Processing shall evaluate the need to rent equipment and provide extra supplies to units.**
- **ii.** Biomedical Engineering and Sterile Processing Departments shall provide additional supplies and equipment as needed from internal and external sources to include contracted vendors.
- **iii.** The Director of Food & Nutrition shall evaluate the need for additional food requests.
- ~~i.~~**iv.** The Director of Pharmacy shall evaluate the need for increased pharmacy services.

~~2.~~**k.** Anticipate staffing needs for the next shift and consider registry staff or premium pay

~~3.~~ During the Census Capacity: **Red ~~Census Zone":~~**

a. ~~If immediate crisis occurs, ensure~~**Ensure** Yellow Zone procedures ~~is~~ are initiated.

**b. Calling a Code** Surge ~~**Triage - RED**~~**, the ED Charge RN shall communicate with the AS for all diversions, critical patients, and codes.**
- ~~i.~~ **ED Leadership, Administrator** on Call **and the** Nurse **Directors** will determine when to initiate a Code Surge~~**of Throughput will determine when to call a Code Triage and will notify the AS and PBX.**~~
- ~~ii.~~ **ED Leadership shall communicate with the ED Charge ~~RN every 2 hours from 0500-2200~~** as needed

~~b.~~**c.** The AS shall:
- **i. Coordinate an emergency bed meeting**
- **ii. Nursing leadership to share census, available staff, plan to accept patients, discharges and downgrades**
- ~~i.~~**iii.** Initiate overflow plan(s) and mobilize staffing resources.
- ~~ii.~~**iv.** Prioritize patient bed assignment and admissions as beds become available.
- ~~iii.~~**v.** Notify ~~Nursing~~ **allthe** Leadership **Team**~~.~~
- ~~Notify the Clinical Operation Leader.~~
- ~~iv.~~**vi.** Notify Hospitalists

~~c.~~**d.** The EVS ~~Manager/~~Supervisor shall page for a STAT bed clean for all available beds. **The goal of STAT cleans is ~~within~~ 10 minutes after the ~~of~~ request**

~~d.~~**e.** The ~~leadership~~**Leadership** of Surgical Services~~,~~ **and Cardiovascular Services, the CMO and CNE** ~~Radiology, nurses~~**Nurses**~~, and Medical Staff office~~ shall evaluate elective procedures on ~~Radiology~~**Rradiology** and surgical schedules for potential delays/reschedules and communication strategies to physicians.

~~e. Case Managers/Discharge Planners shall:~~

~~i. Assess for potential discharges.~~

~~f. Contact Medical Directors to triage patients out of areas.~~**The Leadership of** ~~Supply Chain Management and Sterile Processing shall evaluate the need to rent extra monitors and/or equipment and provide extra supplies to units.~~

~~g. Biomedical Engineering and Sterile Processing Departments shall provide additional supplies and equipment as needed from internal and external sources to include contracted vendors.~~

~~h. The Director of Food & Nutrition shall evaluate the need for additional food requests.~~

~~i. The Director of Pharmacy shall evaluate the need for increased pharmacy services.~~

~~**Biomedical Engineering and Sterile Processing Departments shall provide additional supplies and equipment as needed from internal and external sources to include contracted vendors.**~~

~~**The Director of Food & Nutrition shall evaluate the need for additional food requests.**~~

~~**The Director of Pharmacy shall evaluate the need for increased pharmacy services.**~~

4. The **ANM/** ~~/~~Nurse **Director/Clinical** Manager~~/~~ **or** designee shall make rounds on the units to assess the Census Status and communicate pending discharges to the AS.
5. During the ~~"~~Red Census **Capacity**~~Zone,"~~ status updates shall be given every 1 hour to Nursing Leadership. **The AS shall facilitate continued meetings for on-going throughput and patient placement.**

~~6. Nurse Managers/designee and the AS shall meet to assess overall staffing and census zone status.~~

~~7.~~**6.** ~~Medical r~~**R**ecommendations for Census Capacity Red ~~Census Zone"~~ are as follows:

a. Admitting patients is dependent upon discharges. Physicians shall be asked to re-evaluate for **early** discharges and transfers to accommodate admissions.
b. Patients leaving within one (1) hour and awaiting rides shall be moved to a staff area that is vacant.
    i. **Staff to utilize other means of appropriate transportation for discharged patients.**
c. Case Managers/Discharge Planners/Social Workers shall facilitate skilled nursing facility discharges as a top priority~~.~~ **and communicate with transport companies any STAT requests for patient pick up**
**d. Calling in extra staff as needed or adjust existing staff to accommodate census**
**e. Admitted patients are moved to the unit bed within** 15 **minutes of a Ready Bed regardless of shift change or recent admissions**
**f. The interventions to Rremove barriers to patient flow may include:**
    **i. Bedside report – ED RN giving hand-off at the bedside to the inpatient RN**
    **ii. Utilizing licensed staff to assist with patient transport** such as **educators, nursing leadership**
    **iii. ~~Have i~~Inpatient RNs calling the ED for patient hand-off or receivinge face to face hand-off~~report~~ in the ED** and **then "pull" patients from the ED to a ready bed**

~~3.~~**7.** Elective cases may need to be cancelled in accordance with C Suite approval.

~~4. Patient flow will be reassessed every 2 hours to determine zone color and status.~~

~~d. Leadership will be notified by the AS when the zone changes from Red to Yellow or Green.~~

| Tri-City Medical Center | Patient Care Services |
|---|---|
| **PROCEDURE:** | **STEMI TRANSFER FROM NON-PERCUTANEOUS CORONARY INTERVENTION CAPABLE FACILITY** |
| Purpose: | To define appropriate actions to accommodate a STEMI patient transfer. |

A. **PURPOSE:**

1. To provide a systematic method for responding to ST Elevation Myocardial Infarction (STEMI) patient transfers from non-percutaneous coronary intervention capable facilities.
2. To assure compliance with Centers for Medicare & Medicaid Services (CMS), San Diego STEMI Guidelines as outlined by the County of San Diego Emergency Medical Services (EMS) STEMI Receiving Centers (SRC) Standards and other accreditation organization standards and guidelines.

B. **PROCEDURE:**

1. The transferring facility will notify Tri-City Medical Center (TCMC) Emergency Department of the request to transfer the STEMI patient.
2. The mobile intensive care nurse (MICN) will activate Code STEMI upon the earliest of the request for emergent transport, departure of the patient from the transferring facility, or radio report from the transporting agency.
   a. Contacts Public Branch Exchange (PBX) at 66 and requests Code STEMI activation to the Emergency Department (ED) with estimated time of arrival (ETA).
3. STEMI Team Notification:
   a. PBX operator will notify STEMI team members by sending a bulk page indicating Code STEMI Transfer activation and indicate patient name and ETA.
      1) Cardiac Cath Lab (CCL) team
   b. The ED physician will page the Cardiologist upon verbal acceptance of the patient with the transferring hospital physician.
      i. STEMI Team Response:
      ii. Cardiologist will respond to page by calling ED and consulting with ED physician.
         1) CCL team will respond to PBX confirming page was received and report to CCL and ED within 30 minutes from page .
   c. STEMI Team Response Verification
      i. PBX will notify the Code STEMI call originator of the STEMI team response.
      ii. If no response from a CCL team member, PBX will notify the Cardiac Cath Lab Supervisor on call.
4. Cancellation of Code STEMI:
   a. The ED physician or cardiologist evaluating the patient may, at his/her clinical discretion, cancel Code STEMI activation.

| Department Review | Clinical Policies & Procedures | Nursing Leadership | Department of Emergency Medicine | Division of Cardiology | Medical Executive Committee | Admini stration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 05/14, 03/20, 03/24 | 05/14, 04/20, 03/24 | 05/14, 05/20, 04/24 | 11/1406/20 | 12/15, 11/20 | 01/16, 07/21, 05/24 | 08/21, 06/24 | 02/16, n/a | 02/16, 08/21 |

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy**

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**ISSUE DATE:** 03/00 **SUBJECT:** Consent to Photograph/Videotape

**REVISION DATE:** 05/03, 01/06, 06/06, 06/09 **POLICY NUMBER:** 8610-372

| | |
|---|---|
| **Administrative Content Expert~~Department~~ Approval:** | **~~05/17~~04/24** |
| **Administrative Policies and Procedures Committee Approval:** | **~~05/17~~04/24** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~06/17~~05/24** |
| **Administration Approval:** | **06/24** |
| **Professional Affairs Committee Approval:** | **~~07/17~~ n/a** |
| **Board of Directors Approval:** | **07/17** |

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A. **PURPOSE:**

1. To provide guidelines for photography/videotaping **or recording in any way as ofte patients, or staff members, including hospital data, equipment** within Tri-City Healthcare District (TCHD). Health care providers and outside parties, such as visitors, vendors, law enforcement officers, or the media may photograph patients for various purposes, including patient identification, diagnosis and treatment, patient and/or professional education, research, public relations, marketing, security, and documentation **with prior consent from the Privacy Officer.** ~~.~~
2. **However, in order to preserve the privacy and confidentiality of our patients and staff, recordings and or photographs may only be made for permitted purposes, by authorized individuals.**
3. ~~2.~~ **In the context of treating patients, recordings and photographs should be taken only if the provider has determined that they will add value in treating or diagnosing the patient. Either the patient or, when the patient is unable to consent, their personal representative may consent.**

B. **DEFINITION(S):**

1. Photograph/videotape includes video or still photography, in digital or any other format including cellular phones with camera and any other means of recording or reproducing images.
2. Publication: means any method of displaying or distributing photographs, including simply showing the photograph to one or more individuals.

C. **POLICY**

1. Hospital staff (including medical staff) may not take photos of patients unless specifically allowed by this policy and staff may not show any photos of patients to others persons within or outside the hospital unless specifically allowed in this policy. This is true even if the patient's face is not visible or the employee thinks the patient "doesn't mind."
2. Hospital staff may not use their personal cell phones or other personal equipment to photograph patients, and may not post patient pictures, on social media websites.
3. Hospital staff must understand that approval of administration is required prior to allowing photography not addressed in this policy or for exceptions to this policy.
4. Photographing a patient without his or her consent or over his or her objection, may constitute an invasion of the patient's legally protected right to privacy.
5. When recordings or films are made for publication/external purposes that will be heard or seen by the public, for example, commercial filming, television programs, marketing, there is documentation of a specific, separate consent that includes circumstances for the use of the

recording or film.

a. Patients will not be photographed in any manner without consent except as situations noted below in this policy. Situations not addressed by the following policy will be reviewed by Risk Management.
b. Photography of suspected victims of child abuse or neglect, elder abuse or neglect, dependent adult abuse or neglect, or domestic abuse may be obtained without patient's prior consent.
c. Anyone who engages in recording or filming (who is not already bound by the hospital's Confidentiality policy) will sign a confidentiality statement to protect the patient's identity and confidential information.
d. Consent for routine photography of wound care and decubitus ulcer is covered in item one of the Tri-City Healthcare District Conditions of Admission.
e. Consent for routine photography of newborns is covered in item one of the Tri-City Healthcare District Conditions of Admission.
    i. Photography or video taping of labor and the birthing process shall be possible unless it invades the privacy of other patients or interferes with operations of the hospital or its services to patients.

6. The "Consent to Photograph and Authorization for Use or Disclosure" form must be completed whenever the hospital or any person not requested to do so by the patient, desires to take a photograph or video of a patient or any part of the patient's body for purposes not directly related to the medical treatment of the patient.
    a. This includes photographs or videos taken for patient education, medical education, or research purposes, which may be used for external purposes that will be heard or seen by the public.
7. Photograph or videotaping used for diagnosis or treatment purposes are part of the medical record and must comply with all the legal requirements of confidentiality and retention.
8. Videotapes used for education purposes are not part of the patient's medical record. Therefore, anyone, including the patient who requests the medical record, does not have a right to access the videotape.
9. Obtaining consent for the taking and use of a photograph(s) or videos are designed to reduce the risk that liability will be imposed on the hospital on the basis of invasion of the patients' privacy or an unauthorized use of the patient's photograph. Except for circumstances set forth below, there is documentation of consent before recording or filming,
    a. The recording or filming may occur before consent, provided it is with the established policy of the hospital.
    b. The recording or film remains in the hospitals possession and is not used for any purpose until and unless consent is obtained.
    c. If consent for use cannot subsequently be obtained, the recording or film is either destroyed or the non-consenting patient must be removed from the recording or film.
    d. If consent for use cannot subsequently be obtained, the filming or recording cannot be used in marketing materials.
10. The patient/legal representative will sign, date and time the "Consent to Photograph and Authorization for Use or Disclosure" form.
    a. The person obtaining the consent will specifically explain what, if any, particular uses of the photograph or video is anticipated and, further, to explain that by signing the form, consent is given for those particular uses as well as any further or different uses unless specific restrictions are noted.
    b. If the patient states any restrictions, the hospital would not use the photograph in the unauthorized manner.
    c. If a photograph will be used in a general publication and that use was not specifically contemplated at the time the photograph was taken then:
        i. The patient/legal representative must be notified and given an opportunity to object.
        ii. A record must be maintained documenting that the patient was contacted and did

not (or did) object to the proposed use. Any restrictions imposed by the patient/legal representative will be respected.

11. When a patient requests to have photographs/videos taken of herself/himself, or if parents request that pictures be taken of their hospitalized child, the photography or videotaping shall be possible unless it invades the privacy of other patients or interferes with the operations of the hospital or its services to patients.
    a. Consent given pursuant to this provision does not authorize the use of the photographs for any purpose other than those listed in this policy.
12. Nurses, auxiliary, medical staff, visitors and TCHD employees shall not be included in photos/videos unless their consent is obtained.
13. TCHD reserves the right to terminate filming or recording if the process interferes with care of the patient during an emergency situation, would aggravate the patient's condition or TCHD employees, or interferes with the patient care of hospital business.
14. When a representative of either the news media or law enforcement agencies request to photograph a patient in the hospital, such permission may be given if:
    a. In the opinion of the attending physician, the patient's condition will not be jeopardized.
    b. The patient consents to have the photograph taken by signing a consent to photograph or videotape.
    c. In the process of conducting a criminal investigation, law enforcement agencies need photographs for evidence (State of California Evidence Code 1500, 1500.6).
    d. If above criteria are not met, news media may be escorted by security off hospital property, if they interfere with operations of the hospital, its services to patients or if they are photographing people without their permission.
15. If a patient's photograph will be used for marketing or philanthropy purposes, written consent is required which specifically grants permission for such marketing and/or philanthropy.
16. A new consent form will be signed for each new series of photographs, and for photographs taken of persons other than those named in prior consents.
    a. The consent given for the use of photographs or videos remains valid unless and until the patient or his/her legal representative notifies the hospital that he/she is withdrawing or restricting authorization for any future use.
17. Except with regard to security footage captured and maintained by TCHD, patients, physicians, employees, volunteers or visitors have the right to request cessation of recording or filming and the right to rescind consent for use up until a reasonable timeframe before the recording or film is used unless the recording or filming has been produced in response to a lawful subpoena or otherwise required by law.
18. TCHD maintains security cameras located throughout the facility. The cameras and the footage captured by the cameras are part of TCHD's operations and are used to enhance the safety of its facilities. As a result, patients, visitors, staff, and others may be captured as part of the security footage maintained by TCHD. Under certain circumstances TCHD may, in accordance with this policy and relevant privacy laws, produce copies of photographs or videos captured by the security cameras to facilitate hospital security operations and/or to law enforcement or others as required by law.
19. For further questions regarding photography of patients including Law Enforcement officers using policy body cameras and Google Glasses, please refer to the California Hospital Association Consent Manual.

~~20.~~**D. RECORDING OR PHOTOGRAPHING OF PATIENTS OR STAFF BY PATIENTS OR VISTORS:**

1. **Patients may allow family members or visitors to photograph, film or record (for purposes of this policy, hereinafter referred to as "record") the patient while in the hospital, subject to the specific limitations on this privilege described in paragraph below, and subject to any restrictions that may be imposed by hospital staff related to patient safety and/or disruption of patient care. The hospital expressly reserves the right to suspend this privilege if in the judgment of hospital staff the care of any patient may be jeopardized and/or any time hospital operations may be impaired. Whether or not the**

**request is related to a care issue, the staff member receiving the request should seek assistance through thier~~his/her~~ manager or other appropriate resource; such as, the Privacy Officer, to evaluate and develop an appropriate response to the request. Patients, family members and visitors involved in requests to record a patient should be informed of the rules applicable to this privilege.**

**2. If a patient requests a family member or visitor to record or photograph the patient, the recording or photgraph may take place provided the following conditions are met:**

**a. Staff may not be recorded without their specific knowledge and permission.**

**b. Recording or photograph is not to take place when staff is providing treatment (other than noted in or having a discussion with any patient, including other patients in the room or area, such as in a semi-private room.**

**~~a.~~c. Patients, family or visitors may not record or photograph any other patients without their specific knowledge and permission, or authorization where required.**

**~~b.~~d. Specific rules apply to requests to the recording or photograph of obstetrical and newborn infant patients. If a maternal patient wishes to have a family member or support person record or photograph her and her newborn during the perinatal period, including during labor and delivery, it shall be permitted regardless of the type of delivery, provided the patient agrees. However, the anesthesia evaluation interview, anesthesia block procedures and all aspects of general anesthesia in OB may not be recorded or photographed. As a general rule, family and visitors approved by the patient will be permitted to record or photograph during vaginal delivery procedures, and during cesarean delivery procedures with spinal or epidural anesthesia. However, any member of the OB health care team has the right to direct the location of the activity, and to limit or suspend the activity. Any member of the OB health care team may request and if necessary direct that recording or photograph be stopped if the process interferes with patient care.**

## ~~D.~~E. LAW ENFORCEMENT-BODY CAMERAS

~~1. For staff who work in patient care areas and Public Safety Officers when the need arises.~~

**~~2.~~1. To ensure patient safety and confidentiality Law Enforcement Officers should turn their body cameras off in patient care areas, except for those areas open to the visiting public.**

**~~3.~~a. This does not apply to in-progress emergency situation~~calls~~.**

**~~4.~~b. This does not apply to Law Enforcement interviews conducted at the bedside as long as patient is in a private room.**

**~~5.~~2. Staff should provide Law Enforcement officers with the above section of policy or reinforce this message for those officers who may be in a patient care environment. Law enforcement officers have the trust and confidence of the hospital and therefore are responsible for compliance once they are notified of this policy. It is not staff's responsibility to ~~i~~ensure compliance, but to notify officers of the requirement.**

## ~~E.~~F. GENERAL PROVISIONS

**1. Nothing in this policy will be construed to prevent Tri City medical Center from using security monitoring equipment.**

## ~~F.~~G. FORM(S):

1. Consent to Photograph / Video Form - Sample
2. Consent to Photograph and Authorization for Use or Disclosure Form - Sample
3. Consent to Photography for Philanthropy - Sample

## ~~G.~~H. RELATED DOCUMENT(S):

1. Administrative Police 8610-479 Social Media
2. Administrative Policy 8610-257 Cellular Phones and Other Wireless Electronic Digital Devices Use Of
3. Tri-City Healthcare District Conditions of Admission

## ~~H.~~I. REFERENCE(S):

1. California Hospital Association Consent Manual 2017
2. State of California Evidence Code 1500, 1500.6
3. The Joint Commission Hospital Accreditation Standards Manual (2015)

**Consent to Photograph and Authorization for Use or Disclosure Form - Sample**

# CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Name: _____

## CONSENT TO PHOTOGRAPH AUTHORIZATION FOR USE AND DISCLOSURE

I hereby consent to be photographed while receiving treatment at Tri-City Medical Center. The term "photograph," includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of the photograph(s) by or disclosure of the photograph(s) to:

_____

_____

*(Persons/Organizations authorized to receive the in information) (Address – street, city, state, zip code)*

## PURPOSE

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (describe permitted uses, e.g., dissemination to hospital staff, physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, and charitable purposes):

_____

_____

_____

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, and/or charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Tri-City Medical Center, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

## EXPIRATION

This Authorization expires *(insert date)*: _____

## PURPOSE

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Patient Information Services, Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056-4506. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Consent and Authorization.

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

Initials: _____

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

If this box ☐ is checked, Tri-City Medical Center will receive compensation for the use or disclosure of my photograph(s).

SIGNATURE

Date: _____ Time: _____ AM / PM

Signature: _____
*(Patient/representative/spouse/financially responsible party)*

If signed by someone other that the patient, state your legal relationship to the patient:

_____

Witness: _____
(Hospital Representative)

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

**CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE**

Affix Patient Label

WHITE – Chart YELLOW – Patient

7408_____

## Consent to Photograph / Video Form 2014 - Sample

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

# Consent to Photograph/Video Form

The terms photograph and/or video as used in this agreement shall mean any recording identifying an individual or group's name, image or likeness, including but not limited to video, still photography, sketch or any other electronic or mechanical means of recording and/or reproducing images. This also includes all social media platforms & website.

The undersigned hereby authorizes Tri City Healthcare District, it's employees or agents on behalf of Tri-City Medical Center (individually or together as "Hospital") to photograph or permit other persons to photograph/video:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**Please write legibly the name of Patient, Visitor, Employee, Medical Staff, Auxiliary Member in the above spaces. One form per family may be used. Please list names and relationship next to your name.**

The undersigned agrees that the Hospital, news media personnel or any other marketing agent or publisher may use and permit its employees and associates to use such photographs or videos, including the negatives or reproductions for purposes such as educational, scientific, public relations, advertising/marketing, and charitable purposes. In doing so, the undersigned is also waiving any and all violation(s) of his/her/its Copyright or HIPAA rights. The undersigned has the right to request cessation of recording or filming at any time. The undersigned has the right to rescind consent for use at any time before the recording or film is used or distributed if made in writing to Hospital.

I am authorized and grant permission to be photographed:

Signature: _____ Date: _____

**Original: Marketing Department Files**

## Consent to Photography for Philanthropy - Sample

### AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

**Authorization for Use/Disclosure of Information:** I voluntarily consent to authorize Tri-City Hospital Foundation to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

**Recipient:** I authorize my health care information to be released to the following recipient(s):

Name: Tri-City Hospital Foundation
4002 Vista Way
Oceanside, CA 92056

**Purpose:** I authorize the release of my health information for the following specific purpose:
***For fundraising and advertising purposes.***

**Information to be disclosed:** I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ☐ Only the following records or types of health information:
- ☐ **I authorize only the information I have provided personally and directly to the Tri-City Hospital Foundation and Tri-City Medical Center. No medical records will be requested or released by any and all providers related to my story.**

**Term:** I understand that this Authorization will remain in effect:

- ☐ **Until I revoke this authorization.**
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs: _____

**Redisclosure:** I understand that Tri-City Hospital Foundation cannot guarantee that the viewers of my story will not further disclose information contained in the story.

**Refusal to sign/right to revoke:** I understand that signing this form is voluntary and that if I don't sign, it will in no way affect my relationship with Tri-City Hospital Foundation. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Tri-City Hospital Foundation at the address listed above. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by Tri-City Hospital Foundation in reliance on this Authorization before it received my written notice of revocation.

**Questions:** I may contact the Tri-City Hospital Foundation at 760-940-3520.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Date | Signature of Witness |
| _____ | | _____ |
| Print Name | | Witness Name |

_____

1 **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

**Tri-City Healthcare District**
**Oceanside, California**

**ADMINISTRATIVE**
**DISTRICT OPERATIONS**

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**ISSUE DATE:** 10/02

**SUBJECT:** Disclosure of Unanticipated Adverse Outcomes to Patients, Families, Surrogates, and Agents

**REVISION DATE:** 04/06, 07/09, 06/11, 09/14, 06/11 03/15, 08/20

**POLICY NUMBER:** 8610-275

| | |
|---|---|
| **Administrative Content Expert Approval:** | ~~06/20~~04/24 |
| **Administrative Policies & Procedures Committee Approval:** | ~~06/20~~04/24 |
| **Pharmacy & Therapeutics Committee Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~07/20~~05/24 |
| **Administration Approval:** | ~~08/20~~06/24 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | 08/20 |

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A. **DEFINITION(S):**

1. Disclosure – Communication to patients, their families, surrogates, or agents, of information regarding an unanticipated adverse outcome.
2. Surrogate - an adult, other than a patient's agent or conservator, authorized under the Health Care Decisions Law to make a health care decision for the patient. This designation is made verbally by the patient to the Attending Physician and expires upon the earlier of discharge from the hospital or after 60 calendar days.
3. Agent - an adult, other than a patient's surrogate or conservator, authorized under the Health Care Decisions Law to make a health care decision for the patient. This designation is made in writing, by the patient.
4. Adverse Event – Any occurrence that is not consistent with the routine operation of TCHD and that potentially may, or actually did, result in injury, harm, or loss to a patient.
5. Unanticipated Adverse Outcome – An adverse result that differs significantly from the anticipated result of a treatment or procedure.
6. Treating physician - physician responsible for ongoing patient care.
7. Physician-Related - An adverse event, unanticipated outcome, or error which is attributed primarily of the treating physician.
8. Hospital-related - An adverse event, unanticipated outcome, or error which is attributed primarily to other hospital staff, non-physician, or non-allied health professional.
9. Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors**, Covered Contractors** and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.
10. **Errors are preventable adverse events.**
    a. **Note: An outcome may be negative and/or unanticipated, but not necessarily be the result of an error. The informed consent process should address possible risks, complications and adverse outcomes. A discussion about an unanticipated outcome that was addressed as part of the informed consent process is a much different discussion than disclosing an error.**

B. **PURPOSE:**

1. To foster a culture of open communication with patients, families, surrogates and agents and recognize their right to information about the patient's medical care.

2. To provide Tri-City Healthcare District (TCHD) Workforce Members with guidance and direction regarding communication of unanticipated or adverse outcomes of treatment, to patients, families, surrogates, and agents.
3. To maintain high-quality health care and the integrity of the patient–physician relationship.
4. Commitment on the part of all health care practitioners to establish and utilize the tools needed to help patients, families, surrogates, agents, and health care practitioners through adversity associated with unanticipated adverse outcomes.

C. **POLICY:**

1. **It is the policy of Tri City Medical Center to maintain transparency and integrity in all of the organization's functions. Consistent with this policy, it is appropriate to disclose adverse events, errors and/or unanticipated outcomes that could affect a patient's emotional or physical health. Our framework for discussing unanticipated outcomes is premised on strong communication processes, both before and after treatment or procedures.**
2. It is TCHD's policy to support the right of patients, their families, surrogates and agents to be notified when an unanticipated, adverse outcome occurs. Parties notified will be provided with sufficient information to fully understand the scope and gravity of the event. TCHD will assure that any unanticipated adverse outcome is promptly communicated to the patient, their family, surrogate, or agent and provide assurances that steps have been taken to mitigate harm to the patient as well as prevent similar occurrences in the future, for all patients.

D. **PROCESS:**

1. Reporting
   a. It is the responsibility of all Workforce Member to report <u>any</u> unanticipated adverse outcome immediately to their Department Leadership. An investigation of the event will be conducted in a non-punitive and non-accusatory manner. Failure to report such events may result in progressive discipline as outlined in Human Resources policies.
      i. An incident report must be completed in accordance with Administrative Policy: Event Reporting #8610-396.
         1. The incident report shall NEVER be discussed with the patient, family, surrogate, or agent due to its protected nature under state and federal law.
   b. The Workforce Members involved may need support due to the feelings of guilt, shame, and or responsibility. Disclosures to patients, family, surrogates and agents should be encouraged while avoiding an environment of blame and or shame.
   c. It is the responsibility of the Manager of Regulatory Compliance and Accreditation to draft and submit the initial report to the California Department of Public Health (CDPH) as well as serve as a liaison with that agency during the subsequent investigation process. The Chief **Nurse Executive**~~of Patient Care Service~~ shall remain apprised of all regulatory matters by the Manager of Regulatory Compliance and Accreditation.
   d. Reporting to regulatory agencies (i.e., CDPH, Centers for Medicare/Medicare Services (CMS), The Joint Commission (TJC), Occupational Safety and Health Administration (OSHA), etc.) shall be done in compliance with regulations and applicable law. All reporting to any regulatory agency must first have the approval of a member of the C-Suite.
2. Immediate Actions of Workforce Member
   a. The individual or individuals identifying the event will take the following steps:
      i. Assure that all necessary action is taken to mitigate the extent of the harm to the patient that may be caused by the adverse event.
      ii. Immediately notify the patient's treating Physician, Department Leadership and the Risk Manager.
      iii. Complete an incident report per hospital policy.
      iv. Participate in any investigation initiated to determine the cause of the event and actions that may prevent recurrence of similar events

b. Risk Management, with the cooperation of the Department Leadership will conduct such investigations as indicated. All reports of unanticipated adverse outcomes will be reviewed by Risk Management and evaluated for further action, including disclosure to the patient, family, surrogate, or agent, as appropriate**, and reported to the Legal Department**.
   i. Risk Management will discuss the disclosure with the interdisciplinary team to assure consistency and support. The composition of the team will vary in each case. Workforce Members with whom the patient and/or family have developed a positive relationship and trust should be strongly considered for inclusion on the interdisciplinary team.

3. Disclosure
   a. Once it has been determined that an unanticipated adverse outcome has occurred, disclosure is necessary as soon as possible. Department Leadership, in consultation with the treating Physician, will determine the most appropriate time and manner for disclosure. Risk Management and or Legal Counsel may be involved with the initial decision to disclose, as well the manner, time, and location of disclosure. Preliminary disclosure may need to occur prior to all of the facts being determined. Before disclosure, Workforce Member that will be present during the disclosure should meet to agree upon the content of the discussion and limitations of that content i.e. no acknowledgement of liability or promises regarding billing adjustment(s). The provider bears primary responsibility for the disclosure as well as documentation of same in the medical record. In cases where the unanticipated adverse outcome is associated with non-physician staff, the duty to disclose will rest with responsible hospital leadership with the most thorough knowledge of the event. The treating physician will be made aware of the disclosure prior to the disclosure occurring.
   b. If there is disagreement or uncertainty as to the need to disclose or the means by which disclosure will be conveyed, the Chief of Staff, in conjunction with the Chief Medical Officer, will make the final determination.
   c. Disclosure will include the following elements:
      i. Interpreter services shall be arranged as needed and the patient's level of understanding of medical terminology shall be taken into consideration.
      ii. A clear explanation of the unanticipated adverse outcome to the patient and, when appropriate the family, surrogate, or agent. Disclosure will be limited to a factual explanation of the circumstances and speculative comments will be avoided.
      iii. A clear explanation of the investigation that will take place and plans to discuss the matter further with the patient or family as more facts become known. A tentative time frame and point of contact should be provided.
      iv. The focus should be on the patient's condition, concerns, and treatment plan. It should be clear that their treatment and care are the primary concern.
      v. Adequate explanation to ensure understanding of unanticipated adverse outcome and prognosis.
      vi. Information regarding resources available to support and comfort the patient and/or family.
      vii. Expressions of empathy to include, as appropriate, an expression of sympathy for the patient's inconvenience, distress or discomfort. Communicate what will be done to prevent the error from occurring again. Discuss the treatment plan to remedy or mitigate the effects of any injury.
      viii. Healthcare providers shall not make promises they cannot guarantee, for example, billing adjustments or specific clinical outcomes.
   d. If the patient's clinical condition or care may be negatively impacted by the notification after the event, then the discussion should be held with the patient's family, surrogate, or agent, if appropriate. If this is not practical, notification will be deferred until a later time however, the notification should take place prior to discharge.

i. If the unanticipated significant event is reported or discovered after discharge, the patient, family, or agent should be notified as soon as information about the event and its impact on the patient's health has been determined. Convey to the family and/or family member(s) what will be done to prevent the error from occurring again, and work with the patient to develop a treatment plan to mitigate and or remedy the effects of any injury resulting from the error.

e. **Honest disclosure — Tell the patient the facts as known, and assure the patient that you are committed to obtaining and providing all available information as it becomes known. Consider the use of support services (e.g., social worker, chaplain services, patient relations specialist, mental health therapist), as appropriate.**

f. **Cultural sensitivity — Demonstrate respect for individual cultures and provide interpreters for non-English speaking or cognitively impaired patients.**

g. **Events for which disclosure may be discretionary — Disclosure of certain events is a matter of clinical judgment. Errors that do not harm a patient and do not have the potential to do so may not require disclosure to patients.**

h. **If the event involved a medical device or piece of equipment, preserve these materials for investigation. Do not clean or alter the device or equipment in any way and contact the office manager and/or the physician. Do not return defective devices or equipment to a manufacturer.**

i. **Notify Risk Management of the event.**

~~**Notify your malpractice insurance carrier of the event in a timely manner and obtain guidance, as applicable, report to Legal to report to Carrier.**~~

~~**Defer to the office manager and/or the physician to determine when and if patient billing should occur. Follow compliance policies.**~~

j. **Withholding of Information**

i. **Sometimes the outcome information can put a patient at risk of harm either due to psychological trauma or exposure to physical harm. In such situations, clinical judgment regarding disclosure should be exercised.**

ii. **If information is withheld, document the reasons for such. It may be appropriate to have a mental health provider conduct an assessment to determine concurrence.**

4. The disclosure process will not include the following elements:
   a. Acceptance of liability.
   b. Assignment of fault.
   c. Statements of proposed or actual causation.
   d. Acknowledgement of an existing incident report or intent to file one
   e. Confidential information under State or Federal law. Patient confidentiality must be preserved.
   f. Legal Counsel may be consulted at any time. Occasions when such counsel is indicated include, but are not limited to, apologies, permanent injuries, parties have already threatened legal action, or any time a Workforce Member involved wish to have the support and guidance of legal counsel. California allows a party in an accident to apologize or express sympathy to an injured party without fear that the statements will be used against the party as evidence of an admission of liability. The apology ***must not*** include statements of fault, responsibility, or offer of financial compensation.
5. Documentation
   a. The Risk Manager or other appropriate individual participating in the disclosure shall document the disclosure of unanticipated adverse outcomes **in the incident report**. This documentation should contain a brief statement that the disclosure has occurred and include the following elements:
   b. A full description of the facts of the event.
   c. A note outlining the substance of the disclosure discussions with the patient, family member, surrogate, or agent, about the event, including dates, times, and a list of who was present.

d. Treatment and follow up plans as indicated.
e. Hospital Workforce Member to serve as a point of contact for the patient or their representative.
f. The identity of any interpreter whose services were used.
g. In cases where a decision is made to withhold some or all of the information about the event, the reason(s) for this decision.
h. Any follow-up discussions with the patient, family member or surrogate should be similarly noted.
i. Documentation **within the medical record** should be limited to the medical facts of the case and a brief note stating simply that disclosure occurred and to whom.
**j. Document facts objectively, completely and contemporaneously, including that a discussion of the unanticipated event took place.**
**k. Ensure that the documentation is dated, timed and signed at the time of the entry.**
**l. Avoid writing any information unrelated to the care of the patient (e.g., incident report filed or legal office notified) in the medical record.**
**m. Do not alter any prior documentation or insert backdated information.**
**n. Record the name and relationship of those present.**
**o. Include documentation of any questions posed by the patient/family members and indicate that answers were provided by the caregiver.**
**p. While an addendum to the record may be made, consider carefully whether this information is relevant to the patient's clinical management. Accepted reasons for an addendum are for the correction of facts (i.e., persons involved, time of event, sequence of events) and for the addition of facts or clarifying information. If you participated in the care, but were unable to access the record until a later date, you may provide added information. Do not use an addendum to state your opinions, perceptions or defenses.**
~~j.~~**q. Assign the most involved and knowledgeable staff member(s) to record the factual statement of the event in the patient's record, as well as any follow-up needed or done as a result of the event.**

6. Waiving of Cost and Charges
   a. The purpose of this procedure is to establish guidelines for billing and account resolution when the Business Office is notified to hold or not bill a portion of the account.
   b. The process for this will be a coordinated effort between Administration, Risk Management, Legal Counsel, and the Chief Financial Officer; who are the only individuals authorized to waive charges.
   c. When an unanticipated adverse outcome occurs, the Business Office will, at the request of the Risk Manager, Legal Counsel, or appropriate C-Suite member, ensure that no bills are submitted for reimbursement from the patient or third party payer for charges related to the event. Bills will be placed on hold until an investigation reveals or does not reveal, a need to adjust any aspect of the patient's bill.
   d. The billing adjustment decision will be based on confirmation of the event, investigation, and administrative review.
   e. The Director of Patient Accounting will be the contact person for billing inquiries.

E. **RELATED DOCUMENT(S):**
1. Administrative Policy: Event Reporting #8610-396

F. **REFERENCE(S):**
1. The Joint Commission Manual, 2019, RI.01.02.01, EP 20, 21, 22
2. California Hospital Association Consent Manual 2019 Pgs. 517-518
3. California Health & Safety Code §§ 1279.1
4. California Evidence Code § 1160

| Tri-City Medical Center | Cardiac Catheterization Lab |
|---|---|
| **PROCEDURE:** | **IMPLANT TRAY SET UP** |
| Purpose: | To ~~be performed by scrub personnel for the~~ **ensure consistent** setup **by scrub personnel** ~~of~~ **for** a permanent pacemaker, Implantable cardioverter defibrillator, or Loop recorder tray. |
| Supportive Data: | None |
| Equipment | Sterile pacemaker pack<br>Retractor tray: pacemaker or implantable cardioverter implant<br>Suture (physician's preference);<br>Pacing cables<br>1% Lidocaine 10mg/ml<br>1-Heparinized saline (2units/ml) in 0.9% sodium chloride, 500 ml bag;<br>1-250 ml bag of 0.9 % normal saline<br>Sheath introducer (physician preference)<br>Disposable #10 or #15 with retractable blade cover (physician preference)<br>Sterile gloves<br>Plasma or aqua mantis (generator changes, lead revisions)<br>1-pack sterile towels<br>Surgical Incise Drape (physician preference)<br>Dressing (physician preference) |
| Issue Date: | 01/87 |

A. **PROCEDURE**:

1. Table is wiped with and allowed to dry for per manufacturer's instructions for use.
2. **Hand hygiene to be performed per** ~~Will perform hand hygiene~~ hospital policy.
3. Scrub person will don sterile gown, gloves, hat and mask to organize table.
4. All bowels, syringes and containers will be labeled with **the correct** medication concentration.~~/strength~~
5. Pacemaker pack ~~is~~ **to be** opened in sterile fashion and draped over the table.
6. Equipment ~~is~~ **to be** added in a sterile manner.
7. All sheaths, arterial needle and leads will be wiped down and flushed, if appropriate, with Heparinized saline solution.
8. Initial count to be performed by scrub person and any team member assigned to case, with documentation in McKesson.
9. Sharps, **sutures,** ~~needles~~, **and** x-ray detectable sponges to be counted per hospital policy

| Cardiac Catheterization Lab | Division of Cardiology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| | | | | | | |
| 6/97; 10/00; 4/03; 6/05; 1/09; 9/12, 02/20 | 07/20, **01/24** | 09/20, **04/24** | 10/20, **05/24** | 12/20, **06/24** | n/a | 02/11, 12/20 |

| Tri-City Medical Center | Cardiac Catheterization Lab |
|---|---|
| **PROCEDURE:** | **PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) SETUP** |
| Purpose | To ensure uniform setup for PTCA procedures in the Cath Lab |
| Supportive Data: | None |
| Equipment | Inflation device' 12" high pressure line;<br>6" red stripe line<br>hemostatic valve;<br>35ml Luer lock syringe;<br>PTCA guidewire , (physician's preference)<br>Guide catheter (physician's preference);<br>PTCA balloon catheter (physician's preference)<br>Drug eluting stent or Bare metal stent (physician's preference);<br>Wire torque device<br>contrast solution; |
| Issue Date: | 05/94 |

A. **PROCEDURE**:

1. Setup table according to Policy titled "*Setup for Sterile Table*". .
2. All syringes, bowls and cups to be labeled with medication name, concentration/strength
   a. 50ml of contrast solution in labeled cup on sterile field.
3. Select guiding catheter, PTCA balloon catheter and PTCA guidewire of physician preference.
4. Attach 12" high pressure line and stopcock to inflation device. Fill inflation device with contrast solution according to manufacturer's instructions. Use the 35ml syringe to perform this step.
5. Attach 6" red stripe line to hemostatic valve, then attach the red stripe line to the manifold assembly, flush the hemostatic valve, once flushed connect the guide catheter.
6. Prepare PTCA balloon according to manufacturer's recommendations.
7. Insert
   a. For over the wire (OTW) insert PTCA guidewire into straight port on the PTCA balloon catheter. Attach wire torque device to proximal end of guidewire.
   b. For rapid exchange insert the PTCA guidewire into the vessel via the guide catheter, then the PTCA balloon is inserted over the wire
8. Maintain wire control at all times.
9. Attach inflation device to balloon port on PTCA balloon catheter. Prep balloon by drawing back twice on ~~on~~ 35ml syringe, turn stopcock off to syringe and pull negative on inflation device.
10. Be ready to follow all instructions given by physicians.
11. Upon completion of **the** procedure, ~~attach~~ **the** arterial sheath **will be connected** to **a** continuous pressur**ized**e flush with transducer**; removed and a closure device used; or removed and manual pressure help to obtain hemostasis.** ~~unless closure device is used~~.

| Cardiac Catheterization Lab | Division of Cardiology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 6/97, 10/00, 4/03; 6/05, 1/09, 02/20, **12/23** | 07/20, **01/24** | 09/20, **04/24** | 10/20, **05/24** | 12/20, **06/24** | n/a | 02/11, 12/20 |

| Tri-City Medical Center | Cardiac Catheterization Lab |
|---|---|
| **PROCEDURE:** | **SET-UP AND INSERTION OF INTRA-AORTIC BALLOON CATHETER** |
| Purpose: | To assist the physician with the insertion of the Intra-Aortic Balloon (IAB). |
| Supportive Data: | Arrow Balloon Pump equipment tray instruction insert |
| Equipment: | Arterial pressure tubing x2 ;;<br>30 **cc** or 40 cc Intra–Aortic Balloon **Catheter**<br>Pressure Bag<br>Balloon Pump<br>6 FR sheath<br>StatLlock or suture (physician preference)<br>3-large **T**tegaderms |
| Issue Date: | 01/87 |

A. **PROCEDURE:**

1. Choose correct size of IAB **catheter**, based on ~~patients~~**patient's** height.
2. Prepare an arterial transducer line times 2 for monitoring according to hospital procedure.
3. **Scrub Tech:**
   a. Following manufacturer's instructions for preparation of balloon equipment and pump, assist physician with insertion. .
   b. Wipe down the wire and balloon with Heparinized saline, flush the sheath.
4. **Physician:**
   a. Localize the site.
   b. Insert the balloon under fluoroscopy.
   c. Verify the position of balloon under fluoroscopy and verify complete expansion.
   d. Suture balloon and sheath at insertion site.
5. **Circulating RN:**
   a. Prepare IAB pump according to manufacturer's instructions.
   b. Maintain sterile field when accepting connecting lines, plug in the fiber optic key, cal key, ensure zeroed prior to insertion and connect pressure tubing after insertion.
   c. Verify pump settings with physician.
   d. Begin pumping sequence on physician order.
   e. Verify proper timing of balloon inflation and deflation.
   f. Adjust timing according to patient hemodynamic needs using manufacturer's instructions.
6. **Monitoring Tech:**
   a. Record insertion time, serial number, ~~and~~ expiration date,~~and~~ balloon pump timing.

| Cardiac Catheterization Lab | Division of Cardiology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 06/97,; 04/03,; 06/05,; 07/09; 09/12, 02/20, **12/23** | 07/20, **01/24** | 09/20, **04/24** | 11/20, **05/24** | 12/20, **06/24** | n/a | 02/11, 12/20 |

| Tri-City Medical Center | Cardiac Catheterization Lab |
|---|---|
| **PROCEDURE:** | **STENTING PROCEDURE** |
| Purpose: | ~~Use of e~~**Explain preparation of e**quipment ~~used for~~ **used for** stenting during an ~~intervention~~ **Percutaneous Coronary Intervention (PCI)** |
| Supportive Data: | None |
| Equipment | Sterile heart cath**eterization** tray setup for **percutaneous transluminal coronary angioplasty** (PTCA) **includes:** guide catheter**, interventional guidewire, balloon and stent(s). All are physician preference items.** ~~(physician preference)Interventional wire (Physician preference) Balloon and Stent (s) (Physician preference)~~ |
| Issue Date: | 09/95 |

A. **PROCEDURE:**

1. **Preparation:**
   a. Patient to be prepped and draped according to policy.
   b. Lesions are **sometimes p**re-dilated with a PTCA balloon to allow passage of **the** stent delivery system. **However,** ~~Direct stenting may apply.~~**stents may be delivered and deployed without pre-dilitation referred to as direct stenting.**
2. **After Placing Stent on Table, Perform the Following Steps**:
   a. Remove protective stylet from balloon tip.
   b. Flush balloon central lumen with ~~H~~**h**eparinized saline solution.
   c. Flush delivery sheath with **h**~~H~~eparinized saline solution.
   d. **DO NOT PREP BALLOON** until stent has crossed the lesion.
   e. If there is any doubt regarding balloon integrity, ease of movement or stent placement on the system, it is best to remove the system from the field and begin with a new system.
   f. When position of the stent is optimal, inflate the balloon to expand the stent. Increase inflation pressure to the recommended stent expansion pressure shown on the label. The proximal and distal ends of the balloon will expand first (**do not exceed** the rate burst pressure). **The cardiologist will verbalize desired inflation pressure and length of time of inflation.**
   g. If the stent cannot be deployed, **do not** try to pull it back into the guide. This may embolize the stent. Remove the guide, stent and guiding catheters as a single unit.
3. **Balloon Withdrawal**:
   a. Completely deflate the balloon, using the inflation device or a syringe.
   b. Allow adequate time for the balloon to fully deflate. Adequate deflation requires 15-30 seconds.
   c. Intra-coronary **(IC)** nitroglycerin may help with balloon withdrawal.
   d. Maintain suction on the balloon while withdrawing slowly. Allow the motion of the myocardium to gently dislodge the balloon from the stent.
   e. Maintain the position of the guiding catheter to prevent it from being drawn into the vessel. It may be necessary to pull back on the guiding catheter.
   f. Administer nitroglycerin via the coronary artery to reduce spasm, which may occur after coronary stenting per physician order.
4. **Placing Multiple Stents in Tandem**:
   a. Stent the most distal area first.
   b. Use larger diameter proximal stent if necessary, or use higher inflation pressures
   c. The stents should touch or overlap slightly. Better to overlap than leave a gap.
5. **Placing Multiple Stents in Multiple Vessels**:

| Cardiac Catheterization Lab | Division of Cardiology | Pharmacy & Therapeutics Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 007/97,; 10/00,; 04/03,; 06/05,; 08/09, 09/12, 09/18, 02/20, **12/23** | 07/20, **01/24** | 09/20, **04/24** | 11/20, **05/24** | 12/20, **06/24** | n/a | 09/95, 08/11, 12/20 |

a. It is occasionally necessary to stent lesions in more than one vessel during the same procedure. Patient management is no more difficult in a patient with stents in multiple vessels than in a patient with a single stented vessel.

6. **Removing an Accordion Stent**:
   a. Keep balloon inflated to 1 ATM. This will prevent the stent from slipping off the balloon.
   b. Pull stent back until proximal marker nears distal tip of guiding catheter.
   c. Withdraw guiding catheter and stent catheter and sheath if necessary "as one unit", leaving wire in place.
   d. Discard removed stent.
7. **Stent Delivery and Implantation**:
   a. Once proper positioning of the stent has been established, the physician inflates the balloon to ~~plant~~ **deliver** the stent. AT THIS TIME A NEGATIVE PREP should be performed on the balloon.
   b. Nominal pressure varies from stent to stent depending on manufacturer diameter of the stent.
   c. After stent expansion the balloon is deflated and the entire **stent delivery system** (SDS) is removed, leaving guidewire across the lesion.
   d. Further stent expansion may be performed with a high-pressure balloon.
   e. Post-stent placement patient will be prepared for transport according to existing PTCA protocol

| Tri-City Medical Center | Emergency Department | |
|---|---|---|
| **PROCEDURE:** | **EZ-IO INTRAOSSEOUS (IO) OR NIO_IOINFUSION SYSTEM** | **7010-015** |
| Purpose: | To outline the procedure on use and care of Intraosseous infusions | |
| Supportive Data: | Intraosseous infusion has been proven to be a safe and effective way to administer medications, fluids and blood products in both adults and pediatric patients that require rapid access for fluid resuscitation when standard IV access has not been achieved in a timely manner. | |
| Equipment: | Adult or pediatric Intraosseous Infusion Systems, EZ-IO drill device, appropriate size IO needle for age, local anesthetic (optional but should be considered if the patient is conscious), Chlorhexidine prep, syringe for aspiration, normal saline flush syringe for irrigation, dressing supplies, EX connect extension tubing, IV tubing and fluids, pressure infusion bag, rapid infuser or Alaris pump. For removal of IO device a 10mL syringe, gauze and medical tape. | |
| Issue Date: | 08/07 | |

A. **DEFINITIONS:**

1. Intraosseous (IO) infusion is indicated when rapid access to the circulation for administration of medications is needed and other standard attempts to obtain IV access have failed. IO infusion should be given any time intravenous (IV) cannulation is either too difficult or too time consuming to accomplish. IO needles are recommended for any age group.

B. **POLICY:**

1. The use of the EZ-IO drill and needle **or the NIO IO** device for insertion is performed by a physician/Allied Health Professional (AHP) or Registered Nurse.
2. Infusion through and removal of the IO after insertion is within nursing scope of practice.
3. DO NOT leave the IO catheter in for more than 24 hours. The IO catheter must be removed within 24 hours after initial insertion. Wristband, which is included in the kit, is placed on the patient at time of insertion indicating the time the catheter must be removed.

C. **PROCEDURE:**

1. Insertion of an IO using the EZ-IO **or the NIO IO** device is performed only by a physician/Allied Health Professional (AHP) or Registered Nurse.
2. The physician/Allied Health Professional (AHP) or Registered Nurse will select the appropriate site for insertion of the IO needle.
3. Nursing should position the patient (depending on the site) and stabilize the area for insertion.
4. Cleanse the area with Chlorhexidine antiseptic solution (Chloraprep).
5. The clinician inserting the IO may use local anesthetic (20-40mg of 2% Lidocaine) for patient comfort as necessary.
6. The clinician inserting the IO will insert a 15G x 1" needle for adult or 15G x 0.6" for pediatric, using the EZ-IO device. For use of the NIO IO device, the correct sized device will be selected (infant, pediatric, or adult). **For use of the NIO IO device, the correct sized device will be selected (infant, pediatric, or adult).**
7. After insertion, the placement is confirmed by aspirating blood or marrow contents with a syringe. Syringe bolus (flush) of IO device with 10ml normal saline should infuse easily without resistance.
8. Connect the EZ connect tubing (included in the EZ-IO needle kit) **for the EZ-IO device**. The end with the angle attaches to the IO device catheter and the straight end to the standard IV tubing. **For the NIO IO connect the extension tubing with the 3-way stopcock included in the kit.**
9. Secure tubing and catheter. Apply a sterile dressing.
10. Date dressing. (Must be removed within 24 hours).

| Department Review | Department of Emergency Medicine | Pharmacy and Therapeutics | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|
| 10/14, 02/20, 02/23 | 11/14, 03/20, 04/24 | 01/15, 05/20, 04/24 | 02/15, 08/20, 05/24 | 09/20, 06/24 | 03/15, n/a | 08/07, 02/11; 03/15, 09/20 |

11. While every attempt will be made to remove IO catheters prior to admitting patients to Intensive Care Unit (ICU), there may be the occasion when the catheter must remain until another route may be established, such as standard IV access or appropriate central access device.
12. Pediatric patients may be transferred to other facilities with the IO device in place.
13. Removal of the catheter is accomplished by following the steps listed below:
    a. Supporting the patient's limb with the catheter.
    b. While maintaining aseptic technique connect a sterile 10ml luer-lock syringe to the hub of the catheter to provide a handle to withdraw the IO catheter device from the bone.
    c. Rotate the syringe and catheter clockwise while gently pulling. DO NOT ROCK the IO catheter while removing. Rocking or bending the catheter with a syringe may cause the catheter to separate from the hub.

D. **SAFETY:**

1. Contraindications and Cautions:
    a. An IO is not recommended in any fractured extremities because of the risk of fluid and medication infiltrating into the surrounding tissue.
    b. To decrease the risk of infection, avoid placing the IO line through burned or infected tissue.
    c. General contradictions may include patients with bone disorders, such as osteoporosis and osteogenesis imperfecta.
    d. Do not infuse marrow toxic medications, (such as certain antibiotics) via the IO route.
2. Age Specific Considerations:
    a. IO access is widely recommended for use in pediatric population (AHA, 2002).
    b. It is now recommended in the management of adult patients who are critically ill (Waisman & Waisman, 1997l Frascone et al., 2001).
3. Complications:
    a. Unsuccessful attempts to penetrate the bony cortex or bending the needle by use of excessive force delays vascular access.
    b. Puncture of the posterior cortex as a result of excessive pressure during insertion of the needle.
    c. Fluid leakage from the infusion site. Fluid extravasation may occur, especially if the insertion was difficult or both cortices were penetrated. This fluid extravasation may lead to compartmental syndrome.
    d. Fat embolism resulting from use of high-pressure volume infusions.
    e. Potential osteomyelitis, which appears to be associated with prolonged continuous infusions.
    f. Clot formation within the bone marrow needle, causing slowing of the rate of infusion. The use of a pressure bag often alleviates this issue.
    g. Tibia fractures.

E. **REFERENCE LIST:**

1. Semonin-Holleran, R (2004); *Intraosseous Access* (pg.302-307), 3rd edition,
2. In Proehl, J.A. *Emergency Nursing Procedures*, Saunders; AHA, 4th edition (2008),
3. *Pediatric Advance Life Support manual*, Dallas Author; AHA, (2011),
4. *Advanced Cardiac Life Support manual*, Dallas Author; Stanley, R. (2011),
5. *Intraosseous Infusion* (pg.475-485), In Roberts J.R. & Hedges, J.R (Eds),
6. *Clinical Procedures in Emergency Medicine*, 6th edition (2013), Philadelphia, W.B. Saunders.
7. Lewis GC, Crapo SA, William JG. *Critical skills and Procedures in Emergency Medicine- Vascular Access Skills and Procedures*. Emerg Med Clin N Am 2013;31:59-86 Retrieved from: Http://dx.doi.org/10.1016/j.emc.2012.09.006
8. Ibrahim M, Cairney K. *Intraosseous (IO) Infusion as a Means of Vascular Access*. British J of Resuscitation. Autumn:23-6 (2012)
9. Rogers J, Fox M. *The Safety of Intraosseous Vascular Access*. Emergency Medicine Patient Safety Foundation Forum. Fall 18-21(2012)

10. Weiser G, Hoffmann Y, Galbraith R, Shavit I. *Current Advances in Intraosseous Infusion – A Systematic Review*. Resuscitation; 83(1):20-6. doi:1016/j.resusitation.2011.07.020 (2012)

Tri-City Medical Center
Oceanside, California

**MEDICAL STAFF**

| | | | |
|---|---|---|---|
| **ISSUE DATE:** | **07/11** | **SUBJECT:** | **Credentialing Policy, da Vinci Robotic Surgery** |
| **REVISION DATE:** | **07/12, 01/14, 02/19** | **POLICY NUMBER:** | **8710 – 563** |

| | |
|---|---|
| **Medical Staff Department Approval:** | ~~**08/21**~~**12/23** |
| **Division of GVS Approval:** | ~~**09/21**~~**04/24** |
| **Credentials Committee Approval:** | ~~**11/21**~~**05/24** |
| **Medical Executive Committee Approval:** | ~~**11/21**~~**05/24** |
| **Administration Approval:** | ~~**01/19**~~**06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **12/21** |

A. **PURPOSE**

1. To provide criteria for use in credentialing physicians who request privileges in da Vinci robotic surgery. For purposes of this policy, terms da Vinci and robotic are interchangeable.

B. **INITIAL CREDENTIALING FOR MULTIPLE PORT PROCEDURES:**

1. For surgeons with prior da Vinci experience:
   a. Physicians must have privileges to perform the underlying procedure either as an open or laparoscopic procedure.
   b. If residency/fellowship training included robotic surgery training, provide:
      i. letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device; and
      ii. The surgical log of a minimum of ten (10) da Vinci cases;
      iii. Proctoring: A minimum of two (2) cases within a one-hundred-eighty (180) day period must be proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).
         1) Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.
   c. For surgeons with prior da Vinci experience at an outside institution, provide:
      i. Ten (10) cases beyond proctoring and within the previous 24-month period must be submitted for review.
      ii. Proctoring: A minimum of one (1) case must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).
   d. The above-listed proctoring requirements may be waived for any surgeon on the Intuitive Surgical, Inc. List of Approved Proctors. However, privilege-specific proctoring requirements must be followed.
2. For surgeons without prior da Vinci experience:
   a. Privileges to perform the underlying procedure either as an open or laparoscopic procedure.
   b. Completion of an Intuitive Training Program or comparable program, which includes didactic and hands-on training including cadaver, animal lab, or simulator (See Phase II-Preparation and System Training of Surgeon Clinical Pathway-Intuitive Surgery).
   c. A minimum of one (1) live case observation.
   d. Proctoring: A minimum of three (3) cases within a one hundred eighty (180) day period must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).

i. Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

3. Proctoring requirements include a completed proctoring form from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief of the Division that additional training and/or proctoring be completed.
4. For all physicians granted robotic surgery privileges, the first ten (10) cases will be reviewed for evaluation of case selection, OR time, blood loss, conversion to open procedure, complications, length of hospital stay, etc.
5. For privileges to assist in robotic surgery (for MD/DO, PA, RNFA):
   a. Unrestricted surgical assisting privileges
   b. Documented experience in robotic assisting or completion of Intuitive Training Program for assistants (including on-line module and on-site training by Intuitive or a robotics-trained assistant)
   **c.** Proctoring: A minimum of six (6) cases must be proctored by the primary surgeon. Surgeons granted privileges for both robotic surgery and to assist in robotic surgery may be deemed to have satisfied proctoring requirements as an assistant in robotic surgery once proctoring requirements as the robotic surgeon have been fulfilled.
   ~~c.~~ **NOTE: Providers granted privileges for Xi robotic surgery shall be deemed to have satisfied the initial criteria for privileges to assist in robotic surgery.**

C. **INITIAL CREDENTIALING FOR SINGLE PORT PROCEDURES:**
1. Unsupervised multiple port robotic surgery privileges;
2. Completion of either:
   a. Single port Intuitive (or comparable) training program OR
   b. Training modules
      i. Proctoring: Two (2) cases with a qualified single port surgeon.

D. **REAPPOINTMENT CRITERIA**
1. A minimum of ten (10) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present.
2. If less than ten (10) but greater than or equal to five (5) cases have been performed successfully during the previous 24-month period, the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
3. If fewer than five (5) cases have been performed successfully within the previous 24-month period, additional certified hands-on training must be obtained either by simulator, cadaver or animal lab AND the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
4. For single port procedures, a minimum of two (2) procedures during the previous 24-month period. If fewer than two (2) cases, training modules must be redone or the next one (1) case must be concurrently proctored by a qualified single port surgeon.

E. **ONGOING PROFESSIONAL PRACTICE EVALUATION**
1. Robotic-performed cases may be reviewed on an ongoing basis by the appropriate Division/Department/Committee with the goal of patient safety and successful performance of the procedure(s). This may include OR time, blood loss, conversion to open procedure, complications, length of hospital stay.

Tri-City Medical Center
Oceanside, California

**MEDICAL STAFF**

**RETIRE – incorporated into Medical Staff Policy: Professional Behavior Policy & Committee (8710-570)**

**ISSUE DATE:** 10/08

**SUBJECT:** Medical Staff Standards of Conduct

**REVISION DATE(S):** 02/09, 10/08

**POLICY NUMBER:** 8710 – 552

| | |
|---|---|
| **Medical Staff Department Approval:** | ~~03/17~~05/24 |
| **Professional Behavior Committee Approval:** | ~~02/19~~ n/a |
| **Pharmacy & Therapeutics Committee Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~02/19~~05/24 |
| **Administration Approval:** | ~~03/19~~ 06/24 |
| **Professional Affairs Committee:** | n/a |
| **Board of Directors Approval:** | 03/19 |

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

~~1. Members of the Medical Staff are expected to adhere to the Medical Staff Standards of Conduct including, but not limited to, the following:~~

~~B. **GENERAL CONSIDERATIONS:**~~

~~1. It is the policy of the Medical Staff to require members to fulfill their Medical Staff obligations in a manner within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees, and visitors.~~

~~2. Rude, combative, obstreperous, or dangerous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and Tri-City Medical Center may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level at Tri-City Medical Center, in that all personnel play an important part in the ultimate mission of delivering quality patient care in a safe manner.~~

~~3. In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to the care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces, in addition to medical outcome, matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.~~

~~C. **CONDUCT GUIDELINES:**~~

~~1. Upon receiving Medical Staff membership and privileges at Tri-City Medical Center, the member enters a common goal with all members of the organized Medical Staff to endeavor to maintain the quality of patient care and appropriate professional conduct.~~

~~2. Members of the Medical Staff are expected to behave in a civil and professional manner at all times and with all people, patients, peers, Tri-City Medical Center staff, visitors, and others in affiliation with Tri-City Medical Center.~~

~~3. Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in or affiliated with Tri-City Medical Center.~~

~~4. Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official Medical Staff channels.~~

5. Cooperation and adherence to the reasonable policies of Tri-City Medical Center and the Medical Staff are required.
6. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

D. **DISCIPLINARY PROCEEDINGS FOR FAILURE TO COMPLY:**

1. Any report received due to failure to comply as outlined in Section C will be referred to the respective Department Chair/Division Chief and/or the Chair of the Professional Behavior Committee for review and consideration. If required the Medical Executive Committee (MEC) may promulgate to the Professional Behavior Committee for the purpose of investigating and addressing the perceived misconduct, and providing progressive remedial measures, including, when necessary referring the matter to MEC pursuant to Article IV, §6 to initiate an investigation.

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

1. Behavior Code of Conduct Report - Sample

F. **REFERENCE(S):**

1. Medical Staff Bylaws
2. Sentinel Event Alert # 40 Joint Commission
3. California Hospital Association (CHA) Rules

**Sample**

BEH[illegible] CODE OF CONDUCT REPORT

Name of Facility:

Date:

Name of person completing the

1. What led to the conduct you

2. Check the type of conduct:
   - ☐ Physical, sexual, or verb
   - ☐ Shouting or yelling
   - ☐ Hostile, sarcastic, or der
   - ☐ Non-constructive expres
   - ☐ Non-constructive criticisr
   - ☐ Failing to communicate r
   - ☐ Excessive expression of
   - ☐ Inappropriate comments

   patient's medical record

3. Please describe what happe

4. List names of patients, empl

5. List everyone who saw the e

6. How do you think this conduct affected patient care, hospital operations, your work, or your team members' work?

7. What did you or others first do to address this conduct?

**RETIRE**

8. Did you or others take any other follow-up action?

Information documented will kept as confidential as possible. Forward completed forms to

He or she may contact you for more information.

Tri-City Medical Cent
Oceanside, California

MEDICAL STAFF

**RETIRE - StatRad is no longer the primary telerad group and the procedures referenced in the P&P no longer apply**

**ISSUE DATE:** 9/03

**SUBJECT:** Quality Review Process for Teleradiologists

**REVISION DATE~~(S)~~:** 09/07, 08/12, 01/18, 08/20

**POLICY NUMBER:** 8710 – 525

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|---|---|
| **Department Approval:** | ~~05/20~~10/23 |
| **Credentials Committee Approval:** | ~~06/20~~05/24 |
| **Pharmacy and Therapeutics Approval:** | n/a |
| **Medical Executive Committee Approval:** | ~~07/20~~05/24 |
| **Administration Approval:** | ~~08/20~~ 06/24 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | 08/20 |

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

~~1. Ensure tracking and monitoring of the performance of teleradiologists.~~

~~B. **POLICY:**~~

~~1. A system shall be in place for tracking and trending individual teleradiologists.~~

~~C. **PROCEDURE:**~~

~~1. Preliminary reports are completed daily from StatRad via hospital PACS System during the hours of 10:00 pm to 7:00am.~~

~~2. The on-site radiologist shall review the interpretation and record agreement or disagreement noting minor or major variance. The variances for all teleradiologists are tracked on an ongoing basis and given to the Medical Staff Office for statistical analysis. Copies of the StatRad preliminary reports are kept on file.~~

~~a. If the on-site radiologist records minor or major variances, he/she shall record the results on the preliminary report form and note in the final report. Clinically significant variances are reported to the Emergency Department staff or ordering provider. Clinically significant variances include all category 4 discrepancies as defined by the ACR guidelines and any category 3 discrepancies based on the discretion of the Radiolpgist and clinical severity. All cases with clinically significant variances shall be forwarded to the Imaging Quality Assurance (QA) Officer for review and sent through the Department of Imaging QA peer review process.~~

~~3. The StatRad preliminary report with the noted discrepancy shall be entered in the StatRad QA website.~~

~~4. Access to the teleradiology's website is readily available for tracking the teleradiologists volume of reports, turnaround time, average time, and variances as needed. Report volume and discrepancy data is provided by the Imaging Department staff as requested by the Medical Staff office for the Ongoing Physician Practice Evaluation (OPPE) process~~

~~5. The Chief of the Department of Imaging assures the quality and appropriateness of patient care provided by the teleradiologist.~~

~~6. A deviation rate of ten percent (10%) or greater from the overall group average for any individual teleradiologist (in category 3 and 4 discrepancies) shall trigger a further review by the Department of Imaging chair.~~

Tri-City Medical Center
Oceanside, California

**PULMONARY REHABILITATION**

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**SUBJECT:** **Contraindications to Pulmonary Rehab Exercise**

**ISSUE DATE:** **09/08**
**REVISION DATE:** **11/11, 12/12, 08/21**

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|---|---|
| **Department Approval:** | **~~02/20~~04/24** |
| **Division of Pulmonary Approval:** | **n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~07/21~~05/24** |
| **Administration Approval:** | **~~08/21~~06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **08/21** |

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A. **PURPOSE:**
1. To establish contraindications to pulmonary rehabilitation exercise.

B. **POLICY:**
1. Patients with one or more of these contraindications shall not be allowed to exercise.

C. **DEFINITIONS:**
1. Contraindications to exercise:
   a. Unstable angina
   b. Resting diastolic blood pressure of greater than 110 mm Hg or systolic BP greater than 210 shall be evaluated on a case by case basis
   c. Orthostatic blood pressure drop of greater than 20 mm Hg with symptoms
   d. Acute systemic illness or fever
   e. Uncontrolled atrial or ventricular arrhythmias
   f. Uncontrolled sinus tachycardia (greater than 120 beats per minute)
   g. Uncompensated congestive heart failure
   h. Glucose level greater than 300 unless cleared by physician (participants primary MD or Pulmonary Rehab Medical Director)

Tri-City Medical Center
Oceanside, California

**PULMONARY REHABILITATION SERVICES**

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**SUBJECT:** **Exercise Prescription**

**ISSUE DATE:** **08/08**
**REVISION DATE:** **11/11, 12/12, 10/13, 08/21**

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| **Department Approval:** | **~~02/20~~04/24** |
| **Division of Pulmonary Approval:** | **n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~07/21~~05/24** |
| **Administration Approval** | **~~08/21~~06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **08/21** |

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A. **DEFINITIONS:**

1. To establish guidelines for prescribing maximal safe exercise to Pulmonary Rehabilitation patients. To establish guidelines for exercise prescriptions which enhance cardiopulmonary endurance, body composition, flexibility and muscular strength and endurance.

B. **POLICY:**

1. The initial exercise prescription signed by the MD (on Pulmonary Rehabilitation order sheet) will allow patient to begin the program at a low level of intensity, increasing to reach target heart rate (THR) or other specified parameters set by patients physician. The intensity, duration, and type of exercise to be performed will be determined by the pulmonary rehabilitation staff. The rehabilitation staff will be responsible for the development of the exercise prescription, which will bear the appropriate signature. The Pulmonary Rehabilitation Respiratory Therapist is to increase or progress the intensity or workload in order to titrate target heart rate.
2. The Pulmonary Rehabilitation Respiratory Therapist is to progress the intensity or duration of exercise based on patient's Rate of Perceived Dyspnea (RPD) or 3-5 on the modified Borg scale which is moderate to vigorous intensity (50%-80%) peak work rate.

C. **PROCEDURE:**

1. Intensity of exercise will be prescribed not to exceed 85% of the functional capacity and or an RPD of 5 on the modified Borg Scale. Intensity of exercise may be prescribed by heart rate, rating RPD, Spo2 and Metabolic Equivalents (METS). . Intensity of exercise may be prescribed by hear rate, rating of perceived exertion (RPE) or by METS. The target heart is calculated by the following methods: 60-80% of maximum heart rate, using the physician approved age-related chart for maximum heart rate.
2. The Rating of Perceived Exertion (RPE) Scale may be used as a valid and reliable indicator of the level of physical exertion during constant intensity exercise to establish exercise prescription intensity. Patients' will self-monitor the RPE at a specified heart rate until the heart rate- RPE relationship is learned. Then the RPE may be employed as an additional method for regulating intensity. The intensity of exercise may be prescribed by determining 70% of the patient's functional capacity and then selecting activities with energy expenditure in METS at the desired level.
3. Duration of the conditioning phase will be 20-90 minutes and the patient will report no undue fatigue an hour after exercise.
4. The frequency of exercise sessions shall be 2 times weekly.

5. Progression in the outpatient exercise program is dependent on the patient's functional capacity. Clinical status and needs or goals. The heart rate/signs and symptoms are indicators for progression to higher metabolic workloads.
6. The type of exercise performed includes aerobic activities such as walking, recumbent elliptical, recumbent or upright bike, arm ergometer, free weight and universal weight gym weight machine workouts. Light weights (1pounds each arm up to 5 pounds each arm) with numerous repetitions may be employed to increase muscle strength and endurance. Patients with hypertension dysrhythmias or poor cardiac reserve are excluded from the weight conditioning, or circuit weight/universal gym.

D. **FORMS**

1. The exercise prescription is recorded on a daily exercise sheet.

E. **REFERENCE LIST**

1. Guidelines for Pulmonary Rehabilitation 4th Edition

Tri-City Medical Center
Oceanside, California

**PULMONARY REHABILIATION SERVICES**

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**SUBJECT:** **Home Exercise Program**

**ISSUE DATE:** **10/08**
**REVISION DATE(S): 11/11, 12/12, 10/13, 08/21**

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|---|---|
| **Department Approval:** | **~~02/20~~04/24** |
| **Division of Pulmonary Approval:** | **n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~07/21~~05/24** |
| **Administration Approval:** | **~~08/21~~06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **08/21** |

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A. **DEFINITIONS:**
1. To establish guidelines for home exercise and activity on days when the participant is not exercising within the confines of the outpatient rehabilitation program.

B. **POLICY**
1. All participants will be given instruction in home exercise within two weeks of beginning the outpatient program unless otherwise requested by their physician or it is the consensus of the team that home exercise should be delayed secondary to medical reasons.
2. The home exercise program will be specifically tailored to meet the individual participant's needs and goals. The participant's current functional capacity, medical status, and level of physical fitness will be taken into consideration when writing the home program.
3. Home exercise instruction will include thorough, written information on warm-up, cool-down, mode, intensity, duration, frequency, and progression.
4. A professional staff member will thoroughly instruct the participant regarding home exercise. The participant will be given a written set of instructions, a chart to record progress, heart rates, and RPE. All questions are answered and a staff member must sign and date the record stating that the home program was reviewed. A copy remains in the participant's chart.

C. **FORMS:**
1. The participant is given a weekly home exercise log. The participant will return the exercise log weekly for review by a member of the professional staff. The staff member reviews the record to assure the proper routine, i.e., warm-up, cool-down, heart rate within THRR, and proper progression of the exercise prescription, has been followed. This also provides a prime opportunity for encouragement and motivation.

D. **REFERENCE LIST**

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

Tri-City Medical Center
Oceanside, California

# PULMONARY REHABILIATION SERVICES

**SUBJECT:** **Scope of Services**

**ISSUE DATE:** **08/08**
**REVISION DATE:** **11/11, 12/12, 10/13**

| | |
|---|---|
| **Department Approval:** | **~~02/20~~04/24** |
| **Division of Pulmonary Approval:** | **n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~07/21~~05/24** |
| **Administration Approval:** | **~~08/21~~06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **08/21** |

A. **DEFINITIONS:**

1. The Department of Pulmonary Rehabilitation provides diagnostic, therapeutic and educational services to in patients and out patients under the direction of a licensed pulmonary physician. Services are provided to adult and geriatric age groups. The Pulmonary Rehabilitation Center is open Monday – Friday from 7:30 a.m. to 3 p.m. to meet the needs of our patients.

B. **DIAGNOSTIC SERVICES INCLUDE:**

1. Non-Invasive Oxygen Assessment (Pulse Oximetry)-before, during and after exercise
2. Monitor Heart Rate-before, during and after exercise
3. Blood Pressure- before and after exercise
4. Home Oxygen Assessment
5. Glucose Monitoring and Exercise Therapy for Diabetic Patients

C. **SERVICES INCLUDE:**

1. Patient Pulmonary Assessment
2. Patient Respiratory Education
3. Medical Gas Administration

D. **STAFF RESPONSIBILITIES INCLUDE:**

1. In conjunction with the Medical Director of Pulmonary Rehabilitation develop an individualized treatment plan with collaborative patient goals.
2. Document the need for a skilled level of care and services.
3. Ensure patient safety.
4. Provide patient education and training sessions.
5. Evaluate patient progress.
6. Reassess and (if needed) adjust the treatment plan.
7. In conjunction with the Medical Director of Pulmonary Rehabilitation participate in pulmonary rehabilitation team conferences, staff meetings, and in-services, as appropriate.
8. Monitor patient and program outcomes.
9. Develop a home program plan to promote long-term adherence to recommended life-style changes.
10. Initiate departmental emergency procedures as necessary.
11. Recommend pulmonary rehabilitation to potential patients.
12. Maintain communication with the referring health care professionals.

E. **PROVIDERS OF SERVICE:**

1. All providers of respiratory therapy are appropriately oriented to the Department and are licensed as required by law. Respiratory Care Practitioners (RCPs) acquire additional training and continuing education to ensure the proper care of patients. RCPs function under the direction of a Medical Director who specializes in Pulmonary Medicine.
2. The role of the RCP at Tri-City Medical Center and additional pulmonary support staff is described in the Job Descriptions and Policies and Procedures. The Department of Pulmonary Services is composed of professional, technical, and support staff in the following categories:
   a. Director
   b. Coordinator
   c. Registered Respiratory Therapists (RRTs)
   d. Certified Respiratory Therapists (CRTs)

F. **REFERENCE LIST:**

1. Guidelines For Pulmonary Rehabilitation Programs 4th Edition

Tri-City Medical Center
Oceanside, California

**PULMONARY REHABILIATION SERVICES**

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**SUBJECT:** **Strength Training**

**ISSUE DATE:** **08/08**
**REVISION DATE:** **11/11, 12/12, 10/13, 08/21**

| | |
|---|---|
| **Department Approval:** | ~~07/21~~**04/24** |
| **Division of Pulmonary Approval:** | **n/a** |
| **Pharmacy and Therapeutics Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | ~~07/21~~**05/24** |
| **Administration Approval:** | ~~08/21~~**06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **08/21** |

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A. **DEFINITION(S):**
1. Strength training is beneficial for patients with chronic lung disease. Weight lifting may lead to improvements in muscle strength, increased exercise endurance and fewer symptoms during Activities of Daily Living (ADL's).

B. **POLICY:**
1. A strength training prescription in pulmonary rehabilitation is to begin with lower weights and higher repetitions to work on muscle endurance. On an individual basis, higher weights and fewer repetitions to promote strength development may be indicated. Safety and prevention of muscle tears are of crucial importance. Strength training precautions are warranted for postsurgical pulmonary patients, those with osteoporosis, and patients diagnosed with primary arterial hypertension.
2. According to the AACVPR, patients diagnosed with the following conditions should be excluded from resistance training:
   a. Congestive heart failure
   b. Uncontrolled arrhythmias
   c. Severe valvular disease
   d. Uncontrolled hypertension (SBP $\geq$ 240mm Hg or DBP $\geq$100mm Hg)

C. **PROCEDURE:**
1. Participants must complete a thorough orientation, which includes, but is not limited to the following:
   a. Proper body position with each movement.
   b. Proper range of motion and speed of movement with each motion.
   c. Proper breathing patterns and avoidance of the Valsalva maneuver during activity.

D. **FORM(S):**
1. Strength training is recorded on a daily exercise sheet.

E. **REFERENCE(S):**
1. Guidelines for Pulmonary Rehabilitation Programs 4th Edition
2. Pulmonary Health, Rehabilitation and Exercise Testing

| Tri-City Medical Center | Surgical Services<br>Surgery |
|---|---|
| **PROCEDURE:** | **CELL SAVER SET-UP, USE AND MONITORING** |
| Purpose: | To outline the steps for cell saver set-up, use, and monitoring in surgery for recovery and reinfusion of the patient's own blood. |
| Supportive Data: | The cell saver device is an autotransfusion system for intraoperative processing of blood lost through surgery or trauma. Blood from the surgical field is anticoagulated, collected in a sterile collection reservoir, and processed in a continuous washing process to obtain washed packed red cells for reinfusion to the patient. During this process all plasmatic and non-erythrocytic cellular components of the collected blood, and thus activated coagulation factors, products of fibrinolysis, cell trauma, and anticoagulant, are removed. |
| Equipment: | • Haemonetics Cell Saver 5+ Machine<br>• Cell Saver Collection Reservoir<br>• Bowl and Harness Disposable Set (125mL)<br>• Anticoagulant Suction Line<br>• Yankauer Suction Tip<br>• Transfer Packs with Viaflex Bags<br>• Alcohol Swabs x3<br>• 0.9% NaCl 1000mL Bag (Irrigation)<br>• Heparin 30,000 Units<br>• 5mL Syringe<br>• Medication Added Label<br>• 0.9% NaCl 3000mL Bag (Wash)<br>• 3mL Syringe with Needle<br>• 18 gauge Needle<br>• TUR Tubing Set<br>• Fenwell Adapter |

A. **INSTALLATION OF THE MACHINE DISPOSABLES:**

1. Power ON the Cell Saver 5+ by pressing the white ON/OFF button located on the right side of the lower cabinet. The machine will perform a self-test. Do NOT use the machine unless it passes the self-test.
2. Open reservoir, load reservoir into bracket and close step-down clamp.
3. Attach regulated vacuum source (wall suction) to yellow-capped port on reservoir. Keep suction in the range of -150 to -200mmHg.
4. Open the bowl and harness disposable set and place the bowl firmly into the centrifuge well with higher inlet port facing left.
5. Hang the waste bag on the three support pins located on the front of the machine.
   a. Ensure the drain port on the bottom of the waste bag is closed.
6. Lock support arm around bowl header.
   a. A click will be felt or heard.
   b. Ensure the bowl is level and spins freely.
7. Insert effluent tubing into line sensor.
8. Insert the tubing from the inlet port into the air detector.
9. Open the pump platen.
   a. Thread the pump tubing around the pump and place tubing manifold into its slots.
   b. Close the pump platen, manifold/valve door and latch.
10. Close the centrifuge and fluid deck covers.
11. Hang the reinfusion bag on the IV pole and close small clamps on pigtails.
    a. Ensure blue line tubing clamps are open and twist-lock connection is secure.
12. Connect the red line tubing to the bottom of the collection reservoir and open step-down clamp.
13. Hang wash solution (3L 0.9% NaCl bag) on the IV pole.
14. Close both yellow line tubing clamps and spike 0.9% NaCl bag(s).
15. Open yellow line clamp(s) on 0.9% NaCl bag(s) to be used.
16. Once the disposable set is loaded properly, press START and the system will display CURRENT SETTINGS.

| Department Review | Department of Anesthesiology | Operating Room Committee | Pharmacy & Therapeutics Committee | Medical Executive Committee | Admini stration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|
| 05/00, 04/01, 08/01, 12/05, 09/09, 08/10, 09/12, 06/15, 11/16; 02/20, 08/23 | n/a | 12/16, 03/17, 02/20, 02/24 | 05/17, 03/20, 04/24 | 06/17, 04/20, 05/24 | 05/20, 06/24 | 07/17, n/a | 07/17, 05/20 |

a. While in CURRENT SETTINGS, the operator may press YES to restore default settings.
b. The display prompts the operator to press START to begin a procedure.

B. **COLLECTION SET-UP:**

1. Prepare the anticoagulant solution.
   a. Add 30,000 Units of Heparin into 1000mL bag of 0.9% NaCl.
   b. Complete the Medication Added label and attach to the heparinized saline bag.
   c. Hang the heparinized saline bag on the IV pole located on the right of the machine.
2. Open the sterile suction line and pass it to the sterile field using aseptic technique.
3. Connect the suction tubing to the yellow port of the reservoir and to the regulated wall suction, and turn ON suction. Do NOT use Neptune as suction source for Cell Saver machine.
   a. Regulate suction to keep between -150 and -200mmHg.
   b. Vacuum levels greater than -200mmHg may cause hemolysis.
4. Receive suction line from the sterile field and attach to blue-capped port on collection reservoir.
5. Spike the heparinized 0.9% NaCl bag.
6. Prime the collection reservoir with 200mL of heparinized 0.9% NaCl.
   a. Regulate the anticoagulant drip rate to approximately one drop per second.

C. **COLLECT FIRST OPTION:**

1. Use the collect first method if it is not clear that sufficient volume will be collected during a procedure to process for reinfusion.
2. Set up the machine for collect first:
   a. Load collection reservoir into bracket and close step-down clamp.
   b. Attach regulated vacuum source to yellow-capped port on reservoir.
   c. Receive sterile suction line(s) from the field and attach to blue-capped port(s) on reservoir.
   d. Prepare, hang and spike heparinized 0.9% NaCl solution (as described in B.1)
   e. Prime reservoir with 200mL heparinized 0.9% NaCl solution, then adjust drip rate of heparinized 0.9% NaCl to 1 drop/second.
3. Load Cell Saver 5$^{+}$ processing set if sufficient blood volume is collected.

D. **PROCESSING IN AUTOMATIC MODE:**

1. The FILL mode automatically begins when the preset reservoir level is reached.
   a. To begin processing prior to reaching this preset fluid level, press START.
   b. The Cell Saver 5$^{+}$ automatically advances through the FILL, WASH, and EMPTY modes if enough salvaged blood and wash solution are available.
2. The machine automatically advances to the WASH mode when the RBC's reach the optics trip point, ¼ inch over the shoulder of the Latham bowl.
3. If there is an insufficient volume of blood collected for the RBC's to reach the trip point, the air detector senses air from the red line and the system enters the STANDBY mode.
   a. The machine automatically resumes the FILL mode when the "Resume At" Level has been reached.
4. In the WASH mode, the programmed minimum volume of wash solution is pumped into the bowl to dilute the supernatant contaminants with the RBC's.
5. The EMPTY mode stops the spinning of the centrifuge.
   a. The contents of the bowl are pumped through the blue line to the reinfusion bag.
6. The CONC mode is commonly used at the end of a procedure when no more blood loss is expected and there are not enough red blood cells to fill the bowl.
   a. In this mode, red cells in the reinfusion bag are pumped to the bowl.
7. The RETURN mode pumps the bowl contents to the reservoir.

E. **QUALITY CONTROL:**
1. Test Hematocrit on first bowl of processed blood prior to administration for Quality Control monitoring.

F. **EMERGENCY MODE:**
1. The EMERGENCY mode may be used when the reservoir is filling too fast due to rapid blood loss and it is necessary to process blood urgently for immediate transfusion.
2. The EMERGENCY mode will process blood solution continuously through the FILL, WASH, and EMPTY modes until no more RBC's remain in the reservoir.
   a. When the reservoir is empty, the Cell Saver 5+ will automatically return to Automatic mode.
   b. The operator may also choose to Concentrate or RETURN cells to reservoir while in the EMERGENCY mode.
3. Red cells may spill into the waste bag as a result of choosing the EMERGENCY option, due to the increased pump rate.
4. To enter EMERGENCY option:
   a. Press the MODE key twice within two seconds.
   b. Press the YES key within 5 seconds to confirm.
   c. If the YES key is not pressed within 5 seconds, or the NO key is pressed, the Cell Saver 5+ will revert back to the Automatic mode.
5. To exit EMERGENCY mode and return to Automatic mode, press the MODE key once.

G. **PARTIAL BOWL OPTION:**
1. Use partial bowl option to process a partial bowl of blood at the end of a procedure or whenever it is necessary to process blood before a full bowl has been collected.
2. To process a partial bowl:
   a. Press WASH to begin partial bowl wash.
   b. Double the programmed wash volume by pressing the YES key to automatically double the programmed wash volume for that wash cycle only.
   c. Blood processed in a partial bowl cycle may have a lower hematocrit than blood processed in a normal full bowl cycle.
3. To concentrate RBC's:
   a. If RBC's in reinfusion bag, press CONC to fill bowl.
   b. Wash with minimum wash volume.

H. **EMPTY THE BLUE LINE:**
1. At the completion of the procedure, approximately 40mL of RBC's remain in the blue line that should be emptied to the reinfusion bag.
2. Do not empty the blue line during the procedure or the bowl displacement air will be lost adversely affecting subsequent EMPTY modes.
3. To empty 40mL remaining in the blue tubing into the reinfusion bag:
   a. DONE AT END OF CASE ONLY for last bowl processed!
   b. Press START, then press EMPTY, and repeat (Press START then EMPTY) until the blue striped line is empty.
   c. Alternatively, when the EMPTY mode is complete and prior to entering STANDBY a message will flash for 10 seconds "Is Case Completed? Y/N". If the NO key is pressed or no action is taken within 10 seconds, the machine will enter STANDBY. If the YES key is pressed within 10 seconds, the following message will flash: "Empty Blue Line? Y/N". If the YES key is pressed, the machine will empty the line at 100mL/min and then enter STANDBY. If the NO key is pressed, the machine will enter STANDBY without emptying the line.

I. **EMPTY AND CHANGE THE WASTE BAG:**

1. When emptying/changing the waste bag, do not lose the displacement air from the system. If this occurs, the bowl may not empty properly.
2. Empty the waste bag by draining waste fluid into an empty container for discard or use an extra suction line to suction out the waste bag.
   a. DO NOT completely empty the waste bag. Unless the bowl is completely empty, keep fluid level in the waste bag ABOVE the drain port, to prevent loss of displaced air.
3. Change the waste bag at the end of the EMPTY mode, only when the machine is at rest to prevent the loss of displacement air.
   a. Prior to removing the full waste bag, press STOP to ensure that processing does not begin.
   b. When the new bag is installed press START to resume.

J. **DOCUMENTATION:**

1. Document the following information in the patient's electronic health record (EHR):
   a. Cell Saver operator's name
   b. Cell Saver machine identification number
   c. Type and amount of anticoagulant used
   d. Volume collected in reservoir
   e. Volume returned to patient
   f. Wash volume
   g. Hematocrit of first processed unit (QC)
   h. Name of person reinfusing blood
   i. Comment section to document any complications and/or adverse reactions during the procedure

K. **BREAKDOWN AND CLEANING:**

1. Power the machine OFF.
2. Close all clamps on the disposable tubing.
3. Cap all open ports on the collection reservoir.
   a. Tubing stubs and caps included with the reservoir and processing kit may be used for closing open ports.
4. Remove the waste bag from support pins (may be emptied before removing).
5. Remove the bowl from the centrifuge well.
6. Remove the remaining tubing harness.
7. Remove the collection reservoir; keep tubing harness connected to reservoir outlet to avoid fluid spill.
8. Place the machine disposables in a biohazardous waste bag.
9. Clean machine per manufacturer's instructions for use (IFU).
   a. To prevent damage to the machine, do not spray or pour disinfectant solution directly on machine.
10. Prepare machine for next use by replacing all disposables.

L. **REFERENCE(S):**

1. Haemonetics Cell Saver 5+ System Operator's Manual

Tri-City Medical Center
Oceanside, California

**SURGICAL SERVICES**
**SURGERY**

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**ISSUE DATE:** 04/94 **SUBJECT: Medications in Surgery**

**REVISION DATE(S): 02/05;, 07/11;, 01/13, 09/20**

| | |
|---|---|
| **Surgical Services Department Approval:** | ~~02/20~~08/23 |
| **Operating Room Committee Approval:** | ~~03/20~~02/24 |
| **Department of Anesthesiology Approval:** | n/a |
| **Pharmacy & Therapeutics Committee Approval:** | ~~05/20~~04/24 |
| **Medical Executive Committee Approval:** | ~~08/20~~05/24 |
| **Administration Approval:** | ~~09/20~~06/24 |
| **Professional Affairs Committee Approval:** | n/a |
| **Board of Directors Approval:** | 09/20 |

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A. **PURPOSE:**
1. To outline the access to medications in surgery.

B. **POLICY:**
1. OR STOCK DRUGS:
   a. Medications used in Surgery are dispensed from a PYXIS Medstation. This computerized Medstation system is linked to the Hospitals' main Pharmacy. It provides a control system for dispensing medications and contains an approved menu of medications prescribed by a surgeon or used by an anesthesiologist.
   b. Emergency medications are stored in the Crash Cart, Difficult Airway Cart, and Malignant Hyperthermia Cart. Medications are stocked in these carts by Pharmacy and a yellow numbered lock is applied to the medication drawer by the Pharmacist. Daily checks are performed for lock integrity and verification of lock number.
2. AUTHORIZED ACCESS:
   a. Nursing staff and Anesthesiologists are assigned an access code for the PYXIS Medstation Unit by pharmacy.
   b. Surgical and Anesthesia Technicians are issued PYXIS Medstation access codes allowing access to non-narcotic medications to be removed for surgical procedures and room stocking.
   c. Ancillary personnel (including, but not limited to, Perioperative Aides, Environmental Service workers, and Maintenance workers) are not granted codes for PYXIS Medstation and do not have access to medications in Surgery.
3. PROCUREMENT:
   a. Medication inventory levels in PYXIS Medstation are maintained by the Pharmacy. Pharmacy is to be notified of the need for additional medication stock.
4. DOCUMENTATION:
   a. Administration of narcotics by the anesthesiologist is documented in the anesthesia record and in the Anesthesia Pyxis.
   b. Non-Controlled drugs obtained by a nurse and used by a surgeon will be documented on the Perioperative Nursing Record.
5. OTHER:
   a. Each PYXIS unit will be connected to the hospital's Emergency Power Source generator, for backup power, in the event of a power outage.

| Tri-City Medical Center | Surgical Services |
|---|---|
| **PROCEDURE:** | **SURGERY BLOOD IN ICE CHESTS** |
| Purpose: | To outline the steps for transport and storage of blood in ice chests in Surgery. |
| Supportive Data: | To have blood readily available in the surgical suite when administration is anticipated in a surgical procedure. |
| Equipment: | Ice chest with ice blocks (from Blood Bank). |
| Issue Date: | 08/95 |

A. **POLICY**

1. Surgery staff members may check out blood from the Blood Bank and transport to Surgery after demonstrating competency.
2. Each unit of blood has a Safe-T-Vue temperature monitor affixed.
   a. The Safe-T-Vue temperature monitor is checked by the blood transporter and the Blood Bank staff when checking out the blood.
   b. The Safe-T-Vue temperature monitor must be white; if it is red the blood must be returned to the Blood Bank and may not be used.
3. Ice chests:
   a. Units of blood are placed in an ice chest for transportation to Surgery and storage in the surgical suite during the procedure.
   b. An ice chest may be used when two (2) or more units of blood are ordered to the surgical room.
   c. No more than five (5) units of blood may be placed in an ice chest. Obtain multiple ice chests for more than five (5) units of blood.
   d. Ice blocks to keep the blood cold must be changed every nine (9) hours. After nine (9) hours the ice chest must be returned to the Blood Bank for new ice blocks.
      i. The Blood Bank monitors time for the ice blocks and notifies the surgical suite when ice blocks need to be changed.
   e. Units of blood must be stored in the ice chest with the Safe-T-Vue temperature monitor down.

B. **PROCEDURE:**

1. Transporting blood to surgery:
   a. Blood may only be checked out for one patient at a time.
   b. After blood is checked out from the Blood Bank, the transporter must proceed directly to the receiving surgical suite. The transporter may not stop during transport.
   c. Prior to transfusing, each unit of blood must be checked by two (2) licensed healthcare providers (a registered nurse [RN] and a second RN, perfusionist, or anesthesiologist) in accordance with Patient Care Services Procedure: Blood Products Administration.
   d. If additional blood is required during a procedure, it will be sent in a new ice chest.
   e. Ice chests are low level disinfected (i.e., wiped with hospital approved disinfectant) in the lab after each use.

| Department Review | Department of Anesthesiology | Operating Room Committee | Pharmacy & Therapeutics Committee | Blood Utilization Review Committee | Medical Executive Committee | Administration | Professional Affairs Committee | Board of Directors |
|---|---|---|---|---|---|---|---|---|
| 03/18, 02/20, 01/24 | n/a | 03/18, 02/20, 03/24 | n/a | 07/18, 01/21, 03/24 | 05/18, 07/21, 05/24 | 06/24 | 07/18, 08/21, n/a | 11/96, 06/00, 03/03, 01/06, 10/09, 09/12, 07/18, 08/21 |

Tri-City Medical Center
Oceanside, California

**SURGICAL SERVICES**
**SURGERY**

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**ISSUE DATE:** 04/94 **SUBJECT: Visitors in the Operating Room (OR)**

**REVISION DATE(~~S~~): 02/05, 06/09, 10/12, 04/15, 07/17**

| | |
|---|---|
| **Department Approval:** | **~~02/20~~02/24** |
| **Department of Anesthesiology Approval:** | **n/a** |
| **Operating Room Committee Approval:** | **~~03/20~~04/24** |
| **Pharmacy & Therapeutics Committee Approval:** | **n/a** |
| **Medical Executive Committee Approval:** | **~~04/20~~05/24** |
| **Administration Approval:** | **~~05/20~~06/24** |
| **Professional Affairs Committee Approval:** | **n/a** |
| **Board of Directors Approval:** | **05/20** |

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A. **PURPOSE:**
1. To assure the patient and healthcare team are notified and/or given permission for a medical or non-medical observer in a surgical procedure.

B. **DEFINITION(S):**
1. Non-Medical observer: those who have no clinical or scientific affiliation with Tri-City Medical Center (TCMC), the surgical procedure, or the medical and scientific equipment being used.
2. Medical observer: those who have no clinical or scientific affiliation with TCMC, the surgical procedure, or the medical and scientific equipment being used, however, do have a current valid license in a patient care field, such as a Medical Doctor (MD), Registered Nurse (RN), or Physical Therapist (PT).
3. Exemptions from this policy: Medical and Nursing personnel and students and related health care workers who are affiliated with TCMC.

C. **POLICY:**
1. The request for an observer must be communicated to the Director of Surgical Services/designee prior to the day of surgery by the sponsoring physician.
2. Medical and Non-Medical observers have a maximum of five (5) observation opportunities during a 30 calendar day period.
3. Non-Medical observers:
   a. Must be at least 18 years of age.
   b. The surgeon, anesthesiologist, Charge Nurse, and the patient must consent that the named person be allowed to observe the procedure(s).
   c. The Operating Room must be notified prior to surgery that the named person has permission to observe a specific procedure(s).
   d. A Consent for Observer in Surgical Procedures form shall be completed and in the patient's chart prior to the patient coming to the Operating Room.
   e. Family members and/or significant others of the patient may not observe surgical procedures.
   f. Limit of one observer per room will be allowed to provide for patient confidentiality, to maintain the sterile field, and to control traffic in the Operating Room. Special exceptions will be evaluated on an individual basis.

g. Observers are not allowed to enter the operating room before the patient is fully positioned, prepped and draped for surgery. Special exceptions will be evaluated on an individual basis.
h. Observers are not allowed to touch the patient, "scrub in" or participate in the care of the patient.

4. Medical Personnel:
   a. Medical personnel who wish to observe must have approval of the surgeon, anesthesiologist, and the Director of Surgical Services/designee.

D. **PROCEDURE:**

1. Observers shall report to the Operating Room desk at specified time and state their name, title, and purpose. A name tag will be provided to identify the observer and must be worn at all times.
2. Observers shall don surgical attire in the appropriate Surgery locker room, in accordance with Patient Care Service Policy: Surgical Attire.
3. All valuables shall be secured in the assigned locker.
4. A staff member shall escort the observer to the appropriate room and instruct them in the appropriate use of the mask.
5. A staff member shall introduce the observer to the room personnel and explain appropriate conversation etiquette.
6. The observer shall stand/sit out of the traffic pattern until the circulator can assist in moving him/her to the point of observation.
7. Observers shall ask questions as needed during an appropriate time.
8. Observers shall ask the circulator for assistance if the need arises to move about the room.
9. While moving around the room, proper aseptic technique must be maintained by keeping at least a minimum of 12" distance between non-sterile personnel and any sterile item or person.
10. Observers shall report directly to the OR Desk when leaving the assigned room.
11. Observers shall not enter or exit any operating room without an escort.

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

1. Administrative Policy: 203 Business Visitor Visitation Requirements

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

**May 30, 2024 – 2:00 o'clock p.m.**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on May 30, 2024.

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

Director Rocky J. Chavez
Director Nina Chaya
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Tracy M. Younger called the meeting to order at 2:00 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Chairperson Younger made an oral announcement of the items listed on the May 30, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included three matters of Existing Litigation and Reports Involving Trade Secrets.

4. Motion to go into Closed Session

   **It was moved by Director Chavez and seconded by Director Gleason to go into Closed Session at 2:02 p.m. The motion passed unanimously (7-0).**

5. At 3:30 p.m. the Board returned to Open Session with attendance as previously noted.

6. Report on any action taken in Closed Session.

   Board Counsel Scott reported the Board will be returning to closed session following the open session to complete unfinished business.

7. At 5:00 p.m. the Board adjourned the meeting to return to the reconvened Regular Board meeting.

Tracy M. Younger
Chairperson

ATTEST:

Gigi Gleason
Secretary

# TRI-CITY HEALTHCARE DISTRICT
# MINUTES FOR A REGULAR MEETING
# OF THE BOARD OF DIRECTORS
# May 30, 2024 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on May 30, 2024.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Janice Gurley, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Mark Albright, Chief Information Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Tracy Younger, called the meeting to order at 3:30 p.m. with attendance as listed above.

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

   Board Counsel Scott stated the Board will be returning to Closed Session at the end of today's meeting to complete unfinished business. A report on any action taken in Closed Session will be given at the end of Closed Session.

3. Roll Call/Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Approval of Agenda

   Director Younger pulled item 11(2) Cardiology from the agenda and stated the item will be trailed following Closed Session.

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**It was moved by Director Coulter and seconded by Director Gleason to approve the agenda minus the item that was pulled. The motion passed unanimously (7-0)**

5. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the May 30, 2024 Regular Board of Directors Meeting Agenda.

6. Special Recognitions –

Nurses & Support Staff of the Year for 2024

- Nurse of the Year (Day Shift): Janette Swanson, RN (2 Pavilion
- Nurse of the Year (Night Shift): Jen Catacutan, RN, (PCU)
- Patient Care Support Staff of the year: Rick Vilela, Anesthesia Tech (Surgical Services)

Chairperson Younger recognized the Nurses & Support Staff of the Year for 2024 including Janette Swanson, RN, Jen Catacutan, RN and Rick Vilela, Anesthesia Tech. Each respective manager accompanied their award recipient to the podium and were given the opportunity to speak. Managers were extremely complementary of their respective staff member. Janette Swanson and Rick Vilela expressed their appreciation of the award and their passion for Tri-City. Jen Catacutan was unable to attend the meeting.

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On behalf of the Board of Directors, Chairperson Younger congratulated the award recipients.

7. April, 2024 Financial Statements – Janice Gurley, Chief Financial Officer

Janice Gurley, Chief Financial Officer reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $242,714
- Operating Expense – 275,833
- EBITDA – ($8,570)
- EROE – ($23,919)

Janice reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 115
- Adjusted Patient Days – 67,367
- Surgery Cases – 4,095
- ED Visits – 36,623

Janice reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $27,194
- Operating Expense – $27,929
- EBITDA – $1,977
- EROE – $497

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 128
- Adjusted Patient Days – 7,490
- Surgery Cases – 451
- ED Visits – 3,744

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

Janice noted this is the fourth consecutive month with a positive EROE.

7. New Business - None

8. Old Business - None

9. Chief of Staff –

Dr. Henry Showah, Chief of Staff presented the May 2024 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on May 28, 2024

**It was moved by Director Coulter to approve the May 2024 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee on May 28, 2024. Director Chaya seconded the motion.**

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

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

8. Consideration of Consent Calendar

Director Younger noted the Cardiology item was trailed to follow closed session.

Director Gleason pulled the Special Meeting and Regular Meeting minutes of May 2. 2024.

**It was moved by Director Chavez to approve the Consent Agenda minus the items pulled. Director Gleason seconded the motion.**

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

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

11. Discussion of items pulled from Consent Calendar

Director Gleason stated she would be abstaining from the vote on the minutes due her absence from the meetings.

**It was moved by Director Chavez to approve the minutes of the Special and Regular meetings of May 2, 2024. Director Chaya seconded the motion.**

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

| | | |
|---|---|---|
| **AYES:** | **Directors:** | **Chaya, Chavez, Coulter, Mizell, Sanchez and Younger** |
| **NOES:** | **Directors:** | **None** |
| **ABSTAIN:** | **Directors:** | **Abstain** |
| **ABSENT:** | **Directors:** | **None** |

12. Comments by Members of the Public.

There were no comments from members of the public.

13. Comments by Chief Executive Officer

Dr. Ma stated we had an opportunity to celebrate all of our staff at Nurse's Week and Hospital Week and their many achievements. And today, we recognized the best of the best Janette Swanson, RN, Jen Catacutan, RN and Rick Vilela, Anesthesia Tech. Dr. Ma stated we are fortunate to have such dedicated loyal staff.

Dr. Ma recognized Janice Gurley who has had a great track record with the positive financials for the fourth straight month.

Dr. Ma commented on the Emergency Department renovation. Not only the physical construction, but the focus on ED processes and quality metrics to improve the ED experience for patients and visitors.

14. Board Communications

Director Sanchez stated she is proud to be a Board member and very much appreciates everyone's hard work. She recognized today's award recipients and Chief Nurse Donald Dawkins. Lastly, Director Sanchez stated although there is a lot of work ahead of us, she is anticipating the future partnership with UCSD.

Chairperson Younger complimented Donald Dawkins on the great job he did speaking at Nurse's week and extended her congratulations to the staff who were recognized today.

15. Adjournment

There being no further business, Chairperson Younger adjourned the meeting to closed session to complete unfinished business at 4:00 p.m.

16. At 5:04 p.m. the Board returned to open session with all Board Members present.

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

Board Counsel Scott reported the Board met in Closed Session to confer with legal counsel regarding three (3) existing litigation matters and also met to discuss Reports Involving Trade Secrets and took no action.

18. Cardiology –
Approval of the Emergency Department On-Call agreement for STEMI, General Call and Non-Invasive Cardiology Panel services with Karim El Sherief, M.D., Aaron Yung, M.D. Dimitri Sherev, M.D., Mihir Barvalia, M.D., Jesse Naghi, M.D., Fernandez F. Genaro, M.D., and Mohammad Pashmforoush, M.D., PhD, for a term of 36 months, beginning July 1, 2024 and ending June 30, 2027, with an annual cost of $690,820. and total term cost of $2,072,460.

Dr. Ma stated the Cardiology agenda item before the Board is the awarding of the RFP for Cardiology Services. Upon review of the submissions, staff submitted a recommendation for the Board's consideration.

Jeremy Raimo, COO provided a timeline regarding the RFP that was initially sent out to all Cardiologists in the fall and reopened in May. Jeremy explained the staff's recommendation today is based on certain criteria including physician availability, quality metrics and the ability to provide services for the IPAs.

Chairperson Younger recognized Dr. Bui, Dr. Rajamanickam and Dr. Kabra who spoke regarding their concerns with the staff's recommendation and RFP process in general.

Upon hearing the comments made by the physicians:

**it was moved by Director Mizell to table action on the Emergency Department On-Call agreements for STEMI, General Call and Non-Invasive Cardiology Panel services and provide an additional ten (10) days to resubmit proposals. Director Coulter seconded the motion.**

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

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

19. Hearing no further business, Chairperson Younger adjourned the meeting at 5:30 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi S. Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending May 31, 2024

| Lessor | Sq. Ft. | Base Rate per Sq. Ft. | | Total Rent per current month | LeaseTerm Beginning | LeaseTerm Ending | Services & Location | Cost Center |
|---|---|---|---|---|---|---|---|---|
| **6121 Paseo Del Norte, LLC**<br>6128 Paseo Del Norte, Suite 180<br>Carlsbad, CA 92011<br>V#83024 | Approx 9,552 | $3.59 | (a) | 54,257.88 | 07/01/17 | 06/30/27 | **OSNC - Carlsbad**<br>6121 Paseo Del Norte, Suite 200<br>Carlsbad, CA 92011 | 7095 |
| **Cardiff Investments LLC**<br>2729 Ocean St<br>Carlsbad, CA 92008<br>V#83204 | Approx 10,218 | $2.58 | (a) | 37,447.94 | 07/01/17 | 08/31/24 | **OSNC - Oceanside**<br>3905 Waring Road<br>Oceanside, CA 92056 | 7095 |
| **Creek View Medical Assoc**<br>1926 Via Centre Dr. Suite A<br>Vista, CA 92081<br>V#81981 | Approx 6,200 | $2.70 | (a) | 20,594.69 | 07/01/20 | 06/30/25 | **PCP Clinic Vista**<br>1926 Via Centre Drive, Ste A<br>Vista, CA 92081 | 7090 |
| **SoCAL Heart Property LLC**<br>1958 Via Centre Drive<br>Vista, Ca 92081<br>**V#84195** | Approx 4,995 | $2.50 | (a) | 18,075.40 | 10/01/22 | 06/30/27 | **OSNC - Vista**<br>1958 Via Centre Drive<br>Vista, Ca 92081 | 7095 |
| **BELLA TIERRA INVESTMENTS, LLC**<br>841 Prudential Dr, Suite 200<br>Jacksonville, FL 32207<br>V#84264 | Approx 2,460 | $2.21 | (a) | 7,656.45 | 04/01/23 | 03/31/25 | **La Costa Urology**<br>3907 Waring Road, Suite 4<br>Oceanside, CA 92056 | 7082 |
| **Mission Camino LLC**<br>4350 La Jolla Village Drive<br>San Diego, CA 92122<br>V#83757 | Appox 4,508 | $1.75 | (a) | 16,098.34 | 05/14/21 | 10/31/31 | **Seaside Medical Group**<br>115 N EL Camino Real, Suite A<br>Oceanside, CA 92058 | 7094 |
| **Nextmed III Owner LLC**<br>6125 Paseo Del Norte, Suite 210<br>Carlsbad, CA 92011<br>V#83774 | Approx 4,553 | $4.00 | (a) | 23,811.92 | 09/01/21 | 08/31/33 | **PCP Clinic Calrsbad**<br>6185 Paseo Del Norte, Suite 100<br>Carlsbad, CA 92011 | 7090 |
| **500 W Vista Way, LLC & HFT Melrose**<br>P O Box 2522<br>La Jolla, CA 92038<br>V#81028 | Approx 7,374 | $1.67 | (a) | 12,812.09 | 07/01/21 | 06/30/26 | **Outpatient Behavioral Health**<br>510 West Vista Way<br>Vista, Ca 92083 | 7320 |
| **OPS Enterprises, LLC**<br>3617 Vista Way, Bldg. 5<br>Oceanside, Ca 92056<br>#V81250 | Approx 7,000 | $4.12 | (a) | 31,749.00 | 10/01/22 | 09/30/25 | **North County Oncology Medical Clinic**<br>3617 Vista Way, Bldg.5<br>Oceanside, Ca 92056 | 7086 |
| **SCRIPPSVIEW MEDICAL ASSOCIATES**<br>P O Box 234296<br>Encinitas, CA 234296<br>V#83589 | Approx 3,864 | $3.45 | (a) | 14,880.52 | 06/01/21 | 05/31/26 | **OSNC Encinitas Medical Center**<br>351 Santa Fe Drive, Suite 351<br>Encinitas, CA 92023 | 7095 |
| **BELLA TIERRA INVESTMENTS, LLC**<br>841 Prudential Dr, Suite 200<br>Jacksonville, FL 32207<br>V#84264 | Approx 3,262 | $2.21 | (a) | 9,492.42 | 05/01/23 | 06/30/25 | **Pulmonary Specialists of NC**<br>3907 Waring Road, Suite 2<br>Oceanside, CA 92056 | 7088 |
| Total | | | | **246,876.65** | | | | |

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

**Education & Travel Expense**
**Month Ending May 2024**

| Cost Centers | Description | Invoice # | Amount | Vendor # | Attendees |
|---|---|---|---|---|---|
| 8740 | RESP THERAPY | 50124 EDU | 2,000.00 | 84411 | MORALES GARCIA JIMENA |
| 8740 | PHARMACY | 51524 EDU | 1,085.00 | 999050230 | SHARON LUONG |
| 8740 | Charge | 51724EDU | 200.00 | 83913 | PARKER MICAL |
| 8740 | PTCB TEST | 41224 EDU | 158.00 | 84415 | VALADEZ ANGELICA |
| 8740 | PTCB TEST | 51724 EDU | 158.00 | 84420 | SEGOVIA JAIRO |
| 8740 | RN CONT EDU | 50124 EDU | 149.00 | 84412 | TRAN TIEN |
| 8740 | Charge | 51724 EDU | 146.00 | 84421 | SHOEMAKER SHANNON |
| 8740 | Charge | 52324 EDU | 130.00 | 84419 | SERQUINA DELIA |
| 8740 | PHARMACY | 51524 EDU | 120.00 | 82580 | DROLSHAGEN, ASHLEY |
| 8740 | Charge | 51724 EDU | 104.90 | 84352 | GEORGE CONNIE |

**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.