

AGENDA

REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, May 9, 2018 – 6:15pm

El Camino Hospital | Conference Rooms A&B, F&G (ground floor)
2500 Grant Road Mountain View, CA 94040

MISSION: To heal, relieve suffering, and advance wellness as your publicly accountable health partner.

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|-----------------------|--|
| 1. CALL TO ORDER/ROLL CALL | Lanhee Chen, Board Chair | | 6:15 – 6:17pm |
| 2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES | Lanhee Chen, Board Chair | | 6:17 – 6:18 |
| 3. BOARD RECOGNITION <i>Resolution 2018-07</i> ATTACHMENT 3 | Cheryl Reinking, RN, CNO | <i>public comment</i> | motion required 6:18 – 6:23 |
| 4. QUALITY COMMITTEE REPORT ATTACHMENT 4 | David Reeder, Quality Committee Chair | | information 6:23 – 6:33 |
| 5. PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.</i> b. Written Correspondence | Lanhee Chen, Board Chair | | information 6:33 – 6:36 |
| 6. ADJOURN TO CLOSED SESSION | Lanhee Chen, Board Chair | | motion required 6:36 – 6:37 |
| 7. POTENTIAL CONFLICT OF INTEREST DISCLOSURES | Lanhee Chen, Board Chair | | 6:37 – 6:38 |
| 8. CONSENT CALENDAR <i>Any Board Member may remove an item for discussion before a motion is made.</i> Approval <i>Gov't Code Section 54957.2:</i> a. Minutes of the Closed Session of the Hospital Board Meeting (April 18, 2018) b. Minutes of the Closed Session of the Hospital Board Meeting (April 25, 2018) Information <i>Health and Safety Code Section 32155:</i> c. Organizational Clinical Risks | Lanhee Chen, Board Chair | | motion required 6:38 – 6:40 |
| 9. Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Report | Rebecca Fazilat, MD, Mountain View Chief of Staff; J. Augusto Bastidas, MD, Los Gatos Chief of Staff | | motion required 6:40 – 6:50 |
| 10. Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Bylaws Appeal | Mary Rotunno, General Counsel | | possible motion 6:50 – 7:05 |

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy two (72) hours prior to the meeting.

In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|--|--------------------------|-----------------------|---|
| 11. <i>Health and Safety Code Section 32106(b)</i> for a report and discussion involving health care facility trades secrets; <i>Health and Safety Code Section 32155</i> for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters; <i>Gov't Code Sections 54957</i> and <i>54957.6</i> for report and discussion on personnel matters: - CEO Report on New Services and Programs and Personnel Matters | Dan Woods, CEO | | discussion 7:05 – 8:30 |
| 12. Report involving <i>Gov't Code Section 54957</i> for discussion and report on personnel performance matters – Senior Management: - Executive Session | Lanhee Chen, Board Chair | | discussion 8:30 – 8:35 |
| 13. ADJOURN TO OPEN SESSION | Lanhee Chen, Board Chair | | motion required 8:35 – 8:36 |
| 14. RECONVENE OPEN SESSION/ REPORT OUT | Lanhee Chen, Board Chair | | 8:36 – 8:37 |
| To report any required disclosures regarding permissible actions taken during Closed Session. | | | |
| 15. CONSENT CALENDAR ITEMS: <i>Any Board Member or member of the public may remove an item for discussion before a motion is made.</i> | Lanhee Chen, Board Chair | <i>public comment</i> | motion required 8:37 – 8:40 |
| Approval a. Minutes of the Open Session of the Hospital Board Meeting (April 18, 2018) b. Minutes of the Open Session of the Hospital Board Meeting (April 25, 2018) | | | |
| Reviewed and Recommended for Approval by the Finance Committee c. Pathology Medical Directorship (Enterprise) Renewal d. ICU Nighttime Coverage Agreement (MV) e. ICU Daytime Coverage Agreement (MV) Reviewed and Recommended for Approval by the Medical Executive Committee f. Medical Staff Report Information g. FY18 Period 9 Financials | | | |
| 16. CEO REPORT ATTACHMENT 16 | Dan Woods, CEO | | information 8:40 – 8:42 |
| 17. BOARD COMMENTS | Lanhee Chen, Board Chair | | information 8:42 – 8:44 |
| 18. ADJOURNMENT | Lanhee Chen, Board Chair | | motion required 8:44 – 8:45 pm |

Upcoming Meetings: June 13, 2018

EL CAMINO HOSPITAL BOARD

RESOLUTION 2018-07

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE TO THE COMMUNITY

WHEREAS, the Board of Directors of El Camino Hospital values and wishes to recognize the contribution of individuals who enhance the experience of the hospital's patients, their families, the community, and the staff, as well as individuals who in their efforts exemplify El Camino Hospital's mission and values.

WHEREAS, the Board wishes to honor and acknowledge the Lab and Pathology Services physicians and staff for working behind the scenes to care for every patient who visits El Camino Hospital. The team often plays one of the most important roles in helping to diagnosis a patient's condition. They perform testing on specimens obtained from the human body for the purpose of diagnosis, prevention of disease, or treatment of patients by physicians. Seventy percent of all medical decisions made by physicians are based on information provided by Clinical Lab Scientists. The El Camino Hospital Lab and Pathology Services Department conducts nearly one million tests a year.

The Joint Commission Overuse Summit identified blood transfusions as one of the most overused procedures nationally. Lab and Pathology Services initiated the patient blood management program, which monitors every transfusion for appropriateness and assures the compatibility of blood products for transfusions. Knowing that each unit transfused represents an incremental increase in adverse consequences, our patient blood management program adopted "Why 2 when 1 will do?" when evaluating transfusion orders. The program has reduced red blood cell transfusions by 32 percent and 2 unit transfusions by 31 percent since fiscal year 2014.

Over the past year, Lab and Pathology Services has implemented new technologies and instrumentation to improve safety and efficiencies. One example is the Ventana H&E Automated Stainer, which does not use hazardous xylene and alcohol thereby improving employee safety and reducing the amount of regulated hazardous chemical waste generated by the Lab by 20 percent.

The Lab and Pathology team have been described as "hidden heroes" playing a critical role in patient care. They assure that the correct test is performed on the right person at the right time, producing accurate test results that enable providers to make the right diagnostic and therapeutic decisions.

WHEREAS, the Board would like to publically acknowledge the Lab and Pathology team for their impact on patient care.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously pay tribute to:

Lab and Pathology Services Team

FOR WORKING BEHIND THE SCENES TO CARE FOR PATIENTS.

IN WITNESS THEREOF, I have here unto set my hand this **9TH DAY OF MAY, 2018**.

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee Chen, JD, PhD
Jeffrey Davis, MD
Neysa Fligor

Peter C. Fung, MD
Gary Kalbach
Julie Kliger, MPA, BSN
Julia E. Miller

Bob Rebitzer
David Reeder
John Zoglin

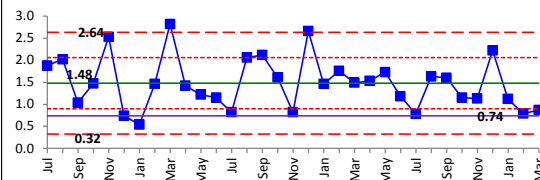
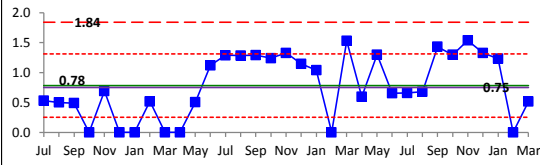
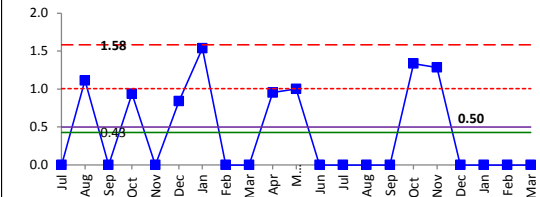
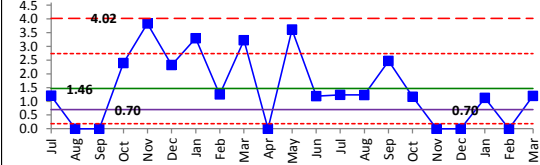
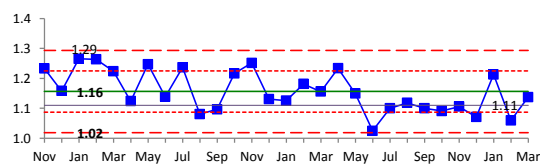
JULIA E. MILLER
SECRETARY/TREASURER,
EL CAMINO HOSPITAL BOARD OF DIRECTORS



ECH BOARD MEETING AGENDA ITEM COVER SHEET

| | |
|--|--|
| Item: | Quality, Patient Care and Patient Experience Committee ("Quality Committee") Report El Camino Hospital Board of Directors May 9, 2018 |
| Responsible party: | Dave Reeder, Quality Committee Chair |
| Action requested: | For Information |
| Background: The Quality Committee meets 10 times per year. The Committee last met on April 30, 2018 and meets next on June 4, 2018. | |
| Summary and session objectives: Summary of April 30, 2018 Meeting: <ol style="list-style-type: none"> <u>Patient Story:</u> The Committee reviewed a letter from a Los Gatos Campus patient detailing the thorough and compassionate care she received. <u>FY18 Quality Dashboard:</u> The FY18 Quality Dashboard was reviewed. Falls remain low, CAUTI trend is down with institution of new nurse protocol for removal of catheters, CLABSI remains at 0, and C. Diff rate reflects 1 case in March. The LOS index remains above 1 at 1.14. Mortality index is stable at .93 YTD and HCAHPS are just below goal. <u>Sepsis Update:</u> This is an area of continued focus as it is the leading cause of inpatient mortality across the country. Compliance with the sepsis (SEP-1) core measure has hovered around 60% which is better than the national average. While sepsis cases are increasing, mortality from sepsis is decreasing at ECH. Special emphasis has been directed toward obstetric sepsis. <u>Proposed FY19 Organizational Goals:</u> Proposed goals were reviewed and discussed. The importance of assuring alignment with organizational strategy was emphasized. There was general consensus that these goals are appropriate. <u>Patient and Family Centered Care Update - Patient Experience Roadmap:</u> Grievances for the past 9 months were reviewed. Overall incidence was 0.19%. The most common grievance category was clinical care concern followed by staff behavior/respect. <u>Pt. Experience and ED Patient Satisfaction:</u> A detailed review of ED patient satisfaction and inpatient satisfaction was performed. It was noted that ECH is higher than others in the Bay Area, yet compared to national standards there is room for improvement. | |
| Suggested discussion questions: None. | |
| Proposed Board motion, if any: None. | |
| Attachments: <ol style="list-style-type: none"> FY18 Quality Dashboard Proposed FY19 Organizational Goals | |

Quality and Safety Dashboard (Monthly)

| | | Performance | | Baseline | FY18 Goal | Trend | Comments |
|---------------|---|------------------|--------------------|---------------|--|--|--|
| SAFETY EVENTS | | Month | FYTD | FY2017 Actual | FY2018 Goal | | |
| 1 | Patient Falls <i>Med / Surg / CC Falls / 1,000 CALNOC Pt. Days</i> <i>Date Period: March 2018</i> | 0.87 (5/5745) | 1.26 (61/48400) | 1.49 | 0.74 (Top decile CALNOC) |  | In March, # of falls increased slightly to 5, and slightly above goal. In qtr 3 FY 18, 1 fall with moderate injury and 4 instances of mild harm (an xray is considered mild harm by CALNOC). Of 16 falls in qtr 3, 5 were considered as preventable. USF students producing videos for ECH nursing staff on the Hendrich II Falls Risk Assessment and the Get Up and go portion of the risk assessment. |
| 2 | *Organizational Goal Hospital Acquired Infection (Infection rate) Catheter Associated Urinary Tract Infection (CAUTI) <i>per 1,000 urinary catheter days</i> <i>Date Period: March 2018</i> <i>SIR Goal: <= 0.75</i> | 0.51 (1/1947) | 0.95 (13/13610) | 1.09 | SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459 |  | No new CAUTIs in February, 1 new CAUTI in March, for a total of 5 in qtr 3 fy18. This HAI was discovered on admission to Acute Rehab with admission surveillance screening, pt had fever for 2 days and opportunity for foley removal before transfer. Nursing badge buddy for Houdini foley removal algorithm in printing process and iCare changes for nursing orders and documentation for foley removal protocol in process. |
| 3 | Central Line Associated Blood Stream Infection (CLABSI) <i>per 1,000 central line days</i> <i>Date Period: March 2018</i> <i>SIR Goal: <= 0.50</i> | 0.0 (0/780) | 0.25 (2/7896) | 0.56 | SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423 |  | No new CLABSI HAI since December 2017. Peer support education beginning new Central line dressing kit. Standardized Sage warmers for CHG bathing installed with new procedure. iCare requests for standardized CVL documentation across all types of lines. Planning started for nursing competency for blood culture draw from central lines (to reduce contamination of specimens). |
| 4 | Clostridium Difficile Infection (CDI) <i>per 10,000 patient days</i> <i>Date Period: March 2018</i> <i>SIR Goal: <= 0.70</i> | 1.19 (1/8376) | 0.94 (7/74331) | 1.89 | SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30 |  | No new C.Diff HAI in February, one noted in March. 66 y/o male on many units, no in hospital transfer noted after review. Pt. colonized on admission. On 5 Antibiotics for peritonitis, protonix w/hx of gastric ulcer, anemia & renal failure, on bowel regimen for constipation, no loose stools. C.Diff toxin/antigen discovered with order at discharge after 28 days. Quality Dir to follow up with hepatoliet |
| Efficiency | | Performance | | FY17 Actual | FY 2018 Goal | | |
| | | Month | FYTD | | | | |
| 5 | *Organizational Goal Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS) <i>(Medicare definition, MS-CC, Inpatient)</i> <i>Date Period: March 2018</i> | 1.14 | 1.11 | 1.16 | 1.11 |  | ALOS increased to 4.64 from 4.28 in February, and the expected LOS increased also (GMLOS), resulting in the ration of 1.14. |

| Reports run: 9/20/17 | | | Baseline | FY18 Goal | Trend | Comments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|-----------------------|-----------------------|---------|--|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|--|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|--|
| 6 | Sepsis Core Measure SEP-1 100% or O% Date Period: Feb 2018 | <p>SEP-1: MONTHLY Compliance Rate ECH vs All Core Measure Hospitals</p> | | | | 5 failures of sampled cases; 3 due to not giving enough crystalloid fluids, 1 septic shock focused exam not completed in the time frame, 1 vassopressor not given. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded) Date Period: Feb 2018 | <p>Percentage of Randomly Sampled ED Patients (LG & MV) with ≥ 30ml/kg Crystalloid IVF or NICOM Ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock <i>Patients Lacking Initial Hypotension or Lactate <3 Excluded</i></p> <table><thead><tr><th></th><th>Oct-16</th><th>Nov-16</th><th>Dec-16</th><th>Jan-17</th><th>Feb-17</th><th>Mar-17</th><th>Apr-17</th><th>May-17</th><th>Jun-17</th><th>Jul-17</th><th>Aug-17</th><th>Sep-17</th><th>Oct-17</th><th>Nov-17</th><th>Dec-17</th><th>Jan-18</th><th>Feb-18</th></tr></thead><tbody><tr><td>Number of Sampled Cases</td><td>30</td><td>30</td><td>29</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td><td>30</td></tr><tr><td>Cases with 30ml/kg or NICOM ordered within 2h TOP</td><td>17</td><td>17</td><td>24</td><td>21</td><td>26</td><td>26</td><td>25</td><td>25</td><td>28</td><td>26</td><td>24</td><td>27</td><td>25</td><td>27</td><td>26</td><td>25</td><td>28</td></tr><tr><td>Cases with 30ml/kg ordered or NICOM within 3h TOP</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>1</td><td>0</td><td>1</td></tr><tr><td>Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation</td><td>57%</td><td>57%</td><td>83%</td><td>70%</td><td>87%</td><td>87%</td><td>83%</td><td>83%</td><td>93%</td><td>87%</td><td>80%</td><td>90%</td><td>83%</td><td>90%</td><td>87%</td><td>83%</td><td>93%</td></tr></tbody></table> | | | | | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Number of Sampled Cases | 30 | 30 | 29 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | Cases with 30ml/kg or NICOM ordered within 2h TOP | 17 | 17 | 24 | 21 | 26 | 26 | 25 | 25 | 28 | 26 | 24 | 27 | 25 | 27 | 26 | 25 | 28 | Cases with 30ml/kg ordered or NICOM within 3h TOP | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation | 57% | 57% | 83% | 70% | 87% | 87% | 83% | 83% | 93% | 87% | 80% | 90% | 83% | 90% | 87% | 83% | 93% | ED physicians are sustaining and continuing to improve regarding ordering of fluids. |
| | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of Sampled Cases | 30 | 30 | 29 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cases with 30ml/kg or NICOM ordered within 2h TOP | 17 | 17 | 24 | 21 | 26 | 26 | 25 | 25 | 28 | 26 | 24 | 27 | 25 | 27 | 26 | 25 | 28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cases with 30ml/kg ordered or NICOM within 3h TOP | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation | 57% | 57% | 83% | 70% | 87% | 87% | 83% | 83% | 93% | 87% | 80% | 90% | 83% | 90% | 87% | 83% | 93% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mortality | | Performance | | FY 2017 | FY 2018 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Month | FYTD | | | Goal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | Mortality Rate Observed/Expected Premier Standard Risk Calculation Mode Date Period: Jan 2018 | 1.05 (2.09%/1.99%) | 0.93 (1.61%/1.73%) | 1.02 (1.88%/1.83%) | 0.62 | <p>1.33 1.01 0.69 0.62</p> | Re-publish of EPIC data from Nov. 2015 completed March 27th. Mortality rate data available from December 2017. Increases noted since Dec. related to severity of flu season. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SERVICE | | Performance | | FY 2017 | FY 2018 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Month | FYTD | | Actual | Goal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10 Date Period: March 2018 | 77.1 (209/269) | 77.1 (1661/2153) | 76.30 | 78.0% | <p>81.71 76.01 70.31 78</p> | Rating increased 2 percentage points since January, near to goal in March. Improvements due to Nursing Communication weekly focus such as actively listening (sit at pt. eye level, and repeat back), and leader rounding training. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

DRAFT FY19 Organizational Goals

| Organizational Goals FY19 | | Benchmark | 2018 ECH Baseline | Minimum | Target | Maximum | Weight | Performance Timeframe |
|----------------------------------|---|--|--|-----------------|------------|------------|-----------|-----------------------|
| Organizational Goals | | | | | | | | |
| | Patient Throughput ED Door to Patient Floor | External Benchmark <i>CMS</i> | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | 30% | Q4 |
| | HCAHPS Service Metric Nurse Communication Responsiveness Cleanliness | External Benchmark <i>PG-HCAHPS Adjusted/Received</i> | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | 30% | Q4 |
| | Truven Quality Metrics AMI 30 day mortality 5% CABG 30 day mortality 5% AMI 30 day readmission 5% HF 30 day readmission 5% | External Benchmark <i>Premier</i> | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | 20% | FY |
| | People Employee Engagement | External Benchmark <i>Press Ganey</i> | FY18 Press Ganey Overall Engagement Indicator Score 4.09 - (40th percentile) | <i>TBD</i> | <i>TBD</i> | <i>TBD</i> | 20% | FY |
| Threshold Goals | | | | | | | | |
| Budgeted Operating Margin | | 95% threshold | Achieved Budget | 95% of Budgeted | | | Threshold | FY 19 |



**Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, April 18, 2018
2500 Grant Road, Mountain View, CA 94040
Conference Rooms F&G (ground floor)**

Board Members Present

Jeffrey Davis, MD
Neysa Fligor
Gary Kalbach
Julie Kliger, RN
Julia E. Miller, Secretary/Treasurer
Bob Rebitzer
David Reeder
John Zoglin, Vice Chair

Board Members Absent

Lanhee Chen, Chair
Peter C. Fung, MD

Members Excused

None

| Agenda Item | Comments/Discussion | Approvals/ Action |
|--|---|---|
| 1. CALL TO ORDER/ ROLL CALL | The open session meeting of the Board of Directors of El Camino Hospital (the “Board”) was called to order at 5:30pm by Vice Chair Zoglin. A silent roll call was taken. Directors Chen and Fung were absent. Director Rebitzer and Director Davis arrived at 5:34pm and 5:37pm respectively during Agenda Item 3: Quality Committee Report. All other Board members were present at roll call. | |
| 2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES | Vice Chair Zoglin asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were reported. | |
| 3. QUALITY COMMITTEE REPORT | <p>Director Reeder, Chair of the Quality Committee, reported that the Committee discussed one of the Committee member’s experience as a patient, her interactions with staff regarding her experience and her subsequent service on ECH’s Patient Family Advisory Council (PFAC) and Pain Management Committee.</p> <p>He described the Committee’s discussion on catheter associated urinary tract infections (CAUTIs) with staff (including the Director of Infection Control), which focused on the nurse-driven protocols.</p> <p>Cheryl Reinking, RN, CNO provided an overview of the Patient Care Experience Road Map reviewed by the Committee. She highlighted the inclusion of patient stories at all physician meetings, incorporation of best practices, training and leader rounding, and recruitment for PFAC, which meets monthly. She noted that implementation of the long-term items on the roadmap will begin in July. She also described the alignment of the Road Map with Picker’s Eight Principles of Patient-Centered Care.</p> <p>In response to Director Zoglin’s question, Iftikhar Hussain, CFO, explained that ECH is not currently paying any penalties to CMS for Hospital-acquired infections.</p> <p>In response to Director Fligor’s questions, Ms. Reinking reported that management is currently analyzing the survey results for how best to communicate internally with employees and that ECH uses HCAHPS scores to evaluate patient experience. Director Fligor requested additional information regarding ECH’s infection rates.</p> <p>Dan Woods, CEO, introduced Mark Adams, MD, Interim CMO.</p> | <i>Staff to provide additional detail regarding ECH infection rates</i> |
| 4. FINANCE COMMITTEE | Iftikhar Hussain, CFO, reviewed the FY18 Period 8 Financials, noting that: | <i>FY18 Period 8</i> |

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| <p>REPORT</p> | <ul style="list-style-type: none"> - ECH is 5.6% ahead of budget on volume, growth over the prior year; fixed cost structure that is offset by payor mix. - The volume in February dropped off due to the lower volume of flu cases. - Operating income is \$2.9m ahead of plan. - Cost for February was unfavorable due to lower volume. <p>Mr. Hussain reported that Los Gatos had a loss for the month of February due to a drop in surgical volume, but overall is still ahead of last year's performance. He noted that there have been some setbacks in the concierge program and that staff are working on filling vacancies.</p> <p>In response to Director Rebitzer's question, Mr. Hussain noted that the increase in volume is due to a combination of the flu season and initiatives of the service lines to build capacity.</p> <p>In response to Director Kliger's question, Mr. Hussain described ECH's collaboration with MayView, including the grant that ECH provides to support MayView's physician recruitment efforts.</p> <p>Director Kliger suggested examining regarding where patients are coming from (geography, which physician practices) to be able to anticipate growth. Mr. Hussain and David Clark, Interim COO, noted that it is physician-related, tied to service line business development, and that staff can provide additional information in this area.</p> <p>Motion: To approve the FY18 Period 8 Financials.</p> <p>Movant: Reeder Second: Kalbach Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None</p> | <p><i>Financials approved</i></p> <p><i>Staff to provide additional information about volume growth</i></p> |
| <p>5. MV SITE PLAN STATUS</p> | <p>Ken King, CASO, reviewed the status of the construction projects currently in progress on the Mountain View campus, highlighting:</p> <ul style="list-style-type: none"> - All projects currently under construction are moving along according to schedule and their approved budgets; and - Development work on the Women's Hospital revolves around how to operationally make room for the construction and expansion while continuing to provide services. He noted that ECH is currently weighing options, and there will be presentations to the Finance Committee in May and the Board in June. <p>In response to Director Fligor's question, Mr. King explained that ECH's property on Phyllis Avenue is currently used for construction staging activities, but there are no definitive future plans for the parcel.</p> | |
| <p>6. EMBEDDING LEAN MANAGEMENT IN CULTURE</p> | <p>Dan Woods, CEO, introduced Isidro ("Izzy") Galicia, President & CEO of Incito Consulting Group. Mr. Galicia presented an overview of LEAN Management, which covered the following:</p> <ul style="list-style-type: none"> - The concept of embedding a LEAN management culture: a systematic approach that aligns purpose, people, and approach, engaging the entire culture, starting from the top of the organization; - The history of LEAN in healthcare; - Focus on both the cultural and technical sides of change through: 1) strategy deployment (ECH's strategy deployment and a system | |

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| | <p>for monitoring progress), 2) value creation (waste identification and processes with true value), 3) continuous improvement (process, performance, and people), 4) people development (leadership coaching, employee engagement), and 5) sustainment-PDCA (plan-do-check); and</p> <ul style="list-style-type: none"> - The importance of strategy alignment and communication. <p>He also outlined the key deliverables over the next 18 months (through Q1 FY20).</p> <p>In response to Director Rebitzer's question; Mr. Galicia described the enterprise-wide value stream mapping and alignment with organizational strategy.</p> <p>In response to Director Kliger's questions, Mr. Galicia explained ways to measure the success of the LEAN effort include standardization and a functioning PDCA system.</p> <p>In response to Director Davis' questions, Mr. Galicia outlined pros and cons of focusing on a departmental versus enterprise level. He spoke to pitfalls and lessons learned from other organizations' LEAN implementation, noting the importance of monitoring system improvement progress and building overall accountability.</p> <p>In response to Director Miller's questions, Mr. Galicia described the progression from procedural change through behavioral change ultimately to cultural change. He also described the identification of priorities through the enterprise value stream mapping.</p> | |
| <p>7. GOVERNANCE COMMITTEE REPORT</p> | <p>Director Kalbach, Vice Chair of the Governance Committee, described the Governance Committee's review of any potential delegation of authority to the Advisory Committees. He noted that the Executive Compensation Committee's proposed delegation is a good test case of this concept. He also commented that the ultimate goal is to increase efficiency and utilization of Advisory Committee member expertise.</p> <p>Director Reeder commented that the expanded Committee structure with subject matter experts is very useful and voiced his support of delegated authority.</p> <p>Director Fligor requested that Mary Rotunno, General Counsel, and outside counsel research whether or not a Committee with delegated authority would continue to be called an Advisory Committee.</p> <p>Director Davis commented that this is a good step, but Committees should be much more conversant with organizational strategy to ensure that the Committee work is effective and aligned.</p> <p>Director Miller expressed concerns about delegating work that is the fiduciary duty of the Board. Director Kalbach commented that any delegation must be very explicit and measured and that it is incumbent on Board members to monitor Committee work. Director Zoglin commented that any delegation should be within the specific areas of expertise for each Committee.</p> <p>In response to Director Davis' question, Director Kalbach explained that the Governance Committee suggested that staff review other specific opportunities for delegation and solicit the specific Committee's feedback. Staff will bring those suggestions and feedback back to the Governance Committee for review. Any recommendations will be brought to the Board.</p> <p>The Board discussed how any the process for delegating authority should</p> | |

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| | <p>work (consistent with what is currently been done for the Executive Compensation Committee):</p> <ol style="list-style-type: none"> 1. Evaluate and specify, on a case-by-case basis, what the appropriate guardrails and limitations for any delegation would be to be vetted by legal counsel; 2. Bring any proposal to the Board for review and eventual approval by Resolution; and 3. Document any approved delegation and changes in the specific Committee's Charter and (if any) applicable policies for review and approval by the Board. | |
| <p>8. EXECUTIVE COMPENSATION COMMITTEE REPORT</p> | <p>Bob Miller, Chair of the Executive Compensation Committee, outlined the proposed delegation of authority as further detailed in the packet.</p> <p>He provided examples of possible Executive Compensation Committee conclusions that, if not within Board-approved policy, would still require Board approval.</p> <p>Mr. B. Miller noted that a future delegation of authority could include approving the participants in the Incentive Plan.</p> <p>Director Reeder commented that this delegation is appropriate and would be beneficial to the Board. Director Rebitzer commended the Committee for this recommendation.</p> <p>Director Zoglin expressed concerns about the average percentage of executive compensation growth exceeding average compensation growth of other, including union, employees. Mr. B. Miller noted that the Committee would review 1) what it takes to stay competitive in the marketplace, 2) recommendations relative to other groups in the organization. He explained that further control comes from the salary budgets set at the beginning of the year and any recommendations outside of the budget would require Board approval. He noted that reports to the Board regarding Committee recommendations and approvals will include the context of 1) the aggregate numbers and 2) comparison with other constituent groups. He also commented that the Board reserves always the right to revoke any delegation.</p> <p>Motion: To (1) approve Draft Resolution 2018-05 including a delegation of authority to approve adjustments to annual salary ranges and base salaries for all executives except the CEO.</p> <p>Movant: Miller Second: Kliger</p> <p>In response to Director Reeder's question, Mr. B. Miller explained that a revised Executive Compensation Committee Charter will be brought back to the Board for review and approval.</p> <p>Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None</p> <p>Motion: To direct staff to develop draft amendments to the Executive Compensation Committee Charter and Policies 3.01, 3.02, 3.03, and 3.04 to comport with the delegation of authority for consideration by the Executive Compensation Committee and the Board.</p> <p>Movant: Miller</p> | <p><i>Resolution 2018-05 approved ; staff directed to draft amendments to applicable policies and the Executive Comp Committee Charter; Draft Procedures approved</i></p> |

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| | <p>Second: Kalbach Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None</p> <p>Motion: To approve the Draft Procedures to be Followed by the El Camino Hospital Compensation Committee When Approving Compensation Pursuant to a Delegation of Authority Under California Nonprofit Corporation Law §5210.</p> <p>Movant: Miller Second: Kliger Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None</p> <p>Director Miller thanked Mr. B. Miller for his leadership as Executive Compensation Committee Chair.</p> | |
| 9. PUBLIC COMMUNICATION | In response to Director Miller's question, Ms. Murphy described the process for processing written communications sent to the Board. | |
| 10. ADJOURN TO CLOSED SESSION | <p>Motion: To adjourn to closed session at 6:58pm pursuant to <i>Gov't Code Section 54957.2</i> for approval of the Minutes of the Closed Session of the Hospital Board Meeting (March 14, 2018) and the Minutes of the Closed Session of the Executive Compensation Committee Meeting (January 31, 2018), pursuant to <i>Health and Safety Code 32155</i> for deliberations concerning reports on Medical Staff quality assurance matters: Organizational Clinical Risks; pursuant to <i>Gov't Code Section 54956.9(d)(2)</i> – conference with legal counsel – pending or threatened litigation: Corporate Compliance/Privacy and Internal Audit Committee Report; pursuant to <i>Health and Safety Code 32155</i> for deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to <i>Health & Safety Code Section 32106(b)</i> for a report and discussion involving health care facility trade secrets: Finance Committee Report: New Programs and Services, including FY19 Budget Assumptions; pursuant to <i>Health & Safety Code Section 32106(b)</i> for a report and discussion involving health care facility trade secrets and <i>Gov't Code Sections 54957</i> and <i>54957.6</i> for report and discussion on personnel matters: CEO Report on New Services and Programs and Personnel Matters; pursuant to <i>Gov't Code Section 54957</i> for discussion and report on personnel performance matters: Executive Session – Senior Management.</p> <p>Movant: Reeder Second: Fligor Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None</p> | Adjourned to closed session at 6:58pm |
| 11. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT | Open session was reconvened at 9:00pm by Vice Chair Zoglin. Agenda items 11-17 were addressed in closed session. Directors Davis and Reeder were absent at the beginning of the second open session and rejoined the meeting during Agenda Item 19: Consent Calendar. | |

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| | During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (March 14, 2018), the Minutes of the Closed Session of the Executive Compensation Committee Meeting (January 31, 2018), and the Medical Staff Report by a unanimous vote in favor of all members present (Directors Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, and Zoglin). Directors Chen and Fung were absent. | |
| 12. AGENDA ITEM 19: CONSENT CALENDAR | <p>Vice Chair Zoglin asked if any member of the Board or the public wished to remove an item from the consent calendar. Director Miller requested that Agenda Item 19b: Draft <i>Resolution 2018-06</i>: Approving Acting as a Member of Pathways Continuous Care to Approve the Winding up and Dissolution of Pathways Continuous Care and Delegating Authority to Certain Officers be pulled for discussion.</p> <p>Barbara Burgess, CEO of Pathways Home Health & Hospice, described the decision and process of dissolving Pathways Continuous Care (of which El Camino Hospital is a voting member) due to the continued shortage of aides who could provide quality services on a sustainable scale. She noted that, the Institute on Aging (IOA) has employed a significant number of former Pathways aides at comparable salary ranges and has assumed responsibility for the care of the clients served by such aides.</p> <p>Director Miller thanked Ms. Burgess and Pathways for 30 years of service.</p> <p>Director Zoglin suggested that, if there is interest, IOA could be involved in ECH's Community Benefit grant program.</p> <p>Motion: To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (March 14, 2018); Draft <i>Resolution 2018-06</i>: Approving Acting as a Member of Pathways Continuous Care to Approve the Winding up and Dissolution of Pathways Continuous Care and Delegating Authority to Certain Officers; Minutes of the Open Session of the Executive Compensation Committee Meeting (January 31, 2018); FY18 Period 7 Financials; Extension of Hospitalist Agreement (MV); Associate Chief Medical Officer Hours Increase (LG); Finance: Pricing and Chargemaster Policy; Draft Revised ECH Bylaws Sections 5.1 and 5.2; Draft Revised Process for Election and Re-Election of Non-District Board Members; Medical Staff Report; and for information: Reports on Educational Activity; Investment Committee Report; and Corporate Compliance/Privacy and Internal Audit Committee Report.</p> <p>Movant: Kalbach Second: Fligor Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None</p> | Consent calendar approved |
| 13. AGENDA ITEM 20: CEO REPORT | Dan Woods, CEO, highlighted current progress toward achievement of the FY18 organizational goals focused on addressing infection rates, the new employed physicians providing services at El Camino Health Primary Care, and CONCERN's Digital Transformation Project. He also acknowledged the recent donations to the El Camino Hospital Foundation and recognized the Auxiliary's contribution of 6,787 volunteer hours in February. | |
| 14. AGENDA ITEM 21: BOARD COMMENTS | Director Miller thanked Directors Kalbach and Kliger for the informational reports on the Estes Park Conference they attended as further detailed in the packet. | |

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| 15. AGENDA ITEM 22: ADJOURNMENT | Motion: To adjourn at 9:15pm. Movant: Reeder Second: Kalbach Ayes: Davis, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Fung Recused: None | <i>Meeting adjourned at 9:15pm</i> |
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Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Hospital:

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services
Sarah Rosenberg, Contracts & Board Services Coordinator



**Minutes of the Open Session of the
El Camino Hospital Board of Directors
Special Meeting to Conduct a Study Session
Wednesday, April 25, 2018**

1560 Country Club Drive, Los Altos, CA 94024 | Sequoia Room

Board Members Present

Lanhee Chen, Chair
Jeffrey Davis, MD
Neysa Fligor
Peter C. Fung, MD
Gary Kalbach
Julie Kliger, RN
Julia E. Miller, Secretary/Treasurer
Bob Rebitzer
David Reeder
John Zoglin, Vice Chair

Board Members Absent

None

Members Excused

None

| Agenda Item | Comments/Discussion | Approvals/ Action |
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| 1. CALL TO ORDER/ ROLL CALL | The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 6:00 pm by Vice Chair Zoglin. A silent roll call was taken. All Board members were present at roll call except Directors Davis and Chen who joined the meeting during the closed session. | |
| 2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES | Vice Chair Zoglin asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were reported. | |
| 3. ADJOURN TO CLOSED SESSION | <p>Motion: To adjourn to closed session at 6:01 pm pursuant to <i>Health & Safety Code Section 32106(b)</i> for a report and discussion involving health care facility trade secrets: Implications of Implementation of Strategy and Development of New Services and Programs for Advisory Committees.</p> <p>Movant: Kalbach Second: Miller Ayes: Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: Chen, Davis Recused: None</p> | <i>Adjourned to closed session at 6:01pm</i> |
| 4. AGENDA ITEM 8: RECONVENE OPEN SESSION/ REPORT OUT | Open session was reconvened at 8:14 pm by Chair Chen. Agenda items 5-7 were addressed in closed session. The Board did not take any action during the closed session. | |
| 5. AGENDA ITEM 9: ADJOURNMENT | <p>Motion: To adjourn at 8:15 pm</p> <p>Movant: Kalbach Second: Kliger Ayes: Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin Noes: None Abstentions: None Absent: None Recused: None</p> | <i>Meeting adjourned at 8:15pm</i> |

Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Hospital:

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services

DRAFT

May 9, 2018

To: El Camino Hospital Board of Directors
From: Cheryl Reinking, RN, CNO
Subject: **Anatomic Pathology & Laboratory Agreement Renewal - Enterprise**

1. **Recommendation:** At its April 26, 2018 meeting the Finance Committee voted to recommend that the Board of Directors approve delegating to the Chief Executive Officer the authority to enter into a renewal of the Pathology Medical Director agreement for the Mountain View and Los Gatos campuses with the same terms.
2. **Problem/Opportunity Definition:** El Camino Pathology Medical Group has provided exceptional Medical Director oversight of the Pathology Department at the Mountain View campus since 2001. In 2014, the Board approved extending leadership and oversight of the Los Gatos campus with an additional sixty (60) hours per month raising the total current, annual compensation to \$347,508.00. Currently, administrative services are provided at both campuses by eight (8) physicians, with an appointed Medical Director. The current agreement expires June 30, 2018, and renewal on the same terms is desirable.
3. **Authority:** According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required prior to the Chief Executive Officer signature of physician agreements are greater than \$250,000 in total annual compensation or when compensation exceeds the 75th percentile.
4. **Process Description:** Upon Board approval, the Pathology Medical Director Agreement will be renewed at the same terms for an additional two years through June 30, 2020.
5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** An alternative solution is not being considered at this time.
6. **Concurrence for Recommendation:** Approval of this recommendation is supported by the Medical Director, Quality and Physician Services and Interim Chief Operating Officer.
7. **Outcome Measures and Deadlines:** El Camino Pathology Medical Group is currently on track to meet the quality incentive goals for FY18. Quality goals for FY19 will be included in the two-year renewal.
8. **Legal Review:** Legal counsel will review the final agreements prior to execution.
9. **Compliance Review:** Compliance will review and approve the final agreements and compensation prior to execution.
10. **Financial Review:** The current Agreement authorizes up to 197 hours per month at \$147.00 per hour of administrative services for a maximum annual compensation of \$347,508.00, which is between the 75th percentile (\$252,340.00) and 90th percentile (\$358,858.00) for two campuses according to the 2018 MD Ranger report for general acute average daily census 150 and over. There is no increase in either dollars or hours.

May 9, 2018

To: El Camino Hospital Board of Directors
From: David Clark, Interim COO
Subject: **Intensivist (Nighttime) On-Site Services Agreement (Mountain View Campus)**

1. **Recommendation:** At its April 26, 2018 meeting the Finance Committee voted to recommend that the Board of Directors approve delegating to the Chief Executive Officer the authority to enter into an agreement with Inpatient Services of California to provide Mountain View Intensivist (Nighttime) Coverage at an annual not to exceed \$865,000 per fair market value opinion plus transitional costs for locum tenens.
2. **Problem/Opportunity Definition:** Since December 2012, Sutter West Bay Hospitals (“SWBH”) has provided remote monitoring services for the Hospital’s critical care patients, seven days per week, during the hours of 4:00pm to 7:00am at the rate of \$728,928.00/year plus \$29,026/year for SWBH IT support. The nighttime coverage has always been consistent and satisfactory, however in response to a serious patient safety event in June 2016, the Hospital Board urged Administration to provide on-site daily nighttime intensivist services. The Hospital is also seeking TJC certification as a Comprehensive Stroke Center which requires 24/7 onsite neuro-intensivist services. The intensivists must attend ENLS training in Neurocritical Care.

The Hospital had discussions with the PAMF intensivists about providing 24/365 on-site intensivist services and the PAMF physicians verbally declined the opportunity to provide such coverage. PAMF will continue to provide onsite daytime coverage between the hours of 7:00am to 7:00pm.

Inpatient Services of California recently acquired Fidere Anesthesia Consultants, Inc., the group that the Hospital is contracted with to provide Anesthesia coverage services at the Mountain View and Los Gatos campuses. Inpatient Services of California has over 30 years of critical care experience and expertise and has proposed to provide on-site intensivist services for the Mountain View campus from the hours of 7:00pm to 7:00am, 365 days per year for an annual compensation of \$865,000 per fair market value opinion plus transitional costs for locum tenens during a 6-12 month transition period. The Hospital will obtain a FMV opinion from a third party consultant to confirm that the proposed compensation is fair market value and commercially reasonable.

3. **Authority:** According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required prior to the Chief Executive Officer signature of physician agreements greater than \$250,000 in total annual compensation and greater than the 75th percentile for fair market value.
4. **Process Description:** Upon Board approval, the Intensivist (Nighttime) Services Agreement for the Mountain View campus will be entered into with Inpatient Services of California for three years for an annual compensation of \$865,000 per fair market value opinion, plus transitional costs for locum tenens. A 30-day termination notice will be sent to SWBH so that the Termination Effective Date will coincide with the Effective Date of the new agreement, which will be September 1, 2018.
5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** We could maintain the remote monitoring agreement with SWBH, however the remote coverage does not meet TJC requirements for Comprehensive Stroke Certification.

6. **Concurrence for Recommendation:** Approval of this recommendation is supported by the Medical Director, Quality and Physician Services and Chief Nursing Officer.
7. **Outcome Measures and Deadlines:** Physicians will participate in the peer review process for consultations related to Intensivist Coverage.
8. **Legal Review:** Legal counsel will review the final agreements prior to execution.
9. **Compliance Review:** Compliance will review and approve the final agreements and compensation prior to execution.
10. **Financial Review:** Compensation will be constrained to a not to exceed annual amount of \$865,000 per fair market value opinion plus transitional costs for locum tenens. The Hospital will obtain a FMV opinion from a third party consultant. A term of three years will be proposed.

May 9, 2018

To: El Camino Hospital Board of Directors
From: David Clark, Interim COO
Subject: **Intensivist (Daytime) On-Site Services Agreement (Mountain View Campus)**

1. **Recommendation:** At its April 26, 2018 meeting, the Finance Committee voted to recommend that the Board of Directors approve delegating to the Chief Executive Officer the authority to execute the Mountain View Intensivist (Daytime) On-Site Services Agreement at the rate of \$1,980.00/12-hour shift.
2. **Problem/Opportunity Definition:** Since September 2012, Palo Alto Medical Foundation (“PAMF”) has subcontracted with Fidere Anesthesia Consultants, Inc. to provide 10-hour on-site daytime Intensivist On-Site Services and 24/7 On-Call Services at the Mountain View campus at the rate of \$1,750.00/day. The physicians under this arrangement have consistently provided excellent intensivist services, with thirteen physicians currently on the panel. The current agreement expires April 30, 2018 and an extension will be entered into through June 30, 2018, pending Board approval on May 9, 2018.

Remote monitoring nighttime intensivist services have been provided by Sutter West Bay Hospitals since December 2012, and the coverage has always been consistent and satisfactory, however in response to a serious patient safety event in June 2016, the Hospital Board urged Administration to provide on-site 24/7 intensivist services. The Hospital had discussions with the PAMF intensivists about providing 24/365 on-site intensivist services and the PAMF physicians verbally declined the opportunity to provide such coverage.

After many months of discussions and negotiations, the Hospital would like to engage:

1) Inpatient Services of California, (a group that recently acquired Fidere Anesthesia Consultants, Inc., the group the Hospital is contracted with to provide anesthesia coverage services) to provide 12-hour on-site nighttime intensivist services (7:00pm to 7:00am) and 2) PAMF to provide 12-hour daytime on-site intensivist services (7:00am to 7:00pm).

The Hospital is seeking TJC certification as a Comprehensive Stroke Center which requires 24/7 on-site neuro-intensivist services. The intensivists must attend ENLS training in Neurocritical Care.

Upon the effective date of the new Agreement, PAMF will provide an additional two hours per shift for 12-hour daily daytime on-site intensivist services plus on-call surge physician coverage at the rate of \$1,980.00/12-hour shift and \$722,700.00 per year. In addition, the Hospital shall pay for the costs of each physician providing services to obtain ENLS Certification, including registration fees and payment for physician’s time in attendance at the ENLS certification training in the amount of One Hundred Fifty Dollars (\$150.00) per hour not to exceed \$1,200.00 per physician.

The Hospital has obtained a FMV opinion from a third party consultant confirming that \$1,980.00 per 12-hour shift and \$722,700.00 maximum annual compensation is at the “upper indication” or 81st percentile for fair market value.

3. **Authority:** According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required prior to the Chief Executive Officer signature of physician agreements

greater than \$250,000 in total annual compensation and greater than the 75th percentile for fair market value.

4. **Process Description:** Upon Board approval, the Intensivist (Daytime) On-Site Services Agreement for the Mountain View campus will be entered into with PAMF for two years at a not-to-exceed rate of \$1,980.00/12-hour shift, projected to be effective July 1, 2018.
5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** PAMF declined the opportunity to solely provide 24/365 intensivist coverage and will not subcontract with Inpatient Services of California to provide such coverage. The Hospital could ask Inpatient Services of California to provide a proposal for 24/365 on-site coverage, but that would disrupt the current PAMF daytime coverage, which is very stable.
6. **Concurrence for Recommendation:** Approval of this recommendation is supported by the Medical Director, Quality and Physician Services and Chief Nursing Officer.
7. **Outcome Measures and Deadlines:** Physicians will participate in the peer review process for consultations related to Intensivist On-Site Services.
8. **Legal Review:** Legal counsel will review the final agreements prior to execution.
9. **Compliance Review:** Compliance will review and approve the final agreements and compensation prior to execution.
10. **Financial Review:** Compensation will be constrained to a not to exceed amount of \$1,980.00/12-hour shift, \$722,700.00 per year plus \$1,200.00 per physician to obtain ENLS Certification. The Hospital has obtained a FMV opinion from a third party consultant confirming that \$1,980.00 per 12-hour shift and \$722,700.00 maximum annual compensation is at the “upper indication” or 81st percentile for fair market value. A term of two years will be proposed.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

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| Item: | Medical Staff Report – Open Session El Camino Hospital Board of Directors May 9, 2018 |
| Responsible party: | Rebecca Fazilat, MD, Chief of Staff Mountain View J. Augusto Bastidas, MD, Chief of Staff, Los Gatos |
| Action requested: | For Approval |
| Background: <p>The Medical Executive Committee met on April 26, 2018. We received the following reports:</p> <ol style="list-style-type: none"> 1. CEO Report – Dan Woods reported that Outpatient Pharmacy will open on 5/2/18 and introduced Interim CMO, Mark Adams, MD. 2. CMIO Report – We received a report on the upcoming implementation of e-prescribing of controlled substances, clarifications of dictations, and California requirements for prescribing narcotics that will become effective in October 2018. 3. Medical Staff elections voting closed on 4/27/18. 4. We approved the Patient Care Policies, ADTs (aka Scope of Services), and Plans as noted below. | |
| Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None. | |
| Summary and session objectives: To obtain approval of the Medical Staff Report | |
| Proposed Board motion: To approve the Medical Staff Report | |
| LIST OF ATTACHMENTS: <ol style="list-style-type: none"> 1. Patient Care Policy Summary Spreadsheet and Policies, ADTs (aka Scope of Services), and Plans for Approval. (23 Documents to Approve) | |

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL - BOARD

May, 2018

| New Documents | | | |
|---|-----------------------|------------------|---|
| Document Name | Department | Type of Document | Summary of Policy Changes |
| Workplace Violence Prevention Plan | Environment of Care | Plan | New plan required by Cal-OSHA |
| FY-18 Safety Management Plan | Environment of Care | Plan | |
| FY-18 Security Management Plan | Environment of Care | Plan | |
| FY-18 Hazardous Material Management Plan | Environment of Care | Plan | |
| FY-18 Fire Prevention Management Plan | Environment of Care | Plan | |
| FY-18 Utility Management Plan | Environment of Care | Plan | |
| Emergency Operations Plan | Environment of Care | Plan | |
| Scope of Service Palliative Care | Palliative Care | Scope | |
| DOCUMENTS WITH MAJOR REVISIONS | | | |
| Document Name | Department | Type of Document | Summary of Policy Changes |
| Scope of Service Medical Surgical Orthopedics LG | Patient Care | Scope | Revised Scope, Complexity of services, Staffing and Requirements for staff. |
| ADT Medical Surgical Orthopedics LG | Patient Care | ADT | Major changes re-wrote ADT |
| DOCUMENTS WITH MINOR REVISIONS | | | |
| Document Name | Department | Type of Document | Summary of Policy Changes |
| Scope of Service Clinical Education | Patient Care Services | Scope | Change nursing education to Clinical Education |
| Scope of Service Patient Care Resources MV | Patient Care Services | Scope | Added new title change - Assistant Hospital Manager |
| Scope of Service Patient Care Resources LG | Patient Care Services | Scope | Added new title change - Assistant Hospital Manager |
| ADT Admission, Transfer Discharge Mother Baby MV | Patient Care Services | ADT | Updated References |
| ADT Admission, Transfer Discharge Mother Baby 3CW | Patient Care Services | ADT | Updated References |

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|---|-----------------------|-------------------------|---|
| Scope of Service - Dialysis Services Mountain View & Los Gatos | Inpatient Dialysis | Scope | Revised Scope and Complexity of services |
| Admission, Discharge Transfer (ADT) Criteria Telemetry-Cardiac Unit | Telemetry | ADT | Updated structural heart procedure patients and references Protocol: Telemetry monitoring for transferring patients off tele |
| Scope of Service Mother Baby | Patient Care Services | ADT | Added Los Gatos now Enterprise |
| DOCUMENTS WITH NO REVISIONS | | | |
| Document Name | Department | Type of Document | No Revisions |
| Philosophy of Nursing | Patient Care Services | Scope | |
| Scope of Service Telemetry Stroke | Telemetry | Scope | |
| Admission Discharge and Transfer Criteria (ADT) for Telemetry/Stroke | Telemetry | ADT | |
| ADT Outpatient Infusion Center | Patient Care Services | ADT | |
| End of Life Options Act | Patient Care Services | Policy | |

TITLE: Workplace Violence Preventions Plan
CATEGORY: Safety – Environment of Care
LAST APPROVAL: New Plan

TYPE: ☐ Policy ☒ Plan ☐ Scope of Service/ADT
☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY: Security Management
OFFICE OF ORIGIN: Security Management
ORIGINAL DATE: 01/19/2018

I. COVERAGE:

This plan covers all employees, physicians, contractors/supplemental workers, students, volunteers, members, patients, and visitors.

II. PURPOSE:

This WORKPLACE VIOLENCE PREVENTION PLAN is developed to meet our commitment to the safety and well-being of all employees. While employee safety has always been a focus area for our organization, in the wake of recent acts of violence and threats of violence across the country and the world, El Camino Hospital has intensified its awareness and commitment to this critical issue. This Plan will provide leaders with tools to provide a safer workplace. This Plan also meets the requirements of Title 8 of the California Code of Regulations, Chapter 4, New Section 3342 (Cal/OSHA Workplace Violence Prevention in Health Care) regulations. The Plan is part of the overall Injury and Illness Prevention Program (IIPP), and includes assessment, violence incident log, annual review, training, reporting and recordkeeping.

The purpose of this Plan is to provide guidance to operationalize Cal/OSHA regulatory requirements aimed at preventing workplace violence.

III. PLAN STATEMENT:

El Camino Hospital (ECH) takes reasonable preventive measures to provide a safe environment for everyone on ECH premises. ECH has zero tolerance for acts or threats of violence, and/or intimidation that involve or affect ECH workers or that occur on ECH premises. See [HR-Harassment](#) Policy.

This plan outlines the prevention and management to safeguard all employees, physicians, contractors/supplemental workers, students, volunteers, patients, and visitors to ECH premises from violence, threats, and/or intimidation by addressing threats and aggressive behavior at the earliest stage; define and mitigate inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.

IV. DEFINITIONS

Regulatory Definitions as outlined by Cal/OSHA Title 8, Chapter 4, New Section 3342, Workplace Violence Prevention in Health Care

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- **Alarm:** a mechanical, electrical or electronic device that does not rely upon an employee's vocalization in order to alert others.
- **Dangerous weapon:** an instrument capable of inflicting death or serious bodily injury.
- **Engineering controls:** an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the worker and the hazard. For purposes of reducing workplace violence hazards, engineering controls include, but are not limited to: electronic access controls to employee occupied areas; weapon detectors (installed or handheld); enclosed workstations with shatter-resistant glass; deep service counters; separate rooms or areas for high risk patients; locks on doors; furniture affixed to the floor; opaque glass in patient rooms (protects privacy, but allows the health care provider to see where the patient is before entering the room); closed-circuit television monitoring and video recording; sight-aids; and personal alarm devices.
- **Environmental risk factors:** factors in the facility or area in which health care services or operations are conducted that may contribute to the likelihood or severity of a workplace violence incident. Environmental risk factors include risk factors associated with the specific task being performed, such as the collection of money.
- **Field operation:** an operation conducted by employees that is outside of the employer's fixed establishment, such as mobile clinics, health screening and medical outreach services, or dispensing of medications.
- **Intimidation or Harassing Behavior.** Threats or other conduct which in any way creates a hostile environment, impairs operations; or frightens, alarms, or inhibits others. Psychological intimidation or harassment includes making statements which are false, malicious, disparaging, derogatory, rude, disrespectful, abusive, obnoxious, insubordinate, or which have the intent to hurt others' reputations. Physical intimidation or harassment may include holding, impeding or blocking movement, following, stalking, touching, or any other inappropriate physical contact or advances.
- **Patient contact:** providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.
- **Patient specific risk factors:** factors specific to a patient, such as use of drugs or alcohol, psychiatric condition or diagnosis, any condition or disease process that would cause confusion and/or disorientation or history of violence, which may increase the likelihood or severity of a workplace violence incident.

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- **Threat of violence:** a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured and that serves no legitimate purpose.
- **Work practice controls:** procedures, rules and staffing which are used to effectively reduce workplace violence hazards. Work practice controls include, but are not limited to: appropriate staffing levels; provision of dedicated safety personnel (i.e. security guards); employee training on workplace violence prevention methods; and employee training on procedures to follow in the event of a workplace violence incident.
- **Workplace violence:** any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:
 - a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
 - b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;
 - c. Four workplace violence types:
 - **Type 1 violence:** workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
 - **Type 2 violence:** workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
 - **Type 3 violence:** workplace violence against an employee by a present or former employee, supervisor, or manager.
 - **Type 4 violence:** workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

V. REFERENCES:

1. ECH Policy: [HR- Harassment](#)

VI. SCOPE

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

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- A. The Plan covers all locations operated by El Camino Hospital. The Plan applies to all employees, physicians, Supplemental Workers, patients, and visitors and volunteers¹.
- B. Cal/OSHA Regulation Title 8 NEW SECTION 3342 – “THE PLAN”

Below are the 11 provisions that are required in to be included in the Plan by Cal/OSHA. These provisions cannot change.

1. Site Specific Locations(s) and title of person(s) accountable for implementing the Plan.
2. Procedures to obtain active involvement of physicians, employees and their representatives in developing, implementing and reviewing the Plan including their participation in identifying, evaluating and correcting workplace violence hazards, designing and implementing training and reporting and investigating incidents.
3. Methods to coordinate with other employers on site including training and reporting, investigating and recording of incidents.
4. A policy prohibiting the employee from disallowing an employee or taking punitive or retaliatory action against an employee for seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.
5. Procedures to ensure that supervisory and non-supervisory employees comply with the plan.
6. Procedures to communicate with employees regarding workplace violence matters, including;
 - a. How the employees will document and communicate between shifts and units regarding conditions that may increase potential for workplace violence incidents
 - b. How an employee can report a violent incident, threat or concern
 - c. How employees can communicate workplace violence concerns without fear of reprisal
 - d. How employees concerns will be investigated and how employees will be informed of the results of the investigations and any corrective actions to be taken
7. Procedures to develop and provide training
8. Assessment procedures to identify and evaluate environmental risk factors, including community based risk factors for each facility unit, service or operation
9. Procedures to identify and evaluate patient specific risk factors and assess visitors

¹ Volunteers are not employees and are not covered by the regulations. However, they should be oriented to the Prevention of Workplace Violence plan.

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10. Procedures to correct workplace violence hazards in a timely manner.

11. Procedures for post incident response and investigation.

VII. ECH PLAN:

1. Plan Owner(s)
 - a. At El Camino Hospital, the responsibility for implementing the Workplace Violence Prevention Plan (Plan) lies with the Hospital Safety Officer.
2. Engaging Employees and their Representative's
 - a. El Camino Hospital will use a variety of procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents.
3. Coordination with External Employers for Supplemental Workers
 - a. El Camino Hospital will coordinate implementation of the Plan with other employers whose employees work in the health Care facility, service, or operation, to ensure that those employers and employees have a role in implementing the Plan. These methods will ensure that employees of other employers and temporary employees are provided the appropriate training and will ensure that workplace violence incidents involving those employees are reported, investigated, and recorded.
 - 1) Training for Supplemental Workers: Supplemental Workers are required to have training based on their roles and responsibilities
 - a) Initial/Basic Training
 - b) Specialized Training
 - Annual training for those involved with patient contact activities
 - Initial and Annual training for those involved in confronting or controlling persons exhibiting aggressive or violent behavior
 - Initial and annual for those assigned to respond to alarms or other notifications of violent behavior or threats.
4. Adherence to Retaliation Policy
 - a. The hospital's Human Resources policy ([HR- Harassment](#)) protects employees and other individuals who report misconduct and describe El Camino Hospitals obligation to take no retaliatory action against any person for reporting ethics issues or suspected violations of laws and regulatory requirements (including false claims acts), accreditation requirements, or El Camino Hospitals policies, or exercising their rights under federal or state laws.

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5. Compliance

- a. El Camino Hospital has established procedures to ensure that both supervisory and non-supervisory employees comply with the plan. The ECH Policy [Security Management- 2.05 Prevention of Workplace Violence](#) sets expectations for compliance. **Managers will work with Human Resources and/or Labor Relations if the policies are not followed.**

6. Communication

- a. El Camino Hospital has established procedures to communicate with employees regarding workplace violence matters. This includes how employees will document and communicate between shifts and units or at anytime regarding conditions that may increase potential for workplace violence incidents.
- b. Employees are encouraged to report workplace violence concerns to their managers or to the Safety and Security Department without fear of reprisal. This may involve director communication or submission of a Quality Review Report (QRR), Accident, Injury or Exposure Report (AIER), Code Gary Critique Forms or Security Incident reports.
- c. To assure a timely response to situations involving an actual or potential physical threat to physicians, personnel, visitors or property, it is the policy of El Camino Hospital's security program that when dealing with a confrontational and/or combative patient, employee and/or visitor the following employee responses will be followed:
 - 1) Aggressor without a weapon: Activate a Code Gray (angry or violent patient) by calling the emergency line (55) to summon assistance from security services and trained staff. All personnel will be encouraged to recognize activities leading to actual or potential physical threats to personnel, visitors or property. Refer to Code Gray Policy ([Security Management- 2.07 Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation](#))
 - 2) Aggressor with a weapon (excluding a gun): Activate Code Silver through the emergency line (55). Since Code Silver is used to inform Security that a patient, visitor, or employee has a weapon, it is important for the Safety of the staff, patients, and security personnel to respond accordingly. Refer to Code Silver Policy ([Security Management- 2.07 Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation](#))
 - 3) Aggressor with a gun: Activate an Active Shooter through the emergency line (55). Upon notification of an Active Shooter, Security will contact local law enforcement for assistance. Refer to Code Silver Policy ([Security Management- 2.07 Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation](#))
- d. Communication about threats or incidents will vary depending on the situation and the work environment. Utilize existing emergency notification communication and documentation procedures that apply to the following situations:
 - Individual situations within departments

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- Larger scale situations across departments
- Wide scale situations involving a significant portion of a facility/campus

- 1) The following should be considered when determining the appropriate communication:
 - a) Identify the party(ies) providing the communication
 - b) the urgency of the situation
 - c) the recipients of the communication
 - d) The mode of transmission (overhead page, email, nurse shift exchanges, group text, etc.)

- e. How an employee can report a violent incident, threat or concern

- 1) The preferred notification process for all workplace violence incidents is through the following reports:
 - a) **Accident, Injury or Exposure Report (AIER):** Report of any injuries or assaults to Employee Wellness and Health. This should be completed as soon as possible by the employee of their supervisor.
 - b) **Code Gray Critique Form:** This form is completed after each code gray incident. Forms are available under the Safety tab on the Toolbox
 - c) **Quality Review Report (QRR):** this is the primary systems for recording and completing all workplace violent incidents, including post-incident responses documentation of workplace violence injury investigation.
 - d) **Security Incident Reports:** Security incident reports are generated for all security responses. If the report notes a workplace violent incident, it may be used to log the incident by the team as noted below.

The information collected will be used to complete the Violent Incident Log and providing the information needed for the 24/72 hour hospital report to Cal/OSHA.

- f. Cal/OSHA Reporting Hospital Reporting Requirements for Incidents Occurring in Hospitals

- 1) Any incident involving physical violence against an employee will be reported regardless of whether this resulted in an injury to the employee or not.
 - a) If there are any questions of whether the incident should be reported, the *Workplace Violence Incident Reporting Team* will review the incident and make a determination.
- 2) The designated person will then complete the internal WPV Reporting Log and the Cal-OSHA Workplace Violence Incident Online Report on the OSHA website.

7. Training

Employees will be assigned to complete to complete Prevention of Workplace Violence Training based on their job description.

- a. Awareness/Basic training:

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Training for employees and supplemental workers is required initially when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which training is required. Refresher training will be required whenever there is a change to the Plan or operations impacting the potential for workplace violence. Employees will be given the opportunity to submit questions and receive a response within 24 hours.

b. Patient Contact Staff Training (annual):

Any staff that perform “patient contact activities” is required to complete advanced, annual training. “Patient contact” is defined as providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient. The training shall include the topics addressed in the Awareness Level training, and techniques for protecting themselves and deescalating potential situations of workplace violence. The training will also include the results of the annual review of the Plan. Employees will be given the opportunity to submit questions and receive a response within 24 hours.

c. High Risk Training

Advanced training is required for all employees and supplemental workers involved in confronting or controlling persons exhibiting aggressive or violent behavior. For El Camino Hospital, this includes high risk departments such as ED, Behavioral Health, Hospital Supervisors, Security officers and Facilities Engineering. This training will include the elements of the Awareness and Patient Contact training and includes defensive techniques and controls for patients exhibiting violent physical behaviors. This training shall be completed annually by all identified employees.

8. Environmental Risk Assessment

The Director of Safety/Security and the EH&S Manager will assess and establish procedures to identify and evaluate environmental risk factors, including community based risk factors for each facility unit, service or operation. The assessment shall include a review of all workplace violence incidents that occurred within the previous year.

a. Department and area managers will participate in completing area assessments with staff to determine and list high and general risk areas.

- Workplace Violence Department Risk Assessment

This tool is to recognize and consider historical hazards and risks (minimally – past 12 months), as well as current hazards and risks, confronting staff. It is to be used to engage and solicit participation from department/service-line staff and representatives in order to develop, implement and review the workplace violence Plan, as well as gain greater insight and obtain solutions and/or alternatives for making the workplace a safer environment.

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- b. The Security Manager and Director may include campus/facility maps to create an assessment that addresses external risk factors that may have an adverse impact on the campus or services delivered (e.g., local law enforcement crime data, etc.).
 - c. The Security Manager and Director may also address risks and protective measures for the Facilities, Operations and Services including Common Areas, Hospital, clinics, and Administrative Buildings.
9. Procedures to identify and evaluate patient specific risk factors and assess visitors
- a. Procedures have been developed to identify and evaluate patient-specific physical and mental risk factors, including;
 - 1) Patient's mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively or aggressively.
 - 2) Patient's treatment and medication status, type, and dosage as it is known.
 - 3) Patient's history of violence, as it is known.
 - 4) Patient's disruptive or threatening behavior.
 - b. Department and services subject to higher behavioral risks may include the Emergency Department, Behavioral Health, and other high risks departments. Typical characteristics of patients and/or family members displaying threatening or disruptive behavior within these higher risk departments include:
 - 1) Emotionally charged over injury or injury of loved one
 - 2) Perceived delay in treatment
 - 3) History of aggressive behavior or violence
 - 4) Substance abuse
 - 5) Feels victimized blames others
 - 6) Emotionally depressed
 - 7) Behaving belligerently using harassing or abusive language and
 - 8) Unfavorable medical diagnosis

These higher risk departments and services are independently assessed as a result of the greater potential for escalated patient/family member behavioral encounters. Enhanced training and engineering and work practice controls are provided to increase staff's awareness, understanding and competency, for de-escalation/protective practices in order to minimize psychological and physical harm resulting from the higher likelihood of threatening behavior.

Procedures to identify, evaluate and remediate vulnerabilities based on behavioral risk factors for and visitors, include, but are not limited to implementation of enhanced staff training, enhanced engineering and enhanced work practice controls.

10. Procedures to correct workplace violence hazards in a timely manner

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- a. El Camino Hospital has developed the following procedures to correct workplace violence hazards in a timely manner. Risks identified during the environmental risk assessment, reported to managers or found as a result of a workplace violence incident must be addressed within the following timeframes:

- 1) Imminent hazards – Employees must be protected immediately.
- 2) Serious hazards – must be corrected within 7 days of discovery.

NOTE: Interim measures may be taken to abate the imminent or serious hazard while completing the permanent corrective action plan.

- b. Corrective Action shall include Enhanced Engineering and Work Practice Controls

Engineering controls and Work Practice Controls are used to eliminate or minimize employee exposure to the identified workplace hazards. Remedial measures to protect employees from imminent hazards shall be taken immediately. Remediation activity (Engineering and Work Practice Controls) will be planned and implemented within 7-days following discovery of a serious hazard. If remediation cannot be completed during the specified timeframe, interim measures to abate imminent or seriousness of the hazard may be taken while completing permanent control measures. Enhanced Engineering and Work Practice Controls shall include, but not limited to:

- 1) Engineering Control considerations
 - a) Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
 - b) Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
 - c) Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.
- 2) Work Practice Control considerations

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- a) Minimizing, removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2* violence are reasonably anticipated to be present.
- b) Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.
- c) Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.
- d) Establishing an effective response plan for actual or potential workplace violence incidents emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.
- e) Assigning or placing minimum numbers of staff, to reduce patient-specific Type 2* workplace violence hazards.
- f) Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.
- g) Maintaining reasonable sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner.
- h) Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1* or Type 2* violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.

11. Incident Response and investigation

- a) El Camino Hospital has procedures for post incident response and investigation based on the below language.
 - 1) Providing immediate medical care or first aid to all employees affected by the incident.

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- 2) Identifying all employees involved in the incident.
- 3) Providing trauma counseling via Employee Assistance Program (EAP)².
- 4) Conducting a post incident debriefing as soon as possible after the incident with all employees, supervisors and security involved.
- 5) Reviewing any patient-specific risk factors and risk reduction measures that were specified for that patient.
- 6) Reviewing whether appropriate corrective measures were effectively implemented.
- 7) Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause and where any measure would have prevented the injury.

NOTE: Ensure there is appropriate communication and coordination with the employers of supplemental workers.

12. Annual Review

- a. The Plan must be reviewed annually, in conjunction with employees, regarding their respective work areas, services, operations as related to prevention of workplace violence. this includes:
 - 1) Staffing, staffing patterns, patient classification systems
 - 2) Sufficiency of security systems, including alarms, emergency response, and security personnel availability
 - 3) Job design, equipment and facilities
 - 4) Security risks associated with specific areas and times of day
 - 5) A review of the violent incident log
- b. The annual review will take place via the Security Work Committee and reported to the Central Safety Committee. Results of the annual review will be used to revise the Plan.

VIII. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Security Management Work Group | 2/2018 |
| Central Safety Committee | 2/2018 |
| e-Policy Committee: | 4/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |

² The EAP at El Camino Hospital is Concern: EAP (www.concern-eap.com, 650-940-7100).

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| Historical Approvals: | |

IX. ATTACHMENTS (if applicable):

- **Workplace Violence Prevention (WPV) Risk Assessment Checklist**

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| TITLE: | FY-18 Safety Management Plan |
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| TYPE: | <input type="checkbox"/> Policy <input type="checkbox"/> Protocol <input type="checkbox"/> Scope of Service/ADT <input type="checkbox"/> Procedure <input checked="" type="checkbox"/> Plan <input type="checkbox"/> Standardized Process/Procedure |
| OFFICE OF ORIGIN: | Safety and Security Services |
| ORIGINAL DATE: | 02/12/2018 |

I. COVERAGE:

This Safe Environment Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics. It covers all employees, contractors, volunteers, students, registry personnel and anyone working under the facility's auspices.

II. PROGRAM OBJECTIVES AND SCOPE:

El Camino Hospital and associated Outpatient Clinics are committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Safe Environment Management Plan that describes the process for:

1. Identification and minimization of safety risks
2. Maintenance of a safe environment

Based on areas of improvement noted in the FY-17 Annual Evaluation, the primary FY-18 performance improvement project for Safety Management involves continuing revision of the initiatives to reduce work-related injuries to further focus on Staff Safety Management Systems. In particular, the focus is on improving our work related injury/illness investigation process to include a tracking mechanism for all staff safety hazards and risks found. This tracking mechanism will allow us to rank the priorities of staff safety hazards and risks and track actual and proposed controls for each hazard and risk identified.

A. Objectives:

Specific objectives of the FY-18 Safe Environment Management Plan include the following:

1. Continue to monitor the availability of PPE by all staff and provide feedback
2. Continue to develop our Safety Rounds program
3. Review Quality Review Reports (QRR) for potential injury reduction opportunities.
4. All workplace injuries will have a completed Accident Investigation Exposure Report (AIER) within 3 days.
5. Evaluate on an annual basis the Safe Patient Handling Program (SPHP) and report to the CSC annually.
6. Develop and implement a Workplace Violence Prevention Plan (WPVP) to meet the requirements of CCR Title 8, Section 3342.

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| TITLE: | FY-18 Safety Management Plan |
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7. Report data and initiatives produced by the Slips, Trips and Falls (STF) committee to lower the overall STF incidents across the campus for both patients and staff to the CSC quarterly.

III. REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .02.01.03, .02.06.01, Code of Federal Regulations, Title 29, Sections 1910 et seq., 1910.1450
2. California Code of Regulations, Title 8, Sections 3203 et seq., 5191;
3. California Code of Regulations, Title 22 70837, 70739.

IV. AUTHORITY

In accordance with its bylaws, the El Camino Hospital Leadership has given Employee Wellness and Health Services (EWHS) and the Central Safety Committee (CSC) the authority to ensure that the plan is formulated appropriately and carried out effectively. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the EH&S Manager and the Safety and Security Director in collaboration with EWHS. EH&S Manager and the Safety and Security Director in concert with EWHS and the Central Safety Committee has oversight over the Workplace Safety Program, which includes reducing injuries and workers compensation claims.

V. PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. El Camino Hospital Leadership Team

The hospital leadership team provides the program vision, leadership, support and appropriate resources to ensure environmental health and safety.

B. Environmental, Health and Safety Manager and Safety and Security Director collaborate to compile reports submitted to the Central Safety Committee,

C. Hospital Safety Officer:

- Has the authority to intervene whenever conditions pose an immediate threat to life or health, or property damage.
- Is appointed by the hospital CEO.
- Provides to the Executive Committee annual summary reports, Issues identified by the CSC, and policies and procedures as applicable for Executive Committee review.

D. Central Safety Committee (CSC)

The CSC ensures that the safe environment program remains in alignment with the organization's core values, goals and social purpose by providing direction, determining priorities, and assessing/approving program changes. The Central Safety Committee provides a forum for and ensures the timely resolution of action items, issues, and risks. This committee

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also addresses recommendations, grants approvals, leverages issues, and develops program imperatives. The charter of the CSC is to:

- Develop strategic goals and annual performance targets relative to the environment of the Hospital
- Carry out analysis and seek resolution of Environment of Care Management issues,
- Prioritize goals and resources,
- Ensure coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, and
- Establish and approve infrastructures to support Performance Improvement techniques.

E. Department Managers

Department Managers are responsible for the provision of a safe working environment for staff, patients, and visitors through full implementation of established EOC programs. This responsibility can include the identification of occupational risks, staff training, the development and management of specific safety policies and procedures, and injury investigation.

F. Employees

All employees are responsible to participate in safety training, as required, as well as to demonstrate core competencies in the given subject matter. Employees must ensure their behaviors, work practices and operations are safe, responsible and in alignment with facility and departmental procedures, applicable training and the provisions of this plan.

VI. PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

Implementation of the safety plan is contingent upon the incorporation of safety principles into the culture and routine clinical and business practices at all levels of the organization. Another imperative of successful program implementation is the integration of cross-functional management systems and processes that relate to the environment provided for members, employees and visitors, as well as aspects of public health and environmental protection. These program components and processes are coordinated through the Safety Officer and processes are monitored through the Central Safety Committee. They include:

- A. Supervision of all grounds and equipment through the implementation of the Safe Environment Program, Fire Prevention Program, Security Management Program, Hazardous Materials and Wastes Program, Medical Equipment Management Program and Utilities Management Program and an ongoing Hazardous Surveillance Rounds process.
- B. Risk Assessments, which proactively evaluate the impact of building, grounds, equipment occupants and internal physical systems on patients and public safety, are accomplished primarily through the use of Hazard Surveillance Rounds.

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- C. The Central Safety Committee, whose make-up includes Administration, Clinical Services, Operation Support Services, Physicians and other appropriate organizational representatives, examines safety issues, including failures, exposures, personal injury and hazards.
- D. Incidents of member, patient and/or visitor injuries and incidents, attributed to environmental conditions or safety hazards are reported and investigated through Risk Management and EH&S departments and reported to the Central Safety Committee.
- E. Occupational injury, illness and exposure data is monitored and tracked on an ongoing basis these include the following:
 - Historical Workers' Compensation data.
 - Injury frequencies by type
 - Injuries by department
 - OSHA "recordable" injuries
 - Ergonomic/Repetitive Motion Injuries
- F. Effective, ongoing surveillance, inspection and testing of operational safety elements and components of the environment is achieved through the use of Safety Rounds coordinated by the EH&S Manager, supply and equipment recalls and alerts (shared by Materiel Management and Clinical Engineering) and preventive maintenance surveys conducted by engineering. Hazard Surveillance Rounds are conducted at least semi-annually in areas where patients are served and annually in other areas.
- G. Product safety recalls - Recall notices are sent from the vendor, Clinical Technology or Material Management Departments. Notices are forwarded to department managers for follow up and resolution. Documentation is kept by departments and reported to the Central Safety Committee monthly by Clinical Technology or Materials Management.
- H. Patient safety is evaluated through hazard surveillance, utilities and equipment preventative maintenance, and incident reports.
- I. Safety Educational Programs are implemented through the development, review, and evaluation of education programs designed to promote health, safety and environmental regulatory compliance.
 - 1. All employees at the time of hire are required to attend General Hospital Orientation. This includes information presented by EH&S personnel, where general information and education regarding the environment of care and safety are provided.
 - 2. At the department level, training is specific to processes, materials, precautions and work practices/behaviors relative to the individual job functions and risks (can include roles during safety inspection, accident/incident reporting, notification and recall processes, preventative maintenance and correct use of equipment). Department managers will verify that each employee possesses the required core competencies with respect to safety and the environment of care. Technical consultative support is provided through EH&S.

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3. Human Resources, EH&S and department managers will periodically revisit their training materials and modify, adjust and improve as indicated, to reflect:
 - The results of education and training needs assessments as determined through employee interview and written test/quiz scores and determinations made by the Central Safety Committee.
 - Organizational experiences and learning, including relevant performance indicator results reported and discussed by the Central Safety Committee.
 - Results of risk assessments, environmental hazard surveillance rounds, audits, inspections and environmental and industrial hygiene monitoring.
 - Injury/illness trends.
 - Changes in applicable laws, regulations, codes or standards.
 - Integrated Safety Committee or EH&S manager recommendations.
 - Continuing education in Environment of Care areas will be conducted at least annually utilizing the on line safety fair, or presentations by manager or technical expert.
- J. The mandatory training and education program provides required EOC elements, to include Safe Environment, Fire Prevention, Secure Environment, Medical Equipment, Utility Management, Hazardous Materials & Waste Management, Emergency Management, and Infection Control.
- K. Department specific safety plans are used to detail the specific hazards, safety precautions, and emergency plans for that area.
- L. Management of Hazardous Materials and Waste is conducted in a manner that controls risks of harm as well as ensures compliance with applicable legal requirements. Program implementation will include employee training, identification and inventory of the hazardous materials and the identification and management of hazardous waste streams.
- M. Identifying and addressing significant concerns pertaining to the management of equipment, utilities and facility grounds.
- N. The establishment of an effective Emergency Management program which is written using a multi-hazard functional planning approach and is based on the nationally recognized “Hospital Incident Command System” model. Semi- annual exercises are conducted to test program effectiveness.
- O. No Smoking Policy: El Camino Hospital has a facility-wide no-smoking policy. No smoking is allowed on the campus property. Smoking cessation education, information, and options are provided to patients who smoke. Security, along with the entire medical center staff monitors compliance with this smoking policy.
- P. Other Environmental Considerations:
 - a. The hospital will plan, develop and maintain an environment that is safe, supports healing assists in achieving positive patient outcomes and consistently meets patients’ needs.

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- b. Facility Services, with Administration, EH&S, and Infection Prevention will ensure planning for remodels, renovations, alterations, modifications and new facilities takes into consideration appropriate space, equipment, privacy, utility systems, etc.
- 1) Design criteria for size configurations, equipment, utilities and life safety systems will include:
- Office of Statewide Health Planning and Development (OSHPD) permitting protocols
 - Uniform Building Code- 24 CCR, section 420A et seq
 - AIA Guidelines for Design and Construction of Health Care Facilities
 - Life Safety Code- NFPA 101
 - Standards, specifications and criteria referenced by health care community or industry consensus
- 2) Appropriateness of Space, Furnishings, and Equipment:
- Facilities Services will work with Nursing and Administration to make certain the design of remodeled areas and new spaces and the maintenance of existing areas are comfortable, safe, and aesthetically pleasing.
- Engineering maintains utilities and services to ensure the mechanical ventilation system provides acceptable levels of temperatures, relative humidity and removal of odors. Adequate space is provided within patient rooms for personal property, clothing and grooming articles.
- 3) Appropriate Privacy and Confidentiality
- Facilities Services and clinical staff will ensure appropriate confidentiality, auditory and visual privacy. Efforts to accomplish this include:
- Space & equipment arrangement
 - Privacy curtains and partitions
 - Assisting patients (when appropriate) to don gowns while preserving patient privacy and dignity
 - Access to telephones for private conversations (where clinically appropriate). Reasonable accommodations will be given to physically challenged patients
 - White boards should only display patient information for staff members (no diagnostic, patient condition, disposition or other sensitive/personal information)
 - Staff will respect the rights of patients and refrain from conversations involving medical condition, diagnoses, prognoses or any other personal information in open/public areas.
 - Confidential patient documentation that is no longer needed will be managed in a secure and appropriate manner from the point of generation to final disposition.

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VII. PROGRAM PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Central Safety Committee recommendations.

A. Intent and Requirement

To monitor, assess and improve staff knowledge, skills and competencies with respect to their roles and responsibilities to the Safe Environment Management Plan.

B. Performance Standard

The FY-18 Performance Improvement Indicators are:

| EOC Area | Indicator | Responsible Dept./Function | Target |
|-----------------|--|-----------------------------------|--|
| Safety | Implement a tracking mechanism for all staff safety hazards and risk found as a result of the Injury Investigation Process | EWHS / EHS | 100% of staff work-related hazards and risks identified will be ranked by priority |
| Safety | Documentation and tracking of actual and proposed control for hazards and risks identified as a result of the Injury Investigation Process | EWHS /EH&S / Facilities | 100% of hazards and risk identified proposed or actual controls will be documented |

C. Frequency of Measurement and Process

All blood borne pathogen exposures (sharps and splashes) and slips/trips/falls injury data is collected through Accident Injury and Exposure Reports (AIER). Incidents will be reviewed by the applicable committee as appropriate for corrective actions and then reported to the Central Safety committee monthly.

VIII. EVALUATION OF PROGRAM EFFECTIVENESS

Through the Safety Trends report and the Central Safety Committee, the effectiveness of the program, including the appropriateness of design, outcomes of implementation, training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the safety program to include: hazardous

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surveillance reports, occupational illness/injury investigation reports, staff educational surveys, security incidents, medical device incidents, fire drills, and disaster exercises

IX. ANNUAL PERFORMANCE EVALUATION

On an annual basis, the safe environment program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Safety Officer and approved by the Central Safety Committee.

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.
- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

X. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|--|-----------------------|
| Central Safety Committee: | 3/2018 |
| ePolicy Committee: | 4/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

TITLE: FY-18 Security Management Plan
CATEGORY: Safety – Environment of Care
LAST APPROVAL: New

TYPE: ☐ Policy ☐ Protocol ☐ Scope of Service/ADT
☐ Procedure ☒ Plan ☐ Standardized Process/Procedure
OFFICE OF ORIGIN: Safety and Security Services
ORIGINAL DATE: 02/12/2018

I. COVERAGE:

This Security Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

II. PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino Hospital Mountain View and Los Gatos and associated Outpatient Clinics are committed to providing a safe, secure, accessible and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients, members, employees, physicians and visitors.

To that end, it is the overall intent of this plan to establish the framework, organization and processes for the development, implementation, maintenance and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology and physical barriers.

A. Goals:

Based on areas of improvement noted in the FY 2016/17 Annual Evaluation, the performance improvement indicators for FY 2017/18 will be:

1. 10 % reduction in the number of Code Gray's over FY 2016/17
2. Security staff response time to emergency codes less than three minutes. Target is 90 % or higher.

B. Objectives:

Specific objectives of the 2017/18 Secure Management Plan include the following:

- Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess and control security risks, vulnerabilities, protect sensitive areas, and to track access control.
- Work with nursing to identify and plan for potential Code Gray patients.
- Use the Code Gray critiques to improve response with a focus of ensuring the safety of the staff and patients during these events.
- Ensure timely and effective responses to security emergencies. Less than three minutes response time
- Ensure quality and effective responses to service requests.

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- Report and investigate incidents of theft, vehicle accidents, threats, and property damage.
- Periodically inspect and test all security systems, devices and equipment.
- Promote security awareness and education.
- Enforce various Medical Center Rules and policies.
- Establish and implement critical program elements to include measures to safeguard people, equipment, supplies, and medications and to control traffic in and around the Medical Center and the outlying medical offices.

III. SCOPE AND APPLICATION:

The Security Management Plan comprises standards applicable to address and facilitate the protection, welfare, safety and security of the environment. Included is a full range of protective services for all persons, property and assets at the Medical Center and outlying facilities. It requires compliance with all policies and procedures from all staff members, physicians and contractors employed by El Camino Hospital and associated outpatient clinics. It provides for quality customer service for all members, patients, visitors and staff, along with the protection of property and assets.

The scope of the plan addresses all elements required to provide a safe and secure environment in which care is delivered, as well as to ensure safety in the workplace. Key aspects include:

- Further develop a comprehensive patrol plan for the Medical Center and the outlying medical offices
- Sustain Nonviolent Crisis Intervention training for all security officers
- Improve/enhance Emergency Department physical and technological security
- Program planning/design, implementation, the measurement of outcomes and performance improvement.
- Risk assessments, identification, analysis, and control of risks.
- Reporting and investigating including incidents, accidents and failures.
- Orientation, education and training of staff and officers.
- Emergency responses.
- Use and maintenance of equipment, such as lights, locks and barriers, C-cure 9000 systems and alarms.
- Traffic control and the security of Sensitive areas.
- Upgrade infant monitoring systems.
- Upgrade the C-Cure 9000 system to increase functionality of systems including the use of cameras.

IV. REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .04.01.0, .04.01.03, .04.01.05
2. California Code of Regulations, Title 8, Sections 8 CCR 3203 et seq.

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3. California Code of Regulations, Title 22, Sections 22 CCR 70738
4. Health & Safety Code, Section 1257.7, 1257.8

V. AUTHORITY

El Camino Hospital Leadership team provides the program, vision, leadership, support and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Security.

VI. PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. Security Director:

1. Responsible for the overall management of the security program including program design, implementation and assessment, identification and control of risks, staff educational needs, and consultation and assistance.
2. Has the authority to intervene whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or the facility.
3. Provides support and direction to the Security Account Manager and Security Management Program by participating in the development and approval of policies and procedures, reviewing and performing security risk assessments and ensuring the appropriate resources are available to permit the completion of the objectives and goals related to the Security Management Plan.
4. Makes recommendations to the Central Safety Committee concerning the implementation of new procedures and operations, as well as installation of new systems.
5. Communicate actions taken secondary to significant security incidents or performance issues to Security Workgroup and the Central Safety Committee.

B. Security Account Manager (AM):

1. Provides security personnel and site management of security operations, compiling relevant information from incident reports and security service date to form the basis for quarterly reports submitted to the Central Safety Committee, functional oversight and responsibility for the day to day operations of the Security department and the implementation of the program.
2. Assures employees receive all security related training, report situations involving threats or the perception of an unsafe work place to the Security Workgroup, assures employees follow security instructions for their areas, and contacts the Director of Security with all security related issues.
3. Periodically inspect and test all security systems, devices, and equipment.

C. Security Department:

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

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1. Works in collaboration with the Mountain View Police Department. Law Enforcement provides the El Camino Hospital campuses with periodic patrols and a prompt response when needed.

D. Central Safety Committee (CSC):

The CSC, comprised of clinical, administrative, operations support services, and labor representatives and other appropriate organizational representatives, ensures the Security management program remains in alignment with the core values and goals of the organization by providing direction, strategic goals, determining priority and assessing the need for change. The committee also ensures coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, including those of existing committees, sub-committees and organizational units and establishes and /or approves infrastructures to support Performance Improvement techniques.

E. Department Managers:

The Department Managers are responsible for the provision of a safe and secure working environment for their staff and patients, suitable provisions for the care of patients, through full implementation of established Environment of Care programs to include identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting and suitable provisions for the protection of patients and their belongings.

F. Employees

Employees are responsible to follow security policies and guidelines of personal protection and report any/all security incidents, risks and threats to the Security Department. For the purpose of this plan, employees include contract employees, volunteers, students, registry personnel and anyone working under the facility's auspices. Employee's Security responsibilities include wearing their identification badges at all times and reporting any suspicious persons or activities in their area.

VII. RISK ASSESSMENT

Security risks, potential vulnerabilities and sensitive areas are identified and assessed through ongoing facility-wide processes and coordinated through the Security Director and Security Account Manager. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics and physical systems. Considerations include:

- Routine Environmental Rounds (i.e. safety inspections).
- Root cause analysis of significant events.
- Quality Review Report (QRR)
- Sentinel Event Alerts produced by the Joint Commission.
- Security Patrols.

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- Information Collection and Evaluation System (ICES) - Committee review of pertinent data/information, incident reports, evaluations and risk assessments.
- Community crime statistical data or review.
- Facility crime, incident and property loss statistics (Perspective)-
- Risk of elopement (such as clinically indicated restraints, medical holds and the need for stand-by services)

The profile for potential risks gives rise to an integrated, proactive approach to risk control and measures to safeguard people and assets. Secondary to the risk assessment(s) performed, identified security “Sensitive Areas” include, but are not limited to; Emergency Department, Newborn Areas, Pediatrics, Pharmacies, Psychiatry, Mechanical Rooms, Main Computer/Information Technology areas, Cash Handling areas, Laboratory, Nutritional Services, Nuclear Medicine, Hazardous Waste Storage area, and Medical Gas Storage areas.

VIII. PROGRAM EFFECTIVENESS

The Security workgroup and the CSC monitor the effectiveness of the Security Program, including the appropriateness of design, outcomes of implementation; training and materials are monitored and assessed on an ongoing basis. Relative documents, reports of action taken, as well as concurrent and retrospective data is tracked and monitored relative to success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the security program.

IX. PERFORMANCE

| EOC Area | Indicator | Responsible Dept./Function | Target |
|-----------------|--|-----------------------------------|--|
| Security | 10 % reduction in the number of Code Gray’s over FY 2016/17 | Security | 10 % Decrease from FY 2016/17 statistics |
| Security | Security staff response time to emergency codes less than three minutes. Target is 90 % or higher. | Security | > 90% |

X. ANNUAL PROGRAM EVALUATION

On an annual basis, the Security Management Program is evaluated relative to its objectives, scope, effectiveness and performance. This evaluation process is coordinated with the Security Director and the onsite Security and reported to the CSC

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.

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- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant policy and procedures, technology, and practices that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

XI. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|--|-----------------------|
| Security Management Work Group | 3/2018 |
| Central Safety Committee: | 3/2018 |
| ePolicy Committee: | 4/2018 |
| Quality Committee | |
| Board of Directors: | |
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| Historical Approvals: | |

TITLE: FY- 18 Hazardous Materials Management Plan
CATEGORY: Safety – Environment of Care
LAST APPROVAL: New

TYPE: ☐ Policy ☐ Protocol ☐ Scope of Service/ADT
☐ Procedure ☒ Plan ☐ Standardized Process/Procedure
OFFICE OF ORIGIN: Safety and Security Services
ORIGINAL DATE: 2/26/2018

I. COVERAGE:

This Hazardous Materials Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

II. PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, accessible and effective Environment of Care, consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, visitors, employees and staff. The intent of this plan is to protect human health and the environment from risks related to hazardous materials and waste by identifying materials that need special handling and implementing processes to minimize the risk of unsafe use and improper disposal of hazardous materials.

Based on areas of improvement noted in the FY-17 Annual Evaluation, the performance improvement indicators for FY-18 will be:

1. Staff will know how to correctly fill out a hazardous waste label
2. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes

A. Objectives:

Specific objectives of the FY-18 Hazardous Materials and Waste Management Plan include the following:

1. All employees will have access to Safety Data Sheets (SDS) on line.
2. All Hazardous Materials Business plans will be submitted to the Santa Clara County Department of Environmental Health.
3. Refresher and initial decontamination training will be offered to staff at least one time in FY 2018.
4. Spill response training will be offered to staff who respond to spills/code orange (e.g., EVS, Engineering, Lab etc.).
5. Any corrective actions from the 2017 Santa Clara County medical and bio hazardous waste inspections will be tracked through the Central Safety Committee.
6. Any corrective actions from the 2017 Santa Clara County hazardous waste inspections will be tracked through the Central Safety Committee.
7. Selective staff will attend part of the FEMA weapons of mass destruction and Decontamination training in Anniston Alabama

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| TITLE: | FY- 18 Hazardous Materials Management Plan |
| CATEGORY: | Safety – Environment of Care |
| LAST APPROVAL: | New |

III. SCOPE AND APPLICATION:

The Hazardous Materials and Waste Management Plan apply to patients, employees, and visitors at all areas of El Camino Hospital. This plan applies to all operations, processes, activities and departments involved in the selection, procurement, handling, storage and disposal of hazardous materials. For the purposes of this plan, the term “hazardous materials” may apply to the following:

- Hazardous substances (as listed and defined under CERCLA , 40 CFR 300),
- Hazardous Materials (as addressed in the OSHA Hazard Communication Standard & Director’s list 8 CCR 339),
- Designated wastes under the federal and state regulations,
- Listed carcinogens and reproductive hazards, under 22 CCR 12000 (Prop. 65),
- Compressed gases,
- Chemotherapeutic agents (CYTOTOXIC),
- Radioactive materials,
- Potentially infectious materials (as defined in the Blood borne Pathogen Standard) and Medical wastes (as defined in the Medical Waste Management Act),
- Pesticides (Title 3, Division 6, Health & Safety Code, Section 25500),
- Universal Waste (batteries, fluorescent light bulbs), or
- Any other material which the user or Administering Agency has reasonable basis to classify as harmful to living organisms or the environment.

This plan addresses all elements required to provide a safe and healthy environment in which care is delivered, as well as to ensure safety in the workplace. Key aspects include:

- Program planning/design, implementation, the measurement of outcomes and performance improvement;
- Risk Assessments; Identification, analysis and control of risks;
- Reporting and investigating including incidents, accidents and failures;
- Occupational health and safety;
- Control of exposures to potentially harmful conditions/industrial hygiene;
- Orientation, education and training;
- Environmental maintenance, testing and inspection;
- Examining and addressing safety issues

The hazardous materials and waste management plan and associated policies, procedures and programs are instituted by the Central Safety Committee through a multi-disciplinary approach which integrates the efforts of key functional areas, including but not limited to EVS, Infection Control (IC Committee), Engineering, Laboratory, Nursing, and Security

IV. REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.02.01

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2. Code of Federal Regulations, Title 29, Sections 1910.101-106, 120, 1000, 1030, 1200, 1450;
3. Code of Federal Regulations, Title 40, Section 261 et seq.;
4. California Code of Regulations, Title 8, Sections 3203, 4650, 5076, 5144, 5155, 5191, 5193, 5194;
5. Title 22, Sections 66261 et seq., 12000;
6. Title 17, Section 30100;
7. Title 3, Section 6145 et seq., 6600 et seq.;
8. California Health and Safety Code, Sections 117600 et seq.;
9. NFPA 30.

V. AUTHORITY

The El Camino Hospital Leadership Team provides vision, leadership, support, and appropriate resources to the program. In accordance with its bylaws, the El Camino Hospital leadership has given the Central Safety Committee the authority to ensure that this plan is developed and implemented. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the Hazardous Materials and Waste Work Group.

VI. PROGRAM ORGANIZATION AND RESPONSIBILITIES

- A. Clinical Laboratory:** Hazardous material and waste management in the Pathology and Clinical Laboratories, and the implementation of the Chemical Hygiene Plan, is the responsibility of the Laboratory Director/Manager.
- B. Radiation Safety Committee:** Radioactive materials and waste management is the responsibility of the site Radiation Safety Officer and the Radiation Safety Committee.
- C. Hazardous Materials and Waste Management Workgroup:** The Hazardous Materials and Waste Management Workgroups or designee in collaboration with the Central Safety Committee is responsible for the overall management of the hazardous materials and waste program. These include:
 - Coordinating the initial assessment of risks,
 - Program design,
 - Developing the facility's written plan and program objectives for each year,
 - Establishing, monitoring and assessing Performance Improvement dimensions
 - Identifying training needs,
 - Regulatory tracking/interpretation,
 - Assistance with departmental implementation,
 - Initial response investigation and reporting of significant events, and
 - Program evaluations.
- D. Central Safety Committee (CSC):** The CSC, as part of the standing agenda, receives and reviews reports and summaries of actions taken related to Hazardous Materials and Waste

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Management. The Committee also identifies and analyzes issues and seeks there timely resolution. Agenda items include:

- Issues requiring action, recommendations or approval,
- Issues requiring monitoring/periodic or ongoing review,
- Needs that are multi-disciplinary in nature,
- Regulatory updates, and
- Performance Data review.

VII. RISK ASSESSMENT

Risks associated with the management of hazardous materials and wastes are typically identified and assessed through facility-wide processes, such as routine safety rounds , product inventory management, the facility's Safety Trends reports, Central Safety Committee review, and Quality Report Review (QRR) evaluations. The risk profile with respect to hazardous wastes includes, but is not limited to: risk of occupational and occupant exposures; fires and chemical reactions; releases; nosocomial infections; and legal exposures.

Key factors driving the level of relative risk include the likelihood of an unwanted event coupled with the magnitude of the consequences. These factors are typically associated with the volume of chemical substances, constituents, inherent physical or chemical properties, concentration and handling practices, as well as invasive procedures involving blood or other potentially infectious materials and waste handling. Identified high risk areas to which additional resources and attention are directed are listed below.

- Clinical Laboratories and the Pathology department
- The Operating Room
- Sterile Processing department
- Material Management
- Facility Engineering
- Pharmacies
- Environmental Services (EVS)
- Gastroenterology (GI)
- Oncology/Hematology
- Radiology
- High volume patient care areas

VIII. PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

The plan provides processes for the following.

- A. The facility developed and maintains an inventory that identifies hazardous materials and waste used, stored, and generated using criteria consistent with applicable laws and regulations as follows:

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

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- A Hazardous Materials Business Plan is kept current in accordance with local and state regulations and ordinances.
 - The facility's policy and procedure requires each department to update a department chemical inventory.
- B. Selection, handling, and use of hazardous materials and waste: Products and substances containing chemical constituents deemed to be hazardous will be identified, evaluated and listed by recognizable names within department-specific inventories. Department managers (in conjunction with the EH&S Manager) will evaluate waste streams to ensure waste materials from all processes, procedures and operations are correctly characterized and classified, per regulatory criteria. Department programs include waste minimization components, such as procurement and inventory control. For each hazardous material used and handled, the department manager will provide a corresponding Safety Data Sheet (SDS). These documents will remain readily available to employees at all times and should form the basis for department-specific training and written procedures for proper handling, storage, safe use and spill procedures. Containers of hazardous substances are labeled in accordance with applicable regulations with appropriate hazard communication and expiration dates.
- C. The facility monitors use and disposal of hazardous gases and vapors including, but not limited to:
- Formaldehyde
 - Various compressed gas cylinders, including oxygen, medical air, nitrous oxide and nitrogen.
- D. Hazardous Materials and waste emergency procedures address the following:
- Incidental and major spills: Emergency procedures and materials are implemented that provide preventative, precautionary measures, response procedures, and appropriate personal protective equipment (PPE). The EH&S Manager participates with department managers in the development and implementation of emergency procedures.
 - Small, relatively innocuous hazardous material spills: These spills are addressed by the individual causing or discovering the spill or appropriately trained staff. The containment materials will be used for proper spill cleanup.
 - Large spills: These spills will be handled by contracted vendor and/or emergency response agency personnel. In the event of a release or exposure involving radioactive materials, the Radiation Safety Officer will immediately be notified and will coordinate the response.
 - Clean-up procedures: Department managers will ensure that appropriate spill procedures and spill control materials are readily available for use within close proximity of where hazardous substances are stored, used or handled. Additionally, facilities engineering maintains a chemical spill cart to supplement existing spill materials and PPE.

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- Personal protective equipment: Department managers will ensure that appropriate personal protective equipment (PPE) is readily available for use within close proximity of where hazardous substances are stored, used or handled. Exposure management equipment, materials, suppression systems, alarm systems and other features of the hazardous materials and waste management program are inspected and maintained primarily through Facilities Services, in concert with the EH&S Manager. Examples include, but are not limited to:
 - Mechanical ventilation
 - Administrative controls
 - Personal Protective Equipment (PPE)
 - Periodic exposure monitoring for operations that involve the handling of solvents, reagents, fixatives and other chemicals that may produce fugitive emissions, volatilize or otherwise off-gas into occupied spaces and/or work areas. **(See PM records and monitoring records).**
 - Personnel monitoring, system assessments, local exhaust ventilation/scavenger units and alarm systems for the control of waste anesthetic gases (including nitrous oxide).
 - Reporting and investigation of hazardous materials incidents:

The EH&S Manager will ensure all releases and exposure incidents are duly investigated and reported to the Central Safety Committee and appropriate agencies.
- E. Documentation is maintained that includes required permits and licenses in Facility Services
- F. As prescribed by governmental standards, hazardous waste is manifested for transport to a permitted, licensed treatment, storage and disposal facility (TSDF), by a licensed contracted hazardous waste hauler in accordance with applicable regulations (See Manifests).
- G. Hazardous materials and waste are properly labeled in accordance with pertinent laws and regulations i.e. DOT shipping requirements, NFPA Placards, Title 22, etc.
- H. Hazardous materials and waste storage and processing areas are separated from other areas of the facility as follows:
- Where hazardous materials or wastes are stored, physical barriers separate incompatible materials. Applied release prevention measures include diversionary structures, bins, tubs, berms, secondary containment, etc. Hazardous materials are used and stored under adequate general ventilation or local exhaust ventilation.
 - Hazardous wastes are collected and accumulated on site in a main accumulation area and in satellite accumulation areas near the point of generation. These accumulation areas are provided with structural features, containers, signage, equipment, and supplies conducive to occupational safety, spill prevention and control, and environmental protection **(Hazardous waste storage area inspection check list).**

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- Bio-hazardous waste is contained within rigid, leak resistant, labeled containers; accumulated on-site within secured and designated areas. Sharps waste is transported by a licensed hauler and incinerated by a permitted facility. Regulated medical (bio-hazardous and sharps) waste is segregated from solid municipal wastes at the point of generation.

I. Education and Training:

All employees attend General Hospital Orientation at the time of hire and annual training where general information and education regarding the management of hazardous materials and wastes is provided. Departments will also conduct training that is specific to processes, materials; precautions and relative risk associated with job function and work practices, to include:

1. Elements of the written programs, interpretation of labeling and hazard warning systems, specific SDS information (physical and health hazards, precautions), proper storage, waste Management, emergency procedures and QRR's (including spills, releases and exposures);
2. Department manager(s) will verify that each employee possesses the required core competencies relative to the safe and effective use of products and substances deemed hazardous;
3. Technical consultative support is provided through the Safety and Security Services Department, as requested;
4. The education department and each department manager will periodically revisit their training materials and modify, adjust and improve, as indicated, to reflect:
 - Organizational experiences and learning
 - Results of risk assessments, hazard surveillance rounds, audits, inspections
 - Changes in pertinent regulations, codes or standards
 - Recommendations from the Central Safety Committee or the Safety and Security Services Department

IX. PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Integrated Safety Committee recommendations.

- A. Intent and Requirement: To monitor, assess and improve staff knowledge, skills and competencies with respect to hazardous materials and waste.
- B. The FY-18 Performance Improvement Indicators are as follows:

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| EOC Area | Indicator | Responsible Dept./Function | Target |
|--|---|----------------------------|--------|
| Hazardous Materials / Waste Management | Staff know how to correctly fill out a hazardous waste label | Safety | >90% |
| Hazardous Materials / Waste Management | Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes | Safety | >90% |

C. Process and Frequency of Measurement

Data will be collected through safety rounds

X. PROGRAM EFFECTIVENESS

The Central Safety Committee evaluates the effectiveness of the program, including the appropriateness of design, outcomes of implementation, training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action(s) taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the hazardous materials and waste program to include: hazardous surveillance results; inspections by regulatory agencies; spills, releases or other emergencies; management of the hazardous waste accumulation area; occupational exposures to hazardous materials; and hazardous materials and waste reduction efforts.

XI. ANNUAL PROGRAM EVALUATION

On an annual basis, the Hazardous Materials and Waste program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Integrated Safety Committee and the Safety Officer.

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.
- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the

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parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.

- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

XII. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|--|-----------------------|
| Hazardous Material Management Work Group: | 3/2018 |
| Central Safety Committee: | 3/2018 |
| ePolicy Committee: | 4/2018 |
| Quality Committee | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

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TYPE: ☐ Policy ☐ Protocol ☐ Scope of Service/ADT
☐ Procedure ☒ Plan ☐ Standardized Process/Procedure
OFFICE OF ORIGIN: Safety and Security Services
ORIGINAL DATE: 2/22/2018

I. COVERAGE:

This Fire Prevention Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

II. PROGRAM OBJECTIVES AND SCOPE:

El Camino Hospital is committed to providing a safe, accessible, effective and efficient Environment of Care consistent with its mission, services and applicable governmental mandate. This includes the provision of environment of care that protects patients, employees, visitors and property from fire and smoke. The intent of this plan is to describe a comprehensive, facility-wide management system, the objectives of which are to:

1. Anticipate, identify, assess and adequately control risks to human health, safety and the care environment relative to fire prevention and life safety;
2. Ensure processes, operations, work practices and behaviors remain conducive to continued fire prevention, safety, and conform to applicable standard and governmental mandate (i.e. Fire prevention Code 101, Title 8, Title 19, various fire codes);
3. Provide education and training that fosters an acceptable level of continuous readiness and emergency preparedness through safety training and fire drills;
4. Maintain the structural and systemic features of fire protection with a level of integrity and functionality that is adequate and compliant; and
5. Implement interim life safety activities to protect occupants during periods when a building does not meet the applicable provision of the life safety code.

A. Goals:

Based on areas of improvement noted in the FY 2016/17 Annual Evaluation, the performance improvement indicators for FY-18 will be:

- Staff knowledge of horizontal and vertical evacuation.
- Staff can locate the nearest location of extinguishers and fire alarm pull stations and can articulate how to use them.
- Staff knowledge of the acronym RACE for responding to a fire situation
- Staff knowledge of the acronym PASS for using a fire extinguisher

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B. Objectives:

Specific objectives of the FY-18 Fire Prevention Management Plan include the following:

- Complete a life safety assessment to compliance with NFPA 101-2012 in Mountain View and Los Gatos.
- Certify identified Engineers to obtain their fire pump certification
- Meet all regulatory fire systems compliance requirements each quarter
- Certify fire doors in Hospital and associated outpatient clinics as applicable

III. REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .02.03.01, .02.03.03, .02.03.05, Code of Federal Regulations, Title 29, Sections 1910.101-106, 155;
2. California Code of Regulations, Title 8, Sections 3203, 3220, 3219, 3221, 6151, 6184;
3. Title 19, Chapters 1 and 5;
4. California Code of Regulations, Title 22, Sections 70741, 70743, 70745;
5. NFPA 101 (Fire prevention Code), Chapters 5, 6, 7 and 13;
6. NFPA 13, 72, 96.

IV. AUTHORITY

In accordance with its bylaws and administrative protocols, the El Camino Hospital Leadership Team has given authority to the Safety and Facility Directors and Chief Engineer to ensure this plan is formulated, appropriately set forth and implemented. Program implementation and day-to-day operational management has been delegated to the Chief Engineer.

The authority and responsibility for fire prevention response education has been delegated to the Facility and Safety Directors/Officer & the Chief of Engineering under the supervision of the Chief Administrative Officer (CAO).

V. PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. Leadership Team

The El Camino Hospital Leadership Team (i.e. the organization's governing body) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of business fundamentals relative to environmental health and safety.

B. Facilities Engineering Department

The El Camino Mountain View and Los Gatos Engineering Department, in partnership with the Facility and Safety/Security Director, is responsible for the overall management of the fire prevention management program. This includes:

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1. Coordinating the initial assessment of risks (including assistance with construction/remodel project risk assessments);
2. Program design and developing the facility's written plan;
3. Monitoring ceiling and wall penetrations for fire prevention;
4. Identifying training needs;
5. Tracking/interpretation of relevant fire codes; and
6. Technical consultation; assistance with implementation; initial response investigation and reporting of emergency events; and evaluation of program efficacy and improvement.

C. Environmental, Health & Safety Manager, Clinical Laboratory, Chief Engineer

The EH&S Manager works together with the Laboratory Departments and Chief Engineer to assess life safety issues and fire hazards within the Pathology and Clinical Laboratories, and ensure that these hazards are addressed through appropriate procedures, processes, and systems.

D. Central Safety Committee

The Central Safety Committee (CSC) ensures the fire prevention management program remains in alignment with the core values and goals of the organization by providing direction, determining priority and assessing the need for change. The CSC also ensures coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, including those of existing committees, sub-committees and organizational units and establishes and /or approves infrastructures to support Performance Improvement techniques.

The Central Safety Committee meets regularly and as part of the standing agenda, receives and reviews reports and summaries of action taken relative to Fire Prevention Management on a quarterly basis. Agenda items include:

- Issues requiring action, recommendations or approval;
- Issues requiring monitoring/periodic or ongoing review; and
- Needs that are multi-disciplinary in nature.

E. Department Managers

Department Managers are responsible for the development and management of department-specific fire prevention programs that include:

- Procedures for fire prevention, where applicable;
- Basic fire response plan; equipment and procedures for the movement of patients to areas of refuge;
- Evacuation procedures;
- Fire safety training for employees; and
- Emergency/incident reporting and investigating procedures.

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- Engineering to provide consultative services to dept. managers around fire safety.

F. Employees

Employees (including contract employees) are responsible to participate in required fire prevention training and fire drills, and must demonstrate core competencies in the subject matter. Employees must ensure their behaviors, work practices and operations are fire safe, responsible and in alignment with the facility and departmental procedures (including the no smoking policy), applicable training, and provisions of this plan.

VI. RISK ASSESSMENT

Risks associated with fire are typically identified and assess through facility-wide processes described within this plan, such as:

1. Routine Hazard Surveillance (rounding)
2. The examination of the building's fire protection features and assessment of LSC compliance, conducted as part of the completion of the **Statement of Conditions (SOC)**.
3. A **Building Inspection/Maintenance Program** to identify and resolve operational/non-structural LSC deficiencies;
4. Comprehensive project evaluations and site assessments to determine the need for **Interim Life Safety Measures**;
5. **Safety Tends Spreadsheet** – Central Safety Committee review of pertinent data/information; incident reports; evaluations, and risk analysis.

The risk profile with respect to fire and life safety includes, but is not limited to: risk of fires; explosions; exposure to smoke and toxic combustion by-products; life safety system failure; risk of harm to patients, staff, and visitors; legal exposures.

Key factors driving the level of relative risk are likelihood of an unwanted event coupled with the magnitude of the consequences. These factors are typically affected by the existence and management of ignition sources (such as smoking and heat producing elements), volume and type of ignitable substances, combustible fuel load, high risk activities, integrity and efficacy of fire prevention systems.

In light of this, high risk areas where additional resources and attention are directed, as appropriate, include the clinical laboratory/pathology, oxygen enriched environments (such as the O.R.), Facility Services, storage areas, construction projects (ILSM), corridors and stairwells, and waste storage.

These resources include:

- The application and maintenance of effective fire prevention features and systems (compartments, automatic suppression, early warning, portable extinguishers, etc.),
- The development and implementation of comprehensive fire prevention procedures

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- Interim Life Safety Measures (ILSM) where identified deficiencies and construction compromise fire prevention systems, and
- Effective response procedures, the efficacy and appropriateness of which are evaluated through Fire Drills.

VII. PROGRAM IMPLEMENTATION

The text that follows highlights the fire prevention management plan implementation processes:

- A. ***Assessment of the building's structural and mechanical features of fire protection*** - The life safety features of the building are periodically evaluated in an effort to assess and ensure compliance with the applicable NFPA 101 (LSC) standards and to preserve their integrity and effectiveness. To this end, processes of inspections, testing, maintenance, interim measures, and repairs are coordinated through the Facility Services Department (and construction services, as appropriate), in concert with the Safety/Security department. Life Safety Code deficiencies and areas of non-compliance are identified and documented through the on-going ***Statement of Conditions (SOC)*** process. This evaluation process gives rise to a single source document that adequately reflects the overall condition of the building and systems, as it relates to the Life Safety Code. Any LSC deficiencies are immediately corrected.
1. In addition to the SOC assessment and correction processes, this facility has established and implemented a ***Building Maintenance Program (BMP)*** to identify and resolve the more ongoing, mechanical and operational deficiencies (e.g. door latches, exit lights, penetrations, corridors, etc.), in lieu of creating PFIs for their resolutions.
 2. A comprehensive Life Safety Code ***Building Inspection Program*** is the primary component of the BMP. Most of this program element is incorporated into and conducted through the Hazard Surveillance and Facilities Services Rounds. The Hazard Surveillance and engineering inspection protocols (Instruction Sets) address required elements set forth in the Joint Commission standards.
 3. The frequency of the Life Safety Code Building Inspections will coincide with the established Hazard Surveillance Rounds and engineering rounds schedule. However, Plant Engineering is responsible for conducting additional inspections if it is so indicated through direct observation of deficiencies, additional projects involving remodeling, structural changes, electrical work or activities that are likely to change or compromise the condition of the life safety features.
 4. The Engineering Department is responsible for periodic inspections of the integrity of the fire and smoke stop partitions, including follow up inspections once a construction project is completed.

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5. The table below describes the common types of LSC deficiencies to be addressed through the BMP, and the responsible functions:

| LSC Compliance Item | Responsible Function(s) |
|---|--|
| <u>Rated Doors</u> , including stairwell and occupancy separation doors have: <ol style="list-style-type: none"> Functioning positively latching assemblies Properly functioning self-closing devices Gaps of less than an 1/8" between double leaf doors Less than 3/4" undercuts (LSC 5-2.1.5.4, 13-3.2.1) | Engineering to assess, repair and maintain |
| <u>Rated Barriers</u> (smoke and fire): <ol style="list-style-type: none"> Have properly functioning self-closing or automatic closing devices (LSC 5-2.6; 5-2.1.5.3) Are maintained to preclude the transmission of smoke/fire (e.g. penetrations sealed with approved rated materials) (LSC 6/3.6.1). Corridor wall penetrations are properly sealed with materials capable of maintaining intended resistance (LSC 6-3.6.1) | Engineering to assess and make repairs. |
| <u>Means of Egress</u> lighting properly functioning (LSC 5-8.1). | <ul style="list-style-type: none"> • Engineering • Safety • Security • Hazard Surveillance team |
| <u>Exit signs and Directional signs</u> clearly show emergency exit routes (LSC 5-10.1.2) | <ul style="list-style-type: none"> • Engineering • Safety • Security • Hazard Surveillance team |
| The following <u>Grease Producing Devices</u> are properly maintained: <ol style="list-style-type: none"> Exhaust hoods Duct systems Grease removal devices (LSC 7-2.3; NFPA 96) | <ul style="list-style-type: none"> • Hazard Surveillance • Safety • Engineering • Nutritional Services |

- B. **Testing of the life safety systems**, as well as annual preventive maintenance of all components and initiating devices are conducted by internal engineering personnel on a pre-determined,

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cyclical schedule that ensures optimal coverage with minimal disruption of care and business activities. (Resources may be supplemented by personnel from a licensed contract firm).

1. Maintenance and testing requirements include:

- a. Inspection and testing of all Initiating Devices at prescribed intervals (including smoke detectors, flow and tamper switches, duct detectors and manual pull stations) and supervisory devices.
- b. Five year hydrostatic testing of standpipes
- c. Annual testing of audible alarms, strobes, PA systems, etc.
- d. Visual inspections of fire department connections
- e. Weekly fire pump testing under no flow conditions
- f. Annual fire pump testing under flow conditions
- g. Operation of smoke and fire dampers (every 6 years)
- h. Annual testing of roll down doors
- i. Maintenance of any cooking facility exhaust hood systems (to include filter changes, hood cleaning and degreasing, and duct maintenance). **(.02.03.05)**
- j. Inspection of water based fire suppression systems; including pumps, drains and connection are coordinated through Engineering.

2. Engineering coordinates the testing of other automatic fire suppression systems (such as kitchen hood system, pre-action, Halon, etc.), through a licensed contractor.

3. Included in the foregoing inspection, testing and maintenance processes are detection and early warning devices that, upon actuation, triggers systems designed to slow the movement of fire and the transmission of smoke such as designated fans, in-duct dampers, and self-closing rated doors. Engineering will ensure that the functionality of the dampers themselves are tested and verified every six years.

4. Fire alarms are monitored externally by a compliant proprietary supervising station (per NFPA 72, 4-4.2.1). Upon activation, the signal enunciates locally and is immediately transmitted to the monitoring agency that notifies the fire department having jurisdiction. This system is periodically tested as part of the fire drill processes.

5. The Security Department is responsible for inspecting portable fire extinguishers monthly and coordinating annual servicing.

C. Fire Drills - In an effort to enhance training and reinforce fire readiness, the Security Department, in concert with engineering, will ensure fire drills are scheduled and conducted at the frequency of one drill per shift per quarter. Each drill will be observed and critiqued to help determine the overall level of emergency preparedness, discern areas requiring improvement,

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and assess the effectiveness of the fire prevention training efforts. Additional fire drills are coordinated as necessary for compliance with Interim Life Safety Measures (ILSM).

In lieu of observing all areas during a drill, a sample of areas will be selected, including the point of alarm/drill origin, an adjacent area, a smoke compartment above and/or below (as applicable) the point of origin. Part of the fire drill process includes an on-the-spot educational component to compliment life safety and fire prevention training efforts. Fire Drill scenarios are designed to simulate fires and ensuing emergency events and to evaluate staff knowledge of the following:

- Use and functioning of fire alarm systems (e.g. manual pull stations)
- Transmission of alarms
- Smoke and fire containment
- Transfer to areas of refuge (horizontal and vertical evacuation)
- Extinguishment
- Specific fire response duties
- Preparing for building evacuation

All personnel are trained in the facility fire response plan and the effectiveness of such training is evaluated as part of the Fire Prevention Program performance measure **(EC .02.03.03)**

- D. **Interim Life Safety Measures** - Where conditions during construction/remodel projects and or identified life safety code deficiencies impair any existing life safety system, appropriate interim systems are implemented in lieu of the impaired system in an effort to compensate for the temporary loss and ensure continued integrity of the program. The Safety and Facility Director will work in partnership with the Construction Project Manager, Chief Engineer and the local fire authority having jurisdiction, as indicated. They will ensure that, prior to the start of any project, risks are adequately assessed, and the appropriate interim measures are selected and implemented, as the level of risk decrees.

If a life safety system is to remain impaired, or if the Chief Engineer feels that the impaired Life safety System is vitally critical, then the Chief Engineer (designee) will instruct the Security department or Construction Services to institute a fire watch and will ensure the local Fire Authority is notified and institute ILSM per code requirements.

- E. **Education and Training** - All employees attend General Hospital Orientation (GHO) at the time of hire, where general information and education regarding the basic fire response plan, fire prevention, the smoking policy, and life safety features of the building are provided. Additionally, subsequent training and practical application are provided during fire drills. Department managers will also ensure that subsequent training is given that is specific to departmental procedures, processes, behaviors and precautions, to include:

1. Specific roles and responsibilities at the fire or alarm's point of origin, including:
 - Relocation of those close to the source or otherwise in immediate danger;

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- Activate emergency notification procedures, including alarm systems and phone numbers;
 - Confinement of the fire, including closing doors and compartments, management of flammables and oxidizers;
 - Proper use of extinguishing equipment.
 - Location and proper use of equipment for evacuating patients to areas of refuge, points of assembly, etc.;
2. Specific roles and responsibilities if a fire alarm actuates and the employee is away from the point of origin, i.e. respond if appropriate, stand by and await further instructions, prepare to close doors and relocate occupants.
 3. Other relevant aspects of life safety, fire prevention, as well as any substantive changes, adjustments and improvements of the subject matter, based upon:
 - Assessment of educational needs, coordinated through the department manager;
 - Organizational experiences and learning's;
 - Results of risks assessments, hazard surveillance, inspections, etc.;
 - Central Safety Committee recommendations;
 - EH&S Manager, Facility Director or the Safety/Security Director's input.

VIII. PROGRAM PERFORMANCE

The standards and indicators by which performance relative to this plan will be measured are developed based upon organizational experiences, discerned risks, inspection results, observed work practices, and Integrated Safety Committee recommendations. They include:

A. Intent/Requirement:

- Staff knowledge, skill and competency necessary for their role(s) in the event of a fire or fire alarm. As part of the facility's ongoing efforts to improve staff knowledge, the average percentage of correct responses to subject questions will be tracked.

B. Performance Standard:

Acceptable Staff performance with respect to the facility's fire prevention program requires that employees understand their roles and responsibilities relative to the use of fire prevention systems, emergency notification, relocation of occupants, etc.

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Based on opportunities for improvement identified in FY-17 annual EOC evaluation the FY-18 Performance Improvement Indicators are as follows:

| EOC Area | Indicator | Responsible Dept./Function | Target |
|-----------------|--|---|--------|
| Fire Prevention | Staff knowledge of the acronym RACE for responding to a fire situation | Engineering, Security and Department Managers | >90% |
| Fire Prevention | Staff knowledge of the acronym PASS for using a fire extinguisher | Engineering, Security and Department Managers | > 90% |
| Fire Prevention | Staff can locate the nearest location of extinguishers and fire alarm pull stations and can articulate how to use them | Engineering, Security and Department Managers | > 90% |
| Fire Prevention | Staff knowledge of horizontal and vertical evacuation. | Engineering, Security and Department Managers | > 90% |

C. Process and Frequency of Measurement:

Progress for this project will be reported out quarterly at the Central Safety Committee. Data will be collected during hazard surveillance rounds and fire drills.

IX. PROGRAM EFFECTIVENESS

The effectiveness of the fire prevention program, including the appropriateness of the program design, training, equipment and behaviors will be monitored and assessed on an ongoing basis through the Central Safety Committee. Relevant documents, reports, as well as concurrent and retrospective statistical data will be tracked through the facility's Safety Trends spreadsheet. The Central Safety Committee will receive periodic fire prevention reports and make recommendations as indicated. Reports include:

- Significant, relevant information gleaned from fire drill reports
- The results of inspections by regulatory agencies
- Reports of actual emergencies
- Interim Fire Prevention Measures that may affect building occupants
- Reports of fire prevention code deficiencies that may require additional time and/or resources to correct.

X. ANNUAL PROGRAM EVALUATION

On an annual basis, the fire prevention management program is evaluated relative to its **objectives, scope, effectiveness and performance**. The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.

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The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant equipment, technology and systems, items that add value and elements conducive to continuous regulatory compliance.

The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.

The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

XI. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Fire Prevention Management Work Group | 3/2018 |
| Central Safety Committee: | 3/2018 |
| ePolicy Committee: | 4/2018 |
| Quality Committee | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

TITLE: FY- 18 Utility Management Plan
CATEGORY: Safety – Environment of Care
LAST APPROVAL: New

TYPE: ☐ Policy ☐ Protocol ☐ Scope of Service/ADT
☐ Procedure ☒ Plan ☐ Standardized Process/Procedure
OFFICE OF ORIGIN: Safety and Security Services
ORIGINAL DATE:

I. COVERAGE:

This Security Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

II. PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, secure, accessible and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients, members, employees, physicians and visitors.

To that end, it is the overall intent of this plan to establish the framework, organization and processes for the development, implementation, maintenance and continuous improvement of a comprehensive Utility Management Program. The program objectives include:

- Promoting a safe, controlled, and comfortable environment
- Ensuring operational reliability of utility systems
- Reducing the potential for healthcare organization-acquired illness to be transmitted through the utility systems
- Assessing the reliability of utility systems and minimizing potential risks of utility system failures.

A. Goals:

Based on areas of improvement noted in the FY-17 Annual Evaluation, the performance improvement indicators for FY-18 will be:

1. Staff are able to locate red/orange outlets and describe their purpose
2. Staff are aware of the locations of the negative pressure, airborne isolation rooms
3. Staff can describe the proper way to store oxygen cylinders

B. Objectives:

Specific objectives of the FY-18 Utility Management Plan include the following:

1. Installation of new chiller in Mountain View
2. Complete the Operating Room electrical distribution upgrades in Los Gatos
3. Update battery replacement cycles for UPS systems to three years cycles

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4. Upgrade Mountain View boiler exhaust to accommodate source testing process
5. Upgrade pneumatic tube system controls in Mountain View

III. SCOPE AND APPLICATION:

- A. This plan applies to utility systems, components and the uses thereof, for the purposes of providing:
 - Environmental control/comfort ventilation
 - Mechanical ventilation for the purposes of infection/exposure control
 - Life support
 - Support to the diagnostic and therapeutic environments
 - Communication systems
 - Support to other critical processes and equipment
- B. The items, processes and critical functions addressed in this plan include, but are not limited to the following:
 - Heating, Ventilation and Air Conditioning (HVAC);
 - Electrical distribution and emergency power;
 - Vertical transport;
 - Domestic Water and plumbing;
 - Boiler/steam;
 - Medical gases (Oxygen, Medical Air, Nitrous Oxide, Nitrogen, Vacuum); and
 - Communications (Phones, Nurse Call systems, Public Address).

IV. REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC .02.05.01, .02.05.03, .02.05.05, .02.05.07, .02.05.09, (lighting and ventilation), .02.06.01
2. California Code of Regulations, Title 22, Sections 70837, 70841, 70849, 70851, 70853, 70855;
3. California Code of Regulations, Title 24 (UMC), Sections 330, 412, 413;
4. California Code of Regulations, Title 8, Sections 5141, 5142, 5143, and 5154.

V. AUTHORITY

The authority and responsibility for program strategic design, and the operational oversight has been assigned to the Facilities Director. Program implementation and day-to-day operational management has been delegated to the Chief Engineer under the authority of the Chief Administrative Officer (CAO).

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The Chief Engineer works in concert with the Environmental Health and Safety (EH&S) Manager, and the Central Safety Committee to ensure the Utility Systems Management Program is in alignment with the direction of the comprehensive EOC program.

VI. PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. Leadership Team:

The El Camino Hospital Leadership Team (i.e. the organization's governing body) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of business fundamentals relative to environmental health and safety.

B. Facilities Engineering and Safety/Security Department

Facilities Engineering and the Safety/Security department have been given the responsibility for the design, implementation and oversight of the Utility Systems Management Program. These responsibilities include:

- Coordination of the initial and ongoing risk assessments
- Development of written plans and operating procedures
- Identifying training needs
- Providing technical consultation and assistance with utilities end users, and emergency response training
- Planning for and organizing initial response to utility failures
- Investigation and reporting of related incidents and significant events
- Evaluating overall program efficacy and performance

C. Environmental, Health & Safety Manager, Clinical Laboratory, Chief Engineer

The EH&S Manager works together with the Laboratory Departments and Chief Engineer to assess life safety issues and fire hazards within the Pathology and Clinical Laboratories, and ensure that these hazards are addressed through appropriate procedures, processes, and systems.

D. Central Safety Committee

The Central Safety Committee (CSC) ensures the utility management program remains in alignment with the core values, direction and goals of the organization by providing leadership, determining priority and assessing the need for changes to the program. The CSC acts as a clearinghouse for action items, recommendations, leveraging issues and the development of program requirements and improvements.

The Central Safety Committee meets regularly and as part of the standing agenda, receives and reviews reports and summaries of action taken relative to Fire Prevention Management on a quarterly basis. Agenda items include:

- Issues requiring action, recommendations or approval;

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- Issues requiring monitoring/periodic or ongoing review; and
- Needs that are multi-disciplinary in nature.

E. Employees

Employees are responsible for participating in utilities training and demonstrating core competencies relative to safe, effective utility systems operations pertinent to their department. Employees must ensure their work practices, operations, and behaviors are safe, and in accordance with departmental procedures, the provisions of this plan, sound infection control principles, hygiene practices and clinical judgment.

Applicable employees are also responsible for knowing the locations of the shut off apparatus for critical utility system components, the proper use, capabilities and limitations of utility systems, and procedures for failures and outages.

VII. RISK ASSESSMENT

The risks associated with the management of Utility Systems are assessed and controlled through the following facility-wide processes:

- Ongoing Utilities management/Quality Control methods and protocols, including those designed to address user errors and system failures;
- Incident Report review/evaluation through the Quality Review Report (QRR) and Central Safety Committee;
- Identifying and mapping the layout of utility systems, and taking inventory of operating components, relative to their impact on critical systems and potential risks associated with system failure;
- Dust Control risk assessments through Infection Control
- Monitoring of ILSM and Methods of Procedures (MOP'S) during construction projects and planned utility shutdowns.
- Environmental rounds and hazard surveillance surveys;
- Communications with end users of utility systems; and
- Results of education and training skills assessments.

The profile of potential physical risks with respect to utilities management includes, patient impact/adverse outcomes, occupational hazards (electrical, mechanical, etc.), and compromised system function/integrity.

Risks are evaluated and controlled through the review of risk management/incident reports, examination and analysis of pertinent data through the QRR, and the response to and correction of utility failures, systemic issues and user errors.

VIII. PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

The following describes the implementation of El Camino Hospitals utility management program:

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- A. The establishment of criteria for identifying, evaluating and taking inventory of critical operating components for inclusion in the utility management system. The basic criteria for designating systems that will be included in the management program are established through collaborative efforts between both Mountain View and Los Gatos campuses. This process begins with the identification of systems that are involved with sustaining a safe, homogenous environment within the facility. These criteria also address utility systems with impact on

- Life safety systems;
- Infection Control systems;
- Environmental support systems;
- Equipment support systems; and
- Communication systems

Specific systems addressed in this maintenance plan include:

- HVAC systems (e.g. comfort ventilation, general dilution and local exhaust ventilation, temperature and relative humidity, air balance and pressure relationships, Indoor Environmental Quality (IEQ))
- Medical vacuum, air, oxygen, nitrogen and nitrous oxide
- Electrical distribution
- Emergency Power/UPS
- Boiler/steam systems
- Water distribution
- Waste water, drains and vents
- Nurse Call
- Overhead page
- Vertical lifts

- B. Inspection, testing and maintaining critical operating components falls under the purview of the Engineering Department. For utility components that meet the above criteria, an equipment file form is completed. Each component included in the program is assigned a unique identification number. From there, it is included within scheduled preventive maintenance and testing activities, as indicated. Specific written procedures (instruction sets) are designed for utility inspection, testing and maintenance (**EC.02.05.01, .02.05.03**)

1. All critical components of the facility's Piped Medical Gas system are inspected, maintained and tested through the engineering department. The general and routine inspection and maintenance of medical gas systems include:

- Visual inspections performed daily to monitor medical gas levels by Engineering. Engineers log and respond to any system alarms;
- Signaling panels and area alarm devices, inspected periodically by Engineering;
- Valves, pressure switches connectors and end-user service outlets, inspection by Engineering;

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- Cross connection testing, purity testing and pressure testing will be coordinated through Engineering whenever the system is modified, repaired or otherwise breached, or at least annually (**22 CCR 70849**). Testing will be conducted in accordance with NFPA 99, section 4-5.
2. As part of the internal system to periodically verify the reliability of the Emergency Power Supply System (EPSS), monthly tests of the emergency generators and transfer switches for 30 continuous minutes are conducted under load by Engineering once per month. Each month, each generator will be exercised for at least 30 continuous minutes under a dynamic load that is at least 30% of the nameplate rating. If this requirement cannot be met, the following conditions shall be implemented (See below). (**EC.02.05.01**)
 - a. As an additional proactive measure to better ensure adequate exercising of the engines and to ensure the requirements for wet stacking are met: A “load bank” test will be performed to test each generator with a graduated process of supplemental loads, in accordance with the Joint Commission standard annually on any engine not under a load of 30% or more during each monthly test. Every 36 months a four hour load bank test will be performed per the prescribed requirements.
 - b. These generator tests are documented and any discovered problem of deficiency is promptly addressed, reported through the safety function, as needed and tracked where applicable to overall system performance metrics. (**EC.02.05.01**)
 3. The Engineering Department implements procedures to effectively reduce the risk of organizational-acquired illnesses through the control of biological agents in water sources. (Such as cooling towers) and other aerosolized water systems as indicated. (**EC.02.05.01**)

This aspect of the utilities program is fashioned after applicable portions of existing standards for the environmental control of *Legionella*. Effective *Legionella* control measures will also impact the colonization and proliferation of other water borne pathogens.
 4. Mechanical ventilation systems designed for optimal control of airborne contaminants are maintained through Engineering.
 5. General air balancing and verification are conducted by Facilities Engineering. Engineering ensures the maintenance and verification of specific air pressure relationships and air exchange ratios, through routine systems maintenance and corrective actions. These specified conditions will be maintained to meet established standards for
 - Negative pressure isolation rooms
 - Positive pressure rooms
 - Atmospheric isolation relative to preventing the transmission of TB
 - Required pressure relationships for certain health facility areas

Additionally Engineering periodically ensures the verification and efficacy of:

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- Dilution air ventilation to limit the concentration of potential airborne contaminants
 - Air flow patterns within a room (such as laminar flow in the OR)
 - Proper Air flow direction (such as “clean” to “soiled” in Central Processing)
 - Filters
- C. The Engineering Department has developed a Building Maintenance Program to address routine maintenance and inspection of site utility systems. In accordance with this program, Preventive Maintenance/Inspection schedules and instruction sets, P.M. completion rates, system reliability and functionality is ensured and relative risks controlled through routine preventive maintenance, testing and the identification and correction of deficiencies. **(EC.02.05.01)**
- D. Mapping the Layout of Utility Systems and Labeling Controls - A complete set of current mechanical drawings of utility systems are maintained in the Engineering Department, to help ensure system reliability, reduce failures and provide for effective response. The Engineers ensure system controls are consistently marked throughout the facility to ensure appropriate recognition for partial or complete emergency shutdown. Examples include valve tags, labeling of shut-off valves, numbering air handlers, distribution/disconnect panels and mechanical equipment, marking of overhead pipes, etc. **(EC.02.05.01)**
- E. Utility system problems, failures and user errors are investigated through Engineering. Each event as well as the corrective actions implemented is documented and reviewed by the Chief Engineer. From this process, training needs, significant events, true leveraging issues and information pertinent to the department’s given performance dimensions are collected and communicated to the Central Safety Committee, as needed. **(EC.02.05.01)**
- F. Education and Training for end users of utilities is provided through the individual department manager.

Training programs address the following:

- System capabilities, limitations and applications;
- Emergency procedures in the event of failure;
- Information needed to perform assigned maintenance duties;
- Location and instructions for emergency shut-off controls;
- Processes for reporting problems, failures or errors

Technical consultative support is provided through the Engineering Department.

IX. PERFORMANCE

The standards and metrics by which Utility Management performance will be measured are based upon organizational experiences, customer expectations/satisfaction, regulatory requirements, discerned risks, Central Safety Committee and Quality Committee recommendations, and/or observed work practices and behaviors.

A. Performance Standard

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Based on opportunities for improvement identified in the FY-17 EOC Annual Evaluation the FY-18 Performance Improvement Indicators are as follows:

| EOC Area | Indicator | Responsible Dept./Function | Target |
|-----------------|---|--|--------|
| Utility Systems | Staff able to locate red plugs outlets and describe their purpose | Engineering & Department Managers | > 90% |
| Utility Systems | Staff know the locations of the isolation rooms | Engineering EH&S & Department Managers | >90% |
| Utility Systems | Staff can describe the proper way to store oxygen cylinders | Engineering EH&S & Department Managers | >90% |

B. Process and Frequency of Measurement

Progress for this project will be reported out quarterly at the Central Safety Committee. Data will be collected during Hazard Surveillance rounds and Engineering Life Safety rounds.

X. PROGRAM EFFECTIVENESS

The effectiveness of the utility management program includes the appropriateness of the program design, training, maintaining systems integrity, failures, emergency generator testing and performance and other pertinent issues will be monitored and assessed on an ongoing basis.

Relevant incident reports, failures and concurrent and retrospective data relative to the management of Utility Systems will be gathered and tracked through Engineering and the Central Safety Committee. The Central Safety Committee will receive periodic reports and give approvals or make recommendations, as indicated. Substance of reports includes, but is not limited to:

- Summaries of monitoring results relative to established Utility Systems Management performance dimensions and standards, including emergency power system performance levels and preventative maintenance; and
- Reports of system failures or sentinel events, issues, investigation and follow-up.

XI. ANNUAL PROGRAM EVALUATION

On an annual basis, the Utility Systems Management Plan/Program is evaluated relative to its **objectives, scope, effectiveness and performance**. This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

- The continued appropriateness and relevance of program objectives, as well as whether or not these objectives were met.
- The Scope of the program, relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.

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- The extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given scope and objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The performance dimensions, to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Utility Management Work Group | 3/2018 |
| Central Safety Committee: | 3/2018 |
| ePolicy Committee: | 4/2018 |
| Quality Committee | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

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| TITLE: | FY- 18 Emergency Operations Plan |
| CATEGORY: | Emergency Management |
| LAST APPROVAL: | New |

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| TYPE: | <input type="checkbox"/> Policy <input type="checkbox"/> Protocol <input type="checkbox"/> Scope of Service/ADT <input type="checkbox"/> Procedure <input checked="" type="checkbox"/> Plan <input type="checkbox"/> Standardized Process/Procedure |
| SUB-CATEGORY: | Emergency Operations Plan |
| OFFICE OF ORIGIN: | Emergency Management |
| ORIGINAL DATE: | |

I. COVERAGE:

This Emergency Operations Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

II. PURPOSE:

This Emergency Operations Plan at El Camino Hospital describes how the organization ensures effective response to disasters or emergencies affecting the safe operation of the hospital. The Emergency Management Committee implements processes for developing, implementing and monitoring the Emergency Management Plan.

III. POLICY STATEMENT:

The Plan describes a comprehensive “all hazards” command system for coordinating the six critical areas: communications, resources and assets, safety and security, staffing, utilities, and clinical activities. The overall response procedures include single emergencies that can temporarily affect demand for services, along with multiple emergencies that can occur concurrently or sequentially that can adversely impact patient safety and the ability to provide care, treatment, and services for an extended length of time.

El Camino Hospital has established the necessary policies and procedures to achieve preparedness and respond to and recovery from an incident. These current plans and procedures are exercised and reviewed to determine and measure functional capability. The Emergency Operations Plan complies with the National Incident Management System (NIMS) components.

IV. RESPONSIBILITIES:

A. Leadership

The hospital’s leaders are involved in the planning activities and the development of the Emergency Operations Plan. The administrators, and department heads are represented in the Emergency Management Committee.

B. Emergency Program Management

The Hospital Safety Officer provides overall support to the hospital’s preparedness efforts, including developing needed procedures, coordinating production or revision of the

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Emergency Operations Plan, planning and executing training and exercises, and coordinating the critiquing of the events and preparing the After Action Reports (AAR).

C. The Emergency Management Committee

The Emergency Management Committee is a group of multidisciplinary hospital representatives, including leadership, clinical and non-clinical representatives from key departments.

The committee meets regularly. The chairperson sets each meeting's agenda and facilitates the committee's work to achieve an annually established set of objectives. Subcommittees or task groups are appointed to accomplish identified projects or to plan training and exercises. Minutes of each meeting are published and available to for review by hospital.

D. Hospital Incident Command System

The hospital utilizes the Hospital Incident Command System (HICS) to manage and direct hospital operations during incidents that could impact hospital operations. Information on HICS and its utilization are available in the Emergency Management Policies and Procedures located online ([Emergency Operations Plan](#))

V. PLANNING

A. Hazard Vulnerability Analysis

Hazard Vulnerability Assessments (HVAs) are conducted annually at each hospital campus to identify the potential emergencies that could affect the ability of the organization to provide normal services. This assessment identifies the likelihood of those events occurring and the consequences of those events. The assessment provides a realistic understanding of the vulnerabilities and to help focus the resources and planning efforts.

The HVA's of other area hospitals and healthcare agencies are shared and summarized to help develop a list of priorities on a county-wide basis. This summary is updated annually.

B. Community Involvement

A strong relationship has been established between other hospitals and agencies within Santa Clara County. The combined group meets regularly to share information and resources and to work together to identify and meet the needs and vulnerabilities of each facility.

C. Mitigation & Preparedness

Specific emergency response plans have been established to address needs based on priorities from the HVA. Each plan addresses the four phases of emergency management activities:

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1. Mitigation: Activities designed to reduce the risk of and potential damage due to an emergency (i.e., the installation of stand-by or redundant equipment, training).
2. Preparedness: Activities that organize and mobilize essential resources (i.e., plan-writing, employee education, preparation with outside agencies, acquiring and maintaining critical supplies).
3. Response: Activities the hospital undertakes to respond to disruptive events. The actions are designed with strategies and actions to be activated during the emergency (i.e., control, warnings, and evacuations).
4. Recovery: Activities the hospital undertakes to return the facility to complete business operations. Short-term actions assess damage and return vital life-support operations to minimum operating standards. The long-term focus should be on returning all hospital operations back to normal or an improved state of affairs.

D. Hospital Command Center

The Hospital Command Center (HCC) will be established according to procedures designated in HICS. See the following documents for additional information:

- [EM 1.13 – Hospital Incident Command Center \(HCC\)](#)
- [HICS Chart](#)
- [HICS Position Mission Statements](#)

E. Inventory & Monitoring of Assets & Resources

The resources and assets that are available on-site and/or elsewhere to respond to an emergency are maintained and inventoried. This includes, but is not limited to the following assets and resources: as:

- Food
- Fuel
- Medical supplies
- Medications
- Personal protective equipment (PPE)
- Water

The organization will establish threshold on resources quantities that trigger a resupply actions. These levels will be the Par Levels, a quantity at a midpoint between extremes on a scale of normal availability.

VI. **Emergency Operations Plans**

A. Response

A response procedure to an emergency can include the following:

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- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation.

1. HICS shall be activated as outlined in:
 - [EM 1.11 Administrative Authority to Activate and Terminate HICS](#)
 - [EM 1.11.01 Activating Code Triage.](#)
2. Staff respond to the emergency as outlined in [EM 1.05 Code Triage](#)

B. Sustainability

A process has been developed for determining the sustainability of the organization during an emergency. The end-point in planning for sustaining an emergency is 96-hours without the support of the local community. The planning on sustainability is coordinated with the Emergency Management Committee and the appropriate departments. The organization will continually monitor the availability and consumption rate of resources and assets to determine the length of time the organization can provide services. When necessary, the organization will adjust the consumption of the resources to extend the sustainability period. When it is determined the organization cannot provide services at an acceptable level of services, safety, and protection, a partial or total evacuation will be considered.

C. Recovery Procedures

The return to normal operations from an emergency will utilize the procedures outlined in [EM 1.11 Administrative Authority to Activate and Terminate HICS](#)

D. Incident Levels and Phases

1. **Emergency Response Level 1:** Potential Emergency - An unusual event or potential emergency effecting a single department of a single building area. The situation is an isolated incident. Life safety is not threatened and patients are not adversely affected.
2. **Emergency Response Level 2:** Localized Emergency - An emergency situation affecting multiple departments or buildings. Patients may be affected and life safety may be threatened.
3. **Emergency Response Level 3:** Major Disaster – A major disaster affecting buildings, utilities and patient care. Life safety may threatened. Code Triage is in effect. Multiple Casualty Incident (MCI) patients are arriving at hospital Emergency Department at a time when buildings and utilities are damaged or disrupted and personnel are affected.

An “All Clear” may be called while the recovery efforts continue until the hospital is back to normal operations.

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Details on the levels of incidents and phases are outlined in [EM 1.11 Administrative Authority to Activate and Terminate HICS](#).

E. Alternate Care Site

In a major emergency situation, there is a possibility that the buildings or spaces in which patient care is normally provided will be rendered unusable. In this event, an alternate care site will be designated as a location on the facility grounds or within the community. More information on the selection of Alternate Care Sites is available in [EM – Surge Plan - 03.00 Hospital Surge Capacity Plan – Alternate Care Sites](#).

VII. Communication Management

A. Internal Communication & Staff Notification

1. Staff shall be notified of an incident utilizing overhead pages through the Fire Alarm System (FAS) or through other methods as outlined in [EM 1.31 Communications Plan](#). This plan also includes back-up communications systems within the hospital.

B. Notification & Communication with External Authorities

When an emergency plan is initiated, the appropriate external authorities and community resources will be notified.

C. Communication with Patients & Family

1. A family support center may be established to coordinate the needs and information to family members of patients, to coordinate the information on the location of patients, and to provide critical incident stress debriefings.
2. These activities will be managed by the Logistics Section with the Support Branch and the Family Unit Leader.
3. There will be direct communication with the Patient Tracking Manager for tracking of patients.
4. If the emergency contact family member is not present with the patient, they will be contacted with the location of the patient once they are moved or evacuated.

D. Communication with Media

1. The Public Information Officer (PIO) is responsible for interacting with media and public information.
 - a. For internal events, the PIO will develop communications to staff and community with the authorization of the Incident Commander in the HCC>
 - b. If the event is external to the hospital, the county Joint Information Center (JIC) will coordinate with the PIO to develop a unified message.

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E. Communication with Suppliers

A list of suppliers, including vendors, contractors, and consultants that can provide specific services before, during, and after an emergency event is available in the Command Center. The list will be maintained by the individual that normally interacts with the purveyor. Where appropriate, Memoranda of Understandings (MOUs) are developed as needed to help facilitate services during the time of a community event.

F. Communication with other Healthcare Organizations

1. A working relationship has been established with other healthcare organizations within Santa Clara County. A Memorandum of Understanding (MOU) is in place to share resources as needed and available.
2. Key information to share with the other healthcare organizations includes:
 - a. Command systems & other command center information
 - b. Names & roles of command center system
 - c. Resources & assets to be potentially shared
 - d. Process for the dissemination of patient & deceased individual names for tracking purposes
 - e. Communication with third parties
3. Interagency communications is maintained through several channels:
 - Telephone
 - 2-Way Command Radio
 - EM-Resources – online hospital status reporting in real-time
 - WebEOC – web-based system for sharing status and requesting resources
 - Amateur Radio - volunteer radio operator system
4. Patient information that must be shared with the other healthcare organizations, local or state health departments, or other law enforcement authorities on the whereabouts on patients during an emergency will be transmitted in accordance with applicable laws and regulations.

G. Alternate Care Site Communications

The Command Center will maintain communications with the Alternate Care Site (ACS). Once an ACS has been established, the site will initiate contact with the HCC and may establish an Alternate Care Command Center (ACCC).

VIII. RESOURCE & ASSET MANAGEMENT

A. Obtaining & Replenishing Medical, Non-Medical & Medication Supplies

The amounts, locations, processes for obtaining and replenishing of medical and non-medical pharmaceutical supplies, are evaluated to determine how many hours the facility

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can sustain before replenishing. The inventory of resources and assets is the starting point of par levels.

Mutual Aid Agreements have been developed to expedite receipt of items when needed. The MOU Agreements references the agreement with the other healthcare organizations on response of assets.

B. Monitoring Resources and Assets

During the emergency, the Logistics Chief will monitor the overall quantities of assets and resources. This information will be communicated to the HCC and to those in the community.

IX. SECURITY & SAFETY MANAGEMENT

A. Managing Hazardous Waste

The hazardous waste generated after decontamination and during isolation procedures, including biological, chemical, and radioactive waste will be stored in the appropriate location and with sufficient security. This would also include the waste that would accumulate during an emergency, but not removed because of vendor issues. A list of alternate vendors will be maintained.

B. Biological, Radiological & Chemical Isolation & Decontamination

For contagious patients in need of isolation, consult the Infection Control guidelines located in the Infection Control Manual for isolation and standard precautions. For contaminated patients, Decontamination Procedures would be implemented.

C. Access & Egress Control

The facility “lock down” procedures will be implemented when deemed appropriate by the Incident Commander (IC) to provide the proper control of access and egress to the facility.

D. Traffic Control

The IC will initiate a Traffic Control Plan to manage the movement of personnel, vehicles, and patients both inside and on the grounds of the facility if deemed appropriate.

1. Security staff will assist in the movement of vehicles, including cars, and emergency and commercial vehicles, on the grounds.
2. When appropriate, local law enforcement will be contacted for assistance in the management of traffic on the grounds of facility.

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|-----------------------|----------------------------------|
| TITLE: | FY- 18 Emergency Operations Plan |
| CATEGORY: | Emergency Management |
| LAST APPROVAL: | New |

X. STAFF MANAGEMENT**A. Roles and Responsibilities**

When HICS is established, the HICS Chart and Job Action Sheets are used to assure critical task positions are filled first. As other staff members become available, they are assigned to the most critical jobs remaining.

If staff is not available for handling critical tasks defined by the Job Actions Sheets, staff will be drawn from the appropriate departments or, if none are available, from the labor pool.

As staff is called in, they will replace personnel on tasks they are better qualified to perform. If questions arise, the Section Leaders will determine who will perform the task. The tasks are evaluated frequently to assure the most appropriate staff members available are being used, burnout or incident stress problems are identified, and staff members in these jobs are rotated as soon as possible.

B. Managing Staff Support Activities

During activations of the Emergency Operation Plan (EOP), the following accommodations are authorized:

1. Where necessary because of conditions, the hospital will accommodate staff that need to sleep, eat, and/or other services in order to be at the hospital to provide needed services.
2. The Logistics Chief with the Service Branch Staff Food and Water Leader will handle the needs of staff during the emergency. The Logistics Chief is authorized to modify the normal use of hospital space and to work with local hotels and motels to provide accommodations for staff. Meal service for staff is authorized where approved by the Logistics Chief.
3. Preparation is made for incident stress debriefings. These areas will be staffed by Concern, the hospitals EAP and/or staff from community mental health services, clergy, and others trained in incident stress debriefing.
4. Communication to staff family members will also be arranged through the Staff Family Support Leader.

C. Managing Staff Family Support Activities

During activations of the EOP, the IC will determine if various accommodations may be made for staff's families to assist staff availability for providing their services.

D. Training and Identification of Staff

1. Training: The staff identified in the critical areas will receive the appropriate training in HICS and NIMS prior to an event.
2. Identification:
 - a. HICS identification apparel is issued to the appropriate roles in the HICS.

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| TITLE: | FY- 18 Emergency Operations Plan |
| CATEGORY: | Emergency Management |
| LAST APPROVAL: | New |

- b. Employees will wear their hospital identification badges at all times during the emergency.
- c. Additional identification will be distributed, as needed to all serving in specific roles during the emergency.

XI. MANAGING UTILITIES

During an emergency, alternate means will be provided for essential utility systems as identified in the plan. These utility systems are identified as well as alternate means for providing the services. The organization will assess the requirements needed to support these systems such as fuel, water, and supplies for a period of time identified. This assessment includes the requirements for 96 hours without community support.

The alternative utility systems and supplies networks shall include, but not be limited to the following:

- Emergency power supply system
- Water supplies for consumption and essential care activities
- Water supplies for equipment and sanitary usage
- Fuel supplies for building operations, generators, and essential transportation services
- Medical gas systems
- Ventilation systems, Vacuum systems and Steam
- Other essential utilities

XII. MANAGING PATIENT CLINICAL & SUPPORT ACTIVITIES

A. Clinical Activities

Clinical activities for the treatment of patients during an emergency include triage, scheduling, assessment, treatment, and discharge. Whenever possible, the routine policies for patient services will be utilized.

B. Evacuation Activities

An evacuation of the hospital for a situation, which renders the facility no longer capable of providing the necessary support patient care, treatment and services, will be directed by the IC. The evacuation will be handled in cooperation with local police, fire departments and county EMS agency.

C. Vulnerable Patients

The policy on the clinical services includes providing for treatment of special patients during an emergency includes pediatrics, geriatrics, and disabled. This may also include patients with serious chronic conditions such as mental health or addiction.

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|-----------------------|----------------------------------|
| TITLE: | FY- 18 Emergency Operations Plan |
| CATEGORY: | Emergency Management |
| LAST APPROVAL: | New |

D. Personal Hygiene and Sanitation Requirements

The HCC will determine appropriate alternative for personal hygiene. This can include baby wipes, personal wipes, or alcohol-based rubs. Family members can also assist to clean the patient during an event. If toilets are inoperable, bags in toilet, bucket brigade, other appropriate alternatives can be used.

E. Mental Health Services

During an emergency, mental health services will be provided to the patients when deemed necessary. Behavioral Health Services will track these patients receiving these services during the emergency.

F. Mortuary Services

In the event of deceased patients, the local medical examiner will be contacted for the appropriate clearance and procedures.

G. Patient Tracking: Internal & External

Patients will be tracked using current policies of the department. This includes discharge or transfer patient. That information will be given to the Patient Tracking Manager who will track all the patients within the facility during disaster. The form to use for patient tracking will be the HICS 254 – Disaster Victim Patient Tracking Form.

If patients are evacuated, the following HICS forms should be utilized:

- HICS 260 – Patient Evacuation Tracking Form, for individual patients.
- HICS 255 – Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated.

XIII. DISASTER PRIVILEGES

A. Volunteer Licensed Independent Practitioners (LIP)

Disaster privileges may be granted to volunteer licensed independent practitioners (LIP) when the EOP has been activated and the hospital is unable to meet immediate patient needs.

The Medical Staffing Office is responsible for granting disaster privileges to volunteer LIP and will distinguish volunteer LIP from other LIP's. Refer to Policy/Procedure: [Medical Staff-Privileging Licensed Independent Practitioners During Disaster Events](#).

B. Other Licensed Volunteers (non-LIP)

Disaster responsibilities may be assigned to volunteers that are licensed, certified and/or registered in a skilled healthcare position when the EOP has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

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|-----------------------|----------------------------------|
| TITLE: | FY- 18 Emergency Operations Plan |
| CATEGORY: | Emergency Management |
| LAST APPROVAL: | New |

The hospital identifies the individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not a LIP and will distinguish volunteer practitioners who are not LIP's from its staff. The hospital will oversee the performance of volunteer practitioners who are not LIPs who are assigned disaster responsibilities by direct observation, mentoring, or medical record review. Refer to Policy: [Emergency Management - 1.43 Volunteer Credentialing Policy For Use In Major Disaster](#).

XIV. EMERGENCY RESPONSE PLANS

Emergency Plans for the incident types listed below can be found in the Emergency Management section of the [Safety Tab](#) on the Toolbox.

- Closed Point of Dispensing (POD)
- Earthquake
- Hospital Evacuation / Shelter in Place
- Hospital Surge
- Mass Fatality
- Pandemic

Additional plans and procedures are available through Facilities, Nutrition Services and Material Management.

XV. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|--|-----------------------|
| Emergency Management Committee: | 3/2018 |
| Central Safety Committee: | 3/2018 |
| Policy Committee: | 4/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

SCOPE OF SERVICE

Palliative Care Services - Enterprise

Types and Ages of Patient Served

Patients living with a life limiting illness

Assessment Methods

Palliative Care services are provided by an interdisciplinary team: physician, nurse practitioner, nurse, social worker, and chaplain. Patients are referred, if desired, to outpatient services that align with their physical needs and goals of care.

Scope and Complexity

Palliative Care is consulted by the primary team at any stage of patient illness trajectory. The National Consensus Project defines palliative care as: “Palliative Care means patient-and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs to facilitate patient autonomy, access to information and choice”. Patient populations include, but not limited to those with diagnosis of Cancer, Congestive Heart Failure, Respiratory Failure, Renal Failure, and Stroke.

Appropriateness, Necessity and Timeliness of Services

The primary team consults the palliative care team when additional support is needed in providing care to the patient and family. The referred cases are reviewed by the team, and assigned to a member of the team to reach out to physicians to determine how our team may be of support. A collaborative approach is utilized in working with the physicians, the patients and their families. The goal is to initiate contact with patient and families within twenty-four hours of consult order (M-F).

Staffing

Palliative Care is provided to patients in Mountain View and Los Gatos, Monday through Friday except holidays, to inpatients. The Palliative Care Team is comprised a physician, nurse practitioner, pharmacist, nurse, social worker and chaplain.

Level of Service Provided

The level of service provided is determined by the patient’s goals, physical needs and the plan of care moving forward. This is an inpatient service though recommendations for outpatient referrals are a component of advanced care planning.

Standard of Practice

Palliative Care is aligned with standards of the American Academy of Hospice and Palliative Medicine. Practice manual for team is: Primer of Palliative Care, published through AAHPM.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2017 |
| Medical Committee : | |
| ePolicy Committee: | 2/2017 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | |



SCOPE OF SERVICE

Medical, Surgical, Orthopedics - **LOS GATOS**

Types and Ages of Patient Served

Medical Surgical Services provides services to patients from adolescence to geriatric as defined in the department's admission criteria. The primary patient population served consists of inpatients with a wide array of medical conditions and provision for services to outpatient medical-surgical cases and surgical inpatient overflow.

Assessment Methods

Nursing care is provided by a registered nurse utilizing the nursing process. Registered nurses provide direct supervision to clinical support caregivers (certified nursing assistants – CNAs) in the provision of patient care.

~~The staff participates in performance improvement processes relating to patient care delivery as well as patient/customer satisfaction in general.~~

Scope and Complexity of Services Offered

Medical Surgical **Orthopedic** Services provides 24-hour nursing care to:

a. Medical, surgical, orthopedic, neurologic and telemetry monitored patients

b. Procedural inpatients & out patients

~~-predominantly to patients with acute medical surgical and orthopedic conditions. Medical Surgical Orthopedics is divided into 2 units 26 on Medical 1 and 16 on Orthopedic Spine and provides comprehensive nursing care to acutely ill patients. Outpatient services include, but are not limited to blood transfusions, and paracentesis with albumin replacement. Overflow surgical patients (due to lack of bed availability on Surgical Nursing Services) are also included in the patients served. A wide variety of medical disorders are treated, including oncological, respiratory, end stage renal, gastrointestinal and neurological conditions. Patients requiring cardiac monitoring will be monitored by staff in the ICU.~~

Care is given as directed and prescribed by the physician. All non-nursing orders are communicated to the appropriate ancillary departments via the computerized Electronic **Medical Health Records**. Staff communicates specific patient needs and coordinate treatment and plan of care with all ancillary departments. The discharge planning process is initiated on admission, in collaboration with the physician(s), care coordinators/social workers, and patient and family/home caregivers. Multidisciplinary patient care rounds are conducted ~~weekly~~ daily that ~~which~~ includes formal review and revision of the plan of care.

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager and shift charge nurses assess the appropriateness, necessity and timeliness of service. The appropriateness of services is addressed in "Patient Care Services Policies ~~and & Services Procedures~~" which are established in collaboration with the medical

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Scope of Service – Medical – Orthopedic – Spine & Surgical Services – Los Gatos
Page 2 of 3

staff.

~~A performance improvement process is in place to identify opportunities for improvement in patient care processes. These processes are measured for compliance on an on-going basis.~~

Patient's progress is evaluated by physician(s), nurses, members of other health disciplines as well as by the patient and family.

Staffing/Staff Mix

~~A~~ The Clinical Manager oversees the operations of Medical/Surgical/Orthopedic Services on a 24-hour basis and reports to the Director of ~~Emergency Services/Inpatient Services~~ Nursing Services.

~~A Charge Nurse is assigned according to the Unit Matrix and needs of the Units. The Unit Matrix is reviewed annually. The Charge Nurse coordinates shift activities and staffing. RNs provide direct care with the assistance of CNAs. Patients are transported to and from the unit by transport personnel. A charge nurse is assigned and s~~Staffing is ~~predicted~~ determined based on a ~~baseline~~ hours per patient day (HPPD) and adjusted according to the nursing intensity measurement system (NIMS), a patient classification system. The charge RN for each shift determines prospective staffing needs based on NIMS and individual patient care needs.

The competency of the staff is evaluated ~~annually, through observation of performance and skills competency validation.~~ Staff education and training is provided to ~~meet and validate assist in the achievement of~~ performance standards.

Other clinical and support staff providing services to patients in this area include:

- X ~~Parenteral therapy RNs~~
- X ~~Enterostomal therapist~~
- ~~Wound/Ostomy RN~~
- X ~~Respiratory therapists~~
- X ~~Laboratory technicians~~
- X ~~Clinical pharmacists~~
- X ~~Diabetes specialist~~
- X ~~Care coordinators~~
- X ~~Medical social workers~~

~~The Clinical Nurse Specialist (CNS) supports patient care through collaborative practice with the clinical nursing staff and consultation. The CNS facilitates meetings and provides staff education and acts as a resource and educator in the area of pain management (acute and chronic) for the nursing staff.~~

Requirements for Staff

- All staff must complete orientation as specified in the department specific orientation module.

Scope of Service – Medical – Orthopedic – Spine & Surgical Services – Los Gatos
Page 3 of 3

- The Heath Stream ~~modules are safety series as well as Safety/Emergency binders are~~ reviewed annually by all staff.
- All staff are required to be B~~E~~LS certified.
- ~~All RN's caring for Telemetry patients~~ are required to have ACLS.
- RNs must have a current California license and CNAs must be currently certified by the State of California.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff. The department is designed to meet the level of care needs of the patient.

~~Performance assessment and improvement processes are evaluated through performance improvement activities in conjunction with the multidisciplinary health care professionals who provide services to the unit.~~

Standards of Practice

Medical Services is governed by state regulations as outlined in Title 22 and standards established by The Joint Commission. Additional practices are described in the Patient Care Services Policies ~~and &~~ Procedures and Clinical Practice Standards.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| LG P&P Workgroup: | 2/2018 |
| ePolicy Committee: | 4/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

TITLE: ADT Medical Surgical Orthopedics - LG

CATEGORY: Patient Care Services

LAST APPROVAL: 2/2011

TYPE:

- ☐ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized
☐ Procedure ☐ Plan ☒ Scope of Service/ADT Procedure

SUB-CATEGORY: Patient Care Services

OFFICE OF ORIGIN: Policy & Procedure Workgroup LG

ORIGINAL DATE: 7/2009

I. **COVERAGE:** Medical / Surgical / Orthopedic Department (M/S/O)

II. **PURPOSE:**

- To establish criteria for the admission, transfer and discharge of Medical-Surgical, Orthopedic and Telemetry monitored patients.
- To define patient populations of Medical, Surgical and Orthopedics which are appropriate for Telemetry monitoring.
- To identify exclusion criteria.

III. **POLICY STATEMENT:**

Patient admissions, discharges and transfers to/from Medical-Surgical and Orthopedic units will be in accordance with the established admission, discharge and transfer criteria.

IV. **PROCEDURE:**

A. Admission to Medical-Surgical and Orthopedics for Telemetry Monitoring

1. All patient admissions will be approved for appropriateness by the Assistant Hospital Manager, Department Manager or designee in collaboration with the admitting physician.
2. All patient transfers received from other acute care hospitals are reviewed and pre-approved by Care Coordination or the Assistant Hospital Manager. All patient transfers to other care facilities will require a physician order, acceptance by the receiving physician, and will be coordinated by the Assistant Hospital Manager or Care Coordination
3. All patients requiring Telemetry must have parameters ordered by the physician

B. Inclusion Criteria for M/S/O with Telemetry Monitoring:

1. New onset stable atrial fibrillation and asymptomatic (by history) arrhythmias.
2. Stable post MI not requiring IV vasoactive medications.
3. Stable acute MI or unstable angina.
4. Syncope of unknown cause.
5. Post electrical Cardioversion, two (2) hours telemetry monitoring.
6. Angina relieved by nitrates.
7. Stable orthopedic, post-surgical and medical patients requiring telemetry monitoring.
8. Acute Stroke / TIA patients.
9. Adolescent patients age 13 and older and weighing greater than 36 kilograms.

TITLE: ADT Medical Surgical Orthopedics - LG

CATEGORY: Patient Care Services

LAST APPROVAL: 2/2011

- C. Exclusion Criteria
 - 1. Hemodynamically unstable patients
- D. Transfer Criteria to Higher Level of Care
 - 1. Patients requiring initiation of IV drugs or drips, and / or requiring increased frequency of intervention and assessment shall be transferred to ICU.
- E. Admission Criteria to Orthopedic Pavilion
 - 1. Joint replacement, spine surgery, neuro and general orthopedic patients.
 - 2. Orthopedic, neuro and spine surgery patients requiring telemetry monitoring.
 - 3. Overflow surgical patients.
 - 4. Overflow medical patients as appropriate (upon review and approval by Manager/designee).
 - 5. MRSA colonized patients.
- F. Exclusion Criteria to Orthopedic Pavilion
 - 1. Patient with active infections.
 - 2. Infections requiring Isolation other than MRSA colonizations.
 - 3. Fractures with multiple medical co-morbidities.
- G. Discharge Criteria to Home, Rehab, Extended Care Facility
 - 1. Patients who no longer qualify for acute care.
 - 2. Patients who have met their functional mobility goals.
 - 3. Patients who can manage their self- care needs, or have a caregiver for assistance.

V. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| UPC Committee | 12/2017 |
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | |

SCOPE OF SERVICE

Clinical Nursing Education Department

Types and Ages of Clients Served

The Clinical Nursing Education Department provides services to all El Camino Hospital employees with a focus on Patient Care Services employees..

Scope and Complexity of Services Offered

The Clinical Nursing Education Department provides a competency based nursing orientation, training, and administrative support to assess and ensure staff competency and encourage and promote professional growth. Services provided include, but are not limited to:

- Nursing orientation for new employees, contracted and temporary staff.
- Clinical support on all shifts for patient care services employees; development of critical thinking; assessment of performance problems and development of action plans for correction.
- Annual training and review on topics as required by regulatory and accrediting organizations and state and federal law, such as point of care testing.
- Continuing education classes.
- Managing nursing practicum experiences, liaison between school and the enterprise
- Tracking of attendance at on-site continuing education. Assistance with locating, scheduling and registering for the above classes.
- Serving as an educational resource to staff and patients.
- Instructional design
- Consulting with managers and staff to best decide the focus and implementation of education.

Staffing

The staff providing services includes: general clinical educators and unit based clinical educators. A director provides operational oversight. Additional instructors may be contracted as needed.

Level of Service Provided

The Clinical Nursing Education Department provides services under hospital policy and procedure guidelines.

Standard of Practice

The Clinical Nursing Education Department is governed by state and federal regulations, Department of Health Services and Joint Commission requirements, and national boards of certification for specialty nurses.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 8/2015 |

SCOPE OF SERVICE

Patient Care Resources (PCR) (MV)

Types and Ages of Clients Served

The Patient Care Resources Department (PCR) provides supplemental clinical staff of various skill levels through our Resource/Float Pool on the Mountain View Campus. The Adult Patient Population is the target of the supplemental clinical staff. PCR also provides staffing and scheduling services and data base management plus travelers procurement through the Mountain View campus Staffing Office to both Los Gatos and Mountain View.

PCR is also responsible for patient rescuing and staff education through the Rapid Response Team Program that covers first responding for stroke alert, sepsis alerts, and cardiac alerts (non STEMI cardiac alerts) which provides patient clinical assessment and treatment by the PCR critical care trained Flex Nurses. PCR staff are responders for the Code Help Program on the Mountain View Campus. {PCR Rapid Response Nurses will serve adult staff members and hospital guests in an emergency situation.}

PCR's Assistant Hospital Manager/Hospital Supervisors provide clinical and administrative leadership to El Camino Hospital, Mountain View campus, including inpatient and open outpatient services through the organization as well as maternity/nursery/NICU, the emergency department, and the Hospital as a whole for 24 hours per day 7 days per week. In addition, the department Staffing Office personnel provide mortuary assistance to families of deceased patients and liaison services between Mountain View Nursing Staff and the Coroner or Public Guardian's Office of San Mateo County.

The Director of Patient Care Resources (PCR) oversees all areas and services of Patient Care Resources Department and the Staffing Office on a 24-hour basis, 7 day a week basis, and reports to the Chief Nursing Officer. in the Patient Care Services Division.

The management responsibility of the Director of PCR includes Assistant Hospital Manager-nursing/-Hospital Supervisors, RNs, LVNs, CNAs, Staffing Office personnel as well as Patient Observers and flexes/rapid response nurses. The Director of Patient Care Resources establishes the skill/competency level and assignment of staff is based on overall patient and hospital needs and those staff competencies.

The PCR Nurse Educator assures that the competency of the staff is evaluated through observation of performance and skills competency validation by staff on their assigned units. Staff education and training is provided to assist in achieving performance expectation standards.

The Director of the Department assumes project leadership to special task forces and/or performance improvement teams as assigned by nursing senior leadership.

Scope and Complexity of Services Offered

Patient Care Resources consists of the following areas/services:

- **E-Time (Electronic Software)Scheduling and Staffing Services Development, Training, Implementation and Maintenance**

The Staffing Office is an enterprise department which provides services to both the Mountain View site and the Los Gatos site. Those enterprise services cover use of the electronic scheduling system, its development, staff training and implementation of clinical and nonclinical individual department across the full organization. ~~The Staffing Office manages the travelers' recruitment program for Mountain View and Los Gatos.~~ Staffing Office oversight is provided by a full-time Supervisor of Staffing and Scheduling Services. A combination of full and part-time administrative support staff provide daily staffing operational support.

- **Staffing at the Mountain View Campus**

The Staffing Office coordinates the staffing functions of most inpatient nursing units and the Emergency Department at the Mountain View site, assists nursing units in managing their staffing schedules through the use of the electronic staffing and scheduling software. The Staffing Office also assists nursing units in the recruitment of additional staff, supplies supplemental nursing staff using the Resource/Float Pool and designated outside agencies and provides scheduling support to designated departments. The Staffing Office also maintains records of per diem agency staff. The Supervisor of Staffing and Scheduling Services oversees the registry program. ~~as well as the attainment program for traveling nurses for key nursing service areas.~~ Staffing Office personnel assist families of deceased patients by facilitating the release of the remains. Staffing Office is open daily from 0430 to 2330. Staffing office is managed by the Supervisor of Staffing and Scheduling Services and who also attends to various projects assigned by her manager or nursing leadership. The Supervisor of the Staffing and Scheduling Services directly reports to the Director of Patient Care Resources.

- **Nursing Resource/Float Pool for Mountain View Campus**

Status'ed RNs, LVNs and Certified Nursing Assistants (CNAs) are scheduled each shift to provide supplemental staffing for patient care units as needed. Staff is deployed only to those clinical areas in which they have demonstrated competency and at this point there are nurses at PCR skill levels one through five. When assigned to a nursing unit for a shift, the Float Pool staff work under the direction of the charge nurse of that unit and shift. The PCR Nurse Educator is available Monday through Friday and has oversight of the orientation and competency programs for the resource/float pool. (S)he varies her/his work schedule so (s)he can assist with training needs of the resource/float pool RNs on all 3 shifts. (S)he also performs quality audits to insure resource/float pool RNs are

thoroughly evaluated in their role. The resource/float pool also provides patient care safety attendants and patient observers to nursing inpatient units. Float pool has CNAs available for all shifts to be supervised by the charge nurse on the placement unit. Hospital Supervisors are the clinical manager's designees for management of the resource/float pool staff on their assigned shift.

- **Flex Nurse/Rapid Response Team RNs at Mountain View**

The Flex Nurse/Rapid Response Nurse is a specially trained RN, who has advanced cardiac life support (ACLS) certification as well as other important competencies. The Flex Nurse/Rapid Response Nurse also responds to clinical staff nurses' concerns regarding the status of patients throughout the hospital either by individual call to the Flex Nurse or through call to the Rapid Response Team. (The Flex Nurse/Rapid Response Nurse is also one of the primary responders for the Stroke Alert Program, [Sepsis Alert Program](#) and to the cardiac alert program. (The Rapid Response Team Nurse takes the lead if the case is not a STEMI as identified by the Emergency Room Physician.)

The Flex Nurse/Rapid Response Nurse assists in any department to assess and intervene in the care of a critically ill patient. (S)he will monitor and assist in stabilizing critically ill patients and accompany them to an appropriate unit and may assist with unplanned treatments and procedures that require the specialized skills of the Flex Nurse. The Flex Nurse aids the [Assistant Hospital Manager](#)/Hospital Supervisor in the facilitating the flow of patients through the hospital so they are moved to the next level of care in an expedient manner. The Flex Nurse/Rapid Response Nurse works under the [Assistant Hospital Manager](#)/Hospital Supervisor of the particular shift during the 24 hours – 7 days a week operations, including all holidays. The Flex Nurse/Rapid Response Team Nurses are formally supervised by the Director of Patient Care Resources.

- **[Assistant Hospital Managers](#)/Hospital Supervisors at Mountain View**

An [Assistant Hospital Manager](#)/Hospital Supervisor is a senior registered nurse who provides overall clinical and administrative responsibility for the [Assistant Hospital Manager](#)/Hospital on all day, evening and night shifts including weekends and holidays. The [Assistant Hospital Manager](#)/Hospital Supervisor is a resource for staff for consultation with problem-solving and decision-making. The Hospital Supervisor, in collaboration with physicians, clinical managers and unit charge nurses, coordinates patient placement in the appropriate level of care. The [Assistant Hospital Manager](#)/Hospital Supervisor serves as the decision maker in the absence of the department's clinical manager or director. The [Assistant Hospital Manager](#)/Hospital Supervisor confers with the Administrator-on-call as necessary. The [Assistant Hospital Manager](#)/Hospital Supervisor reports to the Director of Patient Care Resources.

- **Other functions**

Patient Care Resources is responsible for ensuring the El Camino Hospital Patient Acuity System is validated annually or more frequently if warranted with the Director, Staffing and Scheduling Supervisor, and designated staff nurses from the nursing units to determine nursing care need, by patient category, and pattern of care delivery. The PCR Department monitors staffing variances and develops staff utilization and productivity reports. The Director of Patient Care Resources also provides management consultation to newer Clinical Managers and is assigned to lead special projects as assigned by the Chief Nursing Officer/ ~~Chief of Clinical Operations or the Vice President of Clinical Operations of the of Patient Care Services Division~~ such as, but not limited to, Operations Manager of the Rapid Response Program, The Director of Patient Care Resources serves as a mentor to other leaders in the organization on health care services and hospital operations management.

Level of Service Provided

The Patient Care Resources Department provides services under hospital and departmental policy and procedure guidelines and serves both campuses for specific services.

Standard of Practice

The Patient Care Resources Department is governed by state and federal regulations, as outlined in Title 22 and Joint Commission on Accreditation of Healthcare Organizations Standards. Additional practices are described in the Patient Care Services Policies and Procedures.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 12/2015 |

SCOPE OF SERVICE-~~LOS GATOS~~ **Patient Care Resources (PCR)**

Types and Ages of Clients Served

The Patient Care Resources Department (PCR) provides staffing and scheduling services through the Nursing Staffing Office, as well as supplemental clinical staff through the Float Pool. PCR is also responsible for patient rescuing and staff education through the Rapid Response Team Program which provides patient clinical assessment and treatment by the PCR critical care trained nurses. PCR's Assistant Hospital Manager/Hospital Supervisor provide clinical and administrative leadership to El Camino Hospital Los Gatos inpatient and open outpatient services through the organization as well as maternity/nursery/NICU, the emergency department, and the Hospital as a whole for 24 hours per day 7 days per week.

The Director assumes project leadership to special task forces and/or performance improvement teams as assigned by nursing senior leadership. In addition, the department handles arrangements for families of deceased patients.

Scope and Complexity of Services Offered

Patient Care Resources consists of the following areas:

- **Staffing Office**

Staffing Office coordinates the staffing functions of most inpatient nursing units and the Emergency Department, assists nursing units in managing their staffing schedules through the use of eTIME. The Staffing Office also assists nursing units in the recruitment of additional staff, supplies supplemental nursing staff using the Float Pool and designated outside agencies and provides scheduling support to designated departments. The Staffing Office also maintains records of per diem agency staff. ~~The Staffing Office Supervisor oversees the registry program as well as the attainment program for traveling nurses for key nursing service areas.~~ Staffing Office personnel assist families of deceased patients by facilitating the release of the remains. Staffing Office is open daily from 0430 to 2330. Staffing office is managed by the Staffing Office Supervisor who also attends to various projects assigned by her manager or nursing leadership. The Staffing Office Supervisor directly reports to the Director of Patient Care Resources.

- **Nursing Float Pool**

Status-ed RNs, LVNs and Certified Nursing Assistants (CNAs) & Patient Observers are scheduled each shift to provide supplemental staffing for patient care units as needed. Staff is deployed only to those clinical areas in which they have demonstrated competency and at this point there are nurses at PCR Levels One through Five. When assigned to a nursing unit for a shift, the Float Pool staff work under the direction of the charge nurse of that unit and shift. The Nurse Educator is available Monday through Friday and has oversight of the orientation and competency programs for the float pool.

(S)he self-schedules so she can be assist with training needs of the float pool RNs on all 3 shifts. She also performs quality audits to insure float pool RNs are thoroughly evaluated in their float pool role. The float pool also provides patient care safety attendants and or patient observers to inpatient nursing units. Float pool has CNAs available for all shifts to be supervised by the charge nurse on the placement unit, however, the night shift CNAs are supervised by the Hospital Supervisor.

- **Hospital Supervisors**

A Assistant Hospital Managers/-Hospital Supervisor is a senior registered nurse who provides overall clinical and -administrative responsibility for the Hospital on all shifts and weekends and holidays. The Assistant Hospital Manager/Hospital Supervisor is a resource for staff for consultation with problem-solving and decision-making. The Assistant Hospital Manager/Hospital Supervisor, in collaboration with physicians, clinical managers and unit charge nurses, coordinates patient placement in the appropriate level of care. The Assistant Hospital Manager/Hospital Supervisor serves as the decision maker in the absence of the department's clinical manager or director. The Assistant Hospital Manager/Hospital Supervisor confers with the Administrator-on-call as necessary. The Assistant Hospital Manager/Hospital Supervisor reports to the Director~~Clinical Manager~~ of Patient Care Resources.

- **Other functions**

Patient Care Resources is responsible for ensuring the El Camino Hospital Patient Acuity System is validated annually or more frequently if warranted with the Director, Staffing and Scheduling Supervisor, and designated staff nurses from the nursing units to determine nursing care need, by patient category, and pattern of care delivery.

The PCR Department monitors staffing variances and develops staff utilization and productivity reports. The Director~~Clinical Manager~~ of Patient Care Resources also provides management consultation to newer Clinical Managers and is assigned to lead special projects as assigned by the Chief Nursing Officer~~Vice President or the Executive Director of Patient Care Services such as, but not limited to, the 2 Patient Identifier Performance Improvement Program, the Sub-acute Closure Project and the accompanying Staff Training Program to transition to work in acute care.~~

Staffing

A Director is responsible for all areas of Patient Care Resources Department on a 24-hour basis, 7 day a week basis, and reports to the Chief Nursing Officer. The management responsibility includes ~~nursing~~ Assistant Hospital Manager/Hospital Supervisors, RNs, LVNs, CNAs, Staffing Office personnel, and patient observers.

Assignment of staff is based on overall patient and hospital needs and staff competency. The competency of the staff is evaluated through observation of performance and skills competency validation by staff on their assigned units. Staff education and training is provided to assist in achieving performance expectation standards.

Staffing Office oversight is provided by a full-time Staffing Office Supervisor. A combination of full and part-time administrative support staff provide daily staffing operational support.

Level of Service Provided

The Patient Care Resources Department provides services under hospital and departmental policy and procedure guidelines.

Standard of Practice

The Patient Care Resources Department is governed by state and federal regulations, as outlined in Title 22 and Joint Commission on Accreditation of Healthcare Organizations Standards. Additional practices are described in the Patient Care Services Policies and Procedures.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 12/15 |

TITLE: ADT - Admission, Discharge and Transfer Criteria for Mother Baby MV
CATEGORY: Patient Care Services
LAST APPROVAL: 2/2015

TYPE: ☐ Policy ☐ Protocol ☒ Scope of Service/ADT
☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY: Mother Baby
OFFICE OF ORIGIN: Mother Baby
ORIGINAL DATE: 11/2010

I. COVERAGE:

Mother Baby Mountain View

II. PURPOSE:

- A. To establish criteria for the admission/discharge/transfer for postpartum, antepartum and neonates
- B. To define patient populations which are appropriate for admission to Mother-Baby unit

III. POLICY STATEMENT:

Patient admissions, transfers and discharges to/from the Mother-Baby unit will be in accordance with the established admission, transfer and discharge criteria.

IV. PROCEDURE:

Procedure for Postpartum and Antepartum Care

A. Admission Criteria for Postpartum and Antepartum Care:

- 1. Post-partum patients following a recovery period in Labor and Delivery.
- 2. Non-laboring antepartum patient with obstetrical care not requiring continuous Electronic Fetal Monitor
- 3. Stable post-partum patients requiring magnesium sulfate on 2gm/hr or less following a period of stabilization in Labor and Delivery.
- 4. Stable post-partum patients readmitted to the hospital for Hypertensive Disorder of Pregnancy requiring magnesium sulfate on 2gm/hr or less
- 5. Non-Infectious female patients when bed shortage exists on Surgical/Medical Units:
 - a. Hysterectomy, Laparotomy, Tubal Ligation
 - b. Hyperemesis, Dehydration, Pyelonephritis

B. Bed Emergencies-when a bed shortage exists on Mother-Baby:

- 1. Adult medical/surgical patients may be transferred to a medical-surgical unit if appropriate
- 2. Ask physicians for early discharge for those patients who are medically stable.
- 3. Call Labor & Delivery and ask if they could hold delivered patients until a bed can be made available

G. Transfer Criteria:

- 1. Transfer from Mother-Baby to another unit within the hospital will be dependent upon special needs of patients, i.e., acuity level, bed space and staffing levels.
- 2. Transfer from Mother-Baby unit to another facility - See Patient Care Policy Manual: Procedure: Transfer to Other Acute Care Facilities

H. Discharge Criteria:

- 1. Patients are physiologically stable.
- 2. Patients have an understanding of:
 - a. Limitations

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|-----------------------|---|
| TITLE: | ADT - Admission, Discharge and Transfer Criteria for Mother Baby MV |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

- b. Need for follow-up
- c. Medications, if needed
- d. Potential complications and reporting mechanism
- e. Discharge Process
- f. Patients have had educational needs met

Procedure for Neonates

A. Admission Criteria for Neonates' Care

- 1. Infants admitted to the Mother-Baby unit following a transition period in Labor and Delivery only when physiologically stable
- 2. Infant will go to NICU if not physiologically stable
- 3. Newborn care will be available 24 hours per day

B. Physiological Parameters

- 1. The infant's vital signs will have been documented to be normal and stable
- 2. The infant has received a physical examination by a physician within 24 hour of age

C. Laboratory Parameters

- 1. Place infant on screening criteria as needed:
 - a. Maternal HepB surface antigen status will have been ascertained
 - b. Infant blood type and direct coombs test done as needed
 - c. Results of maternal Group B Strep testing will have been ascertained as well as antibiotics given during labor
 - d. Newborn Screening test done according to state law.
 - e. Surveillance ~~Total Serum~~ (transcutaneous or serum as indicated) Bilirubin done with Newborn Screening to screen for newborn Hyperbilirubinemia

D. Newborn medication

- 1. As ordered by physician

E. Documentation

- 1. A physical exam by physician will be included in the patient's permanent medical record
- 2. Adequacy of the infant's feedings, all vital signs will be documented by an RN/LVN.
- 3. Assessment, interventions and plan of care will be documented by the Social Worker if family, environment or social risk factors are identified
- 4. Document Hearing Screening exam

F. Nursery will provide the following services:

- 1. Routine newborn care if requested by parents (will be available at all times).
- 2. Routine newborn care if either the mother or other banded adult are unable to provide care for the infant in the mother's room (e.g. mom incapacitated following surgery and banded adult not available)
- 3. Assessment of newborn infants demonstrating physiologic instability during the first 6 hours of life will be cared for in Transition Nursery. The covering neonatologist and primary physician will be notified
- 4. Evaluation of infants older than 6 hours of life determined to need closer assessment by staff (not to exceed 2 hours). The covering physician will be notified

G. If an infant's medical condition requires a longer stay, the infant must be admitted to one of the following units as appropriate:

- Pediatric Services
- NICU
- PEC (~~Pediatric Packard~~ at El Camino ~~Hospital~~), a ~~division-satellite unit~~ of Packard Children's Hospital ~~Stanford~~)

| | |
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| TITLE: | ADT - Admission, Discharge and Transfer Criteria for Mother Baby MV |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

1. Admission to the PEC requires the Pediatrician of record to speak with the accepting physician on the PEC Unit and accept the infant for treatment
 2. Infant must be discharged from El Camino Hospital
 3. Patient Transfer Worksheet (form 777) must be filled and signed within six hours of ~~transport transfer discharge~~ by a physician. If the ~~discharging~~ pediatrician is not available to do this they have the choice of asking the neonatologist on call, to provide this service as a consultation. The Neonatologist can ~~transport transfer discharge~~ the infant from MBU to be admitted to PEC or ~~transport transfer~~ through the NICU
 4. Copies of all documents, necessary to continue management of the infant should be provided to the receiving unit
 5. The infant will be transported via crib accompanied by a Mother Baby RN to ~~the~~ PEC
- Discharge Criteria Procedure
- A. Infants discharged from the Mother Baby Unit will fulfill the following criteria:
1. Physiological Parameters:
 - a. The infant has received a physical examination by a physician within 24 hours preceding discharge
 - b. The infant's vital signs will have been documented to be normal and stable for the 12 hours preceding discharge, including respiratory rate of fewer than 60 bpm, a heart rate 100-160 beats per minute, and an axillary temperature of 36.5-37.5C (97.0-98.6F) in an open crib with appropriate clothing
 - c. The baby has urinated and has passed stool
 - d. The baby has completed at least two successful feedings and is able to coordinate sucking, swallowing, and breathing while feeding
 - e. Physical examination reveals no abnormalities that require continued hospitalization
 - f. There is no evidence of excessive bleeding at the circumcision site for at least two hours
 - g. There is no evidence of significant jaundice
 - h. Critical Congenital Heart Disease (CCHD) screening has been completed
 2. Laboratory Parameters
 - a. Maternal hepatitis B surface antigen status will have been ascertained
 - ~~b. Sepsis protocol followed as appropriate~~
 - ~~c. Cord or infant blood type and direct Coombs test will have been done as clinically indicated~~
 - ~~d. Newborn screening tests will have been done in accordance with State regulations (unless the parents sign a refusal)~~
 - ~~e. State regulations (unless the parents sign a refusal)~~
 - ~~f. Surveillance Total: (Transcutaneous or Serum) Bilirubin will have been done as ordered~~
 - ~~g. Initial hepatitis B vaccine has been administered (unless the parents sign a refusal)~~
 3. Follow-up Care:
 - a. A physician directed source of continuing medical care has been identified.
 - b. Family, environmental, and social risk factors have been assessed
 - c. When risk factors are assessed, the discharge should be delayed until they are resolved or a plan to safeguard the infant is in place
 - d. The mother's knowledge, ability, and confidence to provide care for her newborn is assessed when she is receiving the following teaching

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| TITLE: | ADT - Admission, Discharge and Transfer Criteria for Mother Baby MV |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

- e. Breastfeeding or bottle-feeding:
 - i. The breastfeeding dyad has been assessed with regard to position; latch on, and mother's knowledge of frequency of urine and stool
 - ii. Cord, skin, and genital care reviewed
 - iii. The mother is able to recognize signs of illness and common infant problems, to include jaundice and temperature instability
 - iv. Instruction in proper infant safety, including use of car seat and positioning for sleeping
- 4. Mode of Discharge:
 - a. Bands checked before discharge.
 - b. The infant will be discharged in the arms of parent or guardian, seated in a wheelchair
- 5. Documentation

V. DOCUMENTATION:

1. The physician will document his/her physical exam in the patient's permanent medical record.
2. The RN/LVN taking care of the infant will document in the flowsheet the adequacy of the infant's feedings, and all vital signs
3. The RN/LVN taking care of the infant will document in the electronic health record (EHR) system that discharge teaching has been completed and family has signed and received a copy of California's Child Passenger Restraint System Laws
4. If any family, environment, and social risk factors have been identified, the Social Worker will document in the EHR, the assessment, interventions, and plan of action

VI. REFERENCES:

1. Guidelines for Perinatal Care, ~~7th-8th~~ Ed. American Academy of Pediatrics, and the American College of Obstetrics and Gynecology, ~~2012~~2017
2. Applicable Regulations:
 - a. (TJC) JOINT COMMISSION
 - b. Title XXII

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|-------------------------------|
| Mother Baby Unit Partnership Council | 2/2018 |
| Obstetric Executive Committee | 2/48 <u>3/2018</u> |
| Pediatric Executive Committee Department | 2/42 <u>3/2018</u> |
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| Historical Approvals: | 2/10, 5/12, 4/15 |

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TITLE: Admission Discharge Transfer (ADT) for Mother Baby on 3CW (MV)
CATEGORY: Patient Care Services
LAST APPROVAL: 4/2017

TYPE: ☐ Policy ☐ Protocol ☒ ADT
☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY: Mother/Baby
OFFICE OF ORIGIN: Mother/Baby
ORIGINAL DATE: 11/2010

I. **COVERAGE:**
3CW MOUNTAIN VIEW

II. **PURPOSE:**

- To establish criteria for the admission/discharge/transfer for postpartum, and neonates on 3CWest.
- To define patient populations which are appropriate for admission to Mother-Baby unit on 3CWest.

III. **STATEMENT:**
Patient admissions, transfers and discharges to/from the Mother-Baby unit will be in accordance with the established admission, transfer and discharge criteria.

IV. **REFERENCES:**

1. Guidelines for Perinatal Care, ~~7th-8th~~ Ed. American Academy of Pediatrics, and the American College of Obstetrics and Gynecology, ~~2012-2017~~.
2. Applicable regulations:
 - a. The Joint Commission (TJC)
 - b. Title XXII

V. **PROCEDURE:**

Procedure for Postpartum Care

- A. Admission Criteria for Postpartum Care
1. Post-partum patients following a recovery period in Labor and Delivery
 2. Post-partum patients excluded from care on 3 CW:
 - Patient on Magnesium Sulfate Drip
 - Patient whose infant is in NICU
 - Patient who hemorrhaged after delivery
 - Concern voiced by any physician during delivery
- B. Bed Emergencies-when a bed shortage exists on Mother-Baby:

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| TITLE: | Admission Discharge Transfer (ADT) for Mother Baby on 3CW (MV) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 4/2017 |

1. Adult medical/surgical patients may be transferred to a medical-surgical unit if appropriate
 2. Ask physicians for early discharge for those patients who are medically stable
 3. Call Labor & Delivery and ask if they could hold delivered patients until a bed can be made available
- C. Transfer Criteria with physician order:
1. Transfer from Mother-Baby to another unit within the hospital will be dependent upon special needs of patients, i.e., acuity level, bed space and staffing levels.
 2. If Mother or Infant meet exclusion criteria for 3CW after being placed on that unit but can still be cared for on first floor Mother Baby Unit they will be transferred to Mother Baby Unit in Women's Hospital.
 3. Transfer from Mother-Baby unit to another facility - See Patient Care Policy Manual: Procedure: Transfer to Other Acute Care Facilities.
- D. Discharge Criteria with physician order:
1. Patients are physiologically stable.
 2. Patients have an understanding of:
 - Limitations
 - Need for follow-up
 - Medications, if needed
 - Potential complications and reporting mechanism
 3. Discharge Process
 - Patients have had educational needs met

Procedure for Neonates

- A. Admission Criteria for Neonates' Care
1. Infants admitted to the Mother-Baby unit on 3CW following a transition period in Labor and Delivery only when physiologically stable.
 2. Infants excluded for care on 3CW are those infants:
 - Less than 37 weeks gestation
 - Having problems during transition
 - Having spent time in NICU for transition observation
 - Boys expected to have a circumcision
 - Concern voiced by any physician during delivery
 3. Infant will go to NICU if not physiologically stable
 4. Newborn care will be available 24 hours per day

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| TITLE: | Admission Discharge Transfer (ADT) for Mother Baby on 3CW (MV) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 4/2017 |

B. Physiological Parameters:

1. The infant's vital signs will have been documented to be normal and stable
2. The infant has received a physical examination by a physician within 24 hours of age

C. Laboratory Parameters:

1. Maternal HepB surface antigen status will have been ascertained
2. Infant blood type and direct coombs test done as needed
3. Results of maternal Group B Strep testing will have been ascertained as well as antibiotics given during labor
4. Newborn Screening test done according to state law
5. Surveillance ~~Total Serum~~ Bilirubin done ~~with Newborn~~ Screening(transcutaneous or serum as indicated) to screen for newborn hyperbilirubinemia

D. Newborn medication

1. As ordered by physician

E. Documentation:

1. A physical exam by physician will be included in the patient's permanent medical record
2. Adequacy of the infant's feedings, all vital signs will be documented by an RN/ LVN
3. Assessment, interventions and plan of care will be documented by the Social Worker if family, environment or social risk factors are identified

F. Nursery (in Women's Hospital) will provide the following services:

1. Routine newborn care if requested by parents (will be available at all times)
2. Routine newborn care if either the mother or other banded adult are unable to provide care for the infant in the mother's room (e.g. mom incapacitated following surgery and banded adult not available)
3. Assessment of newborn infants demonstrating physiologic instability during the first 6 hours of life will be cared for in Transition Nursery. The covering physician will be notified. If this was required, this couplet should be transferred back to Mother Baby Unit in Women's Hospital
4. Evaluation of infants older than 6 hours of life determined to need closer assessment by staff (not to exceed 2 hours). The covering physician will be notified

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| TITLE: | Admission Discharge Transfer (ADT) for Mother Baby on 3CW (MV) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 4/2017 |

G. If an infant's medical condition requires a longer stay, the infant must be admitted to one of the following units as appropriate:

- Pediatric Services
- NICU
- PEC (~~Pediatric Packard~~ at El Camino Hospital, a ~~division-satellite unit~~ of Lucile Packard Children's Hospital Stanford)

1. Admission to the PEC requires the Pediatrician of record to speak with the accepting physician on the PEC Unit and accept the infant for treatment
2. Infant must be discharged from El Camino Hospital
3. Patient Transfer Worksheet (form 777) must be **filled and signed within six hours, of transport by a physician.** If the ~~transfer discharging~~ pediatrician is not available to do this they have the choice of asking the neonatologist on call, to provide this service as a consultation. The Neonatologist can ~~transport discharge~~ the infant from MBU to PEC or ~~transport-transfer~~ through the NICU
5. **Copies of all documents, necessary to continue management of the infant should be provided to the receiving unit**
6. The infant will be transported via crib accompanied by a Mother -Baby RN to ~~the~~ PEC.

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H. Discharge Criteria Procedure

1. Infants discharged from the Mother Baby Unit on 3CW will fulfill the following criteria:

I. Physiological Parameters:

1. The infant has received a physical examination by a physician within 24 hours preceding discharge
2. The infant's vital signs will have been documented to be normal and stable for the 12 hours preceding discharge, including respiratory rate of fewer than 60 bpm, a heart rate 100-160 beats per minute, and an axillary temperature of 36.5-37.5C (97.0-98.6F) in an open crib with appropriate clothing
3. The baby has urinated and has passed stool
4. The baby has completed at least two successful feedings and is able to coordinate sucking, swallowing, and breathing while feeding
5. Physical examination reveals no abnormalities that require continued hospitalization
6. There is no evidence of excessive bleeding at the circumcision site for at least two hours

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| TITLE: | Admission Discharge Transfer (ADT) for Mother Baby on 3CW (MV) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 4/2017 |

7. There is no evidence of significant jaundice
8. Critical Congenital Heart Disease (CCHD) screening has been completed

J. Laboratory Parameters:

1. Maternal hepatitis B surface antigen status will have been ascertained.
2. Cord or infant blood type and direct Coombs test will have been done as clinically indicated
3. Newborn screening tests will have been done in accordance with State regulations (unless the parents sign a refusal)
- ~~4. Initial hepatitis B vaccine has been administered (unless the parents sign a refusal)~~
- ~~5.4. Surveillance Total Serum Transcutaneous or serum Bilirubin~~ will have been done as ordered

K. Follow-up Care:

1. A physician directed source of continuing medical care has been identified
2. Family, environmental, and social risk factors have been assessed. When risk factors are assessed, the discharge should be delayed until they are resolved or a plan to safeguard the infant is in place
3. The mother's knowledge, ability, and confidence to provide care for her newborn is assessed when she is receiving the following teaching:
 - Breastfeeding or bottle-feeding: The breastfeeding dyad has been assessed with regard to position; latch on, and mother's knowledge of frequency of urine and stool. Bottle-feeding is demonstrated by parent
 - Cord, skin, and genital care reviewed
 - The mother is able to recognize signs of illness and common infant problems, to include jaundice and temperature instability
 - Instruction in proper infant safety, including use of car seat and positioning for sleeping

L. Mode of discharge:

1. Bands checked before discharge
2. The infant will be discharged in the arms of parent or guardian, seated in a wheelchair

M. Documentation:

1. The physician will document his/her physical exam in the patient's permanent medical record



| | |
|-----------------------|--|
| TITLE: | Admission Discharge Transfer (ADT) for Mother Baby on 3CW (MV) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 4/2017 |

2. The RN/LVN taking care of the infant will document in the flow sheet the adequacy of the infant's feedings, and all vital signs
3. The RN/LVN taking care of the infant will document in the electronic ~~medical- Health~~ record (~~EMREHR~~) system that discharge teaching has been completed and family has signed and received a copy of California's Child Passenger Restraint System Laws
4. If any family, environment, and social risk factors have been identified, the Social Worker will document in the ~~EMREHR~~, the assessment, interventions, and plan of action

VII. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|------------------------|
| Mother Baby UPC | 3/17 2/2018 |
| OB Executive Committee: Pediatric Executive Committee | 5/17 3/2018 |
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| Historical Approvals: | |
| Board of Directors: | 7/12, 4/15, 4/17 |

VIII. ATTACHMENTS: N/A

Scope and Complexity of Services Offered

The Inpatient Dialysis Service provides hemodialysis, ~~hemofiltration~~~~hemoperfusion, continuous veno-venous hemofiltration (CVVHD), continuous veno-venous hemodiafiltration (CVVHD),~~ apheresis, and continuous ambulatory peritoneal dialysis (CAPD) at El Camino Hospital. All services are available 24 hours daily.

Scope of Services includes:

The Inpatient Dialysis Service provides Hemodialysis, Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).

Types and Ages of Clients Served

Dialysis Services provides care to adult and geriatric patients with acute renal failure, and end-stage renal disease (ESRD). This care is provided in the inpatient acute care setting.

Assessment Methods

The diagnostic and therapeutic dialysis services provided to patients are assessed by an interdisciplinary team (IDT), including the physician, nurse, patient care technician, and chief technician. A comprehensive patient assessment is completed upon admission. Ongoing response to dialysis treatment is assessed at each treatment.

Appropriateness, Necessity and Timeliness of Services

All services are available 24 hours daily.

Staffing/Skill Mix

A Director of Dialysis Patient Care oversees El Camino Inpatient Dialysis Service in conjunction with a Medical Director. The Medical Director for the El Camino Inpatient Dialysis Service is responsible for the inpatient program. There is a chief technician responsible for plant and technical operations for the inpatient program.

In the inpatient service, the staffing ration is one-to-one for accurately ill or unstable patients.

Level of Service Provided

The levels of service provided by the Dialysis Service are consistent with the diagnostic and therapeutic needs of the patient as determined by the IDT.

Dialysis services are designed to meet patient needs by accurately performing and interpreting diagnostic and therapeutic procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which the Dialysis Service meets patient needs.

Standards of Practice

The Dialysis Service is governed by state regulations as outlines in Title 22 and federal regulations as outlined in the Federal Register, Department of Health, Education and Welfare as related to ESRD facilities. The department also follows guidelines set forth by the TransPacific Renal Network #17, the Renal Physicians' Association (RPA), the American Nephrology Nurses Association (ANNA), the National Association of Nephrology Technicians (NANT), the National Kidney Foundation (NKF), the Council of Renal Social Workers, the Council of Renal Dieticians, and the American Association of Medical Instrumentation (AAMI). Standard of practice are described in department policies, procedures, and protocol.

Approval:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 6/09 |

Approved: 06/09

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Rev. 05/09



TITLE: Admission, Discharge, Transfer (ADT) Criteria Telemetry-Cardiac Unit
CATEGORY: Patient Care Services
LAST APPROVAL: 3/2015

TYPE: ☐ Policy ☐ Protocol ☒ Scope of Service/ADT
☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY: Patient Care Services
OFFICE OF ORIGIN:
ORIGINAL DATE: 5/1995

COVERAGE:

Telemetry Unit Staff

PURPOSE:

- To establish criteria for the admission, transfer and discharge of patients to/from the Telemetry Unit.
- To define patient populations which are appropriate for admission to the Telemetry Unit.
- To identify any exclusion criteria for the Telemetry Unit.
- To define patient populations which are appropriate for monitoring on the Telemetry Unit.

STATEMENT:

Patient admissions, discharges and transfers to/from the Telemetry Unit will be in accordance with the established admission, discharge and transfer criteria.

DEFINITIONS (N/A):

PROCEDURE:

A. Admission to the Telemetry Unit:

1. All direct admissions are screened by the Assistant Hospital Manager/ Hospital Supervisor, Charge Nurse or designee.

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POLICY/PROCEDURE TITLE: ADT Telemetry-Cardiac Unit

2. All patient admissions will be approved for appropriateness by the Hospital Supervisor, Charge Nurse or Clinical Manager in collaboration with the admitting physician.
3. Any admissions who do not clearly meet the admission criteria will be referred to the Medical Director or panel physician for review and approval.
4. All patient transfers in from other acute care hospitals are reviewed and pre-approved by Care Coordination. All patient transfers in from other acute care hospitals and out to other care facilities will be based on physician acceptance/order and coordinated by the Hospital Supervisor in collaboration with the sending/receiving facility and the Charge Nurse.
5. All patients requiring cardiac monitoring must have parameters defined for monitoring on the Telemetry Unit.
6. Patients must have appropriate Telemetry Unit orders on arrival to the unit. No patient will be admitted unless orders are with the patient on arrival to the unit.
7. During times of high census, triage rounds will be conducted by the charge nurse/Clinical Manager who will solicit physician input in identifying patients ready for discharge and those who can be triaged off telemetry and transferred to medical/surgical nursing units.

Comment [AP1]: This needs to be checked with Risk Management. I don't think we can accept pts without admit orders or a set timeframe in which we will have admission orders. (Let's make sure to make best use of our space and resources.)

B. Admission Criteria:

1. New onset stable atrial fibrillation and asymptomatic (by history) arrhythmias.
2. Stable post MI not requiring IV vasoactive medications.
3. Low dose dopamine, 1-5 mcg/kg, not being used for hemodynamic instability and not to be titrated. Dopamine may be started on the Telemetry Unit.
4. Dobutamine, 2.5-10 mcg/kg, not being used for hemodynamic instability and not to be titrated. Dobutamine may be started on the Telemetry Unit.
5. Amiodarone, for hemodynamically stable patients, 1 mg/min for 6 hours followed by 0.5 mg/min for the ensuing 18 hours. Amiodarone may be started on the Telemetry Unit, with a bolus limited to 150 mg given over 30 minutes.
6. Post-op permanent pacemaker insertion or ICD insertion.

POLICY/PROCEDURE TITLE: ADT Telemetry-Cardiac Unit

7. Low probability MI or low probability unstable angina.
8. Syncope of unknown cause.
9. Post cardiac cath procedure without sheaths (i.e., with or without closure device; procedure without complication).
10. Electrophysiology (EP).
 - a. Chemical cardioversion.
 - b/B. Post electrical cardioversion.
11. Suspected permanent pacemaker malfunction with life-sustaining underlying rhythm.
12. Dysrhythmia requiring continuous stable IV antiarrhythmic drug therapy (i.e. lidocaine, procainamide, and Diltiazem). No titration of drips.
13. Angina relieved by nitrates.
14. Cardiomyopathy, CHF, or output failure requiring stable infusions of dopamine, lasix. No titration of drips.
15. Emergency Department Admission: All lab values (i.e., cardiac markers) must be reviewed by the ED physician or admitting physician prior to the patient being admitted.
16. Patients starting new cardiac drugs requiring monitoring.
17. Stable drug overdoses with high probability for arrhythmias.
18. Post-op CABG &/heart valve patients 6 hours after extubation who have demonstrated hemodynamic stability when standing or when sitting in a chair. SaO2 must be acceptable while on nasal oxygen, simple mask or room air.
19. Post-op Video-Assisted Thoracoscopic Surgery (VATS)
20. Pericarditis or endocarditis-
21. Post coronary intervention with ~~pericath closure~~ "percutaneous closure device" and/or radial artery compression and Integrilin drips.

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POLICY/PROCEDURE TITLE: ADT Telemetry-Cardiac Unit

22. Structural heart procedures including:

a. Left atrial appendage closure/ligation

1. Watchman™

2. LARIAT® suture

3. Amulet

b. ASD/PFO repair

c. transcatheter paravalvular leak repair

d. balloon valvuloplasty

e. percutaneous mitral valve clip placement

f. transcatheter aortic valve repair (TAVR)

23. Stable post AAA stent placement.

1st day or post-op day 1 (with no significant heart blocks from CCU)

24. Overflow medical/surgical patients not requiring cardiac monitoring.

25. Stable patients requiring continuous pulse oximetry but not requiring high flow oxygen therapy or acute non-invasive positive pressure ventilation.

C. Exclusion Criteria:

1. Hemodynamically unstable patients.
2. Patients requiring frequent assessments and interventions beyond the routine post procedure observational period
3. Children weighing less than 80 pounds.
4. Patients that are comfort care

5. Stroke/TIA patients (part of patient's current hospitalization problem list); do not resuscitate.

(1) Patients with no signs of dysrhythmia for 48 hours, except post-eurothoracic surgery or post-myocardial infarction.

6. Patients with long-standing history of controlled atrial fibrillation that are hemodynamically stable.

7. Patients requiring Femostop application (with inflation greater than zero mmHg)

D. Transfer Criteria:

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POLICY/PROCEDURE TITLE: ADT Telemetry-Cardiac Unit

(+)1. Patients will be evaluated for transfer off telemetry based on the “Protocol: Telemetry Monitoring – Indications, Continued Use and Discontinuation”. Excluded from transfer off telemetry are patients requiring continuous telemetry monitoring including: ACS – STEMI, ACS – NSTEMI, ACS – unstable angina, post cardiothoracic surgery, thoracic surgery (non-cardiac), EP cases, structural heart cases, LVEF <35%

- a. Absence of significant dysrhythmia for 24 hours.
- b. Absence of IV vasoactive or IV antiarrhythmic medications.
- c. Absence of angina for 8 hours.

(+) d. Patients requiring initiation of IV drugs/drips (not indicated for 3B Telemetry per the IV Medication Reference Guide located on The Toolbox) or titrated drips and/or requiring increased frequency of intervention and assessment may be transferred to CCU or PCU. This includes patients whose condition changes to meet exclusion criteria while on the Telemetry Unit.

+2. If beds are needed, non-monitored patients will be transferred to a medical/surgical unit to allow patients requiring cardiac monitoring to be admitted/transferred to the Telemetry Unit.

E. Discharge Criteria:

1. Patients who have reached an acceptable level of functioning and can manage self-care or have caretaker(s) providing such a level of care may be discharged to home or to an appropriate facility. Patients include same-day PTCA (see: Protocol: Same Day Discharge Radial percutaneous Coronary intervention (PCI).
2. Patients no longer qualifying for acute care criteria and who can manage self-care or have caretaker(s) provide such a level of care may be discharged to home or to an appropriate facility.
3. Patients no longer qualifying for acute care criteria and who may require extended, rehabilitative or terminal care may be discharged to home or to an appropriate facility.

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POLICY/PROCEDURE TITLE: ADT Telemetry-Cardiac Unit

| APPROVAL | APPROVAL DATES |
|----------------------------------|----------------|
| Patient Care Management Council: | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |

Historical Approvals:

Medical Executive Committee: 6/99, 4/01, 2/04, 2/05, 11/06, 03/09,
04/12, 2/15

Board of Directors: 7/99, 5/01, 03/04, 03/05, 12/06, 04/09, 05/12, 3/15

REFERENCES:

[Protocol: Telemetry Monitoring – Indications, Continued Use and Discontinuation”.](#)

[Protocol: Same Day Discharge Radial percutaneous Coronary intervention \(PCI\)](#)

[IV Medication Reference](#)

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE: ADT Telemetry-Cardiac Unit

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

SCOPE OF SERVICE

Mother Baby – Enterprise

Types and Ages of Patient Served

The patient population consists of antepartum, postpartum and healthy neonates. Unless contraindicated by admitting diagnosis, or post-partum diagnosis, all post-partum patients should be admitted to the Mother-Baby Unit where normal newborn care is delivered to the couple.

Assessment Methods

Nursing care is provided by a registered nurse who assess, document, and evaluate patient progress. The licensed vocational nurses work under the direction of a registered nurse. The staff nurses are involved in continual monitoring of quality of care and the performance improvement process.

For patients requiring resources not available in our unit, arrangements will be made to transfer the patient to another unit or facility.

Scope and Complexity of Services Offered

The unit provides total care and support to the patient/family toward the positive discharge process. Care is given as directed and prescribed by the physician. The nurse understands the family is an integral part of care planning and involves family members to the level of their ability and desire. The nursing staff coordinates all necessary needs for intervention and coordinates with any department specific orders and treatment.

Appropriateness, Necessity and Timeliness of Services

The Department Manager, assisted by the Nursing Unit Coordinator and nursing staff, assess the appropriateness, necessity, and timeliness of service. The appropriateness is addressed in hospital and department specific policies and procedures, which are established in coordination with the medical staff, and the Partnership Councils.

A continuous Performance Improvement process is in place to monitor on-going performance. This process is designed to assess all aspects of care. The patient progress is evaluated by nursing, medical staff, and patient and family satisfaction.

Staffing

The Mother-Baby Unit is staffed with sufficient numbers of RNs, LVNs, and Administrative Support to provide established hours of nursing care based on the patient census and acuity. The staffing is provided per guidelines outlined in the department standards and Guidelines for Perinatal Care. Twenty-four hour neonatologist coverage is provided in the NICU ~~and~~[in Mountain View](#) ~~and on-call in Los Gatos~~ ~~and~~ is available for consultation.

Level of Service Provided

The level is consistent with the needs of the patient as determined by the medical staff and nursing assessment. The neonate is observed in Labor & Delivery for a period of time to assess that they have stabilized their temperature and respiratory status. The unit is designed to meet the needs of the patient.

Performance assessment and improvement processes are evaluated through performance improvement activities in conjunction with the multi-disciplinary health care professionals who provide services to the unit.

Standard of Practice

The Mother-Baby Unit is governed by state regulations as outlined in Title 22, Joint Commission requirements, the American College of Obstetrics and Gynecology, California Children's Services (CCS), Guidelines for Perinatal Care (AAP & ACOG), NANN (Neonatal Nurses' Association) and Association of Women's Health and Neonatal Nursing (AWHONN). It is also governed by recommendations from the American Academy of Pediatrics.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Mother Baby UPC Committee: | 2/2018 |
| Pediatric Department: | 3/2018 |
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 9/15 |

| | |
|-----------------------|-----------------------|
| TITLE: | Philosophy of Nursing |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

| | |
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| TYPE: | <input type="checkbox"/> Policy <input type="checkbox"/> Protocol <input checked="" type="checkbox"/> Scope of Service/ADT <input type="checkbox"/> Procedure <input type="checkbox"/> Standardized Process/Procedure |
| SUB-CATEGORY: | Patient Care Services |
| OFFICE OF ORIGIN: | |
| ORIGINAL DATE: | |

EL CAMINO HOSPITAL
PHILOSOPHY OF NURSING

We are committed to excellence in patient care through our competence, confidence and caring.

We believe that caring is the essence of Nursing.

We believe that our patients and their needs are our central focus.

We believe that each person is unique and is characterized by their own life patterns.

We believe it is essential to consider the patient's age, nationality, race creed and cultural background in planning and providing care.

We believe that individuals interact with their environment; therefore patient care must reflect consideration for the psycho-social, spiritual, and cultural variables that influence the perception of their illness.

We believe that our patients have the right to live and die with dignity.

We believe that patient care is optimized when accountability for decisions and actions is shared between patient and care givers.

We believe that patients, families and/or significant others contribute to the patient's wellbeing.

We believe that an environment with clear expectations of professional practice and established standards of care insures optimal patient care.

We believe that quality patient care can best be provided in an atmosphere of continuing staff development, clinical research and professional growth.

We believe that professional growth and staff development is a responsibility shared by the individual employee and organization.

POLICY/PROCEDURE TITLE: Philosophy of Nursing

We believe that nursing is both an art and a science - a professional discipline that requires a sound education and is grounded in its own research base.

We believe in nursing as a clinical discipline, employing physiological, psycho-social, physical and technological means for human comfort, sustenance and improved well-being.

We believe in ourselves and our nursing colleagues and our right to be recognized and rewarded as professional practitioners.

We believe that patient care is enhanced by providing continuity of care through thoughtful patient assignments and relevant communication between care givers.

EL CAMINO HOSPITAL
DEFINITION OF NURSING

In accordance with the California Nurse practice Act, El Camino Hospital adopts the following definitions: “the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill”.

The practice of nursing by a registered nurse shall mean assuming responsibility and accountability for those nursing actions which include but are not limited to:

- a. identifying human responses to actual or potential health conditions;
- b. identifying the nursing care needs of an individual family or group;
- c. executing a nursing treatment regimen through the selection, performance, and management of proper nursing practices;
- d. teaching health care practices;
- e. advocating the provision of health care services through collaboration with other health service personnel;
- f. executing diagnostic and therapeutic regimens prescribed by duly licensed practitioners authorized to order such regimens under the provisions of section 1316.5 of the Health and Safety Code;
- g. prescribing, administering, supervising, delegating and evaluating nursing activities.

The practice of nursing by a licensed practical nurse shall mean assumption of responsibilities and the performing of acts within the LVN scope of practice, under the direction of a registered nurse.

POLICY/PROCEDURE TITLE: Philosophy of Nursing

The practice of nursing at El Camino Hospital is further defined by the hospital's mission statement, the philosophy of nursing, and policies and procedures.

EL CAMINO HOSPITAL**NURSING ETHICS**

Since patients themselves are the primary decision makers in matters concerning their own health, treatment, and well-being, the goal of nursing actions is to support and enhance the patient's responsibilities and self-determination to the greatest extent possible.

When making clinical judgments, nurses base their decisions on consideration of consequences and of universal moral principles, both of which prescribe and justify nursing actions. At El Camino Hospital, nurses adopt the American Nurses Association's Code of Ethics as a guide for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and with high quality in nursing care.

Code for Nurses

The nurse provides services with respect for human dignity and the uniqueness of the patient, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

The nurse safeguards the patient's right to privacy by judiciously protecting information of a confidential nature.

The nurse acts to safeguard the patient and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

The nurse assumes responsibility and accountability for individual nursing judgments and actions.

The nurse maintains competence in nursing.

The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

The nurse participates in the profession's efforts to implement and improve standards of nursing.

The nurse participates in the profession's effort to establish and maintain conditions of employment conducive to high quality nursing care.

The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

POLICY/PROCEDURE TITLE: Philosophy of Nursing

The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 2/2015 |

SCOPE OF SERVICE

Telemetry/Stroke Unit – Mountain View

Types and Ages of Clients Served

The Telemetry/Stroke Unit is a 26-bed medical/surgical unit providing care for patients from adolescence to geriatric who require cardiac monitoring and including all appropriate stroke (ischemic/hemorrhagic) and TIA patients as defined in the department's admission, discharge and transfer criteria. The Telemetry/Stroke Unit also accepts overflow medical/surgical patients not requiring cardiac monitoring when bed availability permits.

Assessment Methods

Nursing care is provided by a registered nurse utilizing the nursing process. Registered nurses provide direct supervision to clinical support staff in the provision of patient care. The staff participates in continuous quality improvement processes relating to patient care delivery.

Scope and Complexity of Services Offered

Common diagnoses served on the Telemetry/Stroke Unit include stroke, TIA, CHF, syncope, hypertension, chest pain, COPD, and patients with cardiac arrhythmias. Care is given as directed and prescribed by the physician. All non-nursing orders are communicated to the appropriate ancillary departments through the electronic health record. Staff communicates specific patient needs and coordinates treatment and the plan of care with all ancillary departments. The discharge planning process is initiated on admission, in collaboration with the physician, social services, care coordinator, other health disciplines, patient, family and homecare providers, if appropriate.

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager, in collaboration with shift charge nurses, assesses the appropriateness, necessity, and timeliness of service. The appropriateness of service is addressed in hospital and department policies and procedures.

A continuous quality improvement process is in place to identify opportunities for improvement in patient care processes and to measure staff performance for compliance with standards. The patient's progress is evaluated by medical staff, nursing and other health disciplines, as well as the perception of patient and family.

Staffing/Skill Mix

The Telemetry/Stroke Unit staffing includes a skill mix of registered nurses (RNs), clinical support staff, monitor technicians and administrative support staff to provide patient care based on patient census and nursing intensity measures. Staffing follows the DHS ratio of 1:4 (RN to patients)

taking into account patient care needs, and shall be determined each shift by the RN in charge. The charge nurse serves to coordinate patient care activities for his/her designated shift.

RN staff must have a California license. On the Telemetry/Stroke Unit, at least 80% of RNs on a given shift must be ACLS certified. At least 80% of RNs on a given shift on the Telemetry/Stroke Unit must be NIHSS certified. All other staff must be BLS certified. Clinical Support staff must be currently certified by the State of California. The competency of the staff is evaluated through observation of performance and skill competency validation. Staff education and training is provided to assist in the achievement of performance standards.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff. The department is designed to meet the level of care needs of the patient.

Performance assessment and improvement processes are evaluated through continuous quality improvement activities in conjunction with the multidisciplinary health care professionals who provide services to the units.

Standards of Practice

The Telemetry/Stroke Unit is governed by state regulations as outlined in Title 22 and standards established by the Joint Commission on Accreditation of Healthcare Organizations. Additional practices are described in the Patient Care Policies and Procedures, and Clinical Practice Standards.

APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|--|-----------------------|
| Patient Care Management Council: | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| Historical Approvals: | 3/2012, 8/2015 |

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| TITLE: | Admission Discharge and Transfer Criteria (ADT) for Telemetry/Stroke Unit (3C) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

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| TYPE: | <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Protocol <input type="checkbox"/> Practice Guideline <input type="checkbox"/> Standardized <input type="checkbox"/> Procedure <input type="checkbox"/> Plan <input checked="" type="checkbox"/> Scope of Service/ADT Procedure |
| SUB-CATEGORY: | Patient Care Services |
| OFFICE OF ORIGIN: | Telemetry/Stroke Unit (3C) |
| ORIGINAL DATE: | 04/09 |

I. COVERAGE:

All El Camino Hospital staff

II. PURPOSE:

- To establish criteria for the admission, transfer and discharge of patients to/from the Telemetry/Stroke Unit.
- To define patient populations which are appropriate for admission to the Telemetry/Stroke Unit.
- To identify any exclusion criteria for the Telemetry/Stroke Unit.
- To define patient populations which are appropriate for monitoring on the Telemetry/Stroke Unit.

III. POLICY STATEMENT:

- It is the procedure of El Camino Hospital regarding telemetry/ stroke patient admission, discharge and transfer to ensure patient safety.
- Patient admissions, discharges and transfers to/from the Telemetry/Stroke Unit will be in accordance with the established admission, discharge and transfer criteria.

IV. PROCEDURE:

- A. Admission to the Telemetry/Stroke Unit (3C):
1. All direct admissions are screened by the Assistant Hospital Manager/Hospital Supervisor or designee.
 2. All patient admissions will be approved for appropriateness by the Charge Nurse or Clinical Manager in collaboration with the admitting physician. The Assistant Hospital Manager/Hospital Supervisor or flex nurse may be utilized to evaluate appropriateness of admission to the Telemetry/Stroke Unit.
 3. Any admissions who do not clearly meet the admission criteria will be referred to the Medical Director or panel physician for review and approval.
 4. All patient transfers in from other acute care hospitals are reviewed and pre-approved by Care Coordination. All patient transfers in from other acute care hospitals and out to other care facilities will be effected based on physician acceptance/order and

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| TITLE: | Admission Discharge and Transfer Criteria (ADT) for Telemetry/Stroke Unit (3C) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

coordinated by the Assistant Hospital Manager/Hospital Supervisor in collaboration with the sending/receiving facility and the Charge Nurse.

5. All patients requiring cardiac monitoring must have parameters defined for monitoring on the Telemetry/Stroke Unit. If no parameters are given by the admitting physician, then standing orders for monitoring parameters will automatically be implemented.
6. All appropriate stroke (ischemic/hemorrhagic) and TIA patients will be admitted or transferred to the Stroke Unit and placed on a cardiac monitor.
7. Patients must have appropriate Telemetry/Stroke Unit orders on arrival to the unit. No patient will be admitted unless orders are in the EHR, written orders are with the patient on arrival to the unit or the physician phones in the orders.
8. During times of high census, triage rounds will be conducted by the charge nurse who will solicit physician input in identifying patients ready for discharge and those who can be triaged off telemetry and transferred to medical/surgical nursing units.

B. Admission Criteria:

1. Acute Stroke/TIA patients.
2. Syncope of unknown cause.
3. New onset stable atrial fibrillation and asymptomatic (by history) arrhythmias.
4. Stable post MI not requiring IV vasoactive medications.
5. Low dose dopamine, 1-5 mcg/kg, not being used for hemodynamic instability and not to be titrated. Dopamine may be started on the Telemetry/Stroke Unit.
6. Dobutamine, 2.5-10 mcg/kg, not being used for hemodynamic instability and not to be titrated. Dobutamine may be started on the Telemetry/Stroke Unit.
7. Amiodarone, for hemodynamically stable patients, 1 mg/min for 6 hours followed by 0.5 mg/min for the ensuing 18 hours. Amiodarone may be started on the Telemetry/Stroke Unit, with a bolus limited to 150 mg given over 30 minutes.
8. Post-op permanent pacemaker insertion or ICD insertion.
9. Low probability MI or low probability unstable angina.
10. Post cardiac cath procedures, with or without intervention, requiring telemetry monitoring (without sheaths).
11. Chemical cardioversion in hemodynamically stable patient.
12. Electrophysiology (EP) patients.
13. Post electrical cardioversion.
14. Suspected permanent pacemaker malfunction with life-sustaining underlying rhythm.
15. Dysrhythmia requiring continuous stable IV antiarrhythmic drug therapy (i.e. lidocaine, procainamide, and Diltiazem). No titration of drips.
16. Angina relieved by nitrates.

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| TITLE: | Admission Discharge and Transfer Criteria (ADT) for Telemetry/Stroke Unit (3C) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

17. Cardiomyopathy, CHF, or output failure requiring stable infusions of dopamine. No titration of drips.
18. Emergency Department Admission: All lab values (i.e., cardiac markers) must be reviewed by the ED physician or admitting physician prior to the patient being admitted.
19. Patients starting new cardiac drugs requiring monitoring.
20. Stable drug overdoses with high probability for arrhythmias.
21. Pericarditis.
22. Carotid stents.
23. Overflow medical/surgical patients not requiring cardiac monitoring.
24. Stable patients requiring continuous pulse oximetry but not requiring high flow oxygen therapy or acute non-invasive positive pressure ventilation.

C. Exclusion Criteria:

1. Hemodynamically unstable patients.
2. Patients requiring frequent assessments and interventions beyond the routine observational period of q 4 hours for more than 8 hours.
3. Children weighing less than 80 pounds.

D. Transfer Criteria:

1. Absence of significant dysrhythmia for 24 hours.
2. Absence of IV vasoactive or IV antiarrhythmic medications.
3. Absence of angina for 8 hours.
4. Patients requiring initiation of IV drugs/drips and/or requiring increased frequency of intervention and assessment may be transferred to CCU or PCU. This includes patients whose condition changes to meet exclusion criteria while on the Telemetry/Stroke Unit.
5. If beds are needed, non-monitored patients will be transferred to a medical/surgical unit to allow patients requiring cardiac monitoring to be admitted/transferred to the Telemetry/Stroke Unit. Stroke/TIA patients will be kept on the Telemetry/Stroke Unit until time of discharge but may be transferred if the patient's code status is DNR: comfort care. Stroke /TIA patients may be transferred if needed when stroke workup and treatment have been initiated, stroke education and other required core measures have been met, the patient is neurologically and hemodynamically stable and is now requiring treatment for an unrelated problem e.g. chemotherapy, dialysis.

E. Discharge Criteria:

1. Patients who have reached an acceptable level of functioning and can manage self-care or have caretaker(s) providing such a level of care may be discharged to home or to an appropriate facility.

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| TITLE: | Admission Discharge and Transfer Criteria (ADT) for Telemetry/Stroke Unit (3C) |
| CATEGORY: | Patient Care Services |
| LAST APPROVAL: | 2/2015 |

2. Patients no longer qualifying for acute care criteria and who can manage self-care or have caretaker(s) providing such a level of care may be discharged to home or to an appropriate facility.
3. Patients no longer qualifying for acute care criteria and who may require extended, rehabilitative or terminal care may be discharged to home or to an appropriate facility.

V. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Services Management: | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 4/09, 5/12 |

TITLE: ADT Outpatient Infusion Center (IFC)

CATEGORY: Patient Care Services

LAST APPROVAL: 3/2015

TYPE:

☐ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized
☐ Procedure ☐ Plan ☒ Scope of Service/ADT Procedure

SUB-CATEGORY: Patient Care Services

OFFICE OF ORIGIN:

ORIGINAL DATE: 2/2009

I. COVERAGE:

Outpatient Infusion Center (IFC)

II. PURPOSE:

- To establish criteria for the admission and discharge of patients to/from IFC.
- To define patient populations which are appropriate for admission to the IFC.
- To identify any exclusion criteria for the IFC

III. STATEMENT:

Patient admissions and discharges to/from IFC will be in accordance with the established admission and discharge criteria.

IV. PROCEDURE:

A. Admission to IFC:

1. All direct patient admissions are screened by the Clinical Manager, Nursing Unit Coordinator, and/or designated Charge Nurse.
2. All patient admissions will be approved for appropriateness by the Infusion Center Charge Nurse or Nursing Unit Coordinator or Clinical Manager in collaboration with the admitting physician.
3. Admitting physician must have privileges at El Camino Hospital.

B. Admission Criteria:

All ambulatory oncology patients requiring:

1. Chemotherapy and Biotherapy
2. Hydration
3. Blood transfusions
4. Infusion of bisphosphonates
5. Management of Central line catheters
6. Blood Draw from Central line catheters
7. Electrolyte replacement
8. Injections for management of neutropenia

TITLE: ADT Outpatient Infusion Center (IFC)

CATEGORY: Patient Care Services

LAST APPROVAL: 3/2015

9. Hormonal injections
10. Injections for management of anemia
11. IV antibiotics therapy/Infusional antifungal therapy

Outpatients requiring:

1. Bisphosphonate infusion to manage osteoporosis
2. IVIG
3. Blood component transfusion
4. Iron Infusions
5. Therapeutic Phlebotomy
6. Other appropriate outpatient infusions

C. Exclusion Criteria:

1. Patients with infectious disease.
2. Patients who are hemodynamically unstable and requiring aggressive intervention/treatment.
3. Patients requiring cardiac monitoring.
4. Anyone under 18 years of age.
5. Non-ambulatory patients.
6. Patients with altered level of consciousness.

D. Discharge Criteria:

1. Patients who have completed their chemotherapy and/or biotherapy regimen. Patients who have completed therapy as ordered by their physician.

V. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|------------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 4/09, 5/12, 3/15 |

VI. ATTACHMENTS (N/A):

TITLE: End of Life Option Act Policy

CATEGORY: Patient Care Services

LAST APPROVAL: 9/2016

TYPE:



Policy



Protocol



Scope of Service/ADT



Procedure



Standardized Process/Procedure

SUB-CATEGORY:

OFFICE OF ORIGIN: Patient Care Administration

ORIGINAL DATE: 5/16

A. COVERAGE: All El Camino Hospital employees, volunteers and medical staff.

B. PURPOSE: To describe and inform El Camino Hospital employees, volunteers and medical staff as to El Camino Hospital Policy as related to the California End of Life Option Act.

1. The California End of Life Option Act (herein after the “Act”) allows an adult patient with capacity, who has been diagnosed with a terminal disease with a life expectancy of six months or less, and who meets other requirements, to request a prescription for a drug for the purpose of ending his or her life (aid-in-dying drug) through self-administration of the drug.
2. The purpose of this policy is to describe the requirements and procedures for compliance with the Act and to provide guidelines for responding to patient requests for information about aid-in-dying drugs in accordance with federal and state laws and regulations and The Joint Commission accreditation standards.
3. The requirements outlined in this policy do not preclude or replace other existing policies, including but not limited to Withdrawing or Foregoing Life Sustaining Treatment, Pain Management, Advance Directives /POLST, Resuscitation Status (DNR) or End-of-Life Care.

C. POLICY STATEMENT: It is the policy of El Camino Hospital to educate and support patients and providers regarding options available under the Act. However, El Camino Hospital shall not permit ingestion of an “aid-in-dying drug” as defined in the Act on any El Camino Hospital campus.

1. El Camino Hospital respects both patient and provider choices.
2. All providers practicing in and for El Camino Hospital should respond to any patient’s query about the Act with openness and compassion. The goal of El Camino Hospital is to ensure patients are educated thoroughly to make informed decisions about

TITLE: End of Life Option Act Policy

CATEGORY: Patient Care Services

LAST APPROVAL: 9/2016

options for and participating in end-of-life care, including Palliative Care and Hospice Care.

3. No patient will be denied other medical care or treatment because of the patient's participation in the Act.
4. El Camino Hospital neither encourages nor discourages participation in the Act; provider and patient participation is entirely voluntary. Only those providers who are willing and desire to participate should do so. Providers who do choose to participate under the Act are reminded that the overall goal is to support the patient's end-of-life wishes, and that participation may not necessarily result in aid-in-dying drugs being prescribed if the patient's needs can be met in other ways (e.g. pain management, hospice or palliative care). Medical staff members shall make an individual decision regarding the degree s/he participates in provision of services permitted under Act.
5. Physicians opting to not be an attending or consulting physician in respect to the Act should facilitate referral to an appropriate participating physician if they are aware of one or to Palliative Care for additional resources.
6. El Camino Hospital shall not permit ingestion of an "aid-in-dying drug" as defined in the End of Life Option Act on any El Camino Hospital campus. Aid in dying drugs cannot be dispensed by a physician in the inpatient setting. However, inquiry and discussion of such a request is permitted during a patient's hospitalization or in the clinic setting. An attending physician may prescribe the aid in dying drug after discharge so long as the requirements of the Act are fulfilled.
7. El Camino Hospital does not accept new patients solely for the purposes of accessing the Act. Eligible individuals should be current ECH patients receiving care for a terminal disease.

D. DEFINITIONS:

1. Aid-in-dying drug: a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his/her death due to terminal disease.
2. Attending physician: physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

TITLE: End of Life Option Act Policy

CATEGORY: Patient Care Services

LAST APPROVAL: 9/2016

3. Consulting physician: a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.

E. PROCEDURE:

1. The End of Life Option Act applies only to adults age 18 years or older. All such adult patients may be provided with educational materials regarding end-of-life options to the degree the patient desires and at the patient's request.
2. When a patient makes an inquiry about or requests access to activities under the Act, the patient should be referred to the Palliative Care Department. The Palliative Care Department is able to assist patients in understanding the requirements of the Act, inform them about the process and provide educational material related to the patient's end of life options. This activity will augment, but not substitute for, the obligations of the attending and consulting physicians' roles. If the patient's physician chooses not to participate in the Act, which is his or her right under the law, Palliative Care can assist in the identification of an appropriate resource.
3. Any patient, family member, surrogate decision maker, employee, independent contractor, medical staff, or volunteer may contact Palliative Care for assistance.
4. Support is also available as needed from Spiritual Care Department and the Ethics Committee.
5. Patients who have met all obligations and all criteria as described in the Act, and desire to ingest "aid-in-dying drug" yet cannot be discharged from the hospital for an extenuating circumstance, will be evaluated on a case-by-case basis by a multi-disciplinary team of physicians, nursing, care coordination, Palliative Care as available, and Risk Management or Legal to develop an acceptable plan of care for the patients/family.
6. Discussions and care conferences with patients and families regarding the End of Life Option Act are to be documented in the electronic health record (EHR).
7. Risk Management and/or Legal should be contacted prior to an ECH provider providing an ECH patient a prescription for an aid in dying drug in an ECH outpatient clinic to ensure that all appropriate processes have been followed and documentation completed.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

TITLE: End of Life Option Act Policy**CATEGORY:** Patient Care Services**LAST APPROVAL:** 9/2016

8. Risk Management and the Legal Department is available to provide guidance to providers regarding the requirements under the law, and may review records as necessary to ensure all the safeguards of the law have been followed along with appropriate documentation completed.

F. REFERENCES:

1. California ABX2-15: End of Life Option Act

G. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|----------------|
| Patient Care Leadership (Policy Day): | 2/2018 |
| Ethics Committee: | 5/2016 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 9/2016 |



El Camino Hospital[®]
THE HOSPITAL OF SILICON VALLEY

Summary of Financial Operations

Fiscal Year 2018 – Period 9
7/1/2017 to 3/31/2018

Financial Overview

- **Volume:**

- For the year, overall volume, measured in adjusted discharges is 5.7% higher than budget.
- IP cases are 4.0% over budget, specifically Neurosciences, HVI, BHS, Oncology and General Medicine. Deliveries are lower to prior year and 4.2% below budget.
- OP cases are higher than budget in General Surgery, General Medicine, Lab, Imaging Services, MCH, Rehab, Outpatient Clinics and Urology.

- **Financial Performance:**

- Operating income is \$4.9M over budget. Revenue for the month include \$205K in unusual items. For the year op margin is \$46.5M ahead of target.
- Investments had a \$3.2 million loss during the month but for the year, investment earnings remain \$32 million ahead of target.

- **Payor Mix:**

- Commercial insurance is 3.6% less of the Payor Mix in March than budget where Medicare has increased 2.1%.

- **Cost:**

- Prod Hrs/APD for March is 30.9 unfavorable vs. target due to lower volume. YTD we are ahead of budget.

- **Balance Sheet:**

- Net days in AR is 48.1 which is 0.1 days more than budget.

Dashboard - ECH combined as of March 31, 2018

| | Month | | | | | YTD | | | |
|----------------------------------|---------|---------|------------|-----------------------|--|---------|---------|------------|-----------------------|
| | PY | CY | Bud/Target | Variance CY vs Bud | | PY | CY | Bud/Target | Variance CY vs Bud |
| Volume | | | | | | | | | |
| Licenced Beds | 443 | 443 | 443 | - | | 443 | 443 | 443 | - |
| ADC | 259 | 244 | 251 | (6) | | 239 | 244 | 240 | 4 |
| Utilization MV | 70% | 67% | 69% | -2% | | 65% | 67% | 66% | 1% |
| Utilization LG | 34% | 31% | 30% | 1% | | 30% | 30% | 29% | 1% |
| Utilization Combined | 58% | 55% | 57% | -1% | | 54% | 55% | 54% | 1% |
| Total Discharges (Excl NNB) | 1,727 | 1,755 | 1,706 | 49 | | 14,659 | 15,394 | 14,803 | 591 |
| Financial Perf. | | | | | | | | | |
| Total Operating Revenue | 75,169 | 82,224 | 73,641 | 8,583 | | 628,926 | 692,328 | 641,138 | 51,189 |
| Operating Income \$ | 8,704 | 11,398 | 6,416 | 4,982 | | 74,932 | 106,040 | 59,554 | 46,487 |
| Operating Margin | 11.6% | 13.9% | 8.7% | 5.1% | | 11.9% | 15.3% | 9.3% | 6.0% |
| EBITDA % | 17.2% | 19.8% | 15.7% | 4.1% | | 18.3% | 21.3% | 16.4% | 4.9% |
| Payor Mix | | | | | | | | | |
| Medicare | 48.9% | 49.5% | 47.4% | 2.1% | | 47.7% | 47.4% | 47.4% | 0.0% |
| Medi-Cal | 6.8% | 7.5% | 7.2% | 0.3% | | 7.3% | 7.8% | 7.2% | 0.6% |
| Total Commercial | 41.5% | 39.3% | 42.9% | -3.6% | | 42.5% | 42.2% | 42.9% | -0.7% |
| Other | 2.8% | 3.7% | 2.5% | 1.2% | | 2.5% | 2.5% | 2.5% | 0.0% |
| Cost | | | | | | | | | |
| Total FTE | 2,549.6 | 2,605.8 | 2,569.9 | 36 | | 2,491.7 | 2,579.9 | 2,528.1 | 52 |
| Productive Hrs/APD | 29.4 | 30.9 | 29.9 | 1 | | 30.2 | 30.0 | 30.5 | (0) |
| Balance Sheet | | | | | | | | | |
| Net Days in AR | 44.8 | 48.1 | 48.0 | 0 | | 44.8 | 48.1 | 48.0 | 0 |
| Days Cash | 444 | 481 | 266 | 215 | | 444 | 481 | 266 | 215 |
| Affiliates - Net Income (\$000s) | | | | | | | | | |
| Hosp | 18,926 | 9,771 | 6,641 | 3,130 | | 114,328 | 149,758 | 61,581 | 88,177 |
| Concern | 51 | 141 | 87 | 54 | | 1,054 | 1,006 | 1,059 | (53) |
| ECSC | (12) | (19) | 0 | (19) | | (72) | (41) | 0 | (41) |
| Foundation | 43 | 5 | 99 | (94) | | 2,089 | 1,520 | 549 | 971 |
| SVMD | (43) | 628 | 6 | 622 | | 118 | 346 | 47 | 299 |

Budget Variances

Fiscal Year 2018 YTD (7/1/2017-03/31/2018) Waterfall

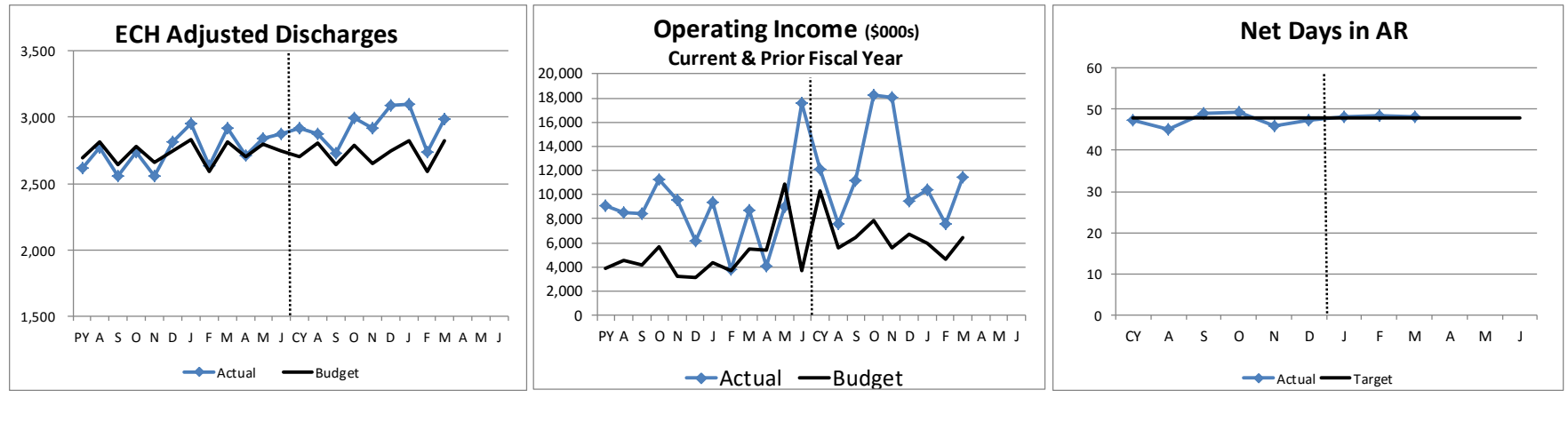
| (in thousands; \$000s) | Year to Date (YTD) | |
|---|--------------------|---------------|
| | Net Income Impact | % Net Revenue |
| Budgeted Hospital Operations FY2018 | 59,554 | 9.3% |
| Net Revenue - Favorable due higher volume, revenue cycle operations and \$11 million unusual items | 51,189 | 7.4% |
| Labor and Benefit Expense Change - Labor favorable vs budget after adjusting for higher volume | (2,585) | -0.4% |
| Professional Fees & Purchased Services -Recruiting costs and backfill for vacant position; | (4,503) | -0.7% |
| Supplies - unfavorable due to increase in surgical and other general supplies, offset by savings in Spine supplies as well as Drugs. Higher volumes also driving increase. | (3,309) | -0.5% |
| Other Expenses - primarily due strategic fund expenses not spent | 1,291 | 0.2% |
| Depreciation & Interest - Favorable due to delay in Parking Structure as well as LG projects | 4,403 | 0.6% |
| Actual Hospital Operations FY2018 | 106,040 | 15.3% |

El Camino Hospital (\$000s)

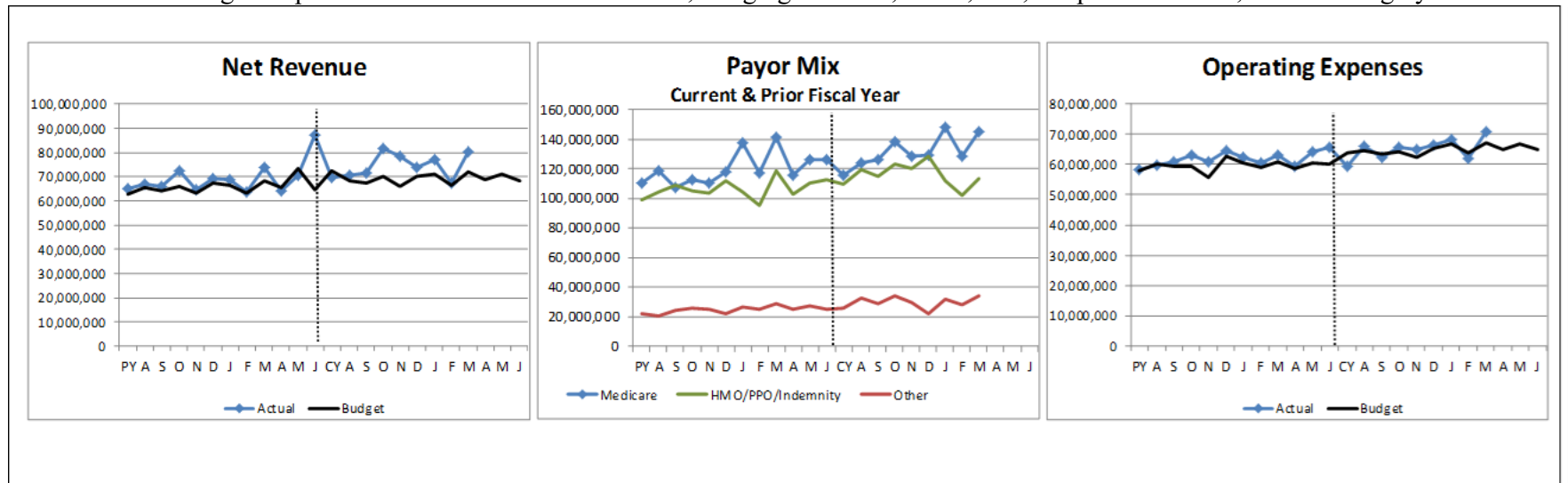
9 months ending 03/31/2018

| Period 9 FY 2017 | Period 9 FY 2018 | Period 9 Budget 2018 | Variance Fav (Unfav) | Var% | | YTD FY 2017 | YTD FY 2018 | YTD Budget 2018 | Variance Fav (Unfav) | Var% |
|---------------------|---------------------|-------------------------|-------------------------|--------------|-----------------------------|----------------|----------------|--------------------|-------------------------|---------------|
| | | | | | \$000s | | | | | |
| | | | | | OPERATING REVENUE | | | | | |
| 289,052 | 292,898 | 278,293 | 14,605 | 5.2% | Gross Revenue | 2,246,502 | 2,494,405 | 2,390,801 | 103,604 | 4.3% |
| (215,465) | (212,815) | (206,530) | (6,285) | 1.0% | Deductions | (1,636,389) | (1,824,147) | (1,767,195) | (56,952) | 3.2% |
| 73,587 | 80,083 | 71,763 | 8,320 | 11.6% | Net Patient Revenue | 610,114 | 670,258 | 623,606 | 46,652 | 7.5% |
| 1,582 | 2,141 | 1,878 | 263 | 14.0% | Other Operating Revenue | 18,813 | 22,069 | 17,532 | 4,537 | 25.9% |
| 75,169 | 82,224 | 73,641 | 8,583 | 11.7% | Total Operating Revenue | 628,926 | 692,328 | 641,138 | 51,189 | 8.0% |
| | | | | | OPERATING EXPENSE | | | | | |
| 37,957 | 41,202 | 40,866 | (336) | -0.8% | Salaries & Wages | 334,058 | 353,569 | 350,984 | (2,585) | -0.7% |
| 11,651 | 12,219 | 10,766 | (1,452) | -13.5% | Supplies | 86,784 | 94,953 | 91,644 | (3,309) | -3.6% |
| 10,395 | 10,327 | 7,981 | (2,346) | -29.4% | Fees & Purchased Services | 72,539 | 75,972 | 71,469 | (4,503) | -6.3% |
| 2,256 | 2,188 | 2,466 | 278 | 11.3% | Other Operating Expense | 20,753 | 20,629 | 21,920 | 1,291 | 5.9% |
| 265 | 691 | 725 | 35 | 4.8% | Interest | 3,688 | 4,293 | 6,529 | 2,236 | 34.2% |
| 3,941 | 4,201 | 4,421 | 220 | 5.0% | Depreciation | 36,172 | 36,871 | 39,039 | 2,167 | 5.6% |
| 66,465 | 70,827 | 67,226 | (3,601) | -5.4% | Total Operating Expense | 553,994 | 586,287 | 581,585 | (4,703) | -0.8% |
| 8,704 | 11,398 | 6,416 | 4,982 | 77.7% | Net Operating Income/(Loss) | 74,932 | 106,040 | 59,554 | 46,487 | 78.1% |
| 10,223 | (1,626) | 225 | (1,852) | -821.9% | Non Operating Income | 39,395 | 43,718 | 2,028 | 41,690 | 2056.1% |
| 18,926 | 9,771 | 6,641 | 3,130 | 47.1% | Net Income(Loss) | 114,328 | 149,758 | 61,581 | 88,177 | 143.2% |
| 17.2% | 19.8% | 15.7% | 4.1% | | EBITDA | 18.3% | 21.3% | 16.4% | 4.9% | |
| 11.6% | 13.9% | 8.7% | 5.1% | | Operating Margin | 11.9% | 15.3% | 9.3% | 6.0% | |
| 25.2% | 11.9% | 9.0% | 2.9% | | Net Margin | 18.2% | 21.6% | 9.6% | 12.0% | |

Monthly Financial Trends

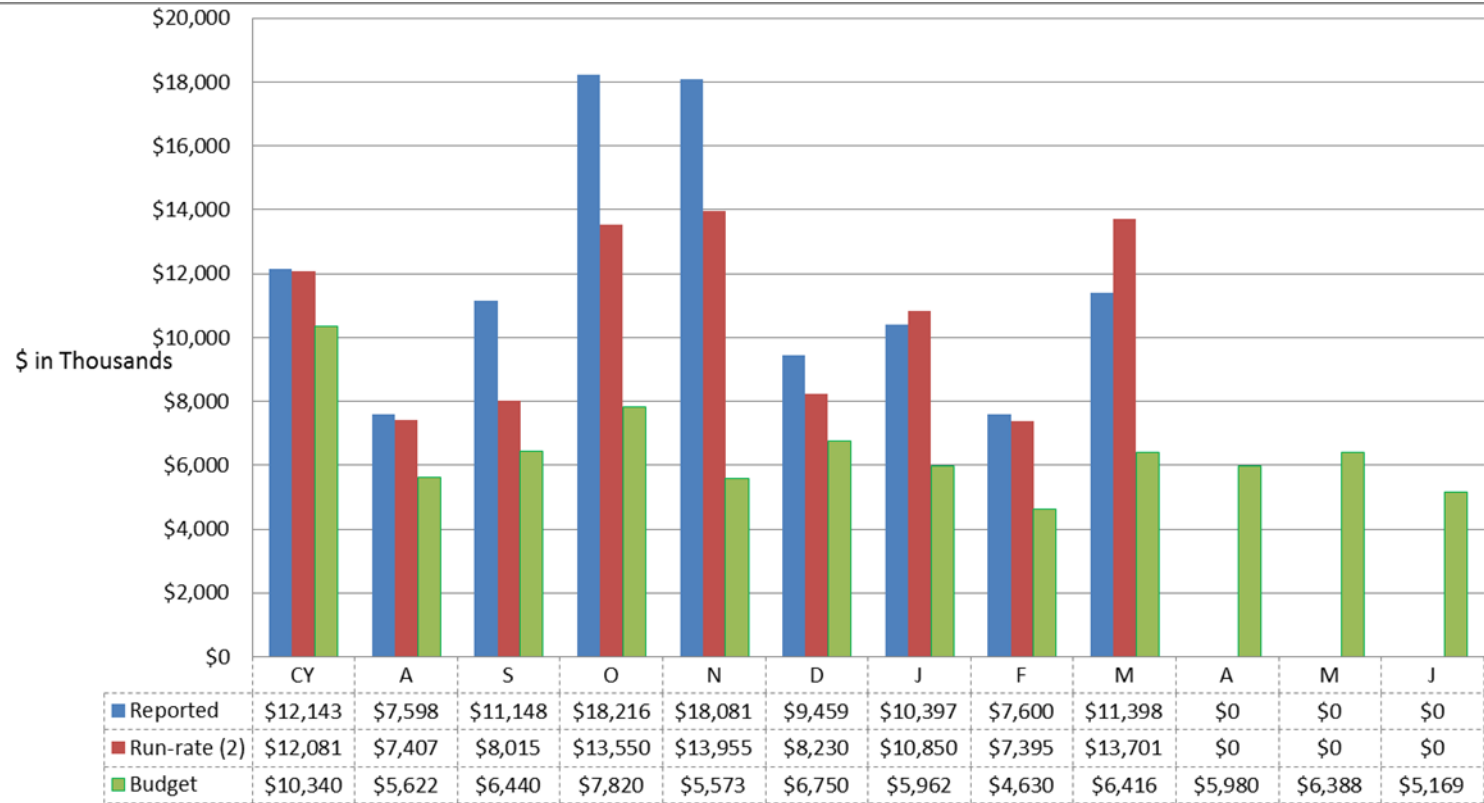


Volume is higher than budget for the month and the year. High inpatient volume is in Inpatient Behavioral Health, HVI, Neurosciences and General Medicine. High Outpatient volume is General Medicine, Imaging Services, MCH, Lab, Outpatient Clinics, General Surgery and Rehab.



ECH Operating Margin

Run rate is booked operating income adjusted for material non-recurring transactions



FY 2018 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>

| Revenue Adjustments | J | A | S | O | N | D | J | F | M | YTD |
|---|-----------|------------|--------------|--------------|--------------|--------------|--------------|------------|----------------|---------------|
| Insurance (Payment Variance) | - | - | - | 611 | - | 669 | 28 | - | 603 | 1,912 |
| Mcare Settltmt/Appeal/Tent Settltmt/PIP | 54 | 155 | 905 | 54 | 184 | 81 | 396 | 92 | 92 | 2,379 |
| AB 915 | - | - | - | - | - | - | - | 103 | 926 | 1,029 |
| Hospital Fee | - | - | - | 712 | 1,024 | - | - | - | - | 1,736 |
| PRIME Incentive | - | - | - | - | 2,902 | - | - | - | - | 2,902 |
| Credit Balance Quarterly Review | - | - | 2,201 | - | - | 472 | - | - | (789) | 1,884 |
| Late Charge Accrual | - | - | - | 3,283 | - | - | - | - | (3,152) | 131 |
| Various Adjustments under \$250k | 9 | 36 | 27 | 6 | 16 | 8 | (878) | 10 | 17 | (749) |
| Total | 63 | 191 | 3,134 | 4,667 | 4,126 | 1,229 | (453) | 205 | (2,303) | 11,223 |

El Camino Hospital Investment Committee Scorecard

March 31, 2018

| Key Performance Indicator | Status | El Camino | Benchmark | El Camino | Benchmark | El Camino | Benchmark | FY18 Year-end Budget | Expectation Per Asset Allocation |
|---|--------|----------------|---------------------------|---|-----------|---|-----------|----------------------------|--|
| Investment Performance | | 1Q 2018 | | Fiscal Year-to-date | | 5y 5m Since Inception (annualized) | | 2018 | |
| Surplus cash balance* | | \$875.2 | -- | -- | -- | -- | -- | \$926.1 | -- |
| Surplus cash return | | 0.1% | -0.6% | 5.5% | 4.9% | 5.7% | 5.5% | 1.9% | 5.3% |
| Cash balance plan balance (millions) | | \$260.0 | -- | -- | -- | -- | -- | \$257.1 | -- |
| Cash balance plan return | | 0.4% | -0.7% | 6.7% | 6.0% | 8.1% | 7.4% | 6.0% | 5.7% |
| 403(b) plan balance (millions) | | \$455.1 | -- | -- | -- | -- | -- | -- | -- |
| Risk vs. Return | | 3-year | | 5y 5m Since Inception (annualized) | | 2018 | | | |
| Surplus cash Sharpe ratio | | 0.93 | 0.91 | -- | -- | 1.29 | 1.26 | -- | 0.43 |
| Net of fee return | | 4.9% | 4.7% | -- | -- | 5.7% | 5.5% | -- | 5.3% |
| Standard deviation | | 4.8% | 4.7% | -- | -- | 4.1% | 4.1% | -- | 6.7% |
| Cash balance Sharpe ratio | | 0.95 | 0.92 | -- | -- | 1.39 | 1.32 | -- | 0.40 |
| Net of fee return | | 6.0% | 5.6% | -- | -- | 8.1% | 7.4% | -- | 5.7% |
| Standard deviation | | 5.9% | 5.6% | -- | -- | 5.5% | 5.3% | -- | 8.1% |
| Asset Allocation | | 1Q 2018 | | | | | | | |
| Surplus cash absolute variances to target | | 6.4% | < 10% | -- | -- | -- | -- | -- | -- |
| Cash balance absolute variances to target | | 4.9% | < 10% | -- | -- | -- | -- | -- | -- |
| Manager Compliance | | 1Q 2018 | | | | | | | |
| Surplus cash manager flags | | 29 | < 24 Green < 30 Yellow | -- | -- | -- | -- | -- | -- |
| Cash balance plan manager flags | | 32 | < 27 Green < 34 Yellow | -- | -- | -- | -- | -- | -- |

*Excludes debt reserve funds (~\$223 mm), District assets (~\$33 mm), and balance sheet cash not in investable portfolio (~\$133 mm).

Includes Foundation (~\$26 mm) and Concern (~\$13 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.



El Camino Hospital

Capital Spending (in millions)

| | | Total | | Total | Spent from Inception | 2018 Current Proj Spend | FY18 Orig Proj Spend | Variance | | |
|---|--|----------|------------------------------|----------------------|-------------------------|----------------------------|-------------------------|--|-----------------|------|
| Category | Detail | Approved | Estimated Cost of Project | Authorized Active | | | | Between Current Proj Spend and Orig Proj Spend | FY 18 YTD Spent | |
| CIP | EPIC Upgrade | | | 1.9 | 1.0 | 1.9 | 1.9 | 0.0 | | 1.0 |
| IT Hardware, Software, Equipment & Imaging* | | | | 12.2 | 1.0 | 12.2 | 12.2 | 0.0 | | 1.0 |
| Medical & Non Medical Equipment FY 17** | | | | 14.0 | 12.9 | 8.6 | 0.0 | 8.6 ² | | 7.5 |
| Medical & Non Medical Equipment FY 18*** | | | | 5.6 | 3.8 | 5.6 | 5.6 | 0.0 | | 3.8 |
| Facility Projects | | | | | | | | | | |
| | 1245 Behavioral Health Bldg | FY16 | 96.1 | 96.1 | 35.4 | 27.0 | 51.4 | -24.4 ¹ | | 17.8 |
| | 1413 North Drive Parking Expansion | FY15 | 24.5 | 24.5 | 23.8 | 2.6 | 3.4 | -0.8 | | 4.1 |
| | 1414 Integrated MOB | FY15 | 302.1 | 302.1 | 88.5 | 72.0 | 130.1 | -58.1 ¹ | | 42.6 |
| | 1422 CUP Upgrade | FY16 | 9.0 | 9.0 | 5.7 | 5.5 | 4.0 | 1.5 | | 3.4 |
| | 1430 Women's Hospital Expansion | FY16 | 120.0 | 6.0 | 2.8 | 3.6 | 7.0 | -3.4 | | 2.4 |
| | 1425 IMOB Preparation Project - Old Main | FY16 | 20.0 | 0.0 | 2.7 | 0.0 | 0.0 | 0.0 | | 0.1 |
| | 1502 Cabling & Wireless Upgrades | FY16 | 0.0 | 0.0 | 2.5 | 0.0 | 0.0 | 0.0 | | 0.1 |
| | 1525 New Main Lab Upgrades | | 3.1 | 3.1 | 2.2 | 2.5 | 0.0 | 2.5 | | 1.7 |
| | 1515 ED Remodel Triage/Psych Observation | FY16 | 5.0 | 0.3 | 0.0 | 0.4 | 0.0 | 0.4 | | 0.0 |
| | 1503 Willow Pavilion Tomosynthesis | FY16 | 0.8 | 0.0 | 0.3 | 0.0 | 0.0 | 0.0 | | 0.0 |
| | 1602 JW House (Patient Family Residence) | | 6.5 | 0.5 | 0.1 | 0.5 | 0.5 | 0.0 | | 0.1 |
| | Site Signage and Other Improvements | | 1.0 | 0.0 | 0.0 | 0.3 | 1.0 | -0.8 | | 0.0 |
| | Nurse Call System Upgrades | | 2.4 | 0.0 | 0.0 | 0.1 | 0.0 | 0.1 | | 0.0 |
| | 1707 Imaging Equipment Replacement (5 or 6 rooms) | | 20.7 | 0.0 | 0.0 | 0.3 | 0.1 | 0.2 | | 0.0 |
| | 1708 IR/ Cath Lab Equipment Replacement | | 19.4 | 0.0 | 0.0 | 0.3 | 2.0 | -1.8 | | 0.0 |
| | Flooring Replacement | | 1.6 | 0.3 | 0.0 | 0.4 | 0.0 | 0.4 | | 0.0 |
| | 1219 LG Spine OR | FY13 | 0.0 | 0.0 | 3.7 | 0.0 | 0.0 | 0.0 | | 0.3 |
| | 1313 LG Rehab HVAC System & Structural | FY16 | 0.0 | 0.0 | 4.1 | 0.0 | 0.0 | 0.0 | | 0.4 |
| | 1248 LG Imaging Phase II (CT & Gen Rad) | FY16 | 8.8 | 8.8 | 8.1 | 0.6 | 0.7 | -0.1 | | 0.7 |
| | 1307 LG Upgrades | FY13 | 19.3 | 19.3 | 17.0 | 4.9 | 5.0 | -0.1 | | 3.1 |
| | 1508 LG NICU 4 Bed Expansion | FY16 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0 |
| | 1507 LG IR Upgrades | | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0 |
| | 1603 LG MOB Improvements (17) | | 5.0 | 5.0 | 4.4 | 3.5 | 3.5 | 0.0 | | 4.2 |
| | 1711 Emergency Sanitary & Water Storage | | 1.4 | 0.3 | 0.1 | 0.2 | 3.2 | -3.0 | | 0.1 |
| | LG Modular MRI & Awning | | 3.9 | 3.9 | 0.0 | 0.4 | 0.0 | 0.4 | | 0.0 |
| | LG Nurse Call System Upgrade | | 2.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0 |
| | LG Observation Unit (Conversion of ICU 2) | | 1.8 | 0.0 | 0.0 | 0.8 | 0.0 | 0.8 | | 0.0 |
| | 1712 LG Cancer Center | | 2.4 | 0.3 | 0.1 | 0.4 | 0.0 | 0.4 | | 0.1 |
| | All Other Projects under \$1M | | 5.6 | 0.4 | 45.1 | 1.8 | 0.0 | 1.8 | | 3.4 |
| | | | 684.4 | 479.6 | 246.6 | 128.0 | 211.9 | -83.9 | | 84.6 |
| GRAND TOTAL | | | | 499.4 | 265.3 | 156.5 | 231.7 | -75.2 | | 97.9 |

* Excluding EPIC

** Unspent Prior Year routine used as contingency

*** Includes 2 robot purchases

¹ Variance due to delay in MV campus plan

² Initial assumption was to spend all FY17 in FY17

Balance Sheet (in thousands)

ASSETS

| | Audited | |
|--|------------------|------------------|
| | March 31, 2018 | June 30, 2017 |
| CURRENT ASSETS | | |
| Cash | 133,219 | 125,551 |
| Short Term Investments | 140,491 | 140,284 |
| Patient Accounts Receivable, net | 120,025 | 109,089 |
| Other Accounts and Notes Receivable | 2,809 | 2,628 |
| Intercompany Receivables | 1,324 | 1,495 |
| (1) Inventories and Prepaids | 54,533 | 50,657 |
| Total Current Assets | 452,400 | 429,705 |
| BOARD DESIGNATED ASSETS | | |
| (2) Plant & Equipment Fund | 148,343 | 131,153 |
| Women's Hospital Expansion | 9,298 | 9,298 |
| (3) Operational Reserve Fund | 127,908 | 100,196 |
| (4) Community Benefit Fund | 18,299 | 12,237 |
| Workers Compensation Reserve Fund | 21,352 | 20,007 |
| Postretirement Health/Life Reserve Fund | 19,632 | 19,218 |
| PTO Liability Fund | 24,148 | 23,409 |
| Malpractice Reserve Fund | 1,634 | 1,634 |
| Catastrophic Reserves Fund | 17,792 | 16,575 |
| Total Board Designated Assets | 388,406 | 333,727 |
| (5) FUNDS HELD BY TRUSTEE | 222,181 | 287,052 |
| LONG TERM INVESTMENTS | 301,597 | 256,652 |
| INVESTMENTS IN AFFILIATES | 32,895 | 32,451 |
| PROPERTY AND EQUIPMENT | | |
| (6) Fixed Assets at Cost | 1,253,052 | 1,192,047 |
| Less: Accumulated Depreciation | (565,353) | (531,785) |
| Construction in Progress | 168,319 | 138,017 |
| Property, Plant & Equipment - Net | 856,018 | 798,279 |
| DEFERRED OUTFLOWS | 28,510 | 28,960 |
| RESTRICTED ASSETS - CASH | 0 | 0 |
| TOTAL ASSETS | 2,282,008 | 2,166,825 |

LIABILITIES AND FUND BALANCE

| | Audited | |
|--|------------------|------------------|
| | March 31, 2018 | June 30, 2017 |
| CURRENT LIABILITIES | | |
| (7) Accounts Payable | 24,344 | 38,457 |
| (8) Salaries and Related Liabilities | 16,618 | 25,109 |
| Accrued PTO | 24,148 | 23,409 |
| Worker's Comp Reserve | 2,300 | 2,300 |
| Third Party Settlements | 9,388 | 10,438 |
| Intercompany Payables | 73 | 84 |
| Malpractice Reserves | 1,634 | 1,634 |
| Bonds Payable - Current | 3,850 | 3,735 |
| (9) Bond Interest Payable | 5,059 | 11,245 |
| Other Liabilities | 7,660 | 4,889 |
| Total Current Liabilities | 95,074 | 121,299 |
| LONG TERM LIABILITIES | | |
| Post Retirement Benefits | 19,632 | 19,218 |
| Worker's Comp Reserve | 19,052 | 17,707 |
| Other L/T Obligation (Asbestos) | 3,831 | 3,746 |
| Other L/T Liabilities (IT/Medl Leases) | - | - |
| Bond Payable | 521,971 | 527,371 |
| Total Long Term Liabilities | 564,485 | 568,042 |
| DEFERRED REVENUE-UNRESTRICTED | 517 | 567 |
| DEFERRED INFLOW OF RESOURCES | 10,666 | 10,666 |
| FUND BALANCE/CAPITAL ACCOUNTS | | |
| Unrestricted | 1,222,860 | 1,132,525 |
| Board Designated | 388,406 | 333,726 |
| Restricted | 0 | 0 |
| (10) Total Fund Bal & Capital Accts | 1,611,266 | 1,466,251 |
| TOTAL LIABILITIES AND FUND BALANCE | 2,282,008 | 2,166,825 |

FEBRUARY 2018 El Camino Hospital Comparative Balance Sheet Variances and Footnotes

- (1) The increase is due to two quarterly pension fundings of \$2.6M in October and January.
- (2) The increase is due 8 months of funded depreciation contributions (130% of straight depreciation expense. Note this amount also contains \$14M reserved for BHS replacement building currently under construction, in conjunction with bond proceeds, item (5).
- (3) The increase here is to reset the Operational Reserve (to cover 60 days of operating expenses) for FY2018. The prior year balance hadn't been reset in a couple of years.
- (4) The increase is due to an approved addition of \$5 million to the Community Benefit Board Designated Endowment as an outcome of the FY2018 budget process to generate additional investment income for the Community Benefits program.
- (5) The decrease is due to additional draws from the 2017 bond financing Project Funds in support of monthly payments to contractors involved with the construction projects at the Mountain View campus. As these projects are now in full progress greater amounts will be withdrawn in future periods.
- (6) The increase is due to the capitalization of the Parking Structure expansion in August and CT upgrades at LG in September.
- (7) The decrease is due to the significant General Contractor construction payments being accrued at year end, along with associated retentions and other general accounts payable activity that were subsequently relieved in this first quarter of fiscal year 2018.
- (8) This decrease is primarily due to the annual 403B match funding that occurred in January
- (9) The significant decrease is due to semi-annual 2015A and 2017 Bond interest payments having been paid in January.
- (10) The increase is attributable to the first eight periods of financial performance producing an operating income of \$94 million and non-operating of \$45 million (mostly from unrealized gains on investments).

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (1 OF 2)

- **Plant & Equipment Fund** – original established by the District Board in the early 1960's to fund new capital expansion projects of building facilities or equipment (new or replacements). The funds came from the M&O property taxes being received and the funding depreciation expense at 100%. When at the end of 1992, the 501(c)(3) Hospital was performed by the District, the property tax receipts remained with the District. The newly formed Hospital entity continued on with funding depreciation expense, but did that funding at 130% of the depreciation expense to account for an expected replacement cost of current plant and property assets. It is to be noted that within this fund is an itemized amount of \$14 million for the Behavioral Health Service building replacement project. This amount came from the District's Capital Appropriation Fund (excess Gann Limit property taxes) of the fiscal years of 2010 thru 2013 by various District board actions.
- **Women's Hospital Expansion** – established June 2016 by the District authorizing the amounts accumulated in its Capital Appropriation Fund (excess Gann Limit property taxes) for the fiscal years of 2014 and 2015 to be allocated for the renovation of the Women's Hospital upon the completion of Integrated Medical Office Building currently under construction.
- **Operational Reserve Fund** – originally established by the District in May 1992 to establish a fund equal to sixty (60) days of operational expenses (based on projected budget) and only be used in the event of a major business interruption event and/or cash flow.
- **Community Benefit Fund** – following in the footsteps of the District in 2008 of forming its Community Benefit Fund using Gann Limit tax receipts, the Hospital in 2010 after opening its campus outside of District boundaries in Los Gatos formed its own Community Benefit Fund to provide grants/sponsorships in Los Gatos and surrounding areas. The funds come from the Hospital reserving \$1.5M a year from its operations, the entity of CONCERN contributing 40% of its annual income each year (an amount it would have paid in corporate taxes if it wasn't granted tax exempt status), that generates an amount of \$800,000 or more a year. \$15 million within this fund is a board designated endowment fund formed in 2015 with a \$10 million contribution, and added to at the end of the 2017 fiscal year end with another \$5 million contribution, to generate investment income to be used for grants and sponsorships, currently anticipated to generate \$500,000 a year in investment income for the program.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (2 OF 2)

- **Workers Compensation Reserve Fund** – as the Hospital is self-insured for its workers compensation program (since 1978) this fund was originally formed in early 2000's by management to reserve cash equal to the yearly actuarially determined Workers Compensation amount. The thought being if the business was to terminate for some reason this is the amount in cash that would be needed to pay out claims over the next few years.
- **Postretirement Health/Life Reserve Fund** – following the same formula as the Workers Compensation Reserve Fund this fund was formed in the early 2000's by management to reserve cash equal to the yearly actuarially determined amount to fund the Hospital's postretirement health and life insurance program. Note this program was frozen in 1995 for all new hires after that date.
- **PTO (Paid Time Off) Liability Fund** – originally formed in 1993 as the new 501(c)(3) Hospital began operations, management thought as a business requirement of this vested benefit program that monies should be set aside to extinguish this employee liability should such a circumstance arise. This balance is equal to the PTO Liability on the Balance Sheet.
- **Malpractice Reserve Fund** – originally established in 1989 by the then District's Finance Committee and continued by the Hospital. The amount is actuarially determined each year as part of the annual audit to fund potential claims less than \$50,000. Above \$50,000 our policy with the BETA Healthcare Group kicks in to a \$30 million limit per claim/\$40 million in the aggregate.
- **Catastrophic Loss Fund** – was established in 1999 by the Hospital Board to be a "self-insurance" reserve fund for potential non-major earthquake repairs. Initially funded by the District transferring \$5 million and has been added to by the last major payment from FEMA for the damage caused the Hospital by the October 1989 earthquake. It is to be noted that it took 10 years to receive final settlement from FEMA grants that totaled \$6.8 million that did mostly cover all the necessary repairs.

APPENDIX

El Camino Hospital – Mountain View (\$000s)

9 months ending 03/31/2018

| Period 9 FY 2017 | Period 9 FY 2018 | Period 9 Budget 2018 | Variance Fav (Unfav) | Var% | | YTD FY 2017 | YTD FY 2018 | YTD Budget 2018 | Variance Fav (Unfav) | Var% |
|--------------------------|---------------------|-------------------------|-------------------------|---------------|--|----------------|----------------|--------------------|-------------------------|---------------|
| | | | | | \$000s | | | | | |
| OPERATING REVENUE | | | | | | | | | | |
| 232,871 | 242,772 | 228,787 | 13,985 | 6.1% | Gross Revenue | 1,839,138 | 2,047,101 | 1,963,775 | 83,326 | 4.2% |
| (172,563) | (175,442) | (170,577) | (4,865) | 2.9% | Deductions | (1,337,120) | (1,493,958) | (1,457,075) | (36,883) | 2.5% |
| 60,309 | 67,330 | 58,210 | 9,121 | 15.7% | Net Patient Revenue | 502,018 | 553,143 | 506,700 | 46,444 | 9.2% |
| 1,407 | 1,924 | 1,663 | 261 | 15.7% | Other Operating Revenue | 17,311 | 20,476 | 15,606 | 4,870 | 31.2% |
| 61,716 | 69,255 | 59,873 | 9,382 | 15.7% | Total Operating Revenue | 519,330 | 573,619 | 522,306 | 51,314 | 9.8% |
| OPERATING EXPENSE | | | | | | | | | | |
| 31,187 | 34,332 | 34,198 | (134) | -0.4% | Salaries & Wages | 277,388 | 294,343 | 293,769 | (573) | -0.2% |
| 9,167 | 10,219 | 8,681 | (1,538) | -17.7% | Supplies | 70,273 | 77,010 | 73,840 | (3,170) | -4.3% |
| 8,979 | 9,082 | 6,677 | (2,405) | -36.0% | Fees & Purchased Services * | 60,278 | 63,993 | 59,942 | (4,050) | -6.8% |
| 651 | 664 | 933 | 269 | 28.9% | Other Operating Expense | 6,241 | 6,556 | 7,927 | 1,371 | 17.3% |
| 265 | 691 | 725 | 35 | 4.8% | Interest | 3,688 | 4,293 | 6,529 | 2,236 | 34.2% |
| 3,454 | 3,512 | 3,662 | 150 | 4.1% | Depreciation | 31,520 | 31,463 | 32,437 | 974 | 3.0% |
| 53,703 | 58,500 | 54,877 | (3,623) | -6.6% | Total Operating Expense | 449,388 | 477,658 | 474,445 | (3,213) | -0.7% |
| 8,012 | 10,754 | 4,996 | 5,758 | 115.3% | Net Operating Income/(Loss) | 69,942 | 95,961 | 47,860 | 48,101 | 100.5% |
| 10,223 | (1,626) | 225 | (1,852) | -821.9% | Non Operating Income | 39,406 | 43,762 | 2,028 | 41,735 | 2058.3% |
| 18,235 | 9,128 | 5,221 | 3,907 | 74.8% | Net Income(Loss) | 109,348 | 139,724 | 49,888 | 89,836 | 180.1% |
| 19.0% | 21.6% | 15.7% | 5.9% | | EBITDA | 20.2% | 23.0% | 16.6% | 6.3% | |
| 13.0% | 15.5% | 8.3% | 7.2% | | Operating Margin | 13.5% | 16.7% | 9.2% | 7.6% | |
| 29.5% | 13.2% | 8.7% | 4.5% | | Net Margin | 21.1% | 24.4% | 9.6% | 14.8% | |

El Camino Hospital – Los Gatos(\$000s)

9 months ending 03/31/2018

| Period 9 FY 2017 | Period 9 FY 2018 | Period 9 Budget 2018 | Variance Fav (Unfav) | Var% | | YTD FY 2017 | YTD FY 2018 | YTD Budget 2018 | Variance Fav (Unfav) | Var% |
|--------------------------|---------------------|-------------------------|-------------------------|---------------|--|----------------|----------------|--------------------|-------------------------|---------------|
| | | | | | \$000s | | | | | |
| OPERATING REVENUE | | | | | | | | | | |
| 56,181 | 50,126 | 49,507 | 619 | 1.3% | Gross Revenue | 407,364 | 447,304 | 427,026 | 20,278 | 4.7% |
| (42,903) | (37,373) | (35,953) | (1,420) | 3.9% | Deductions | (299,269) | (330,189) | (310,120) | (20,069) | 6.5% |
| 13,278 | 12,753 | 13,553 | (801) | -5.9% | Net Patient Revenue | 108,095 | 117,115 | 116,906 | 209 | 0.2% |
| 175 | 217 | 215 | 2 | 0.9% | Other Operating Revenue | 1,501 | 1,593 | 1,926 | (333) | -17.3% |
| 13,453 | 12,970 | 13,768 | (799) | -5.8% | Total Operating Revenue | 109,596 | 118,708 | 118,833 | (124) | -0.1% |
| OPERATING EXPENSE | | | | | | | | | | |
| 6,769 | 6,870 | 6,668 | (202) | -3.0% | Salaries & Wages | 56,670 | 59,226 | 57,214 | (2,012) | -3.5% |
| 2,484 | 1,999 | 2,085 | 86 | 4.1% | Supplies | 16,511 | 17,943 | 17,804 | (139) | -0.8% |
| 1,416 | 1,245 | 1,304 | 59 | 4.6% | Fees & Purchased Services * | 12,261 | 11,979 | 11,527 | (452) | -3.9% |
| 1,605 | 1,524 | 1,533 | 9 | 0.6% | Other Operating Expense | 14,512 | 14,073 | 13,993 | (80) | -0.6% |
| 0 | 0 | 0 | 0 | 0.0% | Interest | 0 | 0 | 0 | 0 | 0.0% |
| 487 | 689 | 759 | 70 | 9.2% | Depreciation | 4,652 | 5,408 | 6,602 | 1,194 | 18.1% |
| 12,762 | 12,326 | 12,349 | 22 | 0.2% | Total Operating Expense | 104,606 | 108,629 | 107,139 | (1,490) | -1.4% |
| 692 | 643 | 1,420 | (776) | -54.7% | Net Operating Income/(Loss) | 4,991 | 10,079 | 11,694 | (1,614) | -13.8% |
| 0 | 0 | 0 | 0 | 0.0% | Non Operating Income | (10) | (45) | 0 | (45) | 0.0% |
| 692 | 643 | 1,420 | (776) | -54.7% | Net Income(Loss) | 4,980 | 10,035 | 11,694 | (1,659) | -14.2% |
| 8.8% | 10.3% | 15.8% | -5.6% | | EBITDA | 8.8% | 13.0% | 15.4% | -2.3% | |
| 5.1% | 5.0% | 10.3% | -5.4% | | Operating Margin | 4.6% | 8.5% | 9.8% | -1.3% | |
| 5.1% | 5.0% | 10.3% | -5.4% | | Net Margin | 4.5% | 8.5% | 9.8% | -1.4% | |

Non Operating Items and Net Income by Affiliate

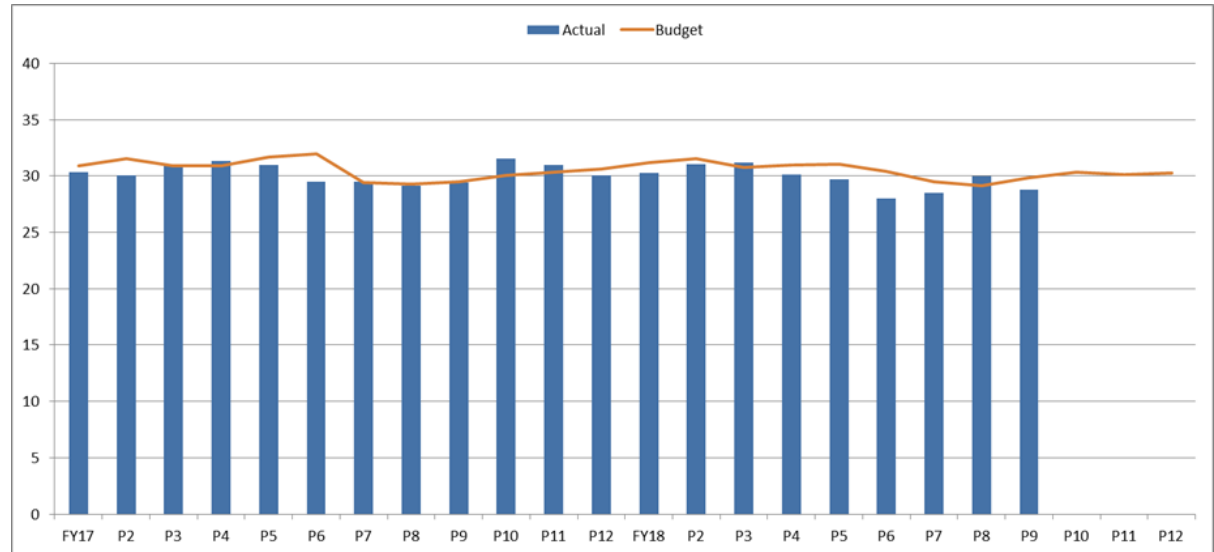
\$ in thousands

| | Period 9 - Month | | | Period 9 - FYTD | | |
|---|------------------|--------------|----------------|-----------------|---------------|---------------|
| | Actual | Budget | Variance | Actual | Budget | Variance |
| El Camino Hospital Income (Loss) from Operations | | | | | | |
| Mountain View | 10,754 | 4,996 | 5,758 | 95,961 | 47,860 | 48,101 |
| Los Gatos | 643 | 1,420 | (776) | 10,079 | 11,694 | (1,614) |
| Sub Total - El Camino Hospital, excl. Affiliates | 11,398 | 6,416 | 4,982 | 106,040 | 59,554 | 46,487 |
| Operating Margin % | 13.9% | 8.7% | | 15.3% | 9.3% | |
| El Camino Hospital Non Operating Income | | | | | | |
| Investments | (3,165) | 1,516 | (4,681) | 45,549 | 13,640 | 31,910 |
| Swap Adjustments | (221) | 0 | (221) | 1,550 | 0 | 1,550 |
| Community Benefit | (613) | (283) | (330) | (3,063) | (2,550) | (513) |
| Pathways | (1,136) | 42 | (1,177) | (210) | 375 | (585) |
| Satellite Dialysis | (40) | (35) | (4) | (190) | (319) | 129 |
| Community Connect | 0 | (141) | 141 | 0 | (1,265) | 1,265 |
| SVMD Funding | (416) | (448) | 33 | (1,365) | (4,035) | 2,670 |
| Premier Investment | 4,234 | 0 | 4,234 | 4,528 | 0 | 4,528 |
| Other | (270) | (424) | 155 | (3,082) | (3,819) | 737 |
| Sub Total - Non Operating Income | (1,626) | 225 | (1,852) | 43,718 | 2,028 | 41,690 |
| El Camino Hospital Net Income (Loss) | 9,771 | 6,641 | 3,130 | 149,758 | 61,581 | 88,177 |
| ECH Net Margin % | 11.9% | 9.0% | | 21.6% | 9.6% | |
| Concern | 141 | 87 | 54 | 1,006 | 1,059 | (53) |
| ECSC | (19) | 0 | (19) | (41) | 0 | (41) |
| Foundation | 5 | 99 | (94) | 1,520 | 549 | 971 |
| Silicon Valley Medical Development | 628 | 6 | 622 | 346 | 47 | 299 |
| Net Income Hospital Affiliates | 754 | 191 | 563 | 2,831 | 1,655 | 1,176 |
| Total Net Income Hospital & Affiliates | 10,526 | 6,832 | 3,693 | 152,590 | 63,236 | 89,353 |

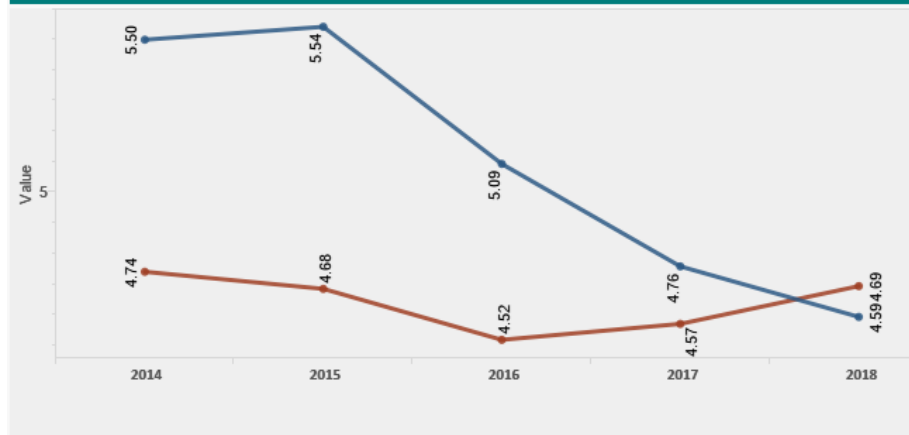
Productivity and Medicare Length of Stay

Work hours per adjusted patient day in March is over budget by 1.0. Overall the month of March is 30.8 worked hours per adjusted patient day

ALOS vs Milliman well-managed benchmark. Trend shows remarkable and steady improvement with FY 2018 at benchmark. Increase in benchmark beginning in FY 2017 due to Clinical Documentation Improvement (CDI)



AVERAGE LENGTH OF STAY TREND BY MONTH/YEAR

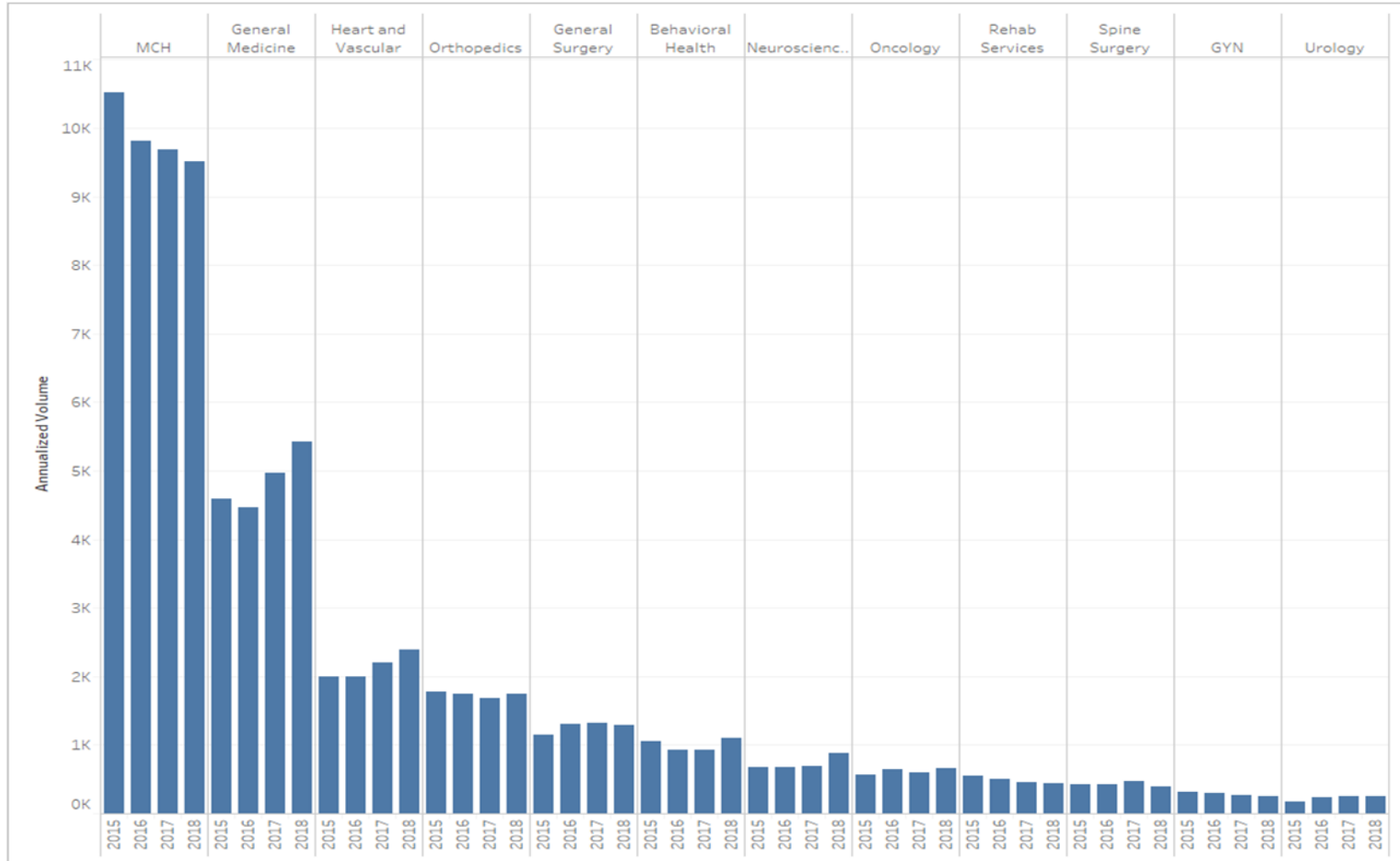


AVERAGE LENGTH OF STAY TREND BY MONTH/YEAR



El Camino Hospital Volume Annual Trends – Inpatient

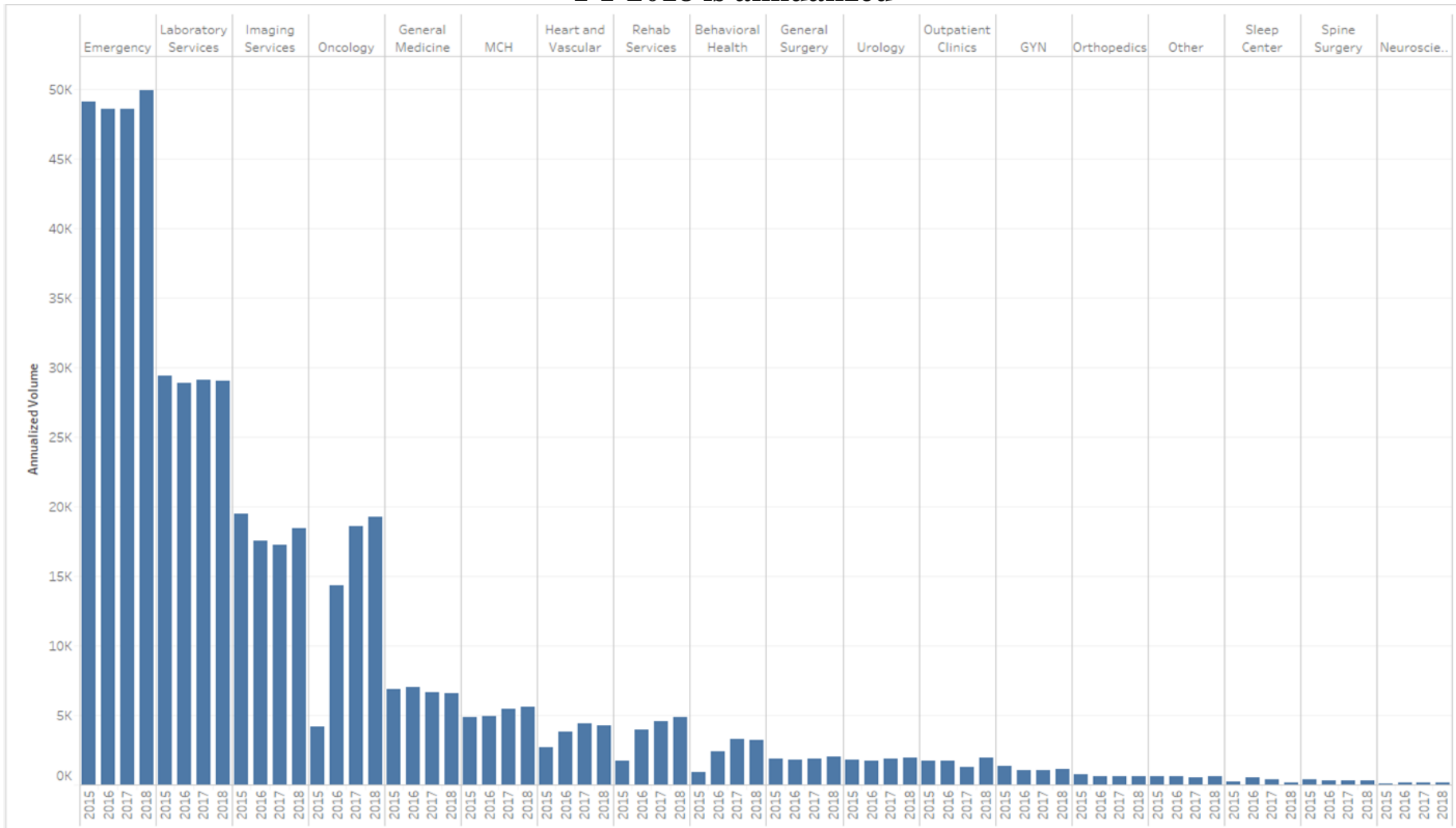
FY 2018 is annualized



- General Medicine, HVI, Behavioral Health, and Neuroscience display an increasing trend.
- Conversely, Rehab Services, MCH and GYN show a decreasing trend.
- The remaining service lines are staying flat.

El Camino Hospital Volume Annual Trends – Outpatient

FY 2018 is annualized



- Comparing year-over-year Oncology, MCH, Rehab Services, Emergency and Outpatient Clinics are all increasing in volume. All others are remaining flat or decreasing.

Capital Spend Trend & FY 18 Budget

| Capital Spending (in 000's) | Actual FY2015 | Actual FY2016 | Actual FY2017 | Projected FY2018 |
|--|------------------|------------------|------------------|---------------------|
| EPIC | 29,849 | 20,798 | 2,755 | 1,922 |
| IT Hardware / Software Equipment | 4,660 | 6,483 | 2,659 | 12,238 |
| Medical / Non Medical Equipment* | 13,340 | 17,133 | 9,556 | 14,275 |
| Non CIP Land, Land I , BLDG, Additions | - | 4,189 | - | - |
| Facilities | 38,940 | 48,137 | 82,953 | 128,030 |
| GRAND TOTAL | 86,789 | 96,740 | 97,923 | 156,465 |
| *Includes 2 robot purchases in FY2017 | | | | |

El Camino Hospital Capital Spending (in thousands) FY 2012 – FY 2017

| Category | 2013 | 2014 | 2015 | 2016 | 2017 |
|---------------------------------------|--------|--------|--------|--------|-------|
| EPIC | 0 | 6,838 | 29,849 | 20,798 | 2,755 |
| IT Hardware/Software Equipment | 8,019 | 2,788 | 4,660 | 6,483 | 2,659 |
| Medical/Non Medical Equipment | 10,284 | 12,891 | 13,340 | 17,133 | 9,556 |
| Non CIP Land, Land I, BLDG, Additions | 0 | 22,292 | 0 | 4,189 | 0 |
| Land Acquisition (1550) | 0 | 0 | 0 | 24,007 | 0 |
| 828 S Winchester Clinic TI (1701) | 0 | 0 | 0 | 0 | 145 |

Facilities Projects CIP

Mountain View Campus Master Plan Projects

| | | | | | |
|---|----------|--------------|--------------|---------------|---------------|
| 1245 - Behavioral Health Bldg Replace | 0 | 1,257 | 3,775 | 1,389 | 10,323 |
| 1413 - North Drive Parking Structure Exp | 0 | 0 | 167 | 1,266 | 18,120 |
| 1414 - Integrated MOB | 0 | 0 | 2,009 | 8,875 | 32,805 |
| 1422 - CUP Upgrade | 0 | 0 | 0 | 896 | 1,245 |
| Sub-Total Mountain View Campus Master Plan | 0 | 1,257 | 5,950 | 12,426 | 62,493 |

Mountain View Capital Projects

| | | | | | |
|--|-------|-------|--------|-------|-----|
| 9900 - Unassigned Costs | 734 | 470 | 3,717 | 0 | 0 |
| 1108 - Cooling Towers | 450 | 0 | 0 | 0 | 0 |
| 1120 - BHS Out Patient TI's | 66 | 0 | 0 | 0 | 0 |
| 1129 - Old Main Card Rehab | 9 | 0 | 0 | 0 | 0 |
| 0817 - Womens Hosp Upgrds | 645 | 1 | 0 | 0 | 0 |
| 0906 - Slot Build-Out | 1,003 | 1,576 | 15,101 | 1,251 | 294 |
| 1109 - New Main Upgrades | 423 | 393 | 2 | 0 | 0 |
| 1111 - Mom/Baby Overflow | 212 | 29 | 0 | 0 | 0 |
| 1204 - Elevator Upgrades | 25 | 30 | 0 | 0 | 0 |
| 0800 - Womens L&D Expansion | 2,104 | 1,531 | 269 | 0 | 0 |
| 1131 - MV Equipment Replace | 216 | 0 | 0 | 0 | 0 |
| 1208 - Willow Pav. High Risk | 110 | 0 | 0 | 0 | 0 |
| 1213 - LG Sterilizers | 102 | 0 | 0 | 0 | 0 |
| 1225 - Rehab BLDG Roofing | 7 | 241 | 4 | 0 | 0 |
| 1227 - New Main eICU | 96 | 21 | 0 | 0 | 0 |
| 1230 - Fog Shop | 339 | 80 | 0 | 0 | 0 |
| 1315 - 205 So. Drive TI's | 0 | 500 | 2 | 0 | 0 |
| 0908 - NPCR3 Seismic Upgrds | 1,302 | 1,224 | 1,328 | 240 | 342 |
| 1125 - Will Pav Fire Sprinkler | 57 | 39 | 0 | 0 | 0 |
| 1211 - SIS Monitor Install | 215 | 0 | 0 | 0 | 0 |
| 1216 - New Main Process Imp Office | 19 | 1 | 16 | 0 | 0 |
| 1217 - MV Campus MEP Upgrades FY13 | 0 | 181 | 274 | 28 | 0 |
| 1224 - Rehab Bldg HVAC Upgrades | 11 | 202 | 81 | 14 | 6 |
| 1301 - Desktop Virtual | 0 | 13 | 0 | 0 | 0 |
| 1304 - Rehab Wander Mgmt | 0 | 87 | 0 | 0 | 0 |
| 1310 - Melchor Cancer Center Expansion | 0 | 44 | 13 | 0 | 0 |
| 1318 - Women's Hospital TI | 0 | 48 | 48 | 29 | 2 |
| 1327 - Rehab Building Upgrades | 0 | 0 | 15 | 20 | 0 |
| 1320 - 2500 Hosp Dr Roofing | 0 | 75 | 81 | 0 | 0 |
| 1340 - New Main ED Exam Room TVs | 0 | 8 | 193 | 0 | 0 |
| 1341 - New Main Admin | 0 | 32 | 103 | 0 | 0 |
| 1344 - New Main AV Upgrd | 0 | 243 | 0 | 0 | 0 |
| 1400 - Oak Pav Cancer Center | 0 | 0 | 5,208 | 666 | 52 |

| Category | 2013 | 2014 | 2015 | 2016 | 2017 |
|--|---------------|---------------|---------------|---------------|---------------|
| Facilities Projects CIP cont. | | | | | |
| 1403 - Hosp Drive BLDG 11 TI's | 0 | 86 | 103 | 0 | 0 |
| 1404 - Park Pav HVAC | 0 | 64 | 7 | 0 | 0 |
| 1405 - 1 - South Accessibility Upgrades | 0 | 0 | 0 | 168 | 95 |
| 1408 - New Main Accessibility Upgrades | 0 | 0 | 7 | 46 | 501 |
| 1415 - Signage & Wayfinding | 0 | 0 | 0 | 106 | 58 |
| 1416 - MV Campus Digital Directories | 0 | 0 | 0 | 34 | 23 |
| 1423 - MV MOB TI Allowance | 0 | 0 | 0 | 588 | 369 |
| 1425 - IMOB Preparation Project - Old Main | 0 | 0 | 0 | 711 | 1,860 |
| 1429 - 2500 Hospital Dr Bldg 8 TI | 0 | 0 | 101 | 0 | 0 |
| 1430 - Women's Hospital Expansion | 0 | 0 | 0 | 0 | 464 |
| 1432 - 205 South Dr BHS TI | 0 | 0 | 8 | 15 | 0 |
| 1501 - Women's Hospital NPC Comp | 0 | 0 | 4 | 0 | 223 |
| 1502 - Cabling & Wireless Upgrades | 0 | 0 | 0 | 1,261 | 367 |
| 1503 - Willow Pavillion Tomosynthesis | 0 | 0 | 0 | 53 | 257 |
| 1504 - Equipment Support Infrastructure | 0 | 0 | 61 | 311 | 0 |
| 1523 - Melchor Pavillion Suite 309 TI | 0 | 0 | 0 | 10 | 59 |
| 1525 - New Main Lab Upgrades | 0 | 0 | 0 | 0 | 464 |
| 1526 - CONCERN TI | 0 | 0 | 0 | 37 | 99 |
| Sub-Total Mountain View Projects | 8,145 | 7,219 | 26,744 | 5,588 | 5,535 |
| Los Gatos Capital Projects | | | | | |
| 0904 - LG Facilities Upgrade | 2 | 0 | 0 | 0 | 0 |
| 0907 - LG Imaging Masterplan | 244 | 774 | 1,402 | 17 | 0 |
| 1005 - LG OR Light Upgrd | 14 | 0 | 0 | 0 | 0 |
| 1122 - LG Sleep Studies | 7 | 0 | 0 | 0 | 0 |
| 1210 - Los Gatos VOIP | 147 | 89 | 0 | 0 | 0 |
| 1116 - LG Ortho Pavillion | 177 | 24 | 21 | 0 | 0 |
| 1124 - LG Rehab BLDG | 49 | 458 | 0 | 0 | 0 |
| 1247 - LG Infant Security | 134 | 0 | 0 | 0 | 0 |
| 1307 - LG Upgrades | 376 | 2,979 | 3,282 | 3,511 | 3,081 |
| 1308 - LG Infrastructure | 0 | 114 | 0 | 0 | 0 |
| 1313 - LG Rehab HVAC System/Structural | 0 | 0 | 0 | 1,597 | 1,904 |
| 1219 - LG Spine OR | 0 | 214 | 323 | 633 | 2,163 |
| 1221 - LG Kitchen Refrig | 0 | 85 | 0 | 0 | 0 |
| 1248 - LG - CT Upgrades | 0 | 26 | 345 | 197 | 6,669 |
| 1249 - LG Mobile Imaging | 0 | 146 | 0 | 0 | 0 |
| 1328 - LG Ortho Canopy FY14 | 0 | 255 | 209 | 0 | 0 |
| 1345 - LG Lab HVAC | 0 | 112 | 0 | 0 | 0 |
| 1346 - LG OR 5, 6, and 7 Lights Replace | 0 | 0 | 285 | 53 | 22 |
| 1347 - LG Central Sterile Upgrades | 0 | 0 | 181 | 43 | 66 |
| 1421 - LG MOB Improvements | 0 | 0 | 198 | 65 | 303 |
| 1508 - LG NICU 4 Bed Expansion | 0 | 0 | 0 | 0 | 207 |
| 1600 - 825 Pollard - Aspire Phase II | 0 | 0 | 0 | 0 | 80 |
| 1603 - LG MOB Improvements | 0 | 0 | 0 | 0 | 285 |
| Sub-Total Los Gatos Projects | 1,150 | 5,276 | 6,246 | 6,116 | 14,780 |
| Subtotal Facilities Projects CIP | 9,294 | 13,753 | 38,940 | 24,130 | 82,808 |
| Grand Total | 27,598 | 58,561 | 86,789 | 96,740 | 97,923 |
| Forecast at Beginning of year | 70,503 | 70,037 | 101,607 | 114,025 | 212,000 |

OPEN SESSION CEO Report

May 9, 2018

Dan Woods, CEO

Organizational Goal Update

| Organizational Goals FY18 | Benchmark | 2017 ECH Baseline | Minimum | Target | Maximum | Weight | Performance Timeframe | FY18 through April |
|--|---|--|-----------------|--------|---------|-----------|-----------------------|--|
| Quality, Patient Safety & iCare | | | | | | | | |
| Arithmetic Observed LOS Average / Geometric LOS Expected for Medicare Population (ALOS / GMLOS) | External: Expected via Epic Methodology | FY 2016: 1.21 (ALOS 4.86/GMLOS 4.00) FY 2017 YTD April: 1.18 (4.81/4.08) | 1.12 | 1.11 | 1.09 | 34% | 4Q FY18 | 1.12 |
| HCHAPS Service Metric: Rate Hospital | External Benchmark | HCAHPS Baseline: 10/2016-12/2016: 75.5% 1/2017-3/2017: 75.1% | 77% | 78% | 79% | 33% | 4Q FY18 | 78% |
| Standardized Infection Ratio (SIR)* Observed HAIs/Predicted HAIs (Hospital Acquired Infections) | External Benchmark | July- Dec 2016 CAUTI 1.37, CLABSI 0.25, C.Diff 0.59 Avg: 0.738 | 0.670 | 0.602 | 0.534 | 33% | FY18 | CAUTI: 1.459 CLABSI: 0.423 C.Diff: 0.30 Avg: 0.727 |
| Threshold Goals | | | | | | | | |
| Budgeted Operating Margin* | 95% Threshold | Achieved Budget | 95% of Budgeted | | | Threshold | FY 18 | Met |

* These metrics are available through March 2018 only- Updated Infection Data will not be available until the end of the Fiscal Year

Quality and Safety

Our length of stay work continues to progress and we are still meeting maximum on the organizational goal. The steering committee is focusing on numerous approaches to improving LOS including tactics to discharge patients by 12 noon. This is a multidisciplinary approach that requires great coordination by all caregivers, patients, and families. The organizational goal to reduce hospital acquired infections continues to track well for CLABSI and C. Diff. We have been quite challenged to achieve the target for CAUTI—although performing 40% better than last year. Nursing staff and medical staff have adopted the new nurse driven protocol to allow nurses to remove foley catheters. We have seen an 8% reduction in foley catheter use so far this fiscal year.

Patient Experience

We are tracking to the organizational service goal target of 78 with a score of 77.7 for March. The patient experience team is progressing against the work plan developed by DTA including leader rounding, care team coaching, nurse communication tool kit, and supplementing Patient and Family Advisory Council (PFAC).

Financial Services

All of our Registration and Scheduling Departments are actively helping our patients enroll in myCare. Our cash collections remain strong with the team consistently reaching beyond their goal and achieving tier 3 results most of the year, which is \$2.5 million or higher than goal.

As of April 24, 2018, we surpassed our cost-savings initiative goal, having implemented \$5,152,788 of our \$4.8 million savings challenge and cost avoidance of \$328,000. The savings amount achieved is double that of the past several years' goals that ranged from \$2.3 million to \$2.6 million. Our reprocessing initiative has not only resulted in substantial savings which helped to reach our cost initiative goal, it also enabled us to avert 15,000 pounds from going to the landfill.

The secondary transcription platform adding iMedx to HIMs current platform is in progress with a tentative go-live date is 06/04/2018.

Operations

The CNO and other leaders are engaged in LEAN management processes on a regular basis. During the May All Leaders Meeting (ALM), senior leadership will recognize a few leaders for their ongoing commitment and valuable work to ensure meaningful outcomes for our patients by using various LEAN protocols.

During the first three quarters of FY18, every one of our service lines improved financial performance compared to the same time a year ago (7/1-3/31). Service line leaders are primarily focusing on growth, physician relations, and strategic planning, and they are also working in collaboration with department managers to reduce operating costs and make healthcare more affordable for our patients and the communities we serve.

Workforce

The Employee Transportation Strategy Task Force continues its work to develop and reassess employee transportation alternatives to mitigate travel to and from the hospital sites as well as increase recruitment and retention of our current and future workforce.

We are conducting an employee engagement "pulse" survey in May for specifically identified hospital departments; a full employee engagement survey will be conducted in the fall for all employees. The executive team recently conducted a talent review at the director level of the organization with a focus on development and succession planning.

Marketing and Communications

We launched our new creative campaign in April across all channels. Videos of the participating patients can be found at www.elcaminohospital.org/stories. In their words, these volunteer patients share their stories about why they chose El Camino Hospital and their experience.

The media covered former ECH patient Ann Marie and her marathon world record effort to benefit the NICU, El Camino Hospital's **first in the country** performance of a robotic bronchoscopy procedure to obtain a lung tissue sample, and for our renewed recognition by Human Rights Coalition as a HEI leader. We are planning and will be supporting the following events: Annual Auxiliary General Meeting, Hospital Week, Mental Health Awareness Week, Robotics Symposium, Annual Men's Health Fair, and the summer "Jazz on the Plazz" concert series.

Government and Community Relations

ECH sponsored the Silicon Valley Leadership Group's Workplace Wellness Symposium, the Family & Children's Services Circle of Support Luncheon, and a two-day Adolescent Mental Wellness Conference hosted by Stanford Children's Health. At the conference, ECH programs were presented (ASPIRE and a teen suicide prevention curriculum ECH developed and taught to students and parents in the Fremont Union High School District, which has five high schools in Cupertino, Sunnyvale and San Jose).

The Mountain View City Council is considering a measure for the November ballot that would increase the city business license fee. The initial proposal included both businesses and nonprofit organizations, which could have raised ECH's license fee from zero to \$250,000-\$500,000 annually. ECH advised the city that state law prohibits taxing qualified nonprofits in this manner, and the license fee options presented to the council now state that nonprofits remain exempt.



ECH submitted a letter opposing AB 3087 (Kalra), *California Health Care Cost, Quality, and Equity Commission*, which would create a commission to unilaterally set commercial payments to hospitals, doctors and other healthcare providers. It is estimated it would result in the loss of \$18 billion dollars to California hospitals, and is opposed by a large coalition of hospitals, physician and dental groups, health plans, and business groups.

Information Services

All of our registration and scheduling departments are actively helping our patients enroll in myCare. Physician experts in the Epic system have completed individualized training and personalization sessions for identified physicians. Positive feedback and requests for continued training has been received by participating physicians and measurement of improved physician efficiency is currently underway.

The Enterprise Resource Planning (ERP) system that supports supporting the Human Resources, Finance and Supply chain areas we have in place is outdated and no longer supported by the vendor. New ERPs operate in the cloud decreasing hardware and software costs for employers and providing increased business efficiency, analytics and security. To impact cultural transformation, selection of a new cloud based ERP System for HR, Finance, and Supply Chain Management will wrap up this week with a recommendation planned for review at the next Finance Committee meeting.

Corporate and Community Health

CONCERN's CEO presented at Chevron's Medical Directors and Medical Professionals conference in San Francisco attended by over 200 professionals. The topic was EAP 2.0 Input from Silicon Valley and we described the expanded role for CONCERN:EAP in many large technology companies. A significant focus was on the digital transformation that is impacting EAPs and the top five trends.

The Community Benefit staff met with the Community Benefit Advisory Council and Board Liaisons to review and discuss the FY19 El Camino Healthcare District and El Camino Hospital grant applications. We provided sponsorships to enhance the work of the following organizations and events were attended by many Community Benefit grantees and some El Camino Hospital staff:

- Healthier Kids Foundation Symposium on the Status of Children's Health
- Uplift Family Services, supporting community mental health needs
- City of Sunnyvale senior support event
- Bay Area Older Adults
- Congregation Shir Hadash: community health fair for underserved
- Services for Brain Injury

Philanthropy

During Period 9 of FY18, the Foundation secured \$390,178, bringing the total raised by the end of March to \$4,959,165. We raised \$39,821 in annual gifts during the month of March, bringing the total year to date to \$546,595, which is 99% of goal. The donations came from Path of Hope, Circle of Caring, Healthy Giving Newsletter, an external fundraiser, and online donations.

Auxiliary

The Auxiliary contributed 7,000 volunteer hours in March 2018.

El Camino Hospital Auxiliary
Membership Report to the Hospital Board
Meeting of May 9, 2018

Combined Data as of March 31, 2018 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

| | | |
|--------------------|------------|--|
| Active Members | 342 | -2 Net change compared to previous month |
| Dues Paid Inactive | 92 | (Includes Associates & Patrons) |
| Leave of Absence | 17 | |
| Subtotal | 451 | |

Resigned in Month 2
Deceased in Month 2

Junior Members

| | | |
|--------------------|------------|---|
| Active Members | 236 | -11 Net Change compared to previous month |
| Dues Paid Inactive | 0 | |
| Leave of Absence | 2 | |
| Subtotal | 238 | |

Total Active Members 578

Total Membership 689

Combined Auxiliary Hours from Inception (to March 31, 2018): 5,887,131
Combined Auxiliary Hours for FY2017 (to March 31, 2018): 64,692
Combined Auxiliary Hours for March 31, 2018: 7,000

Memorandum

DATE: April 25, 2018

TO: El Camino Hospital Board of Directors

FROM: David Reeder, Hospital Board Liaison to the Foundation Board of Directors

SUBJECT: Report on Foundation Activities FY 2018 Period 9

ACTION: For Information

El Camino Hospital Foundation advances health care through philanthropy by raising funds that support El Camino Hospital's strategic priorities, foster innovation, and support patient and family-centered care.

During period 9 of FY18, the Foundation secured \$390,178, bringing the total raised by the end of March to \$4,959,165.

Upcoming Events

May 5, 2018- Spring Forward, a gala to fulfill the promise, benefiting mental health and addiction services at El Camino Hospital. Attendance will be limited to. Special guest Brooke Shields will participate in a conversation with Moryt Milo (grateful parent) and Lisa Abramson (grateful MOMS patient). Cost per ticket is \$1,000, of which \$750 is tax deductible. Register online at www.elcaminohospital.org/springforward.

October 29, 2018 – 23rd Annual El Camino Heritage Golf Tournament, benefiting the Norma Melchor Heart & Vascular Institute. The tournament will be held at Sharon Heights Golf & Country Club. *It will be a day so fun it's scary!*

February 7, 2019 – Norma's Literary Luncheon, benefiting health services for women and families at El Camino Hospital. The event will be held at Sharon Heights Golf & Country Club, and the featured author will be Marta McDowell, who writes about horticulture and garden history.

Memorandum

DATE: April 25, 2018

TO: El Camino Hospital Board of Directors

FROM: Lane Melchor, Chair, El Camino Hospital Foundation Board of Directors
Jodi Barnard, President, El Camino Hospital Foundation

SUBJECT: Report on Foundation Activities FY 2018 Period 9

ACTION: For Information

During the month of March, El Camino Hospital Foundation secured \$390,178, bringing the total raised by close of period 9 to \$4,959,165, which is 81% of the FY18 fundraising goal.

FY 18 Period 8 Fundraising Performance

Major & Planned Gifts

The Foundation received \$127,794 in planned gifts. This includes distributions from a pooled income fund, a charitable gift annuity, and sponsorship payments for the Allied Professionals Seminar, which was held on February 13.

Special Events

- **Spring Forward** – The Foundation is launching a new gala, Spring Forward to fulfill the promise, benefiting mental health and addiction services at El Camino Hospital. It will be held at the Morgan Estate, a private mansion in Los Altos Hills, on Saturday evening, May 5, 2018. Model and actress Brooke Shields will be featured in a conversation with Moryt Milo (a grateful parent) and Lisa Abramson (a grateful MOMS patient). Grammy winner Tony Lindsey, world-renowned singer for Santana, will perform. In March, the Foundation received sponsorship payments totaling \$25,000. Additional sponsorship revenue will be reflected in next fundraising reports. Registration for Spring Forward is open at www.elcaminohospital.org/springforward.
- **Scarlet Ball** – The annual gala benefit for the South Asian Heart Center was held at Dolce Hayes Mansion in San Jose on March 17. The event grossed more than \$340,700, of which \$271,071 is reflected in the period 9 fundraising report. The Foundation expects to receive the outstanding payments for sponsorship and donation commitments in coming months, and Foundation staff is following up with those donors.

- **Norma's Literary Luncheon** – During March, the Foundation received \$12,800 in table sponsorships, a ticket purchase and donations for Norma's Literary Luncheon, which was held on February 8, 2018 at Sharon Heights Golf & Country Club in Menlo Park. This brings total revenue for the event by end of period 9 to \$209,075, which is 139% of goal. Mystery writer Jacqueline Winspear, author of the best-selling Maisie Dobbs series, was the featured speaker.

Annual Giving

The Foundation raised \$39,821 in annual gifts during the month of March, bringing the total year to date to \$546,595, which is 99% of goal. The donations came from Path of Hope, Circle of Caring, Healthy Giving Newsletter, an external fundraiser, and online donations. Additional direct mail outreach for Path of Hope and unrestricted gifts is planned in coming months. The Foundation is on track to exceed the annual giving goal this fiscal year.

FOUNDATION PERFORMANCE

FY18 Fundraising Report through 3/31/18

| ACTIVITY | | FY18 YTD (7/1/17 - 3/31/18) | FY18 Goals | FY18 % of Goal | Difference Period 8 & 9 | FY17 YTD (7/1/16 - 3/31/17) | FY16 YTD (7/1/15 - 3/31/16) |
|-----------------------|--------------------------------|--------------------------------|--------------------|-------------------|----------------------------|--------------------------------|--------------------------------|
| Major & Planned Gifts | | \$3,056,296 | \$3,750,000 | 82% | \$127,794 | \$4,016,355 | \$2,366,541 |
| Special Events | Spring Event | \$26,000 | \$600,000 | 4% | \$25,000 | \$114,300 | \$143,700 |
| | Golf | \$353,650 | \$300,000 | 118% | \$20,000 | \$273,100 | \$326,205 |
| | South Asian Heart Center Event | \$271,071 | \$300,000 | 90% | \$129,250 | \$283,994 | \$274,593 |
| | Norma's Literary Luncheon | \$209,075 | \$150,000 | 139% | \$12,800 | \$148,155 | \$193,977 |
| Annual Gifts | | \$546,595 | \$550,000 | 99% | \$39,821 | \$472,724 | \$461,561 |
| Grants* | | - | - | - | - | - | \$58,333 |
| Investment Income | | \$496,478 | \$500,000 | 99% | \$35,513 | \$931,612 | \$666,579 |
| TOTALS | | \$4,959,165 | \$6,150,000 | 81% | \$390,178 | \$6,240,240 | \$4,491,489 |

*Beginning in FY17 Grants is no longer an activity line. Any grants received in the future will either be reflected in the Annual Gifts or Major & Planned Gifts activity line pending funding level.

Highlighted Assets through 3/31/18

| | |
|------------------------------|--------------|
| Board Designated Allocations | \$1,024,043 |
| Donor Endowments | \$3,307,684 |
| Operational Endowments | \$14,842,881 |
| Pledge Receivables | \$4,487,355 |
| Restricted Donations | \$9,918,363 |
| Unrestricted Donations | \$1,024,314 |

5.6% Investment Return looking back over the last 12 months.