

Community Hospital

Anderson, Indiana



APPLICATION
FOR
“IN THE ACS VERIFICATION PROCESS”
LEVEL III TRAUMA CENTER
DESIGNATION

April 4, 2014



**Community
Hospital Anderson**

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011
T 765.298.4242
eCommunity.com

April 4, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

**SUBJECT: Community Hospital - Anderson's Application for "In the ACS Verification Process"
Level III Trauma Center designation.**

Indiana State Trauma Care Committee (ISTCC):

Community Hospital Anderson is pleased to submit the attached application packet for consideration to be designated an "In the ACS Verification Process" Level III Trauma Center. Our Trauma Team has worked diligently to provide the ISTCC and the Indiana EMS Commission with complete documentation supporting our designation request.

Community Hospital Anderson has been an integral part of the Anderson/Madison County Trauma system for many decades. The documents included in the attached submission demonstrate a strong commitment by our entire staff including our Board- certified Emergency Physicians, General Surgeons, Orthopedic Surgeons and Neurosurgeons. We will work together to pursue opportunities for improvement and continue to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Respectfully,

Beth Tharp
President/CEO

Dwight B. McCurdy, M.D., F.A.C.S.
Trauma Medical Director



**APPLICATION FOR HOSPITAL TO BE DESIGNATED
"IN THE ACS VERIFICATION PROCESS"**
State Form 55271 (5-13)



Date submitted (month, day, year) April 4, 2014
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APPLICANT INFORMATION		
Legal name Community Hospital of Anderson & Madison County, Incorporated		
Mailing address (number and street, city, state, and ZIP code) 1515 North Madison Avenue Anderson, IN 46011		
Business telephone number (765) 298-4242	24-hour contact telephone number (765) 298-4242	Business fax number (765) 298-5848

CHIEF EXECUTIVE OFFICER INFORMATION	
Name Beth Tharp	Title President/CEO
Telephone number (765) 298-5122	E-mail address Beth.Tharp@ecommunity.com

TRAUMA PROGRAM MEDICAL DIRECTOR INFORMATION	
Name Dwight B. McCurdy, M.D., F.A.C.S.	Title Trauma Medical Director
Telephone number (765) 298-4140	E-mail address bmccurdy@ecommunity.com

TRAUMA PROGRAM MANAGER INFORMATION	
Name Douglas S. McGee, R.N., CEN, CPEN	Title Trauma Program Manager
Telephone number (765) 278-5252	E-mail address doug.mcgee@ecommunity.com

TRAUMA LEVEL BEING REQUESTED (check one) LEVEL I LEVEL II LEVEL III

ATTESTATION		
In signing this application, we are attesting that all of the information contained herein is true and correct and that we and the applicant hospital agree to be bound by the rules, policies and decisions of the Indiana Emergency Medical Services Commission regarding our status.		
Signature of chief executive officer 	Printed name Beth Tharp	Date (month, day, year) April 4, 2014
Signature of trauma medical director 	Printed name Dwight B. McCurdy, M.D.	Date (month, day, year) April 4, 2014
Signature of trauma program manager 	Printed name Douglas S. McGee, R.N.	Date (month, day, year) April 4, 2014

INSTRUCTIONS: Address each of the attached in narrative form

APPLICATION FOR "IN THE ACS VERIFICATION PROCESS" LEVEL III TRAUMA CENTER STATUS

Part of State Form 55271 (5-13)

Hospitals that wish to apply for status as an "in the ACS verification process" Level III Trauma Center must provide sufficient documentation for the Indiana Emergency Medical Services Commission to conclude that your hospital complies with each of the following requirements:

1. **A Trauma Medical Director** who is Board-Certified, or Board-Eligible, or an American College of Surgeons Fellow. This is usually a general surgeon who participates in trauma call and is current in Advanced Trauma Life Support (ATLS). The Trauma Medical Director must be dedicated to one hospital.
2. **A Trauma Program Manager**: This person is usually a registered nurse and must show evidence of educational preparation, with a minimum of sixteen (16) hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients.
3. **Submission of trauma data to the State Registry**: The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary data standard within thirty (30) days of application and at least quarterly thereafter.
4. **A Trauma Registrar**: This is someone who abstracts high-quality data into the hospital's trauma registry and works directly with the hospital's trauma team. This position is managed by the Trauma Program Manager.
5. **Tiered Activation System**: There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program.
6. **Trauma Surgeon response times**: Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons. Also, there must be a written letter of commitment, signed by the Trauma Medical Director, that is included as part of the hospital's application. There must be evidence that a trauma surgeon is a member of the hospital's disaster committee.
7. **In-house Emergency Department physician coverage**: The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients.
8. **Orthopedic Surgery**: There must be an orthopedic surgeon on call and promptly available twenty four (24) hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement.

**APPLICATION FOR "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS (continued)**

9. **Neurosurgery**: The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for higher levels of care. This plan must be approved by the facility's Trauma Medical Director. There must be a transfer agreement in place with Level I or Level II trauma centers for the hospital's neurosurgical patient population. The documentation must include a signed letter of commitment by neurosurgeons and the Trauma Medical Director.
10. **Transfer agreements and criteria**: The hospital must include as part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals.
11. **Trauma Operating room, staff and equipment**: There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services twenty four (24) hours per day. The application must also include a list of essential equipment available to the OR and its staff.
12. **Critical Care physician coverage**: Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients. There must be prompt availability of Critical Care physician coverage twenty four (24) hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage twenty four (24) hours a day.
13. **CT scan and conventional radiography**: There must be twenty four (24) hour availability of CT scan and conventional radiography capabilities. There must also be a written letter of commitment from the hospital's Chief of Radiology.
14. **Intensive care unit**: There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources to resuscitate and monitor injured patients.
15. **Blood bank**: A blood bank must be available twenty four (24) hours per day with the ability to type and crossmatch blood products, with adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients.
16. **Laboratory services**: There must be laboratory services available twenty four (24) hours per day.
17. **Post-anesthesia care unit**: The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment twenty four (24) hours per day. Documentation for this requirement must include a list of available equipment in the PACU.
18. **Relationship with an organ procurement organization (OPO)**: There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO.

**APPLICATION FOR "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS (continued)**

19. **Diversion policy:** The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than five percent (5%) of the time. The hospital's documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion.
20. **Operational process performance improvement committee:** There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year.
21. **Nurse credentialing requirements:** Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU.
22. **Commitment by the governing body and medical staff:** There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within one (1) year of this application and to achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one (1) year of this application and/or does not achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status that the hospital's "in the ACS verification process" status will immediately be revoked, become null and void and have no effect whatsoever.



Community Hospital Anderson

MEDICAL STAFF OFFICERS 2014-2015

President of Staff	Carol Magee, M.D.
Vice President of Staff	Thomas Short, M.D.
Chief of Staff	Troy Abbott, M.D.
Secretary/Treasurer	Marc Pinchouck, M.D.
Chief, Primary Care Department	Neva Lynch-Jackson, M.D.
1. Family Medicine Section Rep	Brian Kohles, M.D.
2. General Internal Medicine Section Rep	Ron Harmening, M.D.
3. Pediatrics Department Section Rep	Tony McHerron, M.D.
Chief, Medical Care Department	Naeem Malik, M.D.
1. Emergency Medicine Section Rep	Thomas Short, M.D.
2. Psychiatry Section Rep	Susan Anderson, M.D.
3. Medicine Section Rep	Naeem Malik, M.D.
Chief, Surgical Care Department	Jared Anderson, D.O.
1. Anesthesiology Section Rep	David Tharp, M.D.
2. OB/GYN Section Rep	Donna Tisch, M.D.
3. Radiology Section Rep	Kevin Burton, M.D.
4. Surgery Section Rep	Ben McCurdy, M.D.
Chief Pathologist	Bo Uchman, M.D.
Chairman of Credentials Committee	Troy Abbott, M.D.
Director of Critical Care	Saiful Kabir, M.D.
Infection Control Representative	Nyria Villarreal, M.D.
Education Chairman	Kelly Chambers, M.D.
Disaster Chief	Troy Abbott, M.D.
Alternate Disaster Chief	Carol Magee, M.D.
Member -at-large	Stephen Shick, M.D.
Members-at-large	Joseph Baer, M.D.

March, 2014

The following Physicians participate in twenty-four hour call in their respective specialties:

Anesthesia

- Anderson, Jared, M.D.
- Hendrickson, Scott, D.O.
- Hinds, Ryan, M.D.
- Loghin, Virgil, M.D.
- Rice, Jeb, M.D.
- Tharp, David, M.D.
- Wagner, Martin, M.D.

Critical Care

- Kabir, Saiful, M.D.
- Malik, Naeem, M.D.
- Saltagi, Ahmed, M.D.

Emergency Medicine

- Burns, Linda, M.D.
- Hofmann, Kirk, M.D.
- Ludlow, Clayton, M.D.
- MacDonell, Elizabeth, M.D.
- Miller, Christopher, M.D.
- Ricke, Benjamin, M.D.
- Short, Thomas, M.D.
-

General/Trauma Surgery

- Baer, Joseph, M.D.
- McCurdy, Dwight B., M.D.
- Ritchison, Andrew, M.D.
- Wakim, Khalil, M.D.

Neurosurgery

- Callahan, James, M.D.
- Kim, Daniel, M.D.

Orthopedic Surgery

- Chen, Li, M.D.
- Graybill, David, M.D.
- Herbst, Steven, M.D.
- Jerman, Joseph, M.D.
- Kay, Patrick J., M.D.
- Shick, Stephen, M.D.
- Surtani, Nimu, M.D.

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 1

Trauma Medical Director

1. "A Trauma Medical Director who is Board-Certified, or Board-Eligible, or an American College of Surgeons Fellow. This is usually a general surgeon who participates in trauma call and is current in Advanced Trauma Life Support (ATLS). The Medical Director must be dedicated to one hospital."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 1 are met with a letter from Dwight B. McCurdy, M.D. the Community Hospital – Anderson (CHA) Trauma Medical Director. Dr. McCurdy is a Board-certified General Surgeon who participates in trauma call. While occasionally participating in trauma call at another facility, he is dedicated exclusively to the administration of the CHA trauma program. Dr. McCurdy will refresh his ATLS certification April 25 & 26, 2014 and provide the ISTCC documentation prior to the May 9, 2014 meeting. A copy of the Trauma Medical Director job description is attached.



Community Hospital Anderson

ROLE SUMMARY

TITLE/JOB CODE: Trauma Medical Director

DEPARTMENT/COST CENTER: Trauma Program – 67804

REVISION DATE: New 2014

ROLE OVERVIEW

The Trauma Medical Director is responsible for the ongoing development, growth and oversight/authority of the Trauma Program. He/she must be able to demonstrate effective interpersonal skills and an understanding of the interdependent roles of various allied health professions. The Trauma Medical Director is responsible for promoting high standards of practice through development of trauma policies, protocols and practice guidelines; participating in rigorous performance improvement monitoring; staff education and trauma research. He/she has authority to act on all trauma performance improvement and administrative issues and critically review trauma deaths and complications that occur within the hospital. Decisions affecting the care of trauma patients will not be made without the knowledge, input and approval of the Trauma Medical Director.

REQUIRED EXPERIENCE

Three years clinical experience in emergency/trauma care
Two years administrative experience preferred

REQUIRED EDUCATION

Board certified surgeon

REQUIRED LICENSE CERTIFICATIONS

Current license to practice medicine in the State of Indiana
Current certification in Advanced Trauma Life Support

SUPERVISES:

None

REPORTS TO:

Chief Medical Officer, Chief Executive Officer

PRE-REQUISITE SKILLS

Member in good standing of the hospital medical staff
Ability to establish and maintain effective interpersonal relationships
Ability to accept and implement change
Ability to problem solve & make decisions
Demonstrated history of positive collegial relations with colleagues,

support staff, hospital-based providers, administrators and patients.

ESSENTIAL FUNCTIONS

Administration:

- Participate in the research, development and writing of trauma policies, protocols and practice guidelines.
- Implement all trauma program policies and procedures as they pertain to patient care.
- Organize, direct and integrate the trauma program with all other departments and services within the hospital.
- Promote a cooperative and collaborative working environment among the clinical disciplines involved in trauma care.
- Maintain an effective working relationship with the medical staff, trauma service staff, administration and other departments.
- Provide advice and direction in recommending privileges for the trauma service.
- Participate in trauma program marketing activities.
- Establish a physician case management process that fosters cost-effective, high quality patient care.
- Assesses need for equipment, supplies, budget
- Assist the Trauma Program Manager in developing and meeting the trauma program budgetary goals.
- Oversee, participate in and develop projects that ensure the cost-effectiveness of care provided by physicians and hospital.

Program Initiatives:

- Lead efforts to develop and maintain a trauma center.
- Collaborate with the Trauma Program Manager to establish trauma program goals and objectives consistent with those of the hospital and ensure that those of the trauma program are being met.
- Develop and provide input on the development and maintenance of practice guidelines, policies and methodologies for medical/surgical trauma care.
- Participate in site review by regulatory agencies.
- Organize, direct and implement departmental practices to assure continued compliance with applicable laws including the guidelines established by the Statewide Trauma System and the Joint Commission on Accreditation of Hospitals.
- Demonstrate positive interpersonal relationship with colleagues, referral MDs, hospital personnel, and patients/families in order to achieve maximum operational effectiveness and customer satisfaction.
- Assure transfer agreements in place and in good standing; maintain relationship with receiving facilities, foster collaborative relationship.
- Make appropriate referrals for specialty services and communicate regularly with referring physician as appropriate.
- Ensure that adequate attending physician availability is provided to render care to trauma patients.
- Ensure establishment of physician/surgeon call schedules for all

- trauma care, excluding those who do not meet educational and credentialing requirements.
- Provide trauma care leadership and consultation for emergency, surgery and intensive care unit departments.
 - Participate in regional and statewide activities affecting the trauma program.
 - Attend local and national meetings and conferences to remain current regarding issues relevant to the performance of duties.
 - Demonstrate consistent, efficient, cost effective and quality trauma care at all times.
 - Participate in trauma patient/family satisfaction projects as developed by hospital.

Performance Improvement:

- Determine and implement PI activities appropriate to the trauma program.
- Oversee the trauma PI program and participate in other quality initiatives that deal with the care of injured patients.
- Review and investigate all trauma PI inquiries in collaboration with the Trauma Program Manager and refer to the appropriate committees.
- Monitor compliance with trauma treatment guidelines, policies and protocols.
- Assure that the quality and appropriateness of patient care are monitored and evaluated and that appropriate actions based on findings are taken on a consistent basis.
- Report quality of care issues promptly to appropriate individuals, including Trauma Program Manager and hospital administration.
- Identify and correct deficiencies in trauma care policies, guidelines and protocols.
- Consult with appropriate medical staff and administration regarding quality care issues and adverse outcomes; identify areas to improve patient care.
- Assure that continuum of care is maintained.
- Identify representatives from various disciplines appropriate to participate in PI activities.
- Coordinate, schedule and facilitate the PI peer review process.
- Review all trauma-related peer review and initiate action as necessary.
- Assist the Trauma Program Manager in evaluating the effectiveness of corrective actions resulting from PI processes.
- Assume responsibility for the accuracy and validity of trauma statistics.

Clinical Education:

- Support the requirements for trauma CME by participating and assisting in the education and training of hospital personnel physicians and specialists.
- Provide education for hospital staff regarding trauma program policies and appropriate medical practices.

Community Outreach:

- Maintain relations with community organizations and legislative bodies whose activities relate to trauma care and injury prevention
- Participate in hospital outreach activities as may be requested by administration.
- Develop and participate in trauma community education and injury prevention activities.
- Function as a liaison to other hospitals within the region.

Knowledge and Skill:

- Lead the hospital in trauma program development.
- Analyze and interpret complicated information.
- Determines a course of action based on research, data, standards of care and general guidelines/protocols.
- Communicate effectively with a wide variety of intra- and inter-facility staff and administration using both oral and written communication.
- Possess critical thinking, analytical, teaching/coaching and research skills.
- Maintain the privacy and security of protected health information (PHI), the confidentiality of all information, and conduct all aspects of patient care charting, billing and all operations within the system in a professional and ethical manner in accordance with Federal, State, and HRHS rules and regulations.

Knowledge/Physical Requirements

Knowledge	Occasionally	Frequently	Constantly
Reading Speaking and Writing English			X
Communication Skills			X
Computers			X
Physical			
Walking			X
Bending			X
Standing			X
Sitting			X
Driving			
Lifting up to 50 lbs. with or without assistance			X
Stretching/Reaching			X
Distinguish smell/temperature			X
Hearing/Seeing			X
Exposure to bloodborne pathogens and infectious			X

disease			
Exposure to hazardous material			X
Climbing	X		
Hand/Finger dexterity			X
Stooping (bend at waist)			X
Sensory Activities			
Talking in person			X
Talking on the telephone			X
Hearing in person			X
Hearing on the telephone			X
Vision for close work			X
Other			

**OTHER
COMPETENCIES**

All hospital mandatory competencies.

**PHYSICAL &
ENVIRONMENTAL
REQUIREMENTS**

The "Risk of Exposure Category" for this job has been identified as a Category 1.

DWIGHT B. McCURDY, M.D.

1210 MEDICAL ARTS BLVD., STE. 215

ANDERSON, IN 46011

Telephone: (765) 298-4140

Monday, March 10, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Dept of Health

2 North Meridian Street

Indianapolis, IN 46204

Subject: Community Hospital – Anderson’s Application for “in the ACS Verification Process” for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital- Anderson’s effort to complete the “in the process” Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Our Trauma surgeons rotate call to be promptly available twenty-four hours per day. We are committed to responding to the highest level of activation within thirty minutes of the patient’s arrival. Response times are continuously evaluated through the hospital’s Performance Improvement and Patient Safety (PIPS) program.

In acquiring the ATLS certification requirement of the Medical Director I was certified in residency back in the early 90s. I have reviewed the latest ATLS student course Manual (9th ed.), and plan to take the recertification course in Columbus, OH on the 25th-26th of April.

Respectfully,



Dwight B McCurdy, MD, FACS

Trauma Medical Director



[Find a Doctor](#)

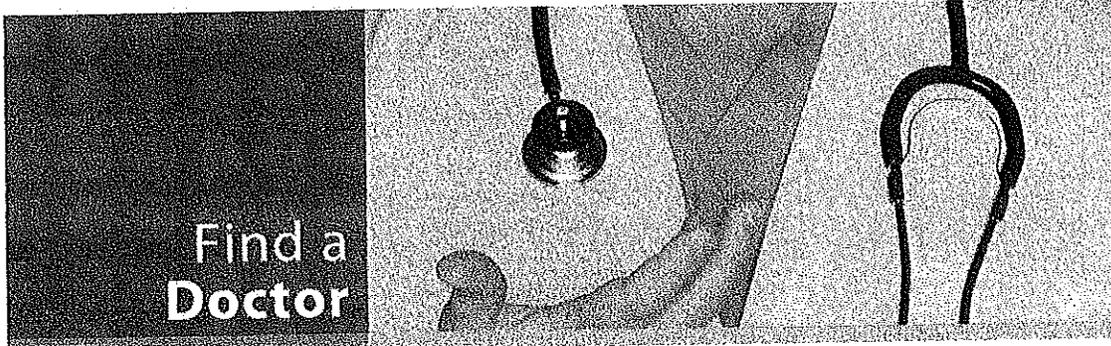
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Dwight B McCurdy, M.D.



Specialty:
Location:
Address:

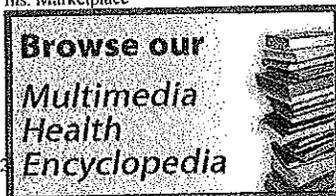
General Surgery
Community Hospital Anderson
1210 Medical Arts Blvd, Suite 215
Anderson, IN 46011

Phone:
Fax:
Board Cert:
Medical School:
Internship:
Residency:

765-298-4140
765-298-4941
American College of Surgeons, 1995
Indiana University School of Medicine, 1990
Akron General Hospital, Akron, OH, 1990
Akron General Hospital, Akron, OH, 1991-95

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He

Dr. McCurdy is a member of the following Continuing Medical Education Foundation:

Audio-Digest Foundation - *Continuing Medical Education*

450 N. Brand Blvd., Suite 900
Glendale, California 91203
(800) 423-2308 - (818) 240-7500

In addition to many general surgery CME credits, Dr. McCurdy has completed the listed trauma-specific audio programs.

Volume 61, Issue 05	3/07/14	Pancreatic Trauma	1 hour
Volume 61, Issue 01	1/07/14	Gunshot Wounds/ cervical spine	2 hours
Volume 60, Issue 16	8/21/13	Mangled Extremity	1 hour
Volume 60, Issue 10	5/21/13	Compartment Syndrome	2 hours
Volume 60, Issue 06	3/21/13	Update on Trauma	2 hours
Volume 59, Issue 21	11/07/12	Trauma & Critical Care	2 hours
Volume 59, Issue 12	5/21/12	More on Trauma	2 hours
Volume 59, Issue 11	5/07/12	Challenges in Trauma	2 hours
Volume 59, Issue 05	3/07/12	Trauma/Critical Care	2 hours

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 2

Trauma Program Manager

"2. **Trauma Program Manager.** This person is usually a registered nurse and must show evidence of educational preparation, with a minimum of 16 hours (internal or external) of trauma- related continuing education per year and clinical experience in the care of injured patients."

NARRATIVE RESPONSE AND DISCUSSION

Doug McGee, R.N. (License #28172050A) is the Community Hospital – Anderson (CHA) Trauma Program Manager. A copy of the job description is attached. Doug maintains current Advanced Trauma Care for Nurses (ATCN) and Trauma Nursing Core Course (TNCC) training. He is also certified in emergency nursing (CEN) and pediatric emergency nursing (CPEN) in addition to ACLS and PALS. Doug is a Charge Nurse in the CHA Emergency Department where he has seven years of clinical experience providing care for trauma patients in all age groups. He retired from EMS after thirty-five years of experience with twenty-four years at the paramedic level. Doug's educational background includes a Master's degree in Business Administration. He has extensive EMS, local government and municipal utility administrative experience. Copies of recent continuing nursing education are attached.



Community Hospital Anderson

ROLE SUMMARY

TITLE/JOB CODE: Trauma Program Manager (0239 – 430)

DEPARTMENT/COST CENTER: Trauma Program - 67804

REVISION DATE: 11/2013, 3/4/14

ROLE OVERVIEW Responsible for the coordination of health care services for all trauma patients during acute and continued care periods. Assists the organized multi-disciplinary trauma team to develop a philosophy of care consistent with providing quality service, including the development of educational and administrative activities related to the care of critically injured patients. Works closely with the Trauma Services Medical Director and other hospital medical staff, leadership, and pre-hospital care providers to coordinate all aspects of the trauma program and ongoing staff/public education.

REQUIRED EXPERIENCE Minimum 5 years Emergency Department experience that includes the care of trauma patients.

REQUIRED EDUCATION Graduate of an approved nursing program. Educational preparation and clinical experience in the care of injured patients.

REQUIRED LICENSE Current Indiana RN license required. Maintains American Heart Associate ACLS certification, TNCC. ATCN within first year.

SKILLS TESTING None

REPORTS TO Emergency Department Director

SUPERVISES Trauma Registrar

ESSENTIAL FUNCTIONS Clinical:
Assure compliance with the American college of Surgeons and the Indiana State Department of Health, EMS commission standards.
Plan and implement strategic goals as a trauma center geared toward excellence and high standards of care.

Coordinate trauma care management across the continuum of care.

Communicate effectively among all caregivers and individuals within the trauma system related to high quality outcomes.

Assess the need for policies, procedures, protocols, supplies and equipment relating to the care of trauma patients in coordination with hospital administration and clinicians.

Develop policies and procedures based on evidence based best practice, input from clinicians and other sources, such as information from the trauma peer review process.

Coordinates the development, implementation, review and revision of trauma standards, policies, procedures, and protocols.

Assesses the need for supplies and equipment related to the care of the trauma patients in coordination with hospital administration.

Clinical Activities:

Coordinate management across the continuum of trauma care, which includes:

- the planning and implementation of clinical protocols and practice management guidelines
- Monitoring care of in hospital patients
- Serving as a resource for clinical practice

Educational Responsibilities:

- Provide for intrafacility and regional professional staff development
- Participate in case review
- Implement practice guidelines
- Direct community trauma education and prevention programs.

Performance Improvement:

- Monitor clinical processes and outcomes,
- system issues related to the quality of care provided
- develop quality filters, audits, and case reviews
- identify trends and sentinel events
- help outline remedial actions while maintaining confidentiality

Administration:

- Manage, as appropriate, the operational, personnel, and financial aspects of the trauma program.
- Serve as a liaison to administration, and represent the trauma program on various hospital and community committees to enhance and foster optimal trauma care management.

Supervision of the Trauma Registry:

- Supervise collection, coding, scoring and developing processes for validation of data.
- Design the registry to facilitate performance improvement activities, trend reports, and research while protecting confidentiality.

Consultant and Liaison:

- Stabilize the complex network of many disciplines that work in concert to provide high-quality care.
- Serve as an internal resource for staff in all departments
- Act as an extended liaison for emergency medical services agencies.

Research:

- Be involved in research projects, analysis and distribution of findings.
- Facilitate protocol design for accurate data collection, feedback, and analysis.

Community and National Involvement in Trauma Care Systems:

Participate in the development of trauma care systems at the community, state, and national levels.

Follows through with commitments including employee health requirements, mandatory education and completion of competencies within established timeframes.

Demonstrates respect for and cooperation with all persons in performing job duties and responsibilities; maintains courteous, complete and confidential communication with all patients, visitors, cooperation-workers and other guests.

Performs any other tasks, duties or responsibilities as assigned or needed for the effective, safe or efficient functioning/operation of the Hospital.

**OTHER
COMPETENCIES**

All hospital mandatory competencies.

**PHYSICAL &
ENVIRONMENTAL
REQUIREMENTS**

See attached checklist

The "Risk of Exposure Category" for this job has been identified as a Category 1 .

Douglas S. McGee, MBA, RN, CEN, CPEN

Emergency nursing and EMS experience:

I am currently employed as Trauma Program Manager and weekend-option Charge Nurse in the Emergency Department of Community Hospital in Anderson, IN. I maintain current certifications in ACLS, PALS, Emergency Nursing (CEN), Pediatric Emergency Nursing (CPEN) and Advanced Trauma Care for Nurses (ATCN).

I recently retired from EMS. I was initially certified at the basic EMT level in 1978 and completed St. Vincent's paramedic program in 1989. I maintained my EMT-P certification until January 2013. I served as the first Director of Advanced Life Support for the Pendleton, Indiana Emergency Ambulance Service. I enjoy teaching and was a field preceptor of paramedic students for many years. I was honored to be named "Paramedic of the Year" in the State of Indiana in 2006. I served as Chairperson of the Indiana Department of Homeland Security Foundation for several years.

Professional management accomplishments:

I retired in September 2013 from local Government employment with the Town of Pendleton, IN after a twenty-seven year career. I began that career in March 1986 as the first full-time Superintendent of Pendleton Falls Park. In November 1996 I accepted the position of Town Manager. My duties as Town Manager included those of Planning Director and Chief Operating Officer of the electric and water utilities. My basic responsibilities included budgeting, personnel supervision, capital purchasing, grant writing and interaction with professional consultants. I have coordinated several large infrastructure projects from concept through design, funding and construction. I was involved with all aspects of safety and risk management including Board of Health and OSHA requirements for utility operations, hazardous materials storage and confined space access.

As Planning Director, I supervised the Town of Pendleton comprehensive long-range planning, economic development, redevelopment activities, historic preservation, zoning ordinance and code enforcement. I am a member of the American Planning Association and have been a certified planner (AICP) since 2006.

Other affiliations, certifications and awards:

- 2003 recipient of the American Public Power Association's Larry Hobart "Seven Hats" national award for excellence in management of a municipal electric utility.
- 1996 and 2004 Lion's Club Citizen of the year in Pendleton, IN
- 1999 graduate of the Anderson Area Leadership Academy
- I served as a Commissioner representing Pendleton on the Indiana Municipal Power Agency (IMPA) Board of Commissioners for seventeen years. Most recently, I was corporate Treasurer and a member of the Executive Committee. I was member and chairperson of both the Audit and Budget Committees.
- Fall Creek Regional Waste District Board of Directors for seventeen years serving as member, Treasurer and Vice-President.
- Retired member of the Pendleton Volunteer Fire Department. Eighteen years of experience in fire suppression, vehicle rescue, fire ground operations and hazardous materials.

Education:

MBA with a concentration in Healthcare Administration from Indiana Wesleyan University

BS in Business Administration with a concentration in Accounting from Indiana University Kelly School of Business

AS in Nursing from the Excelsior College School of Nursing.



Continuing Education Certificate
Society of Trauma Nurses

**Advanced Trauma Care
for Nurses®**

Student Course
Methodist Hospital – Indianapolis, IN

July 16-17, 2010

Doug McGee

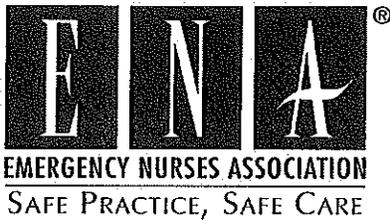
Name

Matthew S. Howard, RN, MSN

Course Director

STN is a licensed continuing education provider in the State of California Board of Registered Nursing. Provider Number CEP 11062. This course has been approved for 19 hours of credit.

23



This certifies that Doug McGee has attended
Trauma Nursing Core Course (Provider)
 earning a total of 14.42 Contact Hours.

ENA has provided 14.25 Contact Hours Category of Clinical.

The Emergency Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The Emergency Nurses Association is recognized as a provider of continuing education in nursing. California Continuing Education Provider #CEP2322.

Wendy St. John

January 15-16, 2014

Course Director (Please Print)

Date of Course

W St John

Indy Roadrunners

Course Director (Signature)

Location of Course

Emergency Nurses Association

Provider Unit
 915 Lee Street
 Des Plaines, IL 60016

Lead Nurse Planner – Emergency Nurses

Association: Betty O. Mortensen, MS, BSN, RN, FACHE

(Do not send this certificate to the Board of Nursing – keep it for your personal files. This certificate must be kept by licensee for a period of six years.)



This is your ENA TNCC Provider verification card.

Please detach and retain.



915 Lee Street • Des Plaines, IL • 60016-6569

Doug McGee

Name

01 / 2018

Expiration Date

has successfully completed all Provider course requirements for the ENA Trauma Nursing Core Course (TNCC).

Wendy St. John

Course Director

BEND & LIFT

Congratulations on the successful completion of the TNCC Provider course. Attached is your TNCC verification card with your expiration date. Verification is valid four years from the end of the month in which the course is completed.

The Emergency Nurses Association is committed to improving emergency nursing practice and trauma care. Your successful completion of the TNCC Provider course demonstrates your knowledge and professional commitment to improving trauma nursing care.

24

Board of Certification for Emergency Nursing

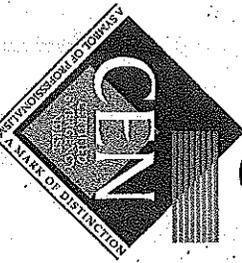
Hereby certifies that

Douglas McGee

having successfully met the qualifications
has attained the designation of

Certified Emergency Nurse

Dorleen O. Williams
Dorleen A. Williams, CNS, MSN, CEN, CCNS
BCEN Chairperson



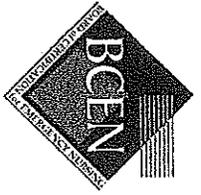
BCEN's Certified Emergency Nurse (CEN®) credential has been accredited by the Accreditation Board for Specialty Nursing Certification (ABSNC).

1/31/2016

Expiration date

100009329

Certification number



*Board of Certification for Emergency Nursing and
Pediatric Nursing Certification Board*



hereby states that

DOUGLAS SCOTT MCGEE

has successfully met the qualifications and competencies of the

Certified Pediatric Emergency Nurse



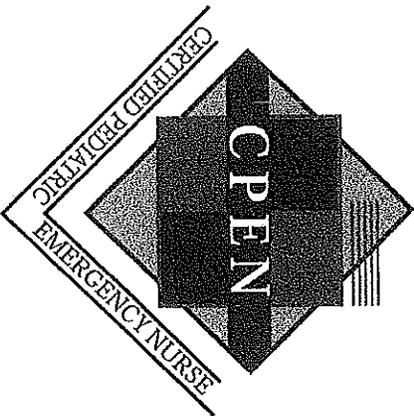
Board of Certification for Emergency Nursing
and Pediatric Nursing Certification Board
hereby states that

DOUGLAS SCOTT MCGEE

is currently certified as a
Certified Pediatric Emergency Nurse

Certification No: CP0044085 Valid Through: 2/25/2018

CP0044085
Certification Number



President, Pediatric Nursing Certification Board

February 25, 2014
Initial Certification Date



Continuing Education Certificate



Society of Trauma Nurses

This certifies that

Doug McGee, RN

has attended and successfully completed:

**Trauma Outcomes Performance
Improvement Course (TOPIC)**

and has been awarded 8.0 contact hours

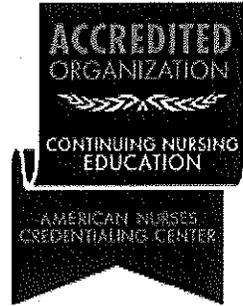
Riley Hospital for Children
Indianapolis, IN
October 28, 2013
Course# 50022

This continuing nursing education activity was approved by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission On Accreditation.

Society of Trauma Nurses • 3493 Lansdowne Dr, Suite 2 • Lexington, KY 40517
This certificate must be retained by the licensee for a period of four years after the completion of the course.



EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE



This Certifies That

Douglas McGee

has completed

CEN Review Web Seminar Series

Earning a total of 18.0 Contact Hours

ENA has designated 18.0 Contact Hours which meets BCEN's Category of Clinical.

ENA has designated 0 Contact Hours which meets BCEN's Category of Other.

The Emergency Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation

The Emergency Nurses Association is recognized as a provider of continuing education in nursing. California Continuing Education Provider #CEP2322.

Activity Date: March 2014

Activity Code: 11-ENA-CENW

Activity Coordinator: Jennifer Benning

Activity Location: Web Seminar

Lead Nurse Planner – Emergency Nurses Association: Jill S. Walsh, DNP, RN, CEN

Provider: Emergency Nurses Association-Provider Unit

Provider Mailing Address: 915 Lee Street

Provider City/State/Zip: Des Plaines, IL 60016

(Do not send this certificate to the Board of Nursing. Keep it for your personal files. This certificate must be kept by licensee for a period of six years.)

Please contact the ENA Provider Unit with questions related to contact hours.

ENA Provider Unit phone 847/460-4123

28

Certificate of Completion

12 CEU's awarded to:

Doug McGee

"Sharper Coding for Trauma

with ICD-10-CM & ICD-10-PCS"



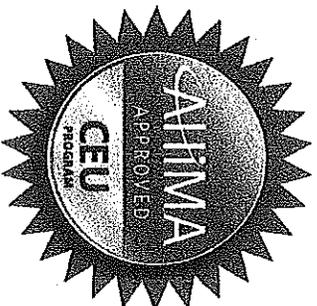
Trauma Consulting LLC

Kathy J. Gohlman
Kathy J. Gohlman, BS, CSTR, CAISS
Course Facilitator

February 27 & 28, 2014

Indianapolis, Indiana

"This program has been approved for 12 continuing education units for use in fulfilling the continuing education requirement of the American Health Information Management Association (AHIMA). Granting prior approval from AHIMA does not constitute endorsement of the program content or its program sponsor."



Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 3

Indiana Trauma Registry Submissions

"3. Submission of trauma data to the State Registry. The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary data standard within 30 days of application and at least quarterly thereafter."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 3 are met with a printout illustrating 157 admitted trauma patient records submitted to the State from the calendar year 2013. The report was generated from data entered throughout the year using Imagetrend, the reporting feature from the Indiana Trauma Registry.



Medical Record Num	Incident Number	Injury Date	Hospital Admission Date	Hospital Discharge Date	Facility Name
M00123216	chamc20130426031	1/1/13	1/1/13	1/4/13	Community Hosp of Anderson & Madison Co.
M00187881	chamc20130426023	1/1/13	1/2/13	1/2/13	Community Hosp of Anderson & Madison Co.
M00025858	chamc20130424018	1/4/13	1/4/13	1/11/13	Community Hosp of Anderson & Madison Co.
M00205372	chamc20130426027	1/4/13	1/4/13	1/9/13	Community Hosp of Anderson & Madison Co.
M00518966	chamc20130424014	1/6/13	1/6/13	1/6/13	Community Hosp of Anderson & Madison Co.
M00111191	chamc20130419004	1/7/13	1/7/13	1/14/13	Community Hosp of Anderson & Madison Co.
M00102257	chamc20130419005	1/7/13	1/7/13	1/14/13	Community Hosp of Anderson & Madison Co.
M00516053	chamc20130424015	1/9/13	1/9/13	1/17/13	Community Hosp of Anderson & Madison Co.
M00183107	chamc20130426020	1/10/13	1/11/13	1/12/13	Community Hosp of Anderson & Madison Co.
M00019544	chamc20130424016	1/13/13	1/13/13	1/18/13	Community Hosp of Anderson & Madison Co.
M00062573	chamc20130423008	1/14/13	1/14/13	1/17/13	Community Hosp of Anderson & Madison Co.
M00118870	chamc20130423009	1/14/13	1/14/13	1/14/13	Community Hosp of Anderson & Madison Co.
m00069932	chamc20130419006	1/17/13	1/17/13	1/25/13	Community Hosp of Anderson & Madison Co.
M00039266	chamc20130426021	1/17/13	1/17/13	1/17/13	Community Hosp of Anderson & Madison Co.
M00250605	chamc20130423010	1/19/13	1/19/13	1/19/13	Community Hosp of Anderson & Madison Co.
M00122344	chamc20130423012	1/19/13	1/19/13	1/19/13	Community Hosp of Anderson & Madison Co.
M00151214	chamc20130423011	1/20/13	1/20/13	1/20/13	Community Hosp of Anderson & Madison Co.
M00080390	chamc20130424013	1/24/13	1/24/13	1/28/13	Community Hosp of Anderson & Madison Co.
M00508123	chamc20130426022	1/28/13	1/28/13	2/1/13	Community Hosp of Anderson & Madison Co.
M00205972	chamc20130424017	1/30/13	1/30/13	2/5/13	Community Hosp of Anderson & Madison Co.
M00211811	chamc20130426025	1/30/13	1/31/13	2/5/13	Community Hosp of Anderson & Madison Co.
M00012202	chamc20130426029	1/31/13	1/31/13	2/4/13	Community Hosp of Anderson & Madison Co.
M00059858	chamc20130517037	2/1/13	2/1/13	2/8/13	Community Hosp of Anderson & Madison Co.
M00080763	chamc20130605055	2/1/13	2/2/13	2/5/13	Community Hosp of Anderson & Madison Co.
M00202748	chamc20130517039	2/6/13	2/6/13	2/8/13	Community Hosp of Anderson & Madison Co.
M00080527	chamc20130517040	2/8/13	2/8/13	2/12/13	Community Hosp of Anderson & Madison Co.
M00261042	chamc20130605053	2/9/13	2/9/13	2/12/13	Community Hosp of Anderson & Madison Co.
M00050869	chamc20130516035	3/2/13	3/2/13	3/5/13	Community Hosp of Anderson & Madison Co.
M00059649	chamc20130416002	3/2/13	3/2/13	3/4/13	Community Hosp of Anderson & Madison Co.

Number of Patients Admitted Yearly

Medical Record Num	Incident Number	Injury Date	Hospital Admission Date	Hospital Discharge Date	Facility Name
M00029958	chamc20130625067	3/11/13	3/11/13	3/11/13	Community Hosp of Anderson & Madison Co.
M00132499	chamc20130625063	3/13/13	3/13/13	3/13/13	Community Hosp of Anderson & Madison Co.
M00316416	chamc20130625066	3/13/13	3/13/13	3/13/13	Community Hosp of Anderson & Madison Co.
M00003239	chamc20130516036	3/14/13	3/14/13	3/19/13	Community Hosp of Anderson & Madison Co.
M00082960	chamc20130617056	3/18/13	3/18/13	3/23/13	Community Hosp of Anderson & Madison Co.
m00171234	chamc20130617058	3/20/13	3/20/13	3/23/13	Community Hosp of Anderson & Madison Co.
M00214521	chamc20130516033	3/21/13	3/21/13	3/28/13	Community Hosp of Anderson & Madison Co.
m00131416	chamc20130617057	3/22/13	3/22/13	4/1/13	Community Hosp of Anderson & Madison Co.
M00067388	chamc20130617060	3/23/13	3/23/13	3/23/13	Community Hosp of Anderson & Madison Co.
M00214325	chamc20130625062	3/30/13	3/30/13	4/2/13	Community Hosp of Anderson & Madison Co.
M00179553	chamc20130716071	5/1/13	5/1/13	5/11/13	Community Hosp of Anderson & Madison Co.
M00524746	chamc20130716073	5/6/13	5/6/13	5/6/13	Community Hosp of Anderson & Madison Co.
M00212109	chamc20130716072	5/6/13	5/6/13	5/10/13	Community Hosp of Anderson & Madison Co.
M00227962	chamc20130716070	5/7/13	5/7/13	5/13/13	Community Hosp of Anderson & Madison Co.
M00201471	chamc20130722078	5/11/13	5/11/13	5/11/13	Community Hosp of Anderson & Madison Co.
M00166981	chamc20130716076	5/11/13	5/11/13	5/13/13	Community Hosp of Anderson & Madison Co.
M00228199	chamc20130722079	5/15/13	5/15/13	5/28/13	Community Hosp of Anderson & Madison Co.
M00208932	chamc20130716075	5/18/13	5/18/13	5/22/13	Community Hosp of Anderson & Madison Co.
M00068000	chamc20130722081	5/18/13	5/18/13	5/27/13	Community Hosp of Anderson & Madison Co.
m00123963	chamc20130722080	5/18/13	5/18/13	5/22/13	Community Hosp of Anderson & Madison Co.
m00064858	chamc20130808088	5/18/13	5/18/13	5/22/13	Community Hosp of Anderson & Madison Co.
M00147945	chamc20130808085	5/18/13	5/19/13	5/21/13	Community Hosp of Anderson & Madison Co.
m00168552	chamc20130808086	5/19/13	5/19/13	5/23/13	Community Hosp of Anderson & Madison Co.
M00524972	chamc20130716074	5/18/13	5/19/13	5/19/13	Community Hosp of Anderson & Madison Co.
M00520885	chamc20130722083	5/23/13	5/23/13	5/23/13	Community Hosp of Anderson & Madison Co.
M00160911	chamc20130805084	5/23/13	5/23/13	5/23/13	Community Hosp of Anderson & Madison Co.
M00123584	chamc20130808087	5/24/13	5/24/13	5/24/13	Community Hosp of Anderson & Madison Co.
M00111996	chamc20130722082	5/25/13	5/25/13	5/25/13	Community Hosp of Anderson & Madison Co.
m00281496	chamc20130822098	6/1/13	6/1/13	6/7/13	Community Hosp of Anderson & Madison Co.
M00503571	chamc20131008117	6/4/13	6/4/13	6/20/13	Community Hosp of Anderson & Madison Co.

Number of Patients Admitted Yearly

Medical Record Num	Incident Number	Injury Date	Hospital Admission Date	Hospital Discharge Date	Facility Name
M00225542	chamc20130828100	6/6/13	6/6/13	6/7/13	Community Hosp of Anderson & Madison Co.
M00525286	chamc20130828099	6/5/13	6/6/13	6/12/13	Community Hosp of Anderson & Madison Co.
M00046354	chamc20130816091	6/8/13	6/8/13	6/12/13	Community Hosp of Anderson & Madison Co.
M00231458	chamc20130822095	6/8/13	6/8/13	6/8/13	Community Hosp of Anderson & Madison Co.
M00525346	chamc20130816092	6/9/13	6/9/13	6/9/13	Community Hosp of Anderson & Madison Co.
M00259217	chamc20130822097	6/11/13	6/11/13	6/11/13	Community Hosp of Anderson & Madison Co.
M00525424	chamc20130910109	6/13/13	6/14/13	6/18/13	Community Hosp of Anderson & Madison Co.
M00079253	chamc20130830102	6/18/13	6/18/13	6/25/13	Community Hosp of Anderson & Madison Co.
M00071800	chamc20130904104	6/21/13	6/22/13	7/3/13	Community Hosp of Anderson & Madison Co.
M00152374	chamc20130918113	6/22/13	6/23/13	6/27/13	Community Hosp of Anderson & Madison Co.
M00007600	chamc20130904105	6/23/13	6/23/13	6/26/13	Community Hosp of Anderson & Madison Co.
M00232733	chamc20130904106	6/23/13	6/23/13	6/27/13	Community Hosp of Anderson & Madison Co.
M00213670	chamc20130910108	6/23/13	6/23/13	6/24/13	Community Hosp of Anderson & Madison Co.
M00524785	chamc20130904107	6/24/13	6/24/13	6/28/13	Community Hosp of Anderson & Madison Co.
M00139403	chamc20130918116	6/25/13	6/25/13	6/26/13	Community Hosp of Anderson & Madison Co.
M00214325	chamc20130910110	6/24/13	6/25/13	6/27/13	Community Hosp of Anderson & Madison Co.
M00176773	chamc20130910112	6/25/13	6/25/13	7/4/13	Community Hosp of Anderson & Madison Co.
M00080016	chamc20130830101	6/26/13	6/26/13	7/2/13	Community Hosp of Anderson & Madison Co.
M00269883	chamc20130904103	6/27/13	6/27/13	6/29/13	Community Hosp of Anderson & Madison Co.
M00525702	chamc20130918114	6/30/13	6/30/13	6/30/13	Community Hosp of Anderson & Madison Co.
M00143566	chamc20130918115	6/30/13	6/30/13	7/14/13	Community Hosp of Anderson & Madison Co.
M00084293	chamc20131121143	7/1/13	7/1/13	7/5/13	Community Hosp of Anderson & Madison Co.
M00231450	chamc20131106133	7/3/13	7/3/13	7/4/13	Community Hosp of Anderson & Madison Co.
M00525219	chamc20131113137	7/4/13	7/4/13	7/5/13	Community Hosp of Anderson & Madison Co.
M00259955	chamc20131113139	7/6/13	7/7/13	7/7/13	Community Hosp of Anderson & Madison Co.
M00524060	chamc20131113141	7/7/13	7/7/13	7/8/13	Community Hosp of Anderson & Madison Co.
M00185800	chamc20131121142	7/7/13	7/7/13	7/8/13	Community Hosp of Anderson & Madison Co.
M00155481	chamc20131030124	7/13/13	7/13/13	7/15/13	Community Hosp of Anderson & Madison Co.
M00111855	chamc20131113135	7/13/13	7/13/13	7/17/13	Community Hosp of Anderson & Madison Co.
M00083500	chamc20131113138	7/13/13	7/13/13	7/13/13	Community Hosp of Anderson & Madison Co.

Number of Patients Admitted Yearly

Medical Record Num	Incident Number	Injury Date	Hospital Admission Date	Hospital Discharge Date	Facility Name
M00252752	chamc20131030122	7/14/13	7/14/13	7/19/13	Community Hosp of Anderson & Madison Co.
m00231494	chamc20131030125	7/15/13	7/15/13	7/16/13	Community Hosp of Anderson & Madison Co.
M00182242	chamc20131030123	7/17/13	7/17/13	7/17/13	Community Hosp of Anderson & Madison Co.
M00199633	chamc20131030127	7/22/13	7/22/13	7/22/13	Community Hosp of Anderson & Madison Co.
M00191481	chamc20131106131	7/22/13	7/22/13	7/22/13	Community Hosp of Anderson & Madison Co.
M00094003	chamc20131106132	7/25/13	7/25/13	7/25/13	Community Hosp of Anderson & Madison Co.
M00510534	chamc20131227159	8/5/13	8/5/13	8/8/13	Community Hosp of Anderson & Madison Co.
M00127721	chamc20131227156	8/8/13	8/8/13	8/21/13	Community Hosp of Anderson & Madison Co.
M00069572	chamc20131227154	8/8/13	8/8/13	8/21/13	Community Hosp of Anderson & Madison Co.
M00056559	chamc20131227155	8/8/13	8/8/13	8/12/13	Community Hosp of Anderson & Madison Co.
M00151459	chamc20131209147	8/8/13	8/8/13	8/12/13	Community Hosp of Anderson & Madison Co.
M00263533	chamc20131227165	8/11/13	8/11/13	8/12/13	Community Hosp of Anderson & Madison Co.
M00168683	chamc20131227166	8/12/13	8/12/13	8/22/13	Community Hosp of Anderson & Madison Co.
M00311082	chamc20131220151	8/11/13	8/12/13	8/20/13	Community Hosp of Anderson & Madison Co.
M00177443	chamc20131220149	8/13/13	8/13/13	8/16/13	Community Hosp of Anderson & Madison Co.
M00304682	chamc20131227161	8/12/13	8/13/13	8/13/13	Community Hosp of Anderson & Madison Co.
M00177443	chamc20131022119	8/13/13	8/13/13	8/16/13	Community Hosp of Anderson & Madison Co.
M00040893	chamc20131220150	8/14/13	8/14/13	8/21/13	Community Hosp of Anderson & Madison Co.
M00208591	chamc20131227158	8/15/13	8/15/13	8/17/13	Community Hosp of Anderson & Madison Co.
M00147209	chamc20131227157	8/16/13	8/16/13	8/16/13	Community Hosp of Anderson & Madison Co.
M00126257	chamc20131209146	8/19/13	8/19/13	8/20/13	Community Hosp of Anderson & Madison Co.
M00145471	chamc20131220152	8/21/13	8/21/13	8/26/13	Community Hosp of Anderson & Madison Co.
M00245264	chamc20131227162	8/22/13	8/23/13	8/23/13	Community Hosp of Anderson & Madison Co.
M00082094	chamc20131227164	8/24/13	8/24/13	8/24/13	Community Hosp of Anderson & Madison Co.
M00526667	chamc20131227163	8/26/13	8/26/13	8/28/13	Community Hosp of Anderson & Madison Co.
M00054871	chamc20140107004	10/1/13	10/1/13	10/2/13	Community Hosp of Anderson & Madison Co.
M00219524	chamc20140103002	10/1/13	10/1/13	10/6/13	Community Hosp of Anderson & Madison Co.
M00195045	chamc20140113006	10/2/13	10/2/13	10/2/13	Community Hosp of Anderson & Madison Co.
M00311038	chamc20140113007	10/3/13	10/3/13	10/10/13	Community Hosp of Anderson & Madison Co.
M00503582	chamc20140113008	10/3/13	10/4/13	10/7/13	Community Hosp of Anderson & Madison Co.

Number of Patients Admitted Yearly

Medical Record Num	Incident Number	Injury Date	Hospital Admission Date	Hospital Discharge Date	Facility Name
M00111741	chamc20140113009	10/7/13	10/7/13	10/8/13	Community Hosp of Anderson & Madison Co.
M00236858	chamc20140117010	10/7/13	10/7/13	10/15/13	Community Hosp of Anderson & Madison Co.
M00302918	chamc20140117011	10/8/13	10/8/13	10/14/13	Community Hosp of Anderson & Madison Co.
M00527483	chamc20140117013	10/10/13	10/10/13	10/10/13	Community Hosp of Anderson & Madison Co.
M00032593	chamc20140117012	10/10/13	10/10/13	10/13/13	Community Hosp of Anderson & Madison Co.
M00001715	chamc20140117014	10/11/13	10/11/13	10/11/13	Community Hosp of Anderson & Madison Co.
M00527509	chamc20140117015	10/11/13	10/11/13	10/12/13	Community Hosp of Anderson & Madison Co.
M00127488	chamc20140127016	10/13/13	10/12/13	10/13/13	Community Hosp of Anderson & Madison Co.
M00134282	chamc20140127017	10/12/13	10/12/13	10/12/13	Community Hosp of Anderson & Madison Co.
M00086748	chamc20140205019	10/12/13	10/12/13	10/18/13	Community Hosp of Anderson & Madison Co.
M00173976	chamc20140205020	10/14/13	10/14/13	10/16/13	Community Hosp of Anderson & Madison Co.
M00141469	chamc20140205021	10/15/13	10/15/13	10/17/13	Community Hosp of Anderson & Madison Co.
M00282535	chamc20140205022	10/16/13	10/16/13	10/19/13	Community Hosp of Anderson & Madison Co.
M00516011	chamc20140205023	10/16/13	10/16/13	10/16/13	Community Hosp of Anderson & Madison Co.
M00256924	chamc20140205024	10/19/13	10/19/13	10/20/13	Community Hosp of Anderson & Madison Co.
M00061955	chamc20140205025	10/19/13	10/20/13	10/22/13	Community Hosp of Anderson & Madison Co.
M00022911	chamc20140205026	10/20/13	10/20/13	10/23/13	Community Hosp of Anderson & Madison Co.
M00504528	chamc20140205027	10/22/13	10/22/13	10/22/13	Community Hosp of Anderson & Madison Co.
M00038397	chamc20140205028	10/22/13	10/22/13	10/29/13	Community Hosp of Anderson & Madison Co.
M00514638	chamc20140205029	10/25/13	10/25/13	11/1/13	Community Hosp of Anderson & Madison Co.
M00162393	chamc20140205030	10/26/13	10/26/13	10/26/13	Community Hosp of Anderson & Madison Co.
M00187545	chamc20140205031	10/28/13	10/28/13	10/31/13	Community Hosp of Anderson & Madison Co.
M00502244	chamc20140205032	10/29/13	10/29/13	10/29/13	Community Hosp of Anderson & Madison Co.
M00063008	chamc20140205033	10/29/13	10/29/13	11/2/13	Community Hosp of Anderson & Madison Co.
M00114168	chamc20140205034	10/29/13	10/29/13	11/4/13	Community Hosp of Anderson & Madison Co.
M00143431	chamc20140205035	11/1/13	11/1/13	11/4/13	Community Hosp of Anderson & Madison Co.
M00160121	chamc20140205036	11/1/13	11/1/13	11/1/13	Community Hosp of Anderson & Madison Co.
M00188245	chamc20140205037	11/3/13	11/3/13	11/8/13	Community Hosp of Anderson & Madison Co.
M00025295	chamc20140205038	11/4/13	11/4/13	11/7/13	Community Hosp of Anderson & Madison Co.
M00144524	chamc20140205039	11/5/13	11/5/13	11/10/13	Community Hosp of Anderson & Madison Co.

Number of Patients Admitted Yearly

Medical Record Num	Incident Number	Injury Date	Hospital Admission Date	Hospital Discharge Date	Facility Name
M00248051	chamc20140205040	11/5/13	11/5/13	11/6/13	Community Hosp of Anderson & Madison Co.
m00062590	chamc20140205041	11/5/13	11/5/13	11/10/13	Community Hosp of Anderson & Madison Co.
M00512760	chamc20140205042	11/6/13	11/6/13	11/6/13	Community Hosp of Anderson & Madison Co.
M00511441	chamc20140205043	11/9/13	11/9/13	11/11/13	Community Hosp of Anderson & Madison Co.
M00166116	chamc20140210045	11/9/13	11/9/13	11/12/13	Community Hosp of Anderson & Madison Co.
M00246326	chamc20140212050	11/17/13	11/17/13	11/17/13	Community Hosp of Anderson & Madison Co.
M00183822	chamc20140212049	11/19/13	11/19/13	11/25/13	Community Hosp of Anderson & Madison Co.
M00089446	chamc20140212047	11/27/13	11/27/13	11/27/13	Community Hosp of Anderson & Madison Co.
					Total Records: 157

Report Filters
Hospital Discharge Date: is between '1/1/2013' and '12/31/2013'

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS" LEVEL III TRAUMA CENTER STATUS

SECTION 4

Trauma Registrar

4. "A Trauma Registrar. This is someone who abstracts high-quality data into the hospital's trauma registry and works directly with the hospital's trauma team. This position is managed by the Trauma Program Manager."

NARRATIVE RESPONSE AND DISCUSSION

The Community Hospital – Anderson (CHA) Trauma Registrar is Robin Mourey, R.N, CEN. Robin has extensive experience in emergency nursing, administration and quality control. She is well-qualified to abstract high-quality data to ensure the integrity of the CHA Trauma database. The Trauma Registrar reports to the Trauma Program Manager. The CHA Trauma Registrar job description is attached.



Community Hospital Anderson

ROLE SUMMARY

TITLE/JOB CODE: Trauma Registrar

DEPARTMENT/COST CENTER: Trauma Program – 67804

REVISION DATE: New 2014

ROLE OVERVIEW The Trauma Registrar is accountable for coordinating the activities for the Trauma Registry. The registrar is responsible for the collection, entry, maintenance, and reporting of data for the Level 3 Trauma Center as required by appropriate regulatory agencies. This position collects trauma data for injury research and prevention as well as performance improvement in the Trauma Program within the facility. This position acts as a liaison with the Trauma Program Manager, Medical Directors, and trauma staff. The Trauma Registrar will assist in the preparation for the American College of Surgeons Committee on Trauma site visit and other regulatory agency visits such as ISDH and JCAHO.

REPORTS TO: Trauma Program Manager

SUPERVISES: None

REQUIRED EXPERIENCE Trauma experience preferred. Preferred knowledge of ICD-9/10; CPT; DRG; AIS and ISS coding. Knowledge of database management and proficiency in Microsoft Office applications.

REQUIRED EDUCATION A Credentialed Emergency Medical Technician; Emergency Department Technician, licensed Paramedic or RN; Certified Coding Specialist; Registered Health Information Technician; Registered Health Information Administrator, or Registered Record Administrator.

REQUIRED LICENSE CERTIFICATIONS Must attend Trauma Registry and ICD-10 training within 6 months of employment. Certified Trauma Registrar within 2 years of employment.

PRE-REQUISITE SKILLS

- Requires knowledge of database management and proficiency in Microsoft Office applications.

- Requires knowledge and proficiency in medical and hospital terminology.
- Requires the ability to communicate clearly and concisely through written and verbal communication.
- Requires strong customer service skills.
- Requires the ability to manage multiple tasks.
- Requires the ability to utilize critical thinking skills to prioritize and problem-solve complex work assignments.

ESSENTIAL FUNCTIONS

Administration:

- Collects and enters data into the trauma registry regarding trauma patients at the Trauma Center in a timely manner.
- Collaborates with Information Technology computer hardware and software maintenance and backup to assure proper registry function.
- Assigns and scores all injuries utilizing the AIS and ICD-9/10 scoring system. Completes and verifies for accuracy all data collected.
- Evaluates the documentation of nursing staff/hospital providers and identifies missing data elements. Coordinates with nursing administration to correct and obtain the information on the hospital record. Reconciles the data as the information becomes available.
- Ensures compliance with National Trauma Data Bank (NTDB) and Indiana Department of Public Health (ISDH) required standards.
- Creates reports and spreadsheets as required and exports or imports data into reports.
- Participates as an integral member of the Trauma Quality Improvement team. Involved in leadership and professional development to assure skills and knowledge of trauma information.
- Evaluates current trends in injury mechanism and advises administrative team regarding needs for Prevention Initiatives.
- Cognitively reviews data and advises on needs for change in the Trauma Center Plan.
- Compiles and analyzes administrative reports for regulatory agencies, participating institutions, and committees as directed by the Trauma Medical Director or Trauma Program Manager.
- Works with the Trauma Program Manager collaborating as an advisor for development of the hospital multidisciplinary team.

Research:

- Actively participates in educational and clinical research projects conducted by the Trauma Medical Director.
- Analyzes data and conducts research relating to education, prevention, and/or trauma services.

Service/Teaching:

- Prepares data and trends for presentation at national, state, and local meetings.
- Education of nursing staff with regards to required trauma documentation

and requirements to maintain the policies and procedures as laid out in the Trauma Center Plan.

- Represents the trauma center at national, state, and local meetings, as requested by the Trauma Medical Director.
- Serves on local, state, and national committees as requested by the Trauma Program Manager.
- Works collaboratively with physicians, coworkers, management and other departments.
- Completes mandatory 4 hours of registry specific training per year in addition to other continuing education and contact education requirements mandated for licensure and certification.

Follows through with commitments including employee health requirements, mandatory education and completion of competencies within established timeframes.

Demonstrates respect for and cooperation with all persons in performing job duties and responsibilities; maintains courteous, complete and confidential communication with all patients, visitors, cooperation-workers and other guests.

Performs any other tasks, duties or responsibilities as assigned or needed for the effective, safe or efficient functioning/operation of the Hospital.

Knowledge/Physical Requirements

Knowledge	Occasionally	Frequently	Constantly
Reading Speaking and Writing English			X
Communication Skills			X
Computers			X
Physical			
Walking			X
Bending			X
Standing			X
Sitting			X
Driving			
Lifting up to 50 lbs. with or without assistance			X
Stretching/Reaching			X
Distinguish smell/temperature			X
Hearing/Seeing			X
Exposure to bloodborne			X

pathogens and infectious disease			
Exposure to hazardous material			X
Climbing	X		
Hand/Finger dexterity			X
Stooping (bend at waist)			X
Sensory Activities			
Talking in person			X
Talking on the telephone			X
Hearing in person			X
Hearing on the telephone			X
Vision for close work			X
Other			

**OTHER
COMPETENCIES**

All hospital mandatory competencies.

**PHYSICAL &
ENVIRONMENTAL
REQUIREMENTS**

The "Risk of Exposure Category" for this job has been identified as a Category 1.

Robin Mourey, RN, CEN
Infection Preventionist/Trauma Registrar
Community Hospital Anderson
1515 N Madison Ave
Anderson, IN 46011
765-298-3009

Work History:

Community Hospital Anderson

Trauma Registrar January 2014 to Present
Infection Preventionist August 2013 to Present
Quality Resource Coordinator May 2012 – September 2013

O'Bleness Memorial Hospital

Emergency Room charge Nurse PRN May 2011 – July 2011 (3 months)

Community Health Network

Care Manager, Network Resource Team May 2011 – May 2012
Clinical Manager, Emergency Department CHE September 2006 – April 2011
Care Manager, Emergency Department CHE May 2004 – September 2006
Patient Support Person II, Emergency Department CHE March 2003 – December 2004
Student Nurse Extern, Emergency Department CHE January 2003 – May 2004

Energy Electric Co., Inc.

Controller, Energy electric, Co., Inc. January 1999 – March 2003

Certifications and Licensure

Certified Emergency Nurse (CEN), Emergency Nurses Association (ENA) March 2008-Present
Indiana RN, Indiana Board of Nursing June 2004 – Present
FMEA certification 2013 - Present
Lean Six Sigma Green Belt certification 2013 – Present
TNCC
ACLS
BLS
NIHSS Stroke Certification

Education

Indiana Wesleyan University
BSN, Nursing 2009 – 2012

Ivy Tech State
ASN, Nursing 2001 – 2004

- Knowledgeable in regards to all CMS requirements, NDNQI data, HCAHP scores, Process Improvement, and Certified Lean Six Sigma Green Belt
- Dedicated and patient-focused Registered Nurse with proven strengths in acute patient care, staff development, finance and patient advocacy.
- Exceptional capacity to multi-task: manage numerous, often competing priorities with ease and foster the provision of superior patient care.
- Administrative and referral experience including admissions, assessment, treatment, referral, and education for a wide range of patients.
- Widely recognized as an excellent care provider and patient advocate.
- Demonstrated ability to forge, lead, and schedule outstanding healthcare teams that provide top-quality patient care within budget constraints and evidence based nurse to patient ratios.
- Outstanding interpersonal and communication skills; superior accuracy in patient history, charting, and other documentation.
- Excellent in data gathering, organization of information and reporting process of data received and relevance of said data in regards to Healthcare Improvement of Outcomes and Quality care.

Certificate of Completion

12 CEU's awarded to:

Robin Mourey

"Sharper Coding for Trauma

with ICD-10-CM & ICD-10-PCS"



Trauma Consulting LLC

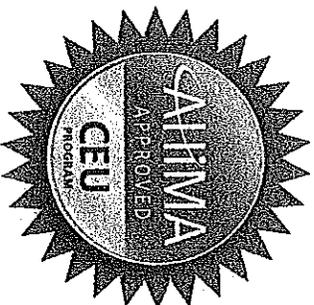
Kathy J. Cookman

Kathy J. Cookman, BS, CSTR, CAISS
Course Facilitator

February 27 & 28, 2014

Indianapolis, Indiana

"This program has been approved for 12 continuing education units for use in fulfilling the continuing education requirement of the American Health Information Management Association (AHIMA). Granting prior approval from AHIMA does not constitute endorsement of the program content or its program sponsor."



Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 5

Tiered Activation System

5. "**Tiered Activation System.** There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program."

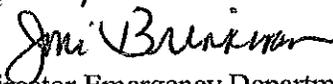
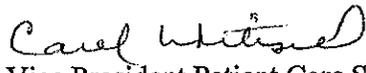
NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 5 are met with a signed copy of the Community Hospital – Anderson (CHA) Tiered Activation policy. The PIPS system continuously evaluates the effectiveness of the specific tiers and the subsequent multi-disciplinary response. All affected caregivers are invited to review each case for effectiveness.



Community Hospital Anderson

Emergency Department Policy and Procedure Manual

Subject:	Tiered Trauma Activation Criteria and Multidisciplinary Response for the Care of Trauma Patients
Originator:	 Trauma Medical Director
Approved By:	 Trauma Program Manager
	 Director Emergency Department
	 Vice President Patient Care Services/CNO
Scope:	Emergency Department
Policy Coordinator:	Cheryl Arnold
Effective:	2/01/14
Revised:	
Reviewed:	
References:	American College of Surgeons, Committee On Trauma. Resources For The Optimal Care Of The Injured Patient 2006. Chicago, IL.
Attachments:	

PURPOSE:

1. To provide criteria for a tiered trauma activation system
2. To establish a systematic approach to the delivery of care of the trauma patient.
3. To provide expedient assessment, treatment of life threatening injuries, stabilization, and/or transportation to a higher level of care.

GENERAL INFORMATION:

1. To clearly define the roles of individuals involved in the care of trauma patients.
2. To define the level of trauma care and response to such levels.

PERSONNEL:

Applicable to staff of the Emergency Department, Administrative Rep., Registration, Switchboard, Laboratory, Radiology, Respiratory Services, Spiritual Care, and the trauma surgeon on call.

EQUIPMENT: Trauma Room and medical supplies to care for the patient.

Portable x-ray machine and CT scanner.

Ultrasound for ED Physician and Trauma Surgeon use

PROCEDURE:

I. Team Members

A. Availability of personnel will depend upon level of staffing and may require initiation of on call systems.

1. Emergency Department (ED) Physician
2. Trauma surgeon
3. ED Trauma nurse(s)
4. ED Charge Nurse
5. Administrative Representative
6. ED Tech(s)
7. Respiratory Therapist
8. Radiology /CT Technologist
9. Patient Transport Tech(s)

B. Additional Department Notifications:

1. ICU (as needed)
2. Operating Room Staff and Anesthesiologist (as needed)
3. Laboratory/Blood Bank
4. Registration
5. Chaplain (as needed)
6. Security

II. Levels of Trauma

A. Trauma Level One: (paged overhead)

1. Confirmed blood pressure <90 at any time in adults and age-specific hypotension in children with mechanism attributed to trauma.
2. Gunshot wound (GSW) to the neck, chest or abdomen.
3. Glasgow Coma Scale (GCS) <13 with mechanism attributed to trauma.
4. Transfer trauma patient from other hospitals receiving blood to maintain vital signs.
5. Intubated patients transferred from the scene or patients with respiratory compromise or obstruction attributed to trauma.
6. Respiratory rate <10 or >29 with mechanism attributed to trauma.
7. Needle chest decompression or cricothyroidotomy in field
8. Penetrating injury to head, neck, chest, abdomen, back, buttocks, or extremities proximal to elbow or knee.
9. Flail Chest
10. Burns >15% or high voltage electrical injury
11. Two (2) or more long bone fractures
12. Crushed, degloved, mangled, or pulseless extremity
13. Traumatic amputation proximal to the wrist or ankle

14. Known or suspected pelvic fracture
15. Open or depressed skull fracture
16. Extremity paralysis suggestive of spinal cord injury
17. Judgment of the Emergency Physician, ER Nurse or EMS

B. TRAUMA ALERT (not paged overhead):

1. History of loss of consciousness following a traumatic event
2. Fall > 20 feet or 2 stories
3. High risk auto crash (mechanism of injury):
 - a. Intrusion > 12 inches occupant site; 18 inches any site
 - b. Ejection from vehicle
 - c. Death in same vehicle
4. Pedestrian or bicyclist struck, thrown, or run over by vehicle
5. Motorcycle crash > 20 mph
6. Traumatic amputation distal to wrist or ankle
7. Open long bone fracture
8. Pregnancy > 20 weeks with significant mechanism of injury
9. Judgment of the Emergency Physician, ER Nurse or EMS

III. Levels of Response

A. Trauma Level One

1. Upon notification from the ED physician or ED RN, the ED staff will notify the switchboard operator by telephone to initiate the Trauma Level One page. The switchboard operator will initiate an overhead verbal page in the entire hospital
2. ED staff will page the trauma surgeon on call and record all relevant times.
3. All trauma team members report to the ED upon paging. The trauma surgeon will initially respond via phone.

B. Trauma Alert

1. Upon notification from the ED physician or ED RN, the ED staff will notify the Administrative Rep., the Respiratory Therapist and the Radiology /CT Technologist by telephone or other appropriate in-house communication
2. There will be no overhead verbal page regarding trauma alerts. The ED staff will record all relevant times.
3. The Radiology /CT Technologist will report to the ED and all other trauma team members are "on-call" at their original location pending further notification

IV. Trauma One Team Member Role Definitions

A. Emergency Department Physician

1. Corresponds with pre-hospital personnel or ED staff taking report to determine level of trauma prior to patient arrival.
2. Overall coordination of trauma room activities until a trauma surgeon or specialist surgeon arrives to assume care or patient has been transferred to a higher level Trauma Center
3. Responsible for patient assessment and to perform life-saving interventions for life-threatening injuries found on primary survey.

B. Trauma Surgeon

1. Responds to the Trauma Level One patient and is available in the ED within 30 minutes of the patient's arrival to the ED.
2. Responsible for the overall care of the trauma patient.
3. Coordinates care with other specialties to facilitate continuity of care.
4. Evaluates and treats the patient.
5. Participates in the initial evaluation and resuscitation of the seriously injured patients.

C. Emergency Department RN

1. Performs primary and secondary assessment of trauma patient upon arrival to ED, assuring priority of care and initiation of resuscitation protocols.
2. Responsible for overall coordination of care delivered by nursing and ancillary personnel.
3. Responsible for adequately stocking the Trauma Room and making sure all equipment is in functioning order.
4. Re-assesses and evaluates patient response to interventions.
5. Responsible for documentation, observation, delegation, and communication of care of the trauma patient:
 - a. Documentation
 1. Completion of Trauma Critical Care Record
 2. Completing all transfer records when applicable
 - b. Observation
 1. Knowledge of patient status at ALL times
 2. Monitors vital functions
 3. Assures that personnel are functioning in proper capacity for protocol and job description
 - c. Delegation
 1. Assures proper patient care by delegation of orders

and/or procedures to appropriate personnel

- d. Communication
 - 1. Assures communication of patient report to receiving unit or hospital
 - 2. Assures patient update reports to the ED physician and/or trauma surgeon

D. ED Charge Nurse

- 1. Assigns trauma staff as required.
- 2. Takes pre-hospital report when ED physician is not available.
- 3. Follows guidelines to make level of trauma determination when ED physician is not available.
- 4. Is present upon patient arrival to ED until stabilized.
- 5. Acts as a resource for trauma team
- 6. Performs interventions for trauma patient care when needed.
- 7. Coordinates continuation of care for existing patients in department.

E. Emergency Department Tech

- 1. Is present upon patient arrival to ED
- 2. Performs tasks delegated by ED Trauma nurse. (example: assists with hemorrhage control, wound care, CPR, immobilization, spine stabilization, Foley insertion, procedure set-up.)

F. Respiratory Therapist

- 1. Team members will respond as assigned to both Level one and trauma alert.
- 2. Maintain an open airway
- 3. Assist with intubation or cricothyrotomy
- 4. Maintain positive pressure ventilation
- 5. May obtain ABG's as delegated
- 6. Accompany patient to other areas if airway management and/or ventilation required.

G. Radiology Technologist

- 1. Team members will respond as assigned
- 2. Obtains images as ordered
- 3. All portable images must be completed prior to patient going to CT scan unless otherwise directed by either the ED physician or the trauma surgeon.
- 4. Will promptly prepare CD copies of all imaging studies in preparation for emergency transfer to a Level 1 facility

H. CT Scan Technologist

1. Upon receiving the page, will finish with any current scans and clear scanner until trauma scans are finished.
 2. Initiate call to the Radiologist as required
- I. Laboratory/Blood Bank
1. Prepares cooler containing two (2) units O negative blood and emergency transfusion documents. Responds to ED with blood when specifically called
 2. Collects necessary blood specimens and properly bands patient
 3. Notifies ED when type-specific and crossmatched blood is available
- J. Registration
1. Makes chart and places ID band on patient. Merges anonymous male/female trauma patient as soon as identification made.
 2. Gives Ed staff identification labels as soon as possible.
- K. Unit Secretary / Emergency Department staff
1. Obtains Trauma Level One alert form/tracks communication times with Physicians.
 2. Performs initial notifications as described in III A & III B
 3. Coordinates phone calls for consultants, inter-facility transfers and transportation as directed
- L. Chaplin
1. Minister to patient and family as necessary
 2. Notify family members as necessary.
 3. Keep family updated on patient care.
- M. Security
1. Crowd control as necessary
 2. Secures helipad for air transport
- N. Additional Department Notifications
1. ICU as needed.
 2. Operating Room Staff and Anesthesiologist as needed
- O. Administrative Representative
1. Responds to ED immediately pursuant to the Trauma Level One overhead page. Assumes documentation role on the Trauma worksheet.
 2. Provides other resources and assistance as needed
 3. Notifies on-call OR team and Anesthesiologist when required

END

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 6

Trauma Surgeon Response Times

"6. Trauma Surgeon response times. Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons. Also, there must be a written letter of commitment, signed by the Trauma Medical Director, that is included as part of the hospital's application. There must be evidence that a trauma surgeon is a member of the hospital's disaster committee."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 6 are met with a letter of commitment from the Community Hospital – Anderson (CHA) Trauma Medical Director. The commitment letter affirms intent of the CHA Trauma Surgeons to comply with the response times as defined by the Optimal Resources document of the American College of Surgeons. There is a letter from the CHA Emergency MGMT/HAZMAT Coordinator affirming the Trauma Medical Director's membership on the CHA Disaster and Emergency Management Committee. A spreadsheet of our surgeons' outstanding response times since implementation of our activation protocol is included and will be updated prior to the May 9, 2014 ISTCC meeting.

DWIGHT B. McCURDY, M.D.

1210 MEDICAL ARTS BLVD., STE. 215

ANDERSON, IN 46011

Telephone: (765) 298-4140

Monday, March 10, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Dept of Health

2 North Meridian Street

Indianapolis, IN 46204

Subject: Community Hospital – Anderson’s Application for “in the ACS Verification Process” for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital- Anderson’s effort to complete the “in the process” Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Our Trauma surgeons rotate call to be promptly available twenty-four hours per day. We are committed to responding to the highest level of activation within thirty minutes of the patient’s arrival. Response times are continuously evaluated through the hospital’s Performance Improvement and Patient Safety (PIPS) program.

In acquiring the ATLS certification requirement of the Medical Director I was certified in residency back in the early 90s. I have reviewed the latest ATLS student course Manual (9th ed.), and plan to take the recertification course in Columbus, OH on the 25th-26th of April.

Respectfully,



Dwight B McCurdy, MD, FACS

Trauma Medical Director

March 6, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process"
for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that Dr. McCurdy, our Trauma
Medical Director, is a member of Community Hospital – Anderson's Emergency Management
Committee.

Respectfully,



Angela M. Miller, C.H.E.P.
Emergency MGMT/HAZMAT Coordinator



Dwight B. McCurdy, M.D., FACS
Trauma Medical Director



Find a Doctor

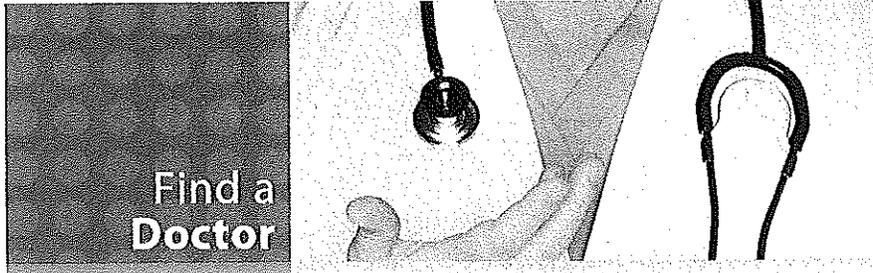
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Khalil G. Wakim, M.D.



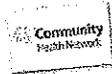
Specialty:	General Surgery
Location:	St. John's Health System
Address:	2101 Jackson Street, Suite 105 Anderson, IN 46016
Phone:	765-646-8555
Fax:	765-646-8554
Board Cert:	American Board of Surgery, 1984
Medical School:	Indiana University School of Medicine, 1977
Internship:	Indiana University Medical Center, 1978-79
Residency:	Indiana University Medical Center, 1979-83
Accepting New Patients:	YES

Joseph C. Baer, M.D.



Specialty:	General Surgery
Address:	1210 Medical Arts Blvd, Suite 215 Anderson, IN 46011
Phone:	765-298-4140
Fax:	765-298-4941
Board Cert:	American Board of Surgery (General), 2000
Medical School:	Indiana University School of Medicine 1994
Internship:	Methodist Hospital, Indianapolis, IN, 1994-1995, Surgery
Residency:	Methodist Hospital, Indianapolis, IN, 1995-1999, General Surgery
Accepting New Patients:	YES

Andrew Ritchison, M.D.



Specialty:	General Surgery
Location:	St. John's Health System
Address:	2101 Jackson Street, Suite 105 Anderson, IN 46016
Phone:	765-646-8555
Medical School:	Indiana University School of Medicine
Internship:	Good Samaritan Hospital, Cincinnati OH
Residency:	Good Samaritan Hospital, Cincinnati OH
Accepting New Patients:	YES

2013/2014 Call Schedule

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Feb 23 R	Feb 24 R W	Feb 25 B	Feb 26 W R	Feb 27 R	Feb 28 W	Mar 1 W
Mar 2 W	Mar 3 M	Mar 4 B	Mar 5 M	Mar 6 W	Mar 7 B	Mar 8 B
Mar 9 B	Mar 10 M	Mar 11 B	Mar 12 R	Mar 13 W	Mar 14 M	Mar 15 M
Mar 16 M	Mar 17 R	Mar 18 B	Mar 19 W	Mar 20 M	Mar 21 R	Mar 22 R
Mar 23 R	Mar 24 W	Mar 25 M	Mar 26 R	Mar 27 M	Mar 28 W	Mar 29 W
Mar 30 W	Mar 31 R	Apr 1 B	Apr 2 B	Apr 3 W	Apr 4 B	Apr 5 B
Apr 6 B	Apr 7 W	Apr 8 B	Apr 9 M	Apr 10 W	Apr 11 M	Apr 12 M
Apr 13 M	Apr 14 R	Apr 15 B	Apr 16 R	Apr 17 M	Apr 18 R	Apr 19 R
Apr 20 R	Apr 21 B	Apr 22 W	Apr 23 R	Apr 24 M	Apr 25 W	Apr 26 W
Apr 27 W	Apr 28 M	Apr 29 B	Apr 30 R	May 1 W	May 2 B	May 3 B
May 4 B	May 5 M	May 6 B	May 7 R	May 8 W	May 9 M	May 10 M
May 11 M	May 12 R	May 13 B	May 14 M	May 15 W	May 16 R	May 17 R

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 7

Emergency Department Physician Coverage

"7. In-house Emergency Department physician coverage. The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 7 are met with a signed letter from Dr. Thomas Short. Dr. Short is the President of Emergency Physicians of Community Hospital Anderson, PC. and Emergency Department Medical Director. The letter affirms that all CHA Emergency Physicians are emergency medicine residency trained and board certified. A copy of a monthly schedule illustrating twenty-four hour per day coverage is included.

EPCHA, PC
12953 Publishers Drive, Suite 200
Fishers, IN 46038
(317) 577-4150 • Fax (317) 577-4142

January 30, 2014

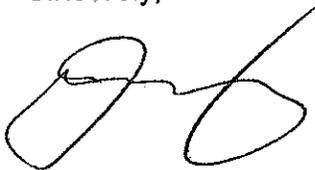
Re: Community Hospital Anderson Emergency Department

To whom it may concern:

EPCHA, PC provides physician coverage to the Emergency Department (ED) at Community Hospital Anderson (CHA). EPCHA currently has 7 physicians credentialed on staff at CHA who ensure the immediate care of all sick and injured patients in our ED. All of these physicians are emergency medicine residency trained and board certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).

I am the president of EPCHA and the ED director. As director, I ensure that the standards of quality and efficiency are maintained by the ED physicians on a daily basis.

Sincerely,



Thomas M. Short, MD FAAEM
President EPCHA, PC

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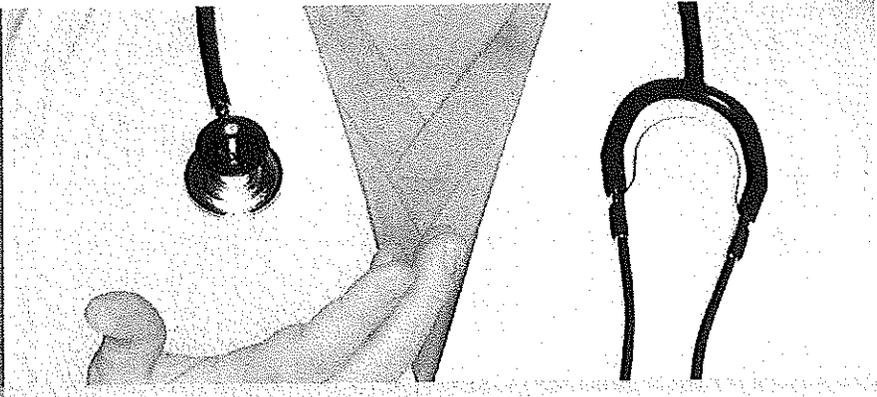
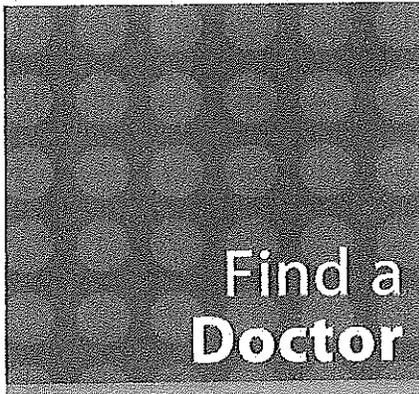
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Thomas M Short, M.D.



Specialty: Emergency Medicine
 Location: Community Hospital Anderson
 Address: 1515 North Madison Avenue
 Anderson, IN 46011
 765-298-5141
 Phone: 765-298-5883
 Fax: American Board of Emergency Medicine,
 Board Cert: Indiana University School of Medicine, 2000
 Medical School: Indiana University Medical Center, 2000-2003, Emergency Medicine
 Residency:

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59

Shift Administrators

EPCHA Schedule - February 2014						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
26 Day Burns Evening Ludlow Night Ricke	27 Day Miller Evening Ludlow Night Hofmann	28 Day Short Evening Ludlow Night Burns	29 Day 0600- 0800 Burns Day 0800- 1300 Short Evening 1300- 2200 Ricke Night Miller	30 Day Short Evening Hofmann Night Ricke	31 Day Miller Evening Short Night Hofmann	1 Day Miller Evening Ricke Night Hofmann
2 Day Miller Evening Short Night Hofmann	3 Day Ricke Evening Miller Night Short	4 Day Hofmann Evening Ricke Night Burns	5 Day Short Evening Ricke Night Miller	6 Day Ludlow Evening Short Night Miller	7 Day Hofmann Evening Ludlow Night Ricke	8 Day Burns Evening Ludlow Night Ricke
9 Day Burns Evening Ludlow Night Ricke	10 Day Miller Evening Short Night Burns	11 Day Ludlow Evening Hofmann Night Short	12 Day Ludlow Evening Ricke Night Short	13 Day Miller Evening Hofmann Night Short	14 Day Ludlow Evening Ricke Night Burns	15 Day Hofmann Evening Ricke Night Burns
16 Day Hofmann Evening Short Night Burns	17 Day Hofmann Evening Miller Night Ludlow	18 Day Short Evening Miller Night Ricke	19 Day Short Evening Ludlow Night Burns	20 Day Miller Evening Ludlow Night Burns	21 Day Hofmann Evening Miller Night Ludlow	22 Day Short Evening Miller Night Ludlow
23 Day Short Evening Miller Night Ludlow	24 Day Burns Evening Hofmann Night Miller	25 Day Short Evening Hofmann Night Burns	26 Day Ricke Evening Ludlow Night Hofmann	27 Day Ricke Evening Short Night Hofmann	28 Day Ricke Evening Short Night Hofmann	1 Day Burns Evening Ludlow Night Short

60

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 8

Orthopedic Surgery

8. "**Orthopedic Surgery**. There must be an orthopedic surgeon on call and promptly available 24 hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 8 are met with a letter from P. Jamieson Kay, M.D. Dr. Kay is the orthopedic surgery liaison from Central Indiana Orthopedics, PC (CIO) to the Community Hospital – Anderson (CHA) trauma service and the Performance Improvement and Patient Safety (PIPS) Committee. The attached letter affirms commitment to the trauma service and prompt availability of an on-call orthopedic surgeon 24 hours per day. The primary on-call schedule is made available to the CHA Emergency Department on a daily basis. Prompt availability and the appropriateness of the decision to transfer or retain major orthopedic trauma cases will be continuously reviewed by the PIPS process. The letter is also signed by the Trauma Medical Director



**Community
Hospital Anderson**

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011
T 765.298.4242
eCommunity.com

March 6, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

**SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process"
for Level III Trauma Center designation.**

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I am the orthopedic surgery liaison to the Trauma Performance Improvement and Patient Safety (PIPS) Committee. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

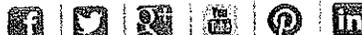
There is a Central Indiana Orthopedics, PC orthopedic surgeon on-call and promptly available 24 hours per day by notification to a central answering service. The name of the on-call surgeon is provided to the emergency department daily.

Respectfully,

P. Jamieson Kay, M.D.
Orthopedic Surgery

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

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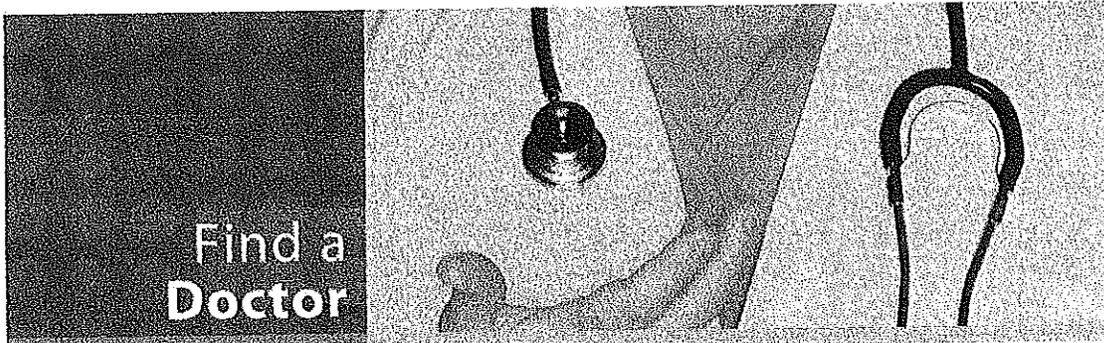
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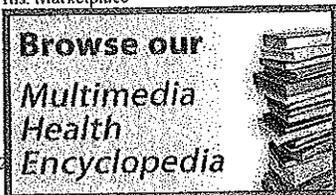
Patrick J Kay, M.D.



Specialty: Orthopedic Surgery
 Location: Central Indiana Orthopedics
 Address: 2610 Enterprise Dr.
 Anderson, IN 46013
 765-683-4400
 765-642-7903
 Phone: Board Certified, Orthopedic Surgery 2003
 Fax: Indiana University School of Medicine 1992-1996
 Board Cert: Indiana University 1996-1997
 Medical School: Indiana University Medical Center, 1997-2001
 Internship: YES
 Residency:
 Accepting:
 New Patients:

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63

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 9

Neurosurgery

"9. **Neurosurgery.** The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for higher levels of care. This plan must be agreed upon by the neurosurgical surgeon and the facility's Trauma Medical Director. There must be a transfer agreement in place with Level I or Level II trauma centers for the hospital's neurosurgical patient population. The documentation must include a signed letter of commitment by neurosurgeons and the Trauma Medical Director."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 9 are met with commitment letter and neurosurgery plan signed by Community Hospital – Anderson (CHA) Chief of Neurosurgery and the Trauma Medical Director. There is a transfer agreement in place with Smith Level I Shock Trauma Center at Eskenazi Health and IU Health/Methodist for adult neurosurgery patients. We have executed a transfer agreement with IU Health/Riley for pediatric patients requiring transfer to a Level I facility for neurosurgical care. CHA Neurosurgeons provide coverage twenty-four hours per day with appropriate OR and surgical ICU facilities. The PIPS program evaluates all neurosurgical cases to "convincingly demonstrate appropriate care" per ACS standards.



**Community
Health Network**

March 7, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Chief of Neurosurgery at Community Hospital - Anderson. I am pleased to support Community Hospital - Anderson's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to continue to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

The CHA Department of Neurosurgery is committed to providing care for patients with traumatic injury. Our scope of practice will include traumatic brain injury and spinal cord injury conducive to our comfort level, provided a neurosurgeon and critical care resources are available. All other injuries will fall under our predetermined transfer policy. I further understand that transfer agreements are in place to accept Trauma patient transfers including those requiring neurosurgical care.

Respectfully,

James Callahan, M.D.
Chief Neurosurgeon

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director



March 7, 2014

Neurosurgery Plan for Trauma Patients

The following list delineates the general types of injuries that should be considered for rapid transfer to a Level I Trauma Center if a Community Hospital Neurosurgeon and appropriate intensive care resources are not available. This list is included in the general transfer policy.

- Penetrating injury/open fracture with or without cerebrospinal fluid leak
- Intra-cranial hemorrhage
- Depressed skull fracture
- GCS <11 or deteriorating mental status or lateralizing neurological signs
- Spinal cord injury or major vertebral injury
- Carotid or vertebral arterial injury

Handwritten signature of James Callahan, M.D.

James Callahan, M.D.
Chief Neurosurgeon

Handwritten signature of Dwight B. McCurdy, M.D., FACS.

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

MD Employees

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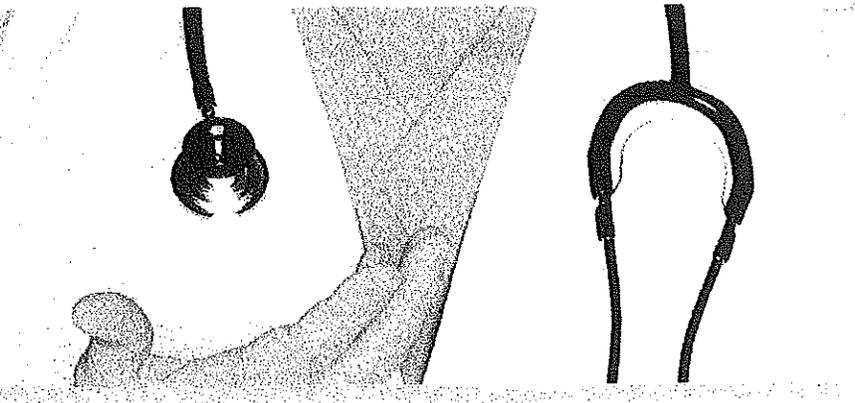
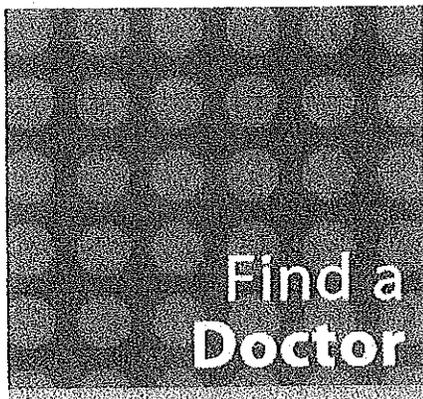
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James Callahan, M.D.



Specialty: Neurosurgery
 Location: Community Physician Network, Neurosurgical Care
 Address: 1210B Medical Arts Blvd, Ste 217
 Anderson, IN 46011
 Phone: 765-298-4470
 Fax: 765-298-4975
 Board Cert: American Board of Neurological Surgery
 Medical School: Indiana University School of Medicine, 1988
 Internship: Indiana University Medical Center, 1989
 Residency: Indiana University Medical Center, 1995
 Fellowship: Indiana University medical Center, 1990
 Accepting: YES
 New Patients:

Daniel Kim, M.D.



Specialty: Neurosurgery
 Address: 1210B Medical Arts Blvd, Ste 217
 Anderson, IN 46011
 Phone: 765-298-4470
 Fax: 765-298-4975
 Medical School: IU School of Medicine
 Internship: IU School of Medicine
 Residency: IU School of Medicine
 Fellowship: IU School of Medicine
 Accepting: YES
 New Patients:

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67

* Schedule Change *

Neurosurgical Care Anderson
Community Hospital Anderson

Jan 2014		~ February 2014 ~					Mar 2014 >	
Sun	Mon	Tue	Wed	Thu	Fri	Sat		
							1 Dr. Kim on call	
2 ****	3 Dr. Callahan on call 2/3-2/9	4	5	6	7	8		
9 ****	10 Dr. Kim on call 2/10-2/16	11	12	13	14	15		
16 ****	17 Dr. Callahan on call 2/17-2/23	18	19	20	21 Dr. Kim on call	22		
23 ****	24 Dr. Kim on call 2/24-3/2	25	26	27	28			

Questions or concerns please contact Jamie @ 765-298-4473

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 10

TRANSFER CRITERIA AND AGREEMENTS

"10. Transfer agreements and criteria. The hospital must include as part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 10 are met with a signed copy of the Community Hospital – Anderson (CHA) Transfer Criteria Policy and copies of transfer agreements with Level I adult and pediatric hospitals.

CHA has established a relationship with the new Smith Level I Shock Trauma Center at Eskenazi Health. The transfer agreement covers adult Level I patients including those requiring neurosurgical and burn care. We anticipate many opportunities for training and performance improvement feedback with Smith Level I Shock Trauma.

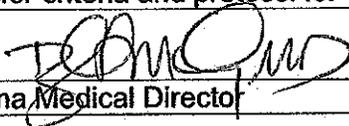
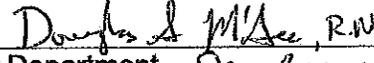
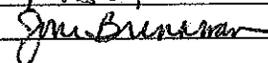
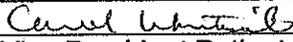
A copy of the transfer agreement between CHA and IU Health is included. CHA has enjoyed a strong relationship with IU/Methodist and IU/Riley for many decades. The agreement covers transfers of Level I adult patients to Methodist and Level I pediatric patients to Riley. IU Health provides neurosurgical care to both adult and pediatric patients.

We anticipate that all three Level I facilities will be valuable resources as we continue to develop our high-quality Level III Trauma Center.



Community Hospital Anderson

Emergency Department Policy and Procedure Manual

Subject:	Transfer criteria and protocol for Trauma Patients
Originator:	 Trauma Medical Director
Approved By:	Trauma Program Manager  Douglas A. McAfee, R.N. Clinical Director Emergency Department  Cheryl Arnold  Carol Whitman Vice President Patient Care Services
Scope:	Emergency Department
Policy Coordinator:	Cheryl Arnold
Effective:	2/01/14
Revised:	
Reviewed:	
References:	<ul style="list-style-type: none"> • American College of Surgeons, Committee On Trauma. Resources For The Optimal Care Of The Injured Patient 2006. Chicago, IL. • Health Insurance Portability and Accountability Act of 1996 (HIPAA). • Emergency Medical Treatment and Active Labor Act (EMTALA)
Attachments:	

Purpose:

Trauma patients who will be transferred out of this facility to a definitive care facility emergently must be identified early, assessed and treated quickly and transferred efficiently in order to provide them the best possible outcome.

General Information:

Transfers from Community Hospital- Anderson ("CHA") will be done in accordance with this policy based solely on the patients' needs and will be conducted with the mutual agreement of CHA and the receiving hospital based upon transfer agreements. Agreements are in place with a Level 1 trauma center to accept all types of trauma patients including those who require neurosurgical care at the discretion of the ER physician and CHA Neurosurgeon.

Patients to be transferred can often be identified before they arrive in the emergency department. Arrangements for emergent transfer can often begin the moment the emergency department staff is notified by EMS that they are en route with a major trauma patient. Other patients may require evaluation by the emergency department physician before the decision to transfer is made.

Once the decision to transfer has been made, it should not be delayed to obtain X rays, CT scans or laboratory results that do not immediately impact the resuscitation. At this point, the focus of the emergency department staff is on resuscitation and stabilization with the goal of minimizing the patient's length of stay in the emergency department. Stabilization and resuscitation efforts are to be expedited to attempt to meet a total ER time goal of thirty minutes.

Consideration should be given to whether the patient will be transferred via ground or air. Generally, seriously injured trauma patients should be transferred by air when possible. Consideration should be given to ground transport if the patient can be received by the definitive care facility sooner than if transported by air or if aero medical transfer is significantly delayed or unavailable for any reason.

Transport vehicles should be ALS equipped and staffed by paramedics and flight nurses whenever possible and appropriate.

A. TRANSFER CRITERIA

The ED Physician may consult with the Trauma Surgeon, Neurosurgeon or the Orthopedic Surgeon at his/her discretion prior to making a transfer decision.

In general, the following are conditions that should immediately activate emergency transfer procedures:

- Central Nervous System
 - Penetrating injury/open fracture with or without cerebrospinal fluid leak
 - Intra-cranial hemorrhage
 - Depressed skull fracture
 - GCS <11 or deteriorating mental status or lateralizing neurological signs
 - Spinal cord injury or major vertebral injury
 - Carotid or vertebral arterial injury
- Chest
 - Major chest wall injury or bilateral pulmonary contusion with PaO₂ to FiO₂ ratio less than 200
 - Wide mediastinum or other signs suggesting great vessel injury
 - Cardiac injury
- Pelvis/Abdomen
 - Unstable pelvic fracture with shock or other evidence of continuing hemorrhage such as requiring > 6 U RBC in 6 h
 - Open pelvic injury
 - Grade IV or V liver injuries requiring > 6 U RBC in 6 h
 - Major abdominal vascular injury
- Major Extremity Injuries
 - Fracture/dislocation with loss of distal pulses
- Multiple-System Injury
 - Head injury combined with face, chest, abdominal, or pelvic injury
 - Burns with associated injuries
- Secondary Deterioration (Late Sequelae)
 - Single or multiple organ system failure (deterioration in central nervous, cardiac, pulmonary, hepatic, renal, or coagulation systems)
 - Major tissue necrosis

- Any other injury or combination of injuries at the discretion of the ED Physician, Trauma Surgeon, Neurosurgeon, Orthopedic Surgeon or the Intensivist.

The following conditions should be considered for transfer:

- Central Nervous System
 - GCS >10 and <14
- Chest
 - Patients who may require prolonged ventilation
 - >2 unilateral rib fractures
- Abdomen
 - Solid organ injury
- Major Extremity Injuries
 - Open long-bone fractures
 - Extremity ischemia
 - Multiple long-bone fractures
- Multiple-System Injury
 - Injury to more than two body regions
- Co-morbid Factors
 - Age >55 years
 - Children \leq 5 years of age
 - Cardiac or respiratory disease
 - Insulin-dependent diabetes
 - Morbid obesity
 - Pregnancy
 - Immunosuppression
- Secondary Deterioration (Late Sequelae)
 - Mechanical ventilation required
 - Sepsis

Procedure:

Before patient arrival:

1. After becoming aware that a trauma patient is en route who likely will require emergent transfer, the emergency department staff activates the trauma team and notifies the emergency department physician of the likelihood of transfer. Ascertain from EMS if they have already ordered helicopter transportation.
2. The physician identifies the appropriate mode of transfer (i.e., helicopter vs. ground) and qualifications of transferring personnel.
3. The ED unit clerk/ ED staff contacts the appropriate helicopter and/or ground transportation, obtains ETA:

After patient arrival:

1. The ED physician identifies and contacts the receiving facility, and requests the receiving physician to accept the transfer. The two should discuss the current physiological status of the patient and the optimal timing of transfer.
2. Before transfer, the ED physician should:
 - Ensure a secure airway. Consider inserting an endotracheal tube or LMA. Establish a surgical airway if indicated.
 - Ensure at least two IV lines are established.

- Ensure chest tubes are placed in the presence of pneumothorax.
 - Consider sending additional blood, equipment and supplies (medications, fluids, etc.) that the patient may need en route if not available in the transporting vehicle.
3. The ED unit clerk/ ED staff copies of all available documentation to accompany the patient:
- EMS report
 - Resuscitation record
 - X rays, CT scans
 - Lab results

END

**TRANSFER AGREEMENT
BETWEEN
COMMUNITY HOSPITAL ANDERSON
AND
INDIANA UNIVERSITY HEALTH, INC.**

THIS AGREEMENT is entered into, by and between Community Hospital Anderson, an Indiana hospital (hereinafter "HOSPITAL"), and Indiana University Health, Inc., an Indiana nonprofit corporation (hereinafter "IU Health").

WHEREAS, HOSPITAL is the owner and operator of a hospital with facilities located at 1515 N. Madison Avenue, Anderson, IN 46011;

WHEREAS, the IU Health Academic Health Center in Indianapolis, Indiana includes IU Methodist Hospital, Riley Hospital for Children and IU University Hospital, a Level I adult trauma center at IU Methodist Hospital, a Level I pediatric trauma center at Riley Hospital, specialized research and teaching institutions, physician group practices and clinics, and other organizations related to the delivery and management of health care services; and

WHEREAS, HOSPITAL wishes to maintain a written agreement with IU Health for timely transfer of patients, including trauma patients, between their facilities;

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

- I. Autonomy. The parties agree that each shall continue to have the exclusive control of the management, business and properties of their respective facilities, and neither party by virtue of this Agreement assumes any liability for any debts or obligations of the other party to the Agreement.
- II. Transfer of Patients. Whenever a transfer of a patient from HOSPITAL to IU Health is determined by medical staff at HOSPITAL to be medically necessary and appropriate, HOSPITAL shall notify IU Health of the proposed transfer request and provide such medical and personal patient information as necessary and appropriate to assist IU Health in evaluating and assuming the medical care of the patient upon patient's arrival. IU Health and HOSPITAL shall develop and adhere to any necessary protocols to facilitate such communication and transfer. HOSPITAL shall give notice to IU Health as far in advance as reasonably possible of a proposed transfer. HOSPITAL shall arrange for transportation of the patient. IU Health shall not be responsible for the notification and the safe transfer of the patient to the applicable IU Health facility except to the extent that IU Health is actually involved in providing the transport service.
- III. Admission Priorities. Admissions to IU Health shall be in accordance with IU Health's general admission policies and procedures and in accordance with IU Health's Medical Staff Bylaws and Rules and Regulations. IU Health is not required to give priority of admission to patients to be transferred from

HOSPITAL over patients from other transferring facilities. IU Health reserves the right to decline acceptance of a HOSPITAL patient transfer if IU Health is on diversion or otherwise does not have appropriate, available resources to treat the patient.

- IV. Medicare Participation. During the term of this Agreement, and any extensions thereof, HOSPITAL and IU Health agree to meet and maintain all necessary Medicare Conditions of Participation and coverage so as to remain approved providers thereunder. HOSPITAL and IU Health shall each be responsible for complying with all applicable federal and state laws.
- V. Compliance. HOSPITAL and IU Health agree that any services provided under this Agreement will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to IU Health and/or HOSPITAL, including, but not limited, to regulations promulgated under Title II, Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-91) - "HIPAA" and Title XVIII, Part D of the Social Security Act (42 U.S.C. § 1395dd) - "EMTALA". Furthermore, HOSPITAL and IU Health shall promptly amend the Agreement to conform with any new or revised legislation, rules and regulations to which HOSPITAL and/or IU Health is subject now or in the future including, without limitation, the Standards of Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Laws") in order to ensure that HOSPITAL and IU Health are at all times in conformance with all Laws. If, within ninety (90) days of either party first providing notice to the other of the need to amend the Agreement to comply with Laws, the parties acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate this Agreement immediately.
- VI. Interchange of Information and Medical Records. HOSPITAL and IU Health agree to transfer medical and other information and medical records which may be necessary or useful in the care and treatment of patients transferred hereunder as required and permitted by all applicable federal and state laws. Such information shall be provided by HOSPITAL and IU Health in advance, when possible, and where permitted by applicable law. HOSPITAL shall commit to subscribing to a spoke connection to the IU Health Radiology Cloud in order to enhance the timely transmission and reading of diagnostic images at IU Health for transferred patients, particularly trauma patients.
- VII. Consent to Medical Treatment. To the extent available, HOSPITAL agrees to provide IU Health with information and assistance, which may be needed by, or helpful to, IU Health in securing consent for medical treatment for the patient.
- VIII. Transfer of Personal Effects and Valuables. Procedures for effecting the transfer of personal effects and valuables of patients shall be developed by the parties and subject to the instructions of the attending physician and of the patient and his or

her family where appropriate. A standard form shall be adopted and used for documenting the transfer of the patient's personal effects and valuables. HOSPITAL shall be responsible for all personal effects and valuables until such time as possession is accepted by IU Health.

- IX. Financial Arrangements. Each party shall each be responsible for billing and collecting for the services which it provides to the patient transferred hereunder from the patient, third party payor or other sources normally billed by each institution. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party to this Agreement.
- X. Return Transfer of Patients. HOSPITAL will accept transferred patients back from IU Health when medically appropriate and in the best interests of the patient.
- XI. Professional and General Liability Coverage. Throughout the term of this Agreement and for any extension(s) thereof, HOSPITAL and IU Health shall each maintain professional and general liability insurance coverage with limits reasonably acceptable to the other party. Each party shall provide the other party with proof of such coverage upon request. HOSPITAL and IU Health shall each maintain qualification as a qualified health care provider under the Indiana Medical Malpractice Act, as amended from time to time, including, but not limited to, proof of financial responsibility and payment of surcharge assessed on all health care providers. Each party shall provide the other party with proof of such qualification upon request.
- XII. Indemnification.
- 12.1. HOSPITAL Indemnification. HOSPITAL agrees that it will indemnify and hold harmless IU Health, its officers, agents, and employees from any loss, cost, damage, expense, attorney's fees, and liability by reason of bodily injury, property damage, or both of whatsoever nature or kind, arising out of or as a result of the sole negligent act or negligent failure to act of HOSPITAL or any of its agents or employees.
- 12.2. IU Health Indemnification. IU Health agrees that it will indemnify and hold harmless HOSPITAL, its officers, agents, and employees from any loss, cost, damage, expense, attorney's fees, and liability by reason of personal injury or property damage of whatsoever nature or kind, arising out of or as a result of the sole negligent act or failure to act of IU Health or any of its employees or agents.
- XIII. Term and Termination.
- 13.1. Term. The term of this Agreement is for a period of one (1) year from the date hereof, with an automatic renewal of successive one (1) year periods unless on or before sixty (60) calendar days prior to the expiration of the annual term, one party notifies the other, in writing, that the Agreement is

not to be renewed, in which event the Agreement will be terminated at the expiration of the then current annual term.

13.2. Termination.

13.2-1 Either party may terminate this Agreement with or without cause at any time by providing written notice to the other party at least sixty (60) days in advance of the desired termination date.

13.2-2 The Agreement shall terminate immediately and automatically if (i) either IU Health or HOSPITAL has any license revoked, suspended, or nonrenewed; or (ii) either party's agreement with the Secretary of Health and Human Services under the Medicare Act is terminated.

13.2-3 Except as provided for elsewhere in this Agreement, either party may declare this Agreement terminated if the other party does not cure a default or breach of this Agreement within thirty (30) calendar days after receipt by the breaching party of written notice thereof from the other party.

XIV. Notices. Notices or communication herein required or permitted shall be given the respective parties by registered or certified mail, documented courier service delivery or by hand delivery at the following addresses unless either party shall otherwise designate its new address by written notice:

HOSPITAL

Community Hospital Anderson
1515 N. Madison Avenue
Anderson, IN 46011

Attention: President/CEO

IU Health

Indiana University Health, Inc.
340 West 10th Street, Suite 6100
Indianapolis, IN 46206-1367

Attention: President/CEO
General Counsel

XV. Assignment. Assignments of this Agreement or the rights or obligations hereunder shall be invalid without the specific written consent of the other party herein.

XVI. Nonexclusive Clause. This is not an exclusive Agreement and either party may contract with other institutions for the transfer of patients while this Agreement is in effect.

XVII. Governing Law. This Agreement shall be construed and governed by the laws of the State of Indiana. The venue for any disputes arising out of this Agreement shall be Marion County, Indiana.

- XXVIII. Waiver. The failure of either party to insist in any one or more instance upon the strict performance of any of the terms or provisions of this Agreement by the other party shall not be construed as a waiver or relinquishment for the future of any such term or provision, but the same shall continue in full force and effect.
- XIX. Severability. If any provision of this Agreement is held by a court of competent jurisdiction to be unenforceable, invalid or illegal, such unenforceability, invalidity or illegality shall not affect any other provision hereof, and this Agreement shall be construed as if such provision had never been contained herein.
- XX. Section and Other Headings. The article and other headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
- XXI. Amendments. This Agreement may be amended only by an instrument in writing signed by the parties hereto.
- XXII. Entire Agreement. This Agreement is the entire Agreement between the parties and may be amended or modified only by a written amendment hereto duly executed by both parties.
- XXIII. Execution. This Agreement and any amendments thereto shall be executed in duplicate copies on behalf of HOSPITAL and IU Health by an official of each, specifically authorized by its respective Board to perform such executions. Each duplicate copy shall be deemed an original, but both duplicate originals together constitute one and the same instrument.

IN WITNESS WHEREOF, the duly authorized officers and representatives of HOSPITAL and IU Health have executed this Agreement the 5 day of March, 2014.

HOSPITAL:

COMMUNITY HOSPITAL ANDERSON

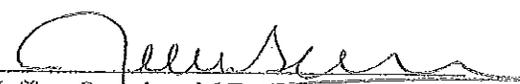
By: 

Title: VP Finance/CFO

AND

IU HEALTH:

INDIANA UNIVERSITY HEALTH, INC.

By: 

Jeffrey Sperring, M.D.

President, IU Health Methodist, Riley and University Hospitals

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is between the Health and Hospital Corporation of Marion County d/b/a Eskenazi Health and Community Hospital Anderson. Eskenazi Health and Community Hospital Anderson are collectively referred to as "Institutions."

Eskenazi Health is a comprehensive public health care system with facilities and services including a hospital, outpatient clinics, inpatient and outpatient mental health services, Level I Trauma Center and the Richard M. Fairbanks Burn Center.

Community Hospital Anderson is an acute care hospital.

Eskenazi Health and Community Hospital Anderson have determined that it would be in the best interest of patient care and would promote the optimum use of facilities to enter into a transfer agreement for transfer of patients between the respective Institutions.

Eskenazi Health and Community Hospital Anderson therefore agree as follows:

1. **Term.** This Agreement shall become effective beginning January 16, 2014 ("Effective Date") and shall remain in effect for a period of one year from the Effective Date, upon which date the Agreement will automatically renew for additional one-year periods.

2. **Purpose of Agreement.** Each Institution agrees to transfer to the other Institution and to receive from the other Institution patients in need of the care provided by their respective Institutions for the purpose of providing improved patient care and continuity of patient care.

3. **Patient Transfer to Eskenazi Health.** The request for transfer of a patient from Community Hospital Anderson to Eskenazi Health shall be initiated by the patient's attending physician. Any authorized member of Eskenazi Health's medical staff may authorize a transfer when the patient in question needs Level 1 Trauma Services, interventional radiology, or the services of the Burn Unit if Eskenazi Health has an appropriate bed available and is not on diversion. All other Community Hospital Anderson requests for patient transfers to Eskenazi Health shall be referred to the Bed Control Coordinator/House Supervisor. Prior to moving the patient, Community Hospital Anderson must receive confirmation from Eskenazi Health that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Sidney & Lois Eskenazi Hospital.

4. **Patient Transfer to Community Hospital Anderson.** The request for transfer of a patient from Eskenazi Health to Community Hospital Anderson shall be initiated by the patient's attending physician. Any authorized member of Community Hospital Anderson's medical staff may authorize a transfer if Community Hospital

Anderson has an appropriate bed available and is not on diversion. Prior to moving the patient, Eskenazi Health must receive confirmation from Community Hospital Anderson that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Community Hospital Anderson's Emergency Department.

5. *Patient Records and Personal Effects.* Each of the Institutions agrees to adopt standard forms of medical and administrative information to accompany the patient from one Institution to the other. The information shall include, when appropriate, the following:

- A. Patient's name, address, hospital number, and age; name, address, and telephone number of the patient's legal guardian (if applicable);
- B. Patient's third-party billing data;
- C. History of the injury or illness;
- D. Condition on admission;
- E. Vital signs prehospital, during stay in emergency department, and at time of transfer;
- F. Treatment provided to patient; including medications given and route of administration;
- G. Laboratory and X-ray findings, including films;
- H. Fluids given, by type and volume;
- I. Name, address, and phone number of physician referring patient;
- J. Name of physician in receiving Institution to whom patient is to be transferred; and
- K. Name of physician at receiving Institution who has been contacted about patient.
- L. Specialized needs and dietary restrictions.

Each Institution shall supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution, and the Institutions shall work together to reduce repetition of diagnostic tests. Transfers of Protected Health Information (PHI) shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In addition, each Institution agrees to adopt a standard form to inventory a patient's personal effects and valuables that shall accompany the patient during transfer. The records described above shall be placed in the custody of the person in charge of the transporting medium who shall sign a receipt for the medical records and the patient's valuables and personal effects and in turn shall obtain a receipt from the receiving Institution when it receives the records and the patient's valuables and personal effects. The transferring Institution shall bear responsibility for the loss of the patient's personal effects and valuables unless it can produce an authorized receipt for the personal effects and valuables from the accepting Institution.

6. *EMTALA Compliance and Transfer Consent.* The transferring Institution shall have responsibility for meeting the requirements for an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act (EMTALA), if applicable. The transferring Institution is responsible for obtaining the patient's consent to the transfer to the other Institution prior to the transfer, if the patient is competent. If the patient is not competent, the transferring Institution shall obtain a family member's consent; if such consent is not possible, the consent of the patient's physician shall be obtained by the transferring Institution.

7. *Payment for Services.* The patient is primarily responsible for payment for care received at either Institution. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

8. *Transportation of Patient.* The transferring Institution shall have responsibility for arranging transportation of the patient to the other Institution, including selection of the mode of transportation and providing appropriate health care practitioner(s) to accompany the patient if necessary. The receiving Institution's responsibility for the patient's care shall begin when the patient is admitted, either as an inpatient or an outpatient, to that Institution.

9. *Advertising and Public Relations.* Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the party whose name is to be used. Both Institutions shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquires with respect to transferred or transferring patients.

10. *Independent Contractor Status.* Both Institutions are independent contractors. Neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by

either Institution, nor shall it in any way alter the control of the management, assets, and affairs of the respective Institutions. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

11. *Liability.* Community Hospital Anderson shall save, indemnify, and hold Eskenazi Health harmless of and from any and all liability, loss, costs, and expenses incurred directly or indirectly from any acts, errors, or omissions by Community Hospital Anderson, its agents, employees or invitees from any cause arising out of or relating to Community Hospital Anderson's performance under this Agreement.

Eskenazi Health shall save, indemnify, and hold Community Hospital Anderson harmless of and from any and all liability, loss, costs, and expenses incurred directly or indirectly from any acts, errors, or omissions by Eskenazi Health, its agents, employees or invitees from any cause arising out of or relating to Eskenazi Health's performance under this Agreement.

Any obligation of Eskenazi Health to save and hold Community Hospital Anderson harmless is limited in substance by statutes designed to protect and limit the exposure and liability of Eskenazi Health as an instrumentality of the State of Indiana under the Indiana Tort Claims Act and as a qualified health care provider under the Indiana Medical Malpractice Act.

12. *Exclusion.* Institutions represent and warrant that the Institution, its employees, directors, officers, subcontractors, and agents are not under sanction and/or have not been excluded from participation in any federal or state program, including Medicare or Medicaid.

13. *Insurance.* Each Institution shall maintain at all times throughout the term of this Agreement commercially reasonable insurance, including but not limited to, comprehensive general liability insurance, professional liability insurance, and property damage insurance. Upon request, each Institution shall provide the other with written documentation evidencing such insurance coverage.

14. *Termination.*

A. *Voluntary Termination.* This Agreement shall be terminated by either party for any reason, by giving thirty (30) days' written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating party will be required to meet its commitments under the Agreement to all patients for whom the other party has begun the transfer process in good faith.

B. *Involuntary Termination.* This Agreement shall be terminated immediately upon the occurrence of any of the following:

1. Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;
2. Either Institution loses its license or accreditation;
3. Either Institution no longer is able to provide the service for which this Agreement was sought; and
4. Either Institution is in default under any of the terms of this Agreement.
5. Either Institution have been debarred, excluded or otherwise determined ineligible from participation in any federal or state program, including Medicare and Medicaid.

14. *Nonwaiver.* No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

15. *Governing Law.* This Agreement is governed by the laws of the State of Indiana. Any litigation arising out of this Agreement shall be brought in a court located in Marion County, Indiana.

16. *Assignment.* This Agreement shall not be assigned in whole or in part by either party without the express written consent of the other party.

17. *Invalid Provision.* In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

18. *Amendment.* This Agreement may be amended at any time by a written agreement signed by the parties.

19. *Notice.* Any notice required or allowed to be given under this Agreement shall be deemed to have been given upon deposit in the United States mail, registered or certified, with return receipt requested. Any and all notices are to be addressed as follows:

ESKENAZI HEALTH:

Eskenzi Health
Attn: Legal Department
720 Eskenzi Avenue
FOB 5th Floor

Indianapolis, IN 46202

COMMUNITY HOSPITAL ANDERSON:
Community Hospital Anderson
Attn: Administration
1515 N. Madison Avenue
Anderson, IN 46011

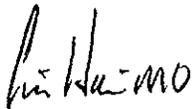
20. *Entire Agreement.* This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to its subject matter and supersedes any and all other agreements, either oral or in writing, between the parties to the Agreement with respect to the subject matter of this Agreement.

21. *Binding Agreement.* This Agreement shall be binding upon the successors or assigns of the parties.

22. *Authorization for Agreement.* The execution and performance of this Agreement by each Institution has been duly authorized by all necessary laws, resolutions, or corporate actions, and this Agreement constitutes the valid and enforceable obligations of each Institution in accordance with its terms.

Eskenazi Health and Community Hospital Anderson are each signing this Agreement on the date stated below that party's signature.

**THE HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY
D/B/A ESKENAZI HEALTH**



Lisa Harris, CEO and Medical Director

Date: 3/11/14

COMMUNITY HOSPITAL ANDERSON

By: John B. Harris
John B. Harris, VP Finance / CFO

Date: 1-16-2014

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 11

Trauma OR, Staff and Equipment

"11. Trauma Operating room, staff and equipment. There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services 24 hours per day. The application must also include a list of essential equipment available to the OR and its staff."

RESPONSE

The requirements of section 11 are met as follows:

1. Commitment letter from David Tharp, M.D.
2. Twenty-four hour anesthesia call schedule example
3. OR equipment list (including craniotomy equipment)
4. Surgery staffing policy
5. Surgery twenty-four hour call policy
6. Quality plan



Community Hospital Anderson

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011
T 765.298.4242
eCommunity.com

February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as Anesthesiology Section Representative. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that a qualified anesthesiologist is promptly available twenty-four hours per day. I attest that we have adequate anesthesia equipment to provide trauma services including neurosurgical procedures.

An anesthesiologist liaison will attend at least 50% of Trauma Peer review and actively participate in the performance improvement process.

Respectfully,

David Tharp, M.D.
Anesthesia Section Rep.

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

September 2013

CHA

SUB	MON	TUE	WED	THU	FRI	SAT
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Tharp

1	2	3	4	5	6	7
Hendrickson	Rice	Hinds	Anderson	Loghin	Wagner	Wagner

8	9	10	11	12	13	14
Wagner	Hinds	Anderson	Rice	Hendrickson	Tharp	Tharp

Loghin

15	16	17	18	19	20	21
Tharp	Loghin	Hinds	Hendrickson	Anderson	Rice	Rice

22	23	24	25	26	27	28
Rice	Wagner	Hendrickson	Hinds	Tharp	Hinds	Hinds

Anderson

29	30					
Hinds	Anderson					



Primary Business Address
 Your Address Line 2
 our Address Line 3
 Your Address Line 4

Phone: 555-555-5555
 Fax: 555-555-5555
 E-mail: someone@example.com

October 2013

CHA

Sun	Mon	Tue	Wed	Thu	Fri	Sat
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R off

		1	2	3	4	5
		Tharp	Wagner	Hendrickson	Anderson	Anderson
					<i>L</i>	<i>L</i>

CM off

6	7	8	9	10	11	12
Anderson	Rice	Wagner	Tharp	Hinds	Loghin	Loghin
<i>L</i>					<i>A</i>	<i>A</i>

LM off

13	14	15	16	17	18	19
Loghin	Wagner	Anderson	Rice	Tharp	Hendrickson	Hendrickson
<i>A</i>		<i>Loghin</i>				

R off

20	21	22	23	24	25	26
Hendrickson	Hinds	Loghin	Anderson	Rice	Wagner	Wagner

R off

27	28	29	30	31		
Wagner	Anderson	<i>Rice</i>	Hendrickson	Wagner		
		<i>Hinds</i>				

November 2013

CHA

Sun	Mon	Tue	Wed	Thu	Fri	Sat
-----	-----	-----	-----	-----	-----	-----

1 Tharp
2 Tharp

3 Tharp
4 Loghin
5 Hinds
6 Hendrickson
7 Anderson
8 Rice
9 Rice

10 Rice
11 Wagner
12 Hendrickson
13 Tharp
14 Hinds
15 Loghin
16 Loghin

17 Loghin
18 Rice
19 Wagner
20 Hendrickson
21 Loghin
22 Anderson
23 Anderson

24 Anderson
25 Hendrickson
26 Tharp
27 Rice
28 Hinds
29 Wagner
30 Wagner

off

off

off

off

December 2013

CHA

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Wagner	2 Loghin Anderson	3 Rice	4 Anderson Loghin	5 Tharp	6 Hinds	7 Hinds
8 Hinds	9 Loghin Anderson	10 Wagner	11 Anderson Loghin	12 Rice	13 Hendrickson	14 Hendrickson
15 Hendrickson	16 Hinds	17 Loghin	18 Anderson	19 Wagner	20 Tharp	21 Tharp
22 Tharp	23 Hendrickson	24 Hinds	25 Loghin	26 Anderson	27 Rice	28 Rice
29 Rice	30 Tharp	31 Wagner	Jan 1 Hendrickson	Jan 2 Hinds	Jan 3 Loghin	Jan 4 Loghin

CH off

T off

R off

W off

SA off

January 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 HENDRICKSON	2 HINDS	3 LOGHIN	4 LOGHIN
5 LOGHIN	6 RICE	7 HENDRICKSON	8 THARP	9 LOGHIN	10 ANDERSON	11 ANDERSON
12 ANDERSON	13 HENDRICKSON	14 RICE	15 ANDERSON	16 THARP	17 HINDS	18 HINDS
19 HINDS	20 ANDERSON	21 LOGHIN	22 HINDS	23 HENDRICKSON	24 RICE	25 RICE
26 RICE	27 HINDS	28 ANDERSON	29 LOGHIN	30 RICE	31 THARP	

(Spill + no Hinds)

(Loghin + no)

(Tharp + no)

(Rice + no Hinds)

February 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 THARP
2 THARP	3 HINDS	4 LOGHIN	5 THARP	6 ANDERSON	7 HENDRICKSON	8 HENDRICKSON
9 HENDRICKSON	10 RICE	11 THARP	12 HENDRICKSON	13 HINDS	14 LOGHIN Valentine's Day	15 LOGHIN
16 LOGHIN	17 HENDRICKSON Presidents' Day	18 THARP	19 RICE	20 LOGHIN	21 ANDERSON	22 ANDERSON
23 ANDERSON	24 HENDRICKSON	25 RICE	26 ANDERSON	27 THARP	28 HINDS	

Rice
Off

Anderson
Off

Hinds
Off

Loghin
Off



Community Hospital Anderson

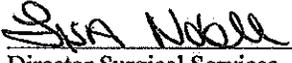
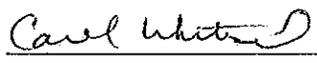
February 25, 2014

OR equipment available for trauma procedures:

- Monitors for basic vital signs and invasive monitoring
- BIS Monitors
- Glide-scope for video intubation
- Bair Hugger-Patient warming
- OR tables
- Fracture Table
- Jackson Table/Wilson Frame-Spine & Craniotomy Procedures
- Cautery-Monopolar
- Cautery- Bi-polar
- Suction
- Tourniquets
- Hand Table
- Headlights
- Hotline Fluid Warmers
- Level 1-Rapid Infuser
- IV pumps
- C-arm
- Fluoroscopy
- Portable x-ray
- X-ray aprons
- SCD units for prevention of VTE
- PACS system for viewing of x-ray and scans
- Computers for documentation
- Ortho instrumentation for all ortho needs: drills, basic instruments, specialized instruments, implant sets, major and minor instrumentation
- Neuro instrumentation for spine: basic and specialized instrumentation, implants, Midas Rex drills
- Navigation System and O-Arm for neuro spine and crani procedures
- Neuro Instrumentation for crani: basic and specialized instrumentation, clips, implants
- Camino Monitor for ICP
- Multiple instruments in sets or single wrapped or peel packed for surgical set up to accommodate all surgical procedures
- Crash Cart with defibrillator and external pacing
- Sponge Counter System

Community Hospital of Anderson & Madison County

**NURSING DEPARTMENT POLICY MANUAL
SURGICAL SERVICES**

SUBJECT:	SURGERY STAFFING
Originator:	 Director Surgical Services
Approved By:	 Vice President Patient Care Services/CNO
Policy Coordinator:	Cheryl Arnold
Effective:	4/06
Revised:	4/08, 5/2012, 2/2014
Reviewed:	
References:	2014 Standards, Recommended Practices, & Guidelines AORN, Inc.

PURPOSE: To provide safe, effective patient care for all perioperative patients.

POLICY STATEMENT:

1. A Registered Nurse will be assigned to perform circulating duties in each Operating Room.
2. A Registered Nurse, Licensed Practical Nurse or Certified Surgical Technologist will be assigned to scrubbing duties as appropriate.
3. Operating Room Assistants will help with delegated patient care tasks as determined by the Registered Nurse.
4. Daily staffing assignments will be made by the Operating Room Coordinator or designee.
5. The demands of each room schedule will be optimally matched with skills and expertise of assigned staff.
6. Assignment of additional personnel per procedure will be provided, as necessary and/or available, with consideration to:
 - * Acuity/Complexity of procedure (e.g. trauma, daVinci, Neuro, Total Joints).
 - * Physician Request (e.g. scrub assistant).
 - * Special equipment (e. g. laser).
7. One Registered Nurse will be dedicated to monitoring the patient and separate from the dedicated Registered Nurse circulator for moderate sedation, local anesthesia and laser procedures.
8. The hours for scheduled surgeries are from 0730 to 1800. Add on cases are scheduled based on available open times, anesthesia and staff availability. Evening and night shift hours, weekend and holidays are covered by call staff consisting of at least one RN.

COMMUNITY HOSPITAL ANDERSON

NURSING DEPARTMENT POLICY MANUAL
SURGICAL SERVICES

SUBJECT:	SURGERY ON CALL POLICY
Originator:	<u>Galen Burkett</u> Clinical Manager of Surgery
Approved By:	<u>Sisa Noble</u> Director Surgical Services
Policy Coordinator:	Cheryl Arnold
Effective:	
Revised:	9/99; 6/14/02; 12/19/05; 10/16/07; 2/17/14
Reviewed:	3/09; 5/12; 9/12
References:	2014 Standards, Recommended Practices & Guidelines AORN, Inc.

PURPOSE: To establish a mechanism to provide adequate staffing for hours outside of the scheduled operating hours.

POLICY STATEMENT: Only staff members who have successfully completed orientation and demonstrated competence will be assigned call independently.

ACTION STEPS:

1. A minimum of three staff members, consisting of at least one RN to circulate and two RN, LPN or CST's to scrub will be on call during non-scheduled hours.
2. Personnel on call must be available to arrive at the hospital within 20 minutes of the initial call. Staff members living outside the 20 minute radius may obtain a hospital room for overnight accommodations by calling the Nursing Administrative Representative.
3. Staff members on call are responsible notifying Clinical Support Specialist of their cell &/or home phone numbers.
4. The on call staff is notified of a case either by the OR Coordinator or Nursing Administrative Representative.
5. On call staff may park in the physicians' parking lot for rapid access to the hospital.
6. Electronic key cards are to be used for entry.
7. Additional staff may be assigned call as deemed necessary by surgical services management.
8. If the on-call person call's in, an attempt will be made to cover that person's call voluntarily. If no one volunteers, the call will be covered by the next appropriate staff member on the "hit list".
9. If a staff member plans a vacation, elective surgery or leave, that staff member will make every effort to cover the call assigned to them during that time period. Any call they are unable to cover needs to be brought to the OR Coordinator to cover prior to the staff member's leave.
10. If a staff member calls in on a day he/she is scheduled to be on call, it is that person's responsibility to notify the OR Coordinator that call needs covered.

**COMMUNITY HOSPITAL
ANDERSON, INDIANA**

**QUALITY MANAGEMENT PLAN
SCOPE OF SERVICE
SURGERY**

SCOPE OF SERVICE

The emphasis of care is on the adult and pediatric inpatient and outpatient requiring therapeutic and diagnostic procedures within the Surgical Services Department. The Operating Room (OR) provides intra-operative nursing care and activities.

The OR environment includes; assessment, diagnosis, treatment and evaluation of perceived, actual, or potential, physical or psychosocial problems that may result from the intrusion of anesthetic agents and techniques.

The OR's primary goal is to provide safe and effective care intraoperatively for the surgical services patient undergoing diagnostic and/or therapeutic surgical procedures.

The scope of care includes use of the nursing process, patient/family teaching, medication administration, implementation of physician orders, maintenance and correct use of equipment/instrumentation and environmental control for patient and staff safety.

Therapeutic and diagnostic procedures representing General, Vascular, Thoracic, Urology, Obstetrics and Gynecology, Orthopedic, Ear/ Nose and Throat, Ophthalmology, Plastics, Orthopedics, Neurosurgical, and Podiatry are performed.

The OR consists of the outer core, which is used to transport patients to and from surgery and to the recovery area. The inner core is a clean area where sterile supplies are stored. There is a separate instrument room where sterile instruments and equipment is stored. There are eight major operating rooms (all eight rooms can be used for different types of procedures), and one cystoscopy/urology room. There is a Cesarean Section surgery suite in the Obstetrics Department, staffed by the surgical services department with the OB Staff in attendance.

Each OR Room has a phone and an emergency button to call for immediate assistance. Each room is equipped with vacuum, oxygen, nitrous and nitrogen. There are eleven Anesthesia machines and cardiac monitors which are mobile and can be moved if necessary. The monitors have the capability to monitor cardiac rhythm, blood pressure, temperature and oxygen saturation, they also have capabilities to monitor for central venous and arterial pressure. The Cesarean Section OR room is equipped the same as OR proper.

The OR hours for scheduled surgeries are from 7:30 A.M. to 6:00 P.M. Add on cases are scheduled based on available open times, anesthesia and staff availability. Evening hours are also covered by "on call" staff. Holidays and weekends are covered by "on call" staff.

Assignments are made daily by the Surgery Core Coordinator and reflect the competency of the individual, patient needs and technology used. A minimum of one Registered Nurse (RN) and one Certified Surgical Technologist/Licensed Practical Nurse (CST /LPN) is assigned to each patient.

The emergency cart is outdated monthly by the pharmacy. The Core Coordinator restocks after use. The defibrillator is checked daily for voltage integrity and documented by the Core Coordinator. The crash cart is checked daily for integrity of locks. Bio-med checks the defibrillator semi-annually for preventive maintenance, calibration and electrical safety.

Operating Rooms Each OR is equipped with equipment and supplies for Anesthesia and Surgery. All electrical equipment is checked by Bio-med for preventive maintenance and electrical safety.

Surgery Medications Medications are supplied through Pyxis. RN's, Licensed Practical Nurses (LPN) and Anesthesia Services are responsible for monitoring and distribution of medications. The Pyxis unit maintains narcotic counts automatically. Pharmacy is responsible for filling and maintaining the Pyxis unit. Narcotics are wasted with a witness. A narcotic discrepancy is reported to pharmacy immediately and the discrepancy is documented in the Pyxis unit. Medications are charged to the patient when they are signed out of the Pyxis unit. Any medications not contained in the Pyxis are ordered directly from the pharmacy and charged by pharmacy.

Communication Surgery works in a cooperative manner with other hospital departments on a daily basis to keep patient care needs as a top priority. A fax/copy machine in the materials management office and scheduling office allows communication inter and intra hospital. Surgery is linked to other hospital departments and Community Hospitals of Indianapolis voice mail and the Internet. Communication on a daily basis is done via the Core Coordinator between staff, physicians, SDS, PACU, Endoscopy, surgery scheduling and other hospital departments to ensure smooth operation and provide safe and effective patient care.

Scheduling Surgical procedures are scheduled through the Surgery Clinical Support Specialists. Surgeries are scheduled through a computer scheduling system. Surgery currently utilizes modified block scheduling. Add on cases may also be scheduled by a staff RN through the Peri-operative nursing documentation system.

Materials Management Surgery maintains a stock level of chargeable and non-chargeable items. Supplies are requested by phone or speaking with materials management (MM) staff personally. MM staff has an office in the surgical services department. The MM Staff checks surgery stock levels daily, orders supplies and stocks supplies. Materials Management checks all supplies in the C-section room in the OB department. Surgery charge clerks are responsible for charging surgical procedures.

Laundry Linen is delivered to the unit daily with additional requests honored. All soiled linen is handled with standard precautions. Soiled linen is taken to the soiled decontamination room via case-cart after each case in a properly labeled linen bag. Surgery staff is supplied with clean

scrub clothes daily. At the end of the day scrubs are changed and placed in a soiled linen bag and sent to the soiled decontamination room.

Engineering (Computer Services, Telecommunications and Plant Operations) Required services or repairs are received by notification via telephone and work order.

Biomedical Engineering The surgery department has a Bio-medical Technologist available to assist with equipment problems. All equipment is checked for preventative maintenance determined by Biomedical Risk Management criteria.

Medical Records are obtained thru the Electronic Medical Record.

Security is available through security officers or by the hospital's Code 7 Policy. Security is available to walk staff out to the parking lot at night; they can be reached by dialing 0.

Laboratory Blood specimens in the OR are collected by Anesthesia; they are transported to lab via surgery personnel. A laboratory specimen slip/or other appropriate slip is sent with every specimen. Patient tissue specimens are placed in the proper agent to preserve and then placed in a covered specimen box located in the frozen section room. They are taken to lab each afternoon by laboratory staff. Some laboratory specimens are sent through the hospital wide tube system from PACU to lab, if appropriate. Frozen Sections on patient tissue is covered and taken directly to the frozen section room just outside of the inner core. Pathology is then called directly to notify them of the frozen section request. The surgery schedule also states when a patient is scheduled for a frozen section. Nursing receives blood and blood products from the blood bank.

Radiology is notified several ways when x-ray is requested. 1. When a patient is scheduled the physician may request x-ray and it will be on the schedule. 2. The day of surgery the staff in the room requesting x-ray can page the radiology technologist covering the OR or call directly to radiology to let radiology know what patient, room number and time needed. 3. The physician may request x-ray during a case, the room staff or Core Coordinator then calls at that time.

Environmental Services maintains a clean and safe environment for the surgery department.

Surgery Instrument Processing Staff in Instrument Decontamination and Sterile processing report to the Director of Surgical Services. The Instrument Processing Technologists provide cleaning, processing and sterilization of instruments.

Organization

The Surgery Department organizational plan interfaces with the Nursing Departments organizational plan and is as follows:

1. The Surgical Services Director has line authority, provides leadership and support on a twenty-four hour basis to all licensed and non-licensed staff in the Surgical Services Department (SDS/PACU, Endoscopy, OR, Instrument Processing). Responsibilities include directing, assessing, planning, implementing, and evaluating the delivery of services in the Surgical Services Department.
2. The Clinical Manager is a qualified Registered Nurse who provides leadership and managerial support on a 24 hour basis to all licensed and non-licensed staff in surgery. The reporting accountability is to the Surgical Services Director.

3. The Surgery Coordinator is a qualified Registered Nurse who has line authority for all licensed and non-licensed staff in surgery. The Core Coordinator is responsible for the provision of nursing care for patients undergoing surgical intervention. Responsible for daily coordination of the schedule and activities of the Operating Room.
4. The Information Systems Coordinator reports directly to the Manager of Clinical Informatics and is responsible for the management of information for Surgical Services.
5. The Surgical Services Educator reports directly to the Director of Surgical Services and is responsible for assessment, planning, implementing, and evaluating educational and orientation needs within the Surgical Services Department.
6. The Registered Nurse reports to the Clinical Manager. The Registered Nurse is responsible for patient care, may direct and evaluate the activities of other ancillary personnel, and will attend and assist the physician as needed and according to policy for procedures performed in the Surgery area.
7. The Licensed Practical Nurse reports to the Registered Nurse and Clinical Manager. The Licensed Practical Nurse is responsible for patient care, may direct and evaluate the activities of other ancillary personnel, and will attend and assist the physician as needed and according to policy for procedures performed in the Surgery area.
8. The Surgical Technologists reports to the Registered Nurse and Clinical Manager. The Surgical Technologists are responsible for patient care, may direct ancillary personnel and will attend and assist the Registered Nurse and physician as needed and according to policy for procedures performed in the surgery area.
9. The Operating Room Assistant is under direct supervision of licensed personnel and they report to the Clinical Manager. The Operating Assistant is responsible for assisting with patient care, and will attend and assist licensed staff and the physician as needed and according to policy for procedures performed in the surgery area.

The Surgery Department is committed to:

- Assist persons in maintaining or regaining optimal wellness. The focus is to provide safe, quality surgical care specific to each patient.
- Is comprised of specialized and dynamic knowledge, skills and techniques.
- Holds the care of persons paramount in its focus.
- Has a concern for the holistic care of people, Nursing care is delivered to persons in a way that we:
 - Recognize the person's unique strengths and needs;
 - Respect the person's rights.
 - Accept each person as important and worthy;
 - Involve the person, family, and community in the care activities.
 - Utilize the nursing process as a framework for our actions.

Budget

The Director of Surgical Services is responsible for preparing and maintaining the capital and operating expense and salary budget for the Surgery/Endoscopy areas, with participation from the Clinical Manager. Consideration of the staffing needs, patient/procedure volume, findings from Performance Improvement activities, and strategic plans for the improvement activities, and strategic plans for the improvement and innovations in nursing practice are the basis for the

budget process. Biweekly and monthly operating reports are prepared for and analyzed by the Director of Surgical Services. Revisions to the plan are made as indicated.

Committees and Meetings

The Surgical Services Team (Director Surgical Services, Surgery Coordinator, Surgery Clinical Manager, Same Day Surgery/PACU Clinical Manager, Surgery Educator and Endoscopy Coordinator) meet weekly to discuss patient care issues, staff and interdepartmental issues. The Director of Surgical Services conducts these meetings. The Surgery Coordinator conducts a morning meeting daily or as needed with OR staff to address immediate concerns and to exchange information regarding daily activities. Unit meetings are conducted Bi-monthly by Surgical Services leadership all Surgical Services staff to maintain open channels of communication, to exchange ideas, to review performance improvement/quality improvement activities and to participate in educational programs within the Surgical Services Department.

Staffing and Scheduling

Staffing assignments are made daily by the Surgery Coordinator and reflect the qualifications of each staff member, type of surgery, technology used, physician requests and patient needs. There is a minimum of one RN and one CST/LPN per patient. The Coordinator adjusts staff assignments throughout the day to meet patient's and physician's needs. The Coordinator communicates throughout the day with surgery scheduling to adjust staff for emergency or add on cases. The Coordinator also communicates with SDS/PACU staff to relay information from those areas to surgery staff and physicians.

The call schedule is made out by the Coordinator on a monthly basis. This schedule covers all call hours and holidays.

Surgery staff assist (Scrub/Circulate) in the care of patients undergoing gastrointestinal or pulmonary endoscopic procedures.

Competency Validation

Each member of the surgery staff is assigned clinical and/or managerial responsibilities based on educational preparation and assessment of current competence. A nursing orientation program is designed to assess each individual's current level of competency through the development of a skills inventory. Surgery staff is expected to demonstrate ongoing competence in areas relative to performance expectations. A Performance Checklist will document staff competency.

Once general orientation is successfully completed, surgery orientation begins. This is done through an established preceptor program. Unit specific information is shared. A unit specific orientation checklist is instituted for each person being orientated into the surgery area and updated as skills are required. All staff is expected to demonstrate competency in areas relative to performance expectations. Staff is also expected to demonstrate competency in using and troubleshooting equipment. Surgery orientation for licensed staff usually requires three to six months with a preceptor. Orientation usually lasts for six to nine months, with staff feeling confident by one year. Non-licensed staff requires eight to twelve weeks of orientation.

Unit specific competencies include current certification in BLS for all staff. ACLS certification is required for Registered Nurses. Other competencies are designed to comply with quarterly

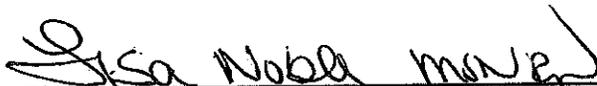
performance indicators, Surgical Clinical Core Group suggestions, patient and staff concerns. All of the competencies are accomplished by the use of educational tools, e.g., in-services, assigned readings; computer based learning modules, actual demonstration and ongoing supervision. The Association of Peri-operative Registered Nurses standards is followed in the surgery area.

Standards of Practice

Each staff member is responsible to provide nursing care based in accordance with the hospital and the nursing standards; which meet legal, state and federal regulatory agency requirements, as well as recommended practices of pertinent national organization (AORN, etc). The Director of Surgical Services is responsible for the provision of appropriate educational and policy manuals to assist the staff.

Performance/Quality Improvement

Aside from the specific Performance Improvement/Quality improvement activities of the Surgery Department, each patient care unit has representation on the Nursing Practice council and the Surgical Services Integrated Practice Council that is responsible for monitoring effects of care delivery and patient outcomes. Examples of monitored outcome indicators are nursing documentation, medication administration, restraints, patient satisfaction, and infection control and pain management. Nursing representation is also present on Clinical Core Groups.


Director Surgical Services

3/21/14
Date

Revised: 10/08, 05/2012, 01/2014

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 12

Critical Care Physician Coverage

12, "Critical Care physician coverage. Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients. There must be prompt availability of Critical Care physician coverage 24 hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage 24 hours a day.

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 12 are met with a commitment letter from the Community Hospital – Anderson (CHA) Medical Director of Critical Care, Naeem Malik, M.D. Dr. Malik affirms prompt availability of twenty-four hour coverage. The primary on-call schedule is made available to the CHA ICU and Emergency Department on a daily basis. Dr. McCurdy, CHA Trauma Medical Director, has also signed the ICU commitment letter affirming the prompt 24-hour availability of the ICU Physicians.



1515 N. Madison Avenue
Anderson, IN 46011

February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as Director of Critical Care. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that there is prompt availability of Critical Care Physician coverage twenty-four (24) hours per day. The service provides rotating continuous call coverage and works closely with all physicians involved in the delivery of trauma care including the in-house Emergency Physician.

Respectfully,

A handwritten signature in black ink, appearing to be "Naeem Malik", written over a horizontal line.

Naeem Malik, M.D.
Director of Critical Care

A handwritten signature in black ink, appearing to be "Dwight B. McCurdy", written in a cursive style.

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 13

CT Scan and Conventional Radiology

"13. CT scan and conventional radiography. There must be 24-hour availability of CT scan and conventional radiography capabilities. There must also be a written letter of commitment from the hospital's Chief of Radiology."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 13 are met with written letters of commitment and affirmation of compliance with requirements from the Community Hospital – Anderson (CHA) Chief of Radiology and the Radiology Administrative Director. We have included policies illustrating the twenty-four hour availability of CT and conventional radiology. CT and X-ray Technologists respond to the Emergency Department immediately on Level One Trauma activations.



**Community
Health Network**

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011-3453
765-298-4242 (tel)
eCommunity.com

February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Radiology Section representative. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I confirm that prompt medical imaging and interpretation including CT scans and conventional radiography is available at Community Hospital- Anderson twenty-four hours per day. Our CT and x-ray technicians respond to all Trauma Level one activations.

Respectfully,

Kevin Burton, M.D.
Radiology Section Representative

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director



**Community
Health Network**

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011-3453
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eCommunity.com

February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

**SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process"
for Level III Trauma Center designation.**

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Radiology Administrative Director. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that prompt medical imaging including CT scans and conventional radiography is available at Community Hospital- Anderson twenty-four hours per day. Our CT and x-ray technicians respond to all Trauma Level one activations.

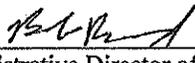
Respectfully,

Robert Reed
Radiology Administrative Director

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director


Community Hospital Anderson

(Manual that policy resides in Hospital, Inpatient Radiology)

Subject:	Emergency Department Radiologic examinations
Originator:	Bob Reed Administrative Director of Radiology
Approved By:	Bob Reed  Administrative Director of Radiology Marc Pinchouck, MD Medical Director of Radiology
Scope:	Radiology, ED
Effective:	Date 11/90
Revised:	Date 4/94 Date 5/99 Date 6/12
Reviewed:	Date 6/04 Date 7/05 Date 5/08
Reference(s):	i.e. JCAHO, ISDOH, etc.
Previous Number:	
Attachment(s):	

PURPOSE: Triage

POLICY STATEMENT: To set forth guidelines for the safe, efficient service for ER department patients.

1. Performed by: Radiology Technologist, Radiologist

ACTION STEPS:

Appointments for Emergency Department patients are not necessary. When possible, Emergency department (ED) patients will be radiographed in the X-ray room located in the ED. If there is not a Technologist in the area, the ED X-ray Technologist will be notified through the designated pager. Emergency department patients will be done in the order of their arrival unless directed otherwise by the ED.

In the event that a patient must be transported to the Radiology Department for specialized tests or the X-ray equipment in the ED has failed, the Emergency Department should call before transporting the patients to make certain that there will not be a long wait for the patient. If a severely injured or extremely ill patient is being sent to the Radiology Department, the ED must notify

Radiology staff to make sure of room availability and ED staff must attend this patient while the patient is in the Radiology Department.

Radiology staff must be notified of the arrival of the patient from the ED. Emergent patients will be done as quickly as possible. Whenever possible, ED patients will take precedence over inpatients and outpatients. The Radiologist over the area will determine staging of patients based on diagnosis and condition of the patients. Some delays for emergent patients may be unavoidable, particularly during the peak hours of 7:00 a.m. to 1:00 p.m. All ED patient films will be returned to Radiology.

If it is necessary to send films to Surgery or another Nursing unit, the films must be kept together and returned to the Radiology Department within twenty-four hours.

If it is necessary for the patient to be transferred to another hospital before the films are read, and the examination is needed, CDs or films will be provided upon request as original copies of our digital exams.

GENERAL INFORMATION:



Community Hospital Anderson

(Manual that policy resides in, i.e., Hospital, General Nursing, etc.)

Subject:	CT Scanner/IP
Originator:	Bob Reed
	Administrative Director of Radiology
Approved By:	Bob Reed
	Administrative Director of Radiology
	Marc Pinchouck, MD
	Medical Director of Radiology
Scope:	
Effective:	Date 11/91
Revised:	Date 5/95, 5/99, 5/01
	Date 11/02
	Date 6/04, 3/14
Reviewed:	Date 7/05
	Date 5/08
	Date 1/09, 6/12, 3/14
Reference(s):	i.e. JCAHO, ISDOH, etc.
Previous Number:	
Attachment(s):	

PURPOSE: Clarify scope of service

POLICY STATEMENT: Scope of service for equipment and operators

1. Performed by: CT Radiology technologists, Radiologists

ACTION STEPS:

The CT Scanner, located in the Radiology Department, is available twenty-four hours a day, seven days a week.

1. All scans at Community Hospital will be performed under the general supervision of a staff radiologist.
2. Emergency scans done after hours (when a Radiologist is not on campus) will be transmitted via the Telerad system (PACs) to the "on-call" Radiologist, or the designated back-up service. The "on-call" Radiologist will direct the CT Technologist on imaging protocols and the use of contrast.
3. Intravenous administration of contrasts will be done only under the directive of a staff physician or Radiologist and will be injected by a staff

physician, a Radiologist, an authorized Radiologic Technologist or a Registered Nurse. There will always be a staff physician or Radiologist available to assume responsibility for the patient that is receiving intravenous contrast media.

4. Oxygen is located in the wall in the CT Scanner room.

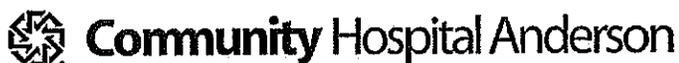
5. If a patient has a contrast reaction, the CT Technologist is to immediately notify the Radiologist or ER physician. If the reaction is life threatening, the Technologist or other available staff will institute "Code Blue" by calling 66.

6. In the event of unexpected downtime or times of excessive patient workload for either CT scanner, the available scanner will be utilized.

7. The following Technologists have completed training and are authorized to do CT scanning:

Adams, Alycia	Combs, Jessica	Jones, Jessica	Murray, Shane	Sherck, Lindsey
Barcus, Layla	Cooper, Carrie	Kelley, Katie		Villarreal, Sergio
Bilskie, Dan	Davis, Brody	Lawrence, Shannon	Sanders, Brittianie	Voss, Carmen
Chimbanda, Anibal	Edmundson, Amanda	Lykins, Amanda	Sankowsky, Caitlin	
Cochran, Linda	Geiger, Ivan	Massie, Christy	Schuck, Andrew	

GENERAL INFORMATION:



(Manual that policy resides in, i.e., Hospital, General Nursing, etc.)

Subject:	Qualifications and responsibilities of the Radiologist
Originator:	Bob Reed
	<i>Bob Reed</i> Administrative Director of Radiology
Approved By:	Bob Reed
	Administrative Director of Radiology
	Marc Pinchouck, MD
	Medical Director of Radiology
Scope:	
Effective:	Date 5/00
Revised:	Date
	Date
	Date
Reviewed:	Date 6/04
	Date 7/05
	Date 5/08, 6/12
Reference(s):	i.e. JCAHO, ISDOH, etc.
Previous Number:	
Attachment(s):	

PURPOSE: To set forth qualifications and duties of the Radiologist

POLICY STATEMENT: Radiology exams must be obtained under the supervision of, and interpreted by, a licensed physician with the following qualifications: see Action steps below.

1. Performed by: All radiologists

ACTION STEPS:

Radiology exams must be obtained under the supervision of, and interpreted by, a licensed physician with the following qualifications:

1. The physician shall have documented a minimum of six months of formal dedicated training in the interpretation and formal reporting of radiology exams in an ACGME-approved residency program, including radiographic training on all body areas of which he/she intends to interpret radiographic studies;

and

2. The physician should have documented training and understanding of the physics of diagnostic radiography and of the equipment needed to safely

produce the images. This should include plain-film radiography, film-screen combinations, conventional image processing and where applicable, digital image processing;

and

3. The physician must be familiar with the principles of radiation protection, the hazards of radiation exposure to both patients and radiologic personnel, and radiation monitoring equipment;

and

4. The physician shall have documented training and understanding of all imaging modalities (plain radiography, fluoroscopy, computed tomography, ultrasound, MRI, nuclear medicine, etc.) and their value in the evaluation of the patient's clinical symptoms;

and

5. Certification in Radiology or Diagnostic Radiology by the American Board of Radiology, American Osteopathic Board of Radiology, or the Royal College of Physicians and Surgeons of Canada

All physicians performing radiography exams who have met the above criteria should also demonstrate evidence of continued competence and appropriate care to the performance and interpretation of radiography exams.

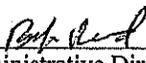
1. A minimum of 300 exams per year is recommended in order to maintain a high level of expertise. If the volume of an imaging modality is too low to maintain this standard, continued qualification is maintained if acceptable technical success, accuracy of interpretation and appropriateness evaluation is monitored.

2. The physician's continuing medical education should be in accordance with the ACR Standard for Continuing Medical Education (CME).

GENERAL INFORMATION:

 **Community Hospital Anderson**

(Manual that policy resides in Hospital, Inpatient Radiology)

Subject:	Staff Radiologist coverage
Originator:	Bob Reed Administrative Director of Radiology
Approved By:	Bob Reed  Administrative Director of Radiology Marc Pinchouck, MD Medical Director of Radiology
Scope:	
Effective:	Date 1/85
Revised:	Date 7/89 Date 5/00 Date 6/02
Reviewed:	Date 6/04 Date 7/05 Date 5/08, 6/12
Reference(s):	i.e. JCAHO, ISDOH, etc.
Previous Number:	
Attachment(s):	

PURPOSE: Scope of service for Radiologists

POLICY STATEMENT: To provide adequate medical coverage to fill customer needs at CHA.

1. Performed by: Radiology physicians

ACTION STEPS:

Northside Radiology Consultants, Inc provides coverage for the Radiology Department of Community Hospital of Anderson.

Two Radiologists are present in the Hospital on weekdays from 7:00 a.m. to 3:00 p.m. A third Radiologist is present on weekdays from 10:00 a.m. to 6:00 p.m. One Radiologist staffs the department on Saturdays from 8:00 a.m. to 12:00 p.m.

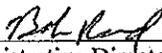
All other hours are covered by an "on-call" Radiologist. The schedule for the "on-call" Radiologist is posted in the Film Finish area.

Radiologists are always available for consultation with ordering physicians during the above stated hours. Outside of the routine hours, the "on-call" Radiologist may be notified of the need for consultation.



Community Hospital Anderson

(Manual that policy resides in, i.e., Hospital, General Nursing, etc.)

Subject:	Teleradiology
Originator:	Bob Reed Administrative Director of Radiology
Approved By:	Bob Reed  Administrative Director of Radiology Marc Pinchouck, MD Medical Director of Radiology
Scope:	
Effective:	Date 5/99
Revised:	Date 8/02 Date Date
Reviewed:	Date 6/04 Date 7/05 Date 5/08, 6/12
Reference(s):	i.e. JCAHO, ISDOH, etc.
Previous Number:	
Attachment(s):	

PURPOSE: Scope of service for non-staffed hours

POLICY STATEMENT: To provide for the transmission and viewing capability of medical imaging procedures to an off site location.

1. Performed by: Outsourced to Virtual Radiologic

ACTION STEPS:

Teleradiology is the electronic transmission of radiologic images from one location to another for the purposes of interpretation and / or consultation. The use of teleradiology does not reduce the responsibilities of the Radiologists for the management and supervision of radiologic medicine.

The goals of teleradiology are:

1. Provide consultative and interpretative radiological services.
2. Facilitate radiological interpretations in on-call situations.
3. Provide direct supervision during on-call situations.

In the event that the teleradiology system is inoperative the following should be done:

1. The PACs Administrator or a BioMed Technician should be notified.
2. If necessary, service calls to the appropriate vendors will be made by the above in-house support staff.
4. The on-call Radiologist will provide on-site interpretation or consultation services, as needed, following notification of the problem with the teleradiography system.

Final reports are generated by the staff Radiologist. Any discrepancy is noted and reported on the final report.

GENERAL INFORMATION:

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 14

Intensive Care Unit

"14. **Intensive care unit.** There must be an intensive care unit with patient/nurse ratio not exceeding 2: 1 and appropriate resources to resuscitate and monitor injured patients."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 14 are met with signed copies of the Community Hospital – Anderson (CHA) ICU policies and an equipment list. The ICU has sufficient equipment and resources to resuscitate and monitor injured patients including those patients requiring neurosurgery. The ICU Clinical Manager has included a letter affirming a maximum 2:1 ratio for trauma patients.

February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that that I serve in the role of Clinical Manager of the Intensive Care Unit. I am pleased to support Community Hospital - Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure A Patient /Nurse ratio that does not exceed 2:1 for Trauma patients. I also certify that our intensive care unit has the appropriate resources to resuscitate and monitor injured patients. Supporting documentation has been included with our application.

Respectfully,



Cynthia L. Beisser, R.N.
ICU Clinical Manager



Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

Equipment Kept in the ICU

- Bispectral Index monitor
- Bronchoscope
- Defibrillator (2)
- Transcutaneous Pacemaker
- Peripheral Nerve Stimulator
- Temporary Transvenous Pacemaker
- Tracheotomy Rhino Kits
- Intubation Cart/exchanges
- Code Cart with Zoll Monitoring systems(2) 1 with pacing capability
- Vents (15) available
- Reverse Isolation rooms (2)
- Patient Ceiling mounted lifts (2 rooms) capable of 880 lb lifts
- Glydescope for visualization during intubation
- Portable bedside ultrasound
- Procedure cart
- Neuro Cart for EVD, Craniotomy available *from SPD*
- Camino
- Dialysis Line Placement Cart Perm/Temp *from SPD*
- Clean Utility on Unit with available supplies including:

Percutaneous tracheotomy

Pneumothorax kit

Chest tubes

Thoracentesis

Paracentesis

Lumbar Puncture

Swan Line

Central Line

Pacer tray

Portable Doppler

Compressor

➤ All rooms have Philips Monitoring System and are capable of monitoring:

Cardiac Output with Swan Line

Arterial Pressures

Intraabdominal pressures

Intracranial pressures

Vital Signs/O2 Sat

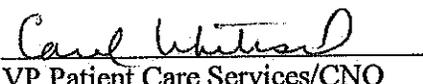
Capnography

Central Venous Pressures

ECG tracing

All with chart integration to Meditech and printing capability

**NURSING DEPARTMENT POLICY MANUAL
Intensive Care Unit**

SUBJECT:	Staffing and Scheduling
Originator:	 Clinical Manager, ICCU
Approved By:	 VP Patient Care Services/CNO
Policy Coordinator:	Cheryl Arnold
Effective:	2/06
Revised:	4/29/10, 11/23/10, 9/11, 5/1/13, 5/21/13, 3/20/14
Reviewed:	
References:	Internal Policy

Performed by: Director or a unit designee.

Purpose: To provide staffing and scheduling guidelines for the Intensive Care unit staff.

Policy Statements:

1. Staffing requirements are determined by the Director or unit designee. There must be core staffing scheduled.
2. There must be at least one ACLS prepared ICU RN present at all times.
3. When the ICU is closed, one ACLS prepared ICU RN will remain in the hospital, to be available when the ICU opens..

Census Fluctuation:

1. Since the ICU is a "closed" unit, during times of high census or high acuity, staff will be expected to work additional hours to maintain adequate staffing.
2. For periods of low census, any person who would be paid overtime should be called off first.
3. Resource staff will be called off next.
4. Staff who are "called off" may be asked to remain PRN.
5. Once called, the PRN person should be present and ready to work within 60 minutes.
6. If a staff member on PRN status is unavailable when called or cannot be reached, their status will be changed from PRN to PO2 (absent).

Schedule/Trades/Days Off:

1. The ICU schedule is printed in 2 (two) week intervals---and generally available to staff 4 (four) weeks ahead of time. The schedule is in a repeating format, so that staff may plan appointments, etc. During the holiday time, the schedule will be subject to change.

2. Two staff members working the same shift may not take vacation at the same time unless their schedules do not overlap and it is approved by the Clinical Director.
3. If another staff member has already requested a day off and you also wish to have the day off, coverage must be found for the **entire** shift for **both** individuals before the second request will be granted.

Vacation:

- Vacation requests are considered in the order they are received, and are granted as staffing permits.
- If a vacation request includes your weekend to work, it is your responsibility to find coverage. Coverage should be noted on the initial vacation request. The request will not be granted until the week-end is covered.
- Vacation days requested from May through September cannot exceed two weeks.
- No vacations will be granted during Thanksgiving week, or from December 23rd through January 2nd.
- It is the responsibility of the staff member to verify that the request appears on the posted schedule as granted.
- CLO staff members may take one calendar weekend off per quarter (intent is for the CLO staff member to work 12 weekends and take the 13th weekend off).
 - a. CLO staff members may not request to take off two weekends in row.
 - b. CLO staff members may not request a weekend that includes a holiday as their weekend off.
 - c. Situations not covered by this policy statement or a signed agreement will be dealt with on an individual basis by the Clinical Manager.

Holidays:

1. The holiday schedule is generally placed in the hours book during the month of December. Christmas and New Years holiday rotate by the year. Other holidays are selected by the individual. ICU must have three RN's each holiday. If holidays are not filled out in an equitable manner, the schedule will be adjusted per the Clinical Director.
2. Holidays may be traded holiday-for-holiday. For staffing reference, original schedule will be kept as record.
3. Holidays, for the night shift are worked and paid on the eve preceeding the actual calendar holiday.
4. Each staff member is responsible for checking the schedule to know how their schedule has been adjusted to accommodate the holiday schedule.
5. Regular staff work 3 of the 6 holidays. Week end option staff work only when the holiday falls on their scheduled time to work.

Tardiness/Absence:

1. Notification of absences (PO2) must be received no later than 2 hours prior to the beginning of a shift. If notification of an absence is not received within 2 hours after the beginning of a shift the absence will be considered an unreported absence (16). Notification must be made

to the Clinical Director, ICU staff or by speaking directly to the Administrative Representative.

2. Tardiness causes a hardship on the effective functioning of the unit, as well as co-workers. Employees who are not clocked in and prepared for work will be considered tardy three minutes after the scheduled time for their shift to begin.

Clocking In and Out:

Each staff member is responsible for clocking in and out each day. For failure to clock in or out, an employee will be given:

Verbal warning after four occurrences.

Formal counseling with written documentation to HR after 6 occurrences

Final warning with written documentation to HR after 8 occurrences.

Termination (in consultation with HR) after 9 occurrences

Bereavement policy:

The hospital bereavement policy will be followed for all Intensive Care unit employees:

- a. Community Hospital will provide two days (16 hours) of paid bereavement time for employees who have experienced the loss of a spouse, parent, grandparent, child, sibling and in-laws of the same degree.
- b. While the hospital provides two (2) days of bereavement time, it should in no way be construed that this is the amount of time that an employee may take off for bereavement. Employees may use Paid Days Off to supplement their time away from work.
- c. Persons responsible for time cards will use Code 60 in the timekeeping system to designate paid bereavement days.

Crisis pay:

In the event of multiple open positions/LOAs, crisis pay may be offered. This will be at the discretion of the Director.

**NURSING DEPARTMENT POLICY MANUAL
INTENSIVE/CRITICAL CARE UNIT**

SUBJECT:	ADMISSION/ PRIORITIZATION/ DISMISSAL/CONSULTATIONS
Originator:	<u>Cindy Beism</u> Clinical Manager, ICCU
Approved By:	<u>Carol Whitsett</u> Vice President Patient Care Services/CNO
Policy Coordinator:	Cheryl Arnold
Effective:	1969
Revised:	7/6/89, 1/26/93, 8/28/96, 7/1/98, 7/26/00, 6/26/01, 5/20/02, 4/30/03, 4/29/10, 5/14/2010, 1/13, 3/20/14
Reviewed:	4/06
References:	

PURPOSE: To concentrate in one area patients who will benefit from monitoring, close observation, and intensive nursing care.

POLICY STATEMENTS:

A. Admission

1. Admission to the ICCU is by the attending physician's request, and is based on severity of illness or intensity of service rather than a specific diagnosis.
2. Patients who will be receiving comfort care only (no diagnostic or therapeutic treatment) will be excluded.
3. Generally, any patient 14 years of age or greater, with a presently or potentially life-threatening condition, may be a candidate for ICCU. This includes the following:
 - a. Acute Respiratory Failure requiring mechanical ventilation, or patients being weaned from the ventilator.
 - b. Invasive monitoring
 - c. Vasoactive drips that necessitate titration
 - d. Medications not administered in the Med/Surg units, as per the established policy
 - e. Patient is physiologically unstable and requires patient assessment and intervention every 2 hours or more frequently.
4. No patient will be refused admission to a special care unit on the basis of not meeting unit criteria. If specialized knowledge is required, a resource nurse will be identified in the area of speciality to assist with care of that patient.

B. Prioritization

1. If the ICCU is filled to capacity, the Medical Director of Critical Care, or his designate, shall have the authority and responsibility to request the attending physician of a less critically ill patient to transfer his patient so that a more critically ill patient may be admitted. (In most cases, the involved attending physicians and the nurse in charge will make this decision.) To assist with this

123

process, a priority list has been formulated. Those patients having the higher priority number (III) would be looked at first, then in decreasing order by priority number.

- a. Priority I
 1. Unstable patients needing intensive treatment modalities.
- b. Priority II
 1. Stable patients needing intensive treatment modalities. These patients benefit from intensive monitoring and are at risk for needing immediate intensive care.
- c. Priority III
 1. Unstable patients not requiring intensive treatment modalities, but require intensive nursing care. Priority III patients receive intensive treatment to relieve acute complication, but therapeutic efforts might stop short of life-prolonging measures such as intubation or CPR.
- d. Pandemic event
 1. Refer to Alternate Staffing Plan for ICU Pandemic Event policy

C. Discharge

1. Dismissals from ICCU are by physician's order only.
2. Patients are eligible for discharge when their conditions have stabilized and their needs for intensive nursing care and/or ICCU treatment modalities no longer exist.
3. General guidelines for discharge to a nursing unit from ICCU are:
 - a. Priority for room assignment will be given for patients transferred from the unit.
 - b. Patients requiring telemetry:
 1. A "Telemetry Transmitter Request Form" will be sent to the telemetry office (must have a patient sticker on it).
 2. The form will be returned with the transmitter number and signature of person who issued the transmitter.
 3. Verify that the number on the sheet of paper and the number on the telemetry transmitter match.
 4. Verify patient armband matches the name on the request form.
 5. Chart: "Transferred from ICU room # __ to Room ___ with transmitter number ___ on"
 - c. Surgical patients will be transferred to the surgical nursing unit unless cardiac monitoring is needed.

D. Consultations

1. A consultation is required when the patient's needs exceed the privileges of the attending physician. Questions may be referred to the Medical Director of Critical Care. Communication from physician to physician rather than nurse to physician is preferred.

Community Hospital Anderson

PLAN FOR THE PROVISION OF NURSING CARE INTENSIVE/CORONARY CARE UNIT

Scope of Service

The purpose of this document is to provide the operational link to the Network Organizational performance Improvement and Safety Plan.

Mission: With caring and compassion, we continually strive to improve the health and well being of those individuals in Central Indiana who entrust their care to us.

Goals of patient Care Service: The goal of the ICCU staff is "to give the best care to every patient, every day". We are a 12 bed combined medical/surgical unit. The purpose of the ICCU is to provide safe and effective care to patients, concentrated in one area, which may be unstable and/or require a high complexity of nursing care. This care is managed by an all R.N. staff that:

- Delivers exceptional quality of care guided by the following values:
 - Patients *First-putting patients first*
 - Relationships-*build strong relationships*
 - Integrity-*maintain the highest integrity*
 - Innovation-*constantly strive for innovation*
 - Dedication and Drive-*work with drive and dedication*
 - Excellence-*pursue excellence*
- Uses a systematic approach to (1) collect the patient health data, (2) analyze the assessment data in determining diagnosis, (3) identify individual expected outcomes for the patient, (4) develop a plan that prescribes interventions to attain expected outcomes, (5) implements interventions identified in the plan of care, and (6) evaluate the extent to which the goals have been achieved.
- Is involved in the continuous quality improvement, utilizing a variety of different mechanisms to track, trend, and implement process improvements. These include Focus-PDRA as the framework for planned, systematic assessment and improvement, tracking, and trending outcomes.
- Participates in the Nursing Shared Governance Model, which consists of: Unit Based Councils, Safety/Quality/PI Council, Leadership Council, Clinical Core Groups, and Nursing Professional Practice Council..
 - Through the Unit Based Council, staff promotes professional accountability for clinical practice, education, quality, research and communication.

- The Nursing Professional Practice Council facilitates communication among the disciplines and makes decisions that impacts nursing as a whole.
 - Through representation on Clinical Core Groups, staff facilitates communication with other disciplines. The Critical Care/Medical Care Clinical Core Group is responsible for monitoring the effects of care delivery and patient outcomes. The Clinical Core Groups monitor processes of care, measure the output of processes, analyze the effectiveness of care delivery and/or make improvements as identified by the group. The multi-disciplinary structure of this group enhances the organization's ability to timely identify and improve common areas of concern or interest.
- Are committed to establishing and maintaining a healthy work environment through:
 - Continually striving for proficiency in communication skills
 - Pursuing and fostering true collaboration
 - Being involved in patient care decisions
 - Staff based on variance in patient needs and acuity
 - Recognizing others for their value to the work organization, and accepting recognition
 - Realize that both they and the nurse leaders impact creating and sustaining a healthy work environment

Types and Ages of Patients Served: The unit's focus is on patients with a mixture of cardiac, respiratory, trauma and surgical problems. Patients who are unstable, require intensive treatment modalities, are at risk for requiring immediate intensive treatment, or who require intense nursing care may be admitted to the Intensive Care Unit. Any patient 14 years of age or greater, may be a candidate for ICCU.

Scope and Complexity of Patient Care Needs: Total patient care is provided or supervised by an RN staff that is ACLS Certified (Advanced Cardiac Life Support) within one year of their ICCU employment. The scope of care includes use of the nursing process, patient/family teaching, intravenous therapy administration, medication and treatment administration, implementation of physician orders and environmental control for patient safety. Complexity of patient care needs may include, but is not limited to (1) ventilator care, (2) invasive monitoring, (3) titration of critical care medications, (4) and drug therapy not done on units outside of ICCU.

The unit organizational plan interfaces with the Nursing Departments organizational plan and is as follows:

- 1) The Manager is a qualified Registered Nurse with 24-hour accountability for the unit. The reporting accountability is to the Director of Acute Care Services. The

12/6

Manager is accountable for the management of patient care and personnel within the unit.

- 2) The registered nurse (RN Care Manager) is responsible for functioning within the guideline of the Indiana State Board of Nursing Standards for the Competent Practice of Nursing. The registered nurse is responsible for total patient care of designated patients, and reports to the Manager.
- 3) The PCT, SNE, and EMT are responsible for functioning within the guidelines of their job description under the supervision/direction of the RN Care Manager.
- 4) Unit Clerk/tech reports to the Manager. The clerk/tech is responsible for providing the clerical support needed by the ICCU staff, maintaining logs for Quality Improvement and ordering supplies for the unit.

The ICCU has a rectangular floor plan around the nursing station with easy visibility into each private room. There are two emergency carts, one intubation cart, a fire alarm, a fire extinguisher; medical gas and oxygen turn off access, oxygen pressure alarm, medication room and physicians' dictation room. The unit is part of the hospital's smoke free environment.

All rooms are on the Phillips component monitoring system. All rooms are capable of monitoring ECG traces, respiration, temperature, non-invasive blood pressure, cardiac output and multiple invasive pressures. Each room has either 2 or more suctions and oxygen. Ventilators may be used in all rooms, however rooms 1 through 4 have piped in medical air. All rooms have a patient call light, emergency call light (nurse needs help) and a code blue alarm that goes directly to the switchboard. Room #10 and Room #12 have reverse airflow for reverse isolation, and room #12 has an ante-room. Room #10 also has a phone jack. The other rooms have the availability of a cordless phone. TV's are in all rooms. Battery operated radios are permitted unless restricted by the physician. Cell phones may be used only in the lobby area.

The Emergency Carts (2) are outdated monthly by the pharmacy department and are exchanged with SPD after codes. The defibrillators are checked twice per day for voltage integrity and appropriate documentation is maintained. Bio-med checks the defibrillator quarterly for preventive maintenance, calibration and electrical safety. An intubation cart kept on the unit, as well as the procedure cart, are stocked by staff after each use and contain only equipment needed for intubation and procedures.

The Medication Room is supplied with individual patient bins as well a BioID PYXIS machine, which contains unit dose medication, IV kits, IV fluids, routine meds, PRN meds and controlled substances.

Communication: ICCU works in a cooperative manner with other hospital departments on a daily basis to keep patient care needs as top priority. The unit is supplied with a FAX machine and I-phone, which allows communication inter and intra hospital with future capabilities.

Electronic communication is present for communication throughout the network, with e-mail available for all Nursing staff, as well as Vocera. In addition, the intra-net may be

used to access information throughout the CHI network. The Pneumatic Tube system is available to other units throughout the hospital. When patients are transported to other areas for tests, or as a change of room, passport to transport is utilized.

Visitation: Visitation is at the discretion of the patient's nurse.

- Generally speaking, immediate family (we ask no more than two at a time) and ministers may come at any time.
- Report is given 7a-8a and 7p-8p, so for privacy reasons, no visitation is permitted during this period of time. In the event that a visitor must remain in the room (patient comfort), the doors to the patient room will be closed.
- One individual, selected by the patient, (if they are able to do so) will be designated as the contact person. The contact person may call for updates at any time. The contact person will then be responsible for communicating information to others.
- The patient may decline visitation at any time

Extent to which the level(s) of care or service provided meets patient's needs:

Opportunities for improvement are identified through on-going assessment of quality indicators, as reported in the Clinical Core Group. Patient outcomes are looked at, as are patient surveys and physician/staff satisfaction.

The Medical Director is responsible for directing the medical care of patients while they are in ICCU, either through direct care or collaborative with other physicians. A consultation is required when the patient's needs exceed the privileges of the attending physician. Questions may be referred to the Medical Director. Communication from physician to physician, rather than nurse to physician is preferred.

Appropriateness, clinical necessity and timeliness of support services provided directly by the organization or through referral contacts:

Admitting Office: Intensive Care Bed assignments are generally handled between Admitting and the ICCU RN. Requests for admission to the unit are made by the attending physician. The Administrative Representative handles bed control for patients being transferred from ICCU to a med/surg room, through collaboration with the nursing unit to which they will be transferred.

Case Management: Case management is utilized in the Intensive Care setting to assure a continuum of care. Rounds are made in the unit daily to assess for patient/family need, and to communicate with the staff.

Dietary Department: All dietary orders are sent to dietary via computer. Community Hospital utilizes Room Service. Each patient looks over the menu to see what they would like to order. Then either the patient, or their representative, may order meal(s). In addition, families may assist patients by ordering for them from their home. Trays will be delivered within 45 minutes of order, or at a time requested if ordered in advance. Staff will assist patients with their meals as needed. A nutritional screen is done on all ICCU patients. Those patients who have low serum albumen, diagnosis related to

gastrointestinal disease, or are on a ventilator, receive a nutritional profile by dietary. This is completed within 48 hours, except for ventilator patients who have a profile done within 24 hours. Nutritional status of the ICCU patients is monitored on a regular basis.

Cardiopulmonary Service: Therapeutic orders and treatments are processed via the computer. All treatments are initiated and continued by the cardiopulmonary personnel on a 24-hour basis. (Incentive spirometry may be done by the nursing staff.) Cardiopulmonary is responsible for the monitoring and changes made for all ventilator patients. Nursing works very closely with Cardiopulmonary, and when patients are weaned from the ventilator, this is done as a team effort.

Materials Management: The unit maintains a pre-determined amount of chargeable and non-chargeable items. PAR levels are determined by collaboration of ICU staff and SPD personnel monitor supplies for inventory and restock the unit every 24 hours, and upon request. (Specific supplies may be requested by phone or computer and are received promptly.) Materials management staff collects used equipment from the soiled holds area for reprocessing. There is also a return bin in the clean supply room from which SPD collects supplies to be returned.

Laundry Linen is delivered to the unit daily with additional requests honored. Soiled linen is placed in the soiled utility room, picked up daily, and is handled with standard precautions.

Engineering Services: Required services or repairs are received by notification via telephone and work order. (Bio-Med and maintenance). Preventive safety checks are done as determined by Bio-Med. Each piece of equipment has a Preventive Maintenance identifier to indicate when the clinical equipment is due for routine inspection. History of the equipment may be accessed through the computer.

Environmental Services: Environmental Services is responsible for the routine and terminal cleaning of discharge units and the maintenance of a clean environment.

Medical Records: Medical Records requests records from other institutions, and copy information to be sent with patients upon transfer to another institution. Records on file since Computerized documentation are available through Medical Records.

Security: This service is available through security officers or by the hospital's Code 7 policy. The security officer is available to assist with difficult patient and family situation as the need arises, and may be reached via pager or urgently per the security button and the central monitor station. A red "call" button is also located just below the west end of the monitor bank in the ICCU. This button provides a direct page to security.

Laboratory: Laboratory tests are ordered via the computer. Lab personnel collect all blood cultures and all Type & Crossmatch samples. Nursing collects all other blood samples. (Laboratory will assist in the collection of samples upon nursing request, and Cardiopulmonary may be used for back-up ABG draws.) Specimens are transported to

the lab via the pneumatic tube system. Nursing obtains blood and blood products from the blood bank. Quality control records for point-of-care tests are maintained in the laboratory.

Radiology: All orders are processed via the computer. Patients are escorted to and from the department by ICCU nursing staff who will stay with the patient {if the radiology nurse cannot}. The ICCU beds are radioluscent, providing a means of doing radiology procedures at the bedside with the use of a C-Arm.

Emergency Department: The emergency department physician responds to all code blues, including the ICCU. Patient admissions coming from the ED will have a RN accompany them to ICCU. Telephone report will be given before the patient is received. If an inpatient or family member should sustain an injury, medical attention is offered in the ED. Staff may also obtain care should an incident occur.

Surgical Services: The ICCU RN accompanies a surgical patient from ICU to OR. When report is given, surgery personnel receive the patient and assume all responsibility for care until the patient is returned to ICCU. After surgery, ICCU personnel receive patient report and take responsibility from the recovery room staff upon arrival. When necessary for a surgery patient to go directly to ICCU from surgery, the patient is recovered in ICCU by the Recovery Room staff.

Pharmacy: Pharmacists are available for consultation with the physician whenever needed. Pharmacists make rounds daily Monday – Friday, and are available for questions or information as needed. Medication and intravenous therapy orders are sent to Pharmacy by fax, phone and direct communication. (Intravenous solutions that contain medication are ordered from pharmacy, while intravenous solutions that do not contain medication are stocked by S.P.D.) The unit receives orders at a pre-scheduled time, however medicines may also be sent via a secure Pneumatic Tube system. Nursing Administration assists Pharmacy according to pre-determined arrangement as well as having access to night pharmacy via phone and fax. Pharmacy consults as requested by the physicians. The registered nurse is responsible for total patient care of designated patients, and reports to the Manager.

Referral contacts: These contacts are made by communication between the sending physician and the receiving physician. Once bed availability is confirmed, the sending nurse will call report to the receiving nurse prior to transfer. The need for referral is made either by the attending physician or at request of the family.

Availability of necessary staff: Competent Practice of Nursing: Nursing care responsibilities are assigned to a nursing staff member in accordance with qualifications of the nursing staff member and the needs of the patient. The Director, or designee, does staffing schedules on a bi-weekly basis.

Nurse-patient ratio is 1:2 and may change to 1:1 based on the acuity of the patients (copy of acuity attached). ICCU acuity is done on the computer at 0600 and 1800 [or twice per

day]. This reflects what has occurred on the previous shift, and projects what staff will be needed on the following shift.

Each member of the nursing staff is assigned clinical and/or managerial responsibilities based on educational preparation and assessment of current competence. The nursing staff must demonstrate ongoing competence, or skills credentialing, in areas relative to performance expectations..

For the new employee, a unit specific orientation program is designed to assess each individual's current level of competency through the use of a skills inventory. Formal unit specific orientation is done through an established preceptor program. Time for completion usually requires from 4-8 weeks, depending on the individual's previous education and experience. Employees are required to attend mandatory hospital education.

Personnel must have completed formal education requirements; general orientation, unit specific orientation, and special training that may be necessary to comply with patient care needs. ICCU nurses will obtain their ACLS certification within their first year of employment. Personnel are permitted to "float" to other units, but do not assume the direct operations of said unit. Personnel who "float" to ICCU are assigned to an ICU nurse, who is responsible for managing any patient requirements beyond the expertise of the nurse floated to the unit. (for example, ECG monitoring)

Recognized Standards or guidelines for practice: American Association of Critical Care Nurses provide "Standards for Acute and Critical Care Nursing Practice" to guide us in our practice. These standards address assessment, diagnosis, outcome identification, planning, implementation and evaluation. A copy of the standards is found in the ICU. Each employee is responsible to provide nursing care based on CHA Policy and Procedures, Guidelines of Practice, and AACN Standards for Nursing Care of the Critically Ill, while functioning within the guideline of the Indiana State Board of Nursing Standards for the Competent Practice of Nursing. The Manager is responsible for the provision of appropriate educational and policy manuals to assist the staff. If problems or questions should arise, the established chain of reporting is followed. The unit Clinical Director and registered nurses assist in the development of unit specific guidelines.

Methods that are used to assess and meet patient needs, including staffing effectiveness indicators as appropriate: Please see Scope of Assessment. Staffing effectiveness indicators are monitored and evaluated quarterly. These are reported on the Nursing Report Card.

Our focus to provide excellent patient care is based on five "pillars":

- People
- Quality
- Growth
- Finance

- Service

Identification of major internal and major external customers: Our major external customers are patients, patient's families, significant others, physicians and their office staff, clergy, facilities to which we transfer our patients, and the community at large. Our major internal customers are Patients, Emergency Department, Cardiopulmonary, Case Management, Dietary, Laboratory, Radiology, Nuclear Med, Pharmacy, Admitting Office, Materials Management, Bio-med, Surgical Services, Med/Surg units, Environmental Services, and Medical Records.

Education of the patient: Education begins on admission to the ICCU as the patient data base is completed, with orientation to the pain scale, the room and routine of the hospital. An individualized plan of care which includes educational needs, is formulated at time of admission, initiated and implemented. Reassessments are completed daily, or more often, as needed using the multidisciplinary goal sheets. Methods of teaching include, but are not limited to, verbal instruction, written materials, demonstrations, return demonstrations, audio-visual aides, and handouts of written information.

Safety Management: It is the responsibility of the employees to participate in the Safety Management Program through compliance with safety policies and procedures and attendance at safety in-services. Employees must identify and refer safety related issues to the unit safety nurse, their manager, and/or the Safety Core Group. Employees must perform their job responsibilities in accordance with established safety policies and procedures.

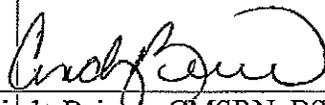
Some safety initiatives in the ICCU include: using BMV to administer medications, limiting the VTBI to 2 times the rate of infusion, double independent checks on "critical drips"---as identified by pharmacy, immediately removing critical weaned drips from the room, and repeating and verifying all verbal orders/calls of critical values.

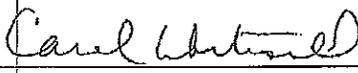
The Vice President of Patient Care Services meets with the ICCU Director to discuss patient care issues, staff and interdepartmental issues. Information is shared and recommendations are made. The Vice President of Patient Care Services conducts these meetings.

Staff meetings, to maintain open channels of communication, to exchange ideas, to review quality activities, and to resolve problems within the nursing unit, are conducted by the Manager, or a designee. Communication is maintained through e-mail, fliers, or verbal exchange. The Unit Based Council also conducts meetings and reports to the Nurse Professional Practice Council.

Staff serve on various committees, as needed, to improve patient care issues.

Staff serve on various committees, as needed, to improve patient care issues.

Plan Formulated By:  Date 3-24-14
Cindy Beisser, CMSRN, BSN, RN
Clinical Manager, ICCU

Approved By:  Date 3-24-14
Carol Whitesel, MSN, BSN, RN
Vice President, Patient Care Services/CNO

 Date 3-27-14
Dr. Nacem Malik
Medical Director, ICCU

Rev. 5/90, 1/93, 3/95, 5/96, 11/96, 1/97, 12/97, 12/98, 7/00, 6/01, 4/02, 9/02, 8/05, 11.05, 4/06, 8/08, 4/11, 8/11, 10/11, 5/12, 5/13, 3/14

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 15

Blood Bank

"Blood bank. A blood bank must be available 24 hours per day with the ability to type and cross match blood products, with adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 15 are met with a signed copy of the Community Hospital - Anderson (CHA) Blood Bank policies including "Emergency Release of Blood", "Massive Transfusion" and "Transfusion Service Turn-around Times". A copy of our contract with the Indiana Blood Center is included. Our Laboratory Administrative Director and our Chief Pathologist have executed letters affirming compliance with all requirements. We have included an audit filter in our Performance Improvement and Patient Safety (PIPS) policy to monitor emergency request delivery times from the Indiana Blood Center delivered to CHA which are greater than three hours.



**Community
Hospital Anderson**

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February 12, 2014

**William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204**

SUBJECT:Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Chief Pathologist , Laboratory and Blood Bank Medical Director. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to continue to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that Blood Bank services are available twenty-four hours per day at Community Hospital - Anderson. This service includes the ability to type and cross-match blood products.

I confirm that we maintain an inventory of adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP) and other proper clotting factors. We have a contract with the Indiana Blood Center to have platelets, cryoprecipitate and a wide variety of other blood products delivered to CHA when needed twenty-four hours per day. These are typically available to administer within two to three hours.

Respectfully,

Boguslaw I. Uchman, M.D.
Chief Pathologist

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director



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February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT:Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Laboratory Administrative Director. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to continue to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that Blood Bank services are available twenty-four hours per day at Community Hospital - Anderson. This service includes the ability to type and cross-match blood products.

We maintain an inventory of adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP) and other proper clotting factors. We have a contract with the Indiana Blood Center to have platelets, cryoprecipitate and a wide variety of other blood products delivered to CHA when needed twenty-four hours per day. These are typically available to administer within two to three hours.

Respectfully,

Dan H. Yates
Lab Administrative Director

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director



1.8.00 - Transfusion Service Turn-Around Times And Policies For ER, Nursing Units, Short Stay, And Off-Site Transfusions For Provision Of Blood Pathologist's or Designee's Yearly Review & Revisions

Prepared: April 2005
Accepted: April 2005

By: Darlene Garrison, MT (ASCP)

Approved by: *Boguslaw Uchman* Date: 04.01.05
Boguslaw I. Uchman, M.D., Pathologist
Blood Bank Medical Director

DATE	BY
4-1-06	<i>Darlene Garrison (MT(ASCP))</i>
4-1-07	<i>Darlene Garrison (MT(ASCP))</i>
4-1-08	<i>Darlene Garrison (MT(ASCP))</i>
3-11-09	<i>[Signature] (MT(ASCP))</i>
3-19-10	<i>[Signature]</i>
3-21-11	<i>[Signature]</i>
3-4-12	<i>[Signature]</i>
3-14-13	<i>[Signature]</i>

Revision:



Transfusion service turn-around times and policies for ER, Nursing Units, Short Stay, and Off-site transfusions for provision of blood

Usual Orders of Leukoreduced Packed Red Blood Cells

Without a current T&S usually 1 hour – must be drawn, ABO/Rh, an indirect coombs, and a crossmatch for each unit ordered preformed.

With a current T&S usually 20 min or less – only crossmatches for each unit ordered must be preformed.

Special orders for FFP

Without a current T&S usually 50 min-patient must be drawn, and an ABO/Rh must be preformed before the units are ready for thaw. *Usually only one unit of FFP will be thawed at a time. This is to reduce wastage of this product. Once thawed this product has an adjusted expiration date of 24 hours.*

With a current T&S is usually ready in 20 minutes per unit. Up to 4 units can be thawed in one thaw cycle.

Special orders for CMV neg., Irradiated, Washed PC, or Thawed Deglycerized PC,

Without a current T&S – usually the testing will take at least 1 hour before the order can be placed to the blood center, then < 24 hours for the blood center to prepare the order or locate products and ship to us. Washed PC and Thawed Deglycerized units have an adjusted expiration date of 24 hours.

Special orders for platelets, HLA matched platelets and Factor VIII

These are all Non-stock items at CHA and are obtained from our blood product supplier when ordered. Without a current T&S- 50 min. patient must be drawn, and an ABO/Rh must be preformed before platelets can be ordered from the Blood Centers.

Apheresis platelets (usually this product can be shipped to us within 2-3 hours of the order) - ready for issue upon arrival (depending on product availability).

HLA matched Platelets – the patient must be drawn and sent to the blood center for testing. Once an HLA type has been established the blood center must then call HLA matched donor in for collection. The units collected must then be tested for infectious diseases, then crossmatched by the HLA reference lab and then delivered to our facility. This process can take up to a week for an available product (depending on product availability).

Factor VIII (usually this product can be shipped to us within 2-3 hours of the order) - ready for issue upon arrival. Each vial must be reconstituted prior to administration. This is not a stock item and will be special ordered from a supplier as needed.

Cryoprecipitate (usually this product can be shipped to us within 2-3 hours of the order) – must be thawed for ≤ 20 min/unit. This product is available from IBC as a pre pooled product.



Rhogam and Micrhogam

NON-OB Patients must have ABO/Rh preformed, if the patient is Rh negative an indirect coombs will be preformed prior to the release of the product. Usually this product can be ready for issue in 1 hour.

OB Patients will have an ABO/Rh and Direct Coombs preformed on the infant's cord blood. The mother will need to have an ABO/Rh and Fetal screen preformed when the infant is Rh positive. The sample needed for this testing must be post delivery. Usually this product can be ready for issue in < 2 hours.

Service Providers

Blood products are first attempted to be obtained through the Indiana Regional Blood Center (IBC), Indianapolis, Indiana. If products cannot be obtained through IBC, then we will contact the American Red Cross, Fort Wayne, Indiana, secondly.

The blood products are usually delivered to our facility by the NOW Courier service. Should there be a delay in obtaining or difficulty in crossmatching blood products the Blood Bank will notify the nursing staff immediately upon discovery.

It is the recommendation of this Blood Bank for all patients' possibly needing blood or blood products without an order to infuse these products to only have a T & S ordered. Product orders can be added when the order to infuse is given. This will help lower the Hospital's blood wastage, and help save the patient excessive testing charges.

References

- Indiana Regional Blood Center, 3450 N. Meridian Street (PO Box 88206), Indianapolis, IN 46208
- American Red Cross, 1212 E California Road, Fort Wayne, IN 46825
- CAP Checklist, Current Edition



5.6.00D – Massive Transfusion Policy

Principle

Massive transfusion may be defined as replacing a patient's total blood volume by transfusion within a 24-hour period. The most important factor in supporting tissue oxygenation is maintenance of adequate blood flow and blood pressure by infusing a sufficient volume of blood components to correct or prevent a hypovolemic shock. The response of the blood bank must be one of urgency without sacrificing patient safety. If the patient requires immediate transfusion, blood may be issued before completion of routine testing as described in the procedure for Emergency Release of blood components (5.8.00). When a bleeding patient receives a large volume transfusion in short time, the composition of his circulating blood is profoundly altered. The proportion of the patient's cells and plasma diminishes as homologous blood is given. A pretransfusion specimen ceases to represent his current status, and crossmatching using the initial specimen has limited validity.

Coagulation abnormalities developing during massive transfusion have been attributed to the dilution of platelets or coagulation factors, but consumptive coagulopathy also plays a role. Abnormal coagulation test results do not always correlate with clinical problems, but platelet counts do decline predictably in massively transfused patients.

Specimen

The same specimen as for use in routine compatibility testing is required.

Procedure

The following statements pertain to a patient who has received an amount of blood approximating his/her total blood volume (10 units in an adult) within a 24 hour period.

- ABO/Rh type specific blood is the component of choice. See Normally Compatible Blood Groups Procedure (5.6.00A), when type specific products are not available. Inquire about the number of units the physician suspects to require and order additional units from IBC if inventory is not adequate.
- After the patient has been stabilized and the immediate crisis is over, if there is an order for more blood, obtain a new blood specimen at this time for crossmatching.

If it has been 24 hours or more since the massive infusion of blood products and there is an order for more blood, obtain a new blood specimen at this time for crossmatching. If there are no compatibility problems at this time, a new blood specimen for future compatibility testing may be obtained every three days.



- When Group O blood products are given to recipients who are not Group O, there is infusion of plasma containing antibodies against the recipient's own red blood cells. The amount of infusion is dependent upon the amount and typed of product infused. The decision to switch back to type specific is based on the presence or absence of Anti-A and/or Anti-B antibodies in subsequent samples of the patient's blood. **A fresh blood sample should be obtained at each request for transfusion until it is determined safe to switch back to type specific blood for compatibility testing.** Thereafter, a new blood specimen may be obtained every three days for compatibility testing.

References

AABB Technical Manual, current edition

AABB Standards for Blood Banks and Transfusion Services, current edition



5.8.00 - Policy for Emergency Release of Blood Pathologist's or Designee's Yearly Review & Revisions

Prepared: July 2001
Accepted: July 2001

By: Darlene Garrison, MT (ASCP)

Approved by: (See previous page) Date: _____
Boguslaw I. Uchman, M.D., Pathologist
Blood Bank Medical Director

DATE	BY
1-10-06	<i>[Signature]</i>
1-17-07	<i>[Signature]</i>
1-13-08	Darlene Garrison MT(ASCP)
3-17-09	<i>[Signature]</i>
3-28-10	<i>[Signature]</i>
3-31-11	<i>[Signature]</i>
3-4-12	<i>[Signature]</i>
3-14-13	<i>[Signature]</i>

Revision:

L6-09 Added ABO/Rh antibody line for patient
check history 01.13.09

[Signature]



Policy for Emergency Release of Blood

Principle

In an emergency, the patient's physician must weigh the risk of infusing uncrossmatched blood against the hazard of waiting for a proper compatibility test. If he believes the urgency of the situation warrants release of blood without crossmatch, this may justifiably be done. The physician must accept responsibility for any complication in the patient caused by an antigen/antibody reaction that would have been detected by compatibility testing. He must indicate his acceptance of this in writing. Such a release does not absolve the blood bank from its responsibility to issue properly grouped or labeled blood.

Equipment

1. Blood Bank Coolers (plastic or Styrofoam)
2. Transport Thermometers
3. Cold Packs
4. Cardboard Separators
5. Emergency Release Forms
6. Blood Filters
7. Blood with a few segments removed.

Procedure

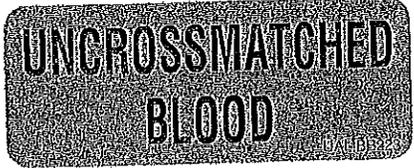
1. Perform a history check and be sure to document any antibodies found on the Authorization for Emergency Transfusions sheet that the doctor will sign.
2. Select blood for the Emergency Transfusion:
 - a. If there is time to determine the recipient's ABO and Rh type, then select blood of the recipient's own type.
 - b. If there is not time to determine the recipient's blood type then choose the appropriate group O-packed cells:
 - O Negative:* To all males and females until the supply is depleted or until the blood type is determined.
To women under the age of 50 (who may be of childbearing age) until the blood type is determined.
 - O Positive:* To women over the age of 50 and to males when the O Negative supply is depleted.
 - c. In Acute Emergencies, the supply of Rh-negative red blood cells may become exhausted. The patient's physician in consultation with the blood bank may then decide to use Rh-positive blood for an Rh-negative patient.
 - d. Label all units of blood with transfusion worksheets and tie tags. Indicate the unit is emergency released and for Compatibility indicate "incomplete". Refer to Attachment 5.8.00A for an example.
3. If the physician requests more than four units of packed cells at one time, then deliver the blood in one of the BB coolers with 1 - 2 ice packs (separated from the blood by cardboard) along with a transport bottle containing a thermometer. Tell them to keep the cooler closed and to return the unused blood to the Blood Bank immediately.
 - a. Document the units in the computer log.
 - b. Pull a few segments from all units issued.



- c. Record the temperature of the cooler in the log comment screen. Temperatures should be 1 - 10°C. When the blood is returned to the Blood Bank, record the temperature again.
 - i. *O.K. Temperature:* return the blood to inventory through the computer
 - ii. *Not O.K. Temperature:* put the blood on the quarantined shelf and leave a note for the Supervisor and quarantine in the computer.
 - iii. If the Blood is going on Lifeline then use a Styrofoam cooler or box and do not put a thermometer in the box or send a IBC box with a green transfer sheet.
4. Complete the Emergency Release Form and have the physician sign the release form indicating the clinical situation urgent enough to require the emergency release of blood.
NOTE: In rare cases a patient on the floor may require an emergency transfusion and the attending physician is not in house. In those cases a verbal order can be given over the phone by the physician. It must be given to an RN and there must be a 'witness' who also hears the doctor's verbal order. The RN and witness must both sign the Emergency Release Form and the ordering physician must sign the form within 24 hours of the emergency release.
5. Obtain a sample from the patient. Refer to procedure 5.5.00 for specimen collection in an emergency.
6. Begin routine compatibility testing. Refer to procedure 5.6.00.
7. If the patient is still bleeding after the ABO and Rh has been determined then switch to type specific blood.
NOTE: When group O red blood cells are transfused into a recipient who is not group O, there is also an infusion of some plasma containing antibodies against the recipient's own cells. It is safe to return to group specific blood provided that a fresh patient serum specimen shows little or no incompatibility due to transfused antibodies. The infusion set must be changed before group specific blood is started.
7. Complete the compatibility test as soon as possible. If incompatibility is detected at any stage of testing, immediately notify the patient's physician and the blood bank physician.

Doe, Jane
 ER 8-14-02
 Uncrossmatched
 Unit # 46241

5.800A



Anderson, IN 46011
 B.I. UCHMAN, M.D. - PATHOLOGISTS

EMERGENCY ISSUE TRANSFUSION WORKSHEET

Patient Information

Name: Doe, Jane
 Medical Record #: _____ Age: _____
 Location: ER Room: _____
 Doctor: _____
 Messages: _____
 Antibodies: _____

Unit Information

Patient ABORh : _____ Unit # : 46241
 Donor ABORh : _____ Product : LDPCD
 Compatibility test : Uncrossmatched Volume : 200 ml
 Hollister # : _____ Exp. Date : _____
 Date / Tech : 8-14-02 DMS Condition : OK
 Order # : _____ Instr. : _____
 Neg. for Antig. : _____

Issue: Date + Time: 8-14-02 Tech: Andrew Dawson UTW200

Transfusion Information

I certify that I have identified the Patient immediately before starting the transfusion and the patient's name, medical record No., and Hollister Number agree with the unit of blood or blood component.

Physician: _____
 Nurse: _____
 Nurse: _____
 Time: _____ T _____ P _____
 R: _____ B/P _____

Additional Notes:

Transfusion Started: Date _____ Time _____
 Flow Rate _____ Imed _____ Gravity Flow _____

15 Min. Continuous RN Observation by: _____

Time	Flow Rate	Vital Signs / Abnormal Symptoms	Nurse
15 min			
30 min			

Time Transfusion Discontinued _____
 Amount Given _____ T _____
 P _____ R _____ B/P _____
 Signature _____

Reaction _____ Time _____
 Urticaria _____ Dyspnea _____ Chills _____ Pain _____
 Fever _____ Shock _____ Cyanosis _____ Hematuria _____
 Other _____



Notification of Reaction: ___ Physician ___ Blood Bank Outpatient Instructions Given: ___ Yes ___ No
 WHITE - CHART COPY YELLOW - BLOOD BANK COPY PINK - ISSUE COPY

ADMIT	DICT	PROG NOTE	PHYS ORD	MAR	ED/SUR	LAB	XRAY	DIAG TEST	IN NOTE PATH	THER	NURS INFO	HISC
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147

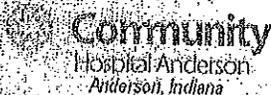
COMMUNITY HOSPITAL OF ANDERSON-MADISON COUNTY, Anderson, Ind.
TRANSFUSION REQUISITION

PROCEDURES REQUESTED		TRANSFUSION NUMBER R 12128		Date _____	Room _____
TYPE AND SCREEN <input type="checkbox"/>		PREVIOUS TRANSFUSION DATE _____		Patient <u>Doe, Jane</u>	
TYPE AND CROSSMATCH <input type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO		Hosp. No. <u>ER</u> Surgeon <u>5/27/94</u> Physician _____	
<input type="checkbox"/> PRE-OP <input type="checkbox"/> ROUTINE <input type="checkbox"/> ASAP <input type="checkbox"/> STAT <input type="checkbox"/> UNIT(S) RED CELLS <input type="checkbox"/> UNIT(S) WHOLE BLOOD <input type="checkbox"/> UNIT(S) PLATELETS <input type="checkbox"/> UNIT(S) FRESH FROZEN PLASMA <input type="checkbox"/> UNIT(S) _____		PREVIOUS REACTION <input type="checkbox"/> YES <input type="checkbox"/> NO		Address/Phone _____	
REQ. PREPARED BY _____		UNIT	DONOR NUMBER	J.D. WHITAKER, M.D., Pathologist	
TIME & DATE REQ.D. _____		1	<u>46241</u>	A.F. MARCINIAK, M.D., Pathologist	
TIME & DATE OF SURGERY _____		2	<u>46308</u>	Recipient's Identification Verified, Specimen Drawn and Blood Band Applied: TECH. <u>J.M. Cartney</u> DATE/TIME <u>5-27-94 6:45</u>	
ORDERED BY _____ M.D.		3		SECTION BELOW FOR BLOOD BANK USE ONLY	
DIAGNOSIS _____		4		<input type="checkbox"/> ABO & Rh Anti-A Anti-B Anti-A, B A, Cells B Cells BY: _____	
Remarks or Special Instructions (Lab Use Only)		5		<input type="checkbox"/> Anti-D Control Du II Rh Neg. Du Control DATE: _____	
		6		<input type="checkbox"/> Antibody Screen Interpretation _____ <input type="checkbox"/> Direct Antiglobulin Test AHG ton	
		7			
		8			

T COPY

R12128 Doe, Jane 5-27-94 ER

1. Fill out card. Do not remove backing. 2. Push it deeply into Ident-A* Blood Recipient Band. 3. Snap off stub at dotted line.



Authorization for Emergency Transfusions

Date: _____ Time: _____

Patient's Name: _____ MR#: _____

Patient's ABO: _____ RH: _____ Antibody History: _____

Type: _____ RH: _____ of units issued

Donor Number(s): _____

Nature of Emergency: _____

I authorize release of blood for infusion with awareness of antibody history indicated above:

Without Compatibility Testing: _____ M.D.

With Incomplete Compatibility Testing: _____ M.D.

Following a Suspected Transfusion Reaction: _____ M.D.

*This section is only to be completed in those rare cases where a medical patient on the floor requires an emergency transfusion and the attending physician isn't in house.
* Phone consent for Emergency Transfusion: _____ R.N.
Witness: _____
Signature of Physician:* _____ M.D.
*Required within 24 hrs after verbal order.

Technologist: _____



Donor Unit No.: _____	
Patient: _____	Med Rec No: _____
Laboratory Studies: _____	
Patient: ABO/RH _____	
Donor: ABO/RH _____	
<u>Interpretation of Compatibility Tests</u>	
Compatible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Released: <input type="checkbox"/> Yes <input type="checkbox"/> No
Untested and Uncrossmatched: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Technologist: _____	Date: _____

Donor Unit No.: _____	
Patient: _____	Med Rec No: _____
Laboratory Studies: _____	
Patient: ABO/RH _____	
Donor: ABO/RH _____	
<u>Interpretation of Compatibility Tests</u>	
Compatible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Released: <input type="checkbox"/> Yes <input type="checkbox"/> No
Untested and Uncrossmatched: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Technologist: _____	Date: _____



3450 N. Meridian St. PO Box 88273
Indianapolis, IN 46208-0206
Ph 317-916-6265

July 1, 2013

Ms. Beth Tharp, RN, MBA
Community Hospital Anderson
1515 North Madison Avenue
Anderson, IN 46011

Dear Ms. Tharp:

Enclosed is the Services Agreement between Community Hospital Anderson and Indiana Blood Center.

Please sign and initial where indicated. Once completed, please return a copy to my attention, either via mail or email (tjester@indianablood.org).

If you have any questions or concerns, please feel free to contact me.

Thank you!

Sincerely,

Tonya Jester, CAP
Executive Assistant, Administration
O: 317.916.5020 | F: 317.916.5005
tjester@indianablood.org



SERVICES AGREEMENT

PROVIDED BY:

Indiana Blood Center
3450 N. Meridian Street
Indianapolis, IN 46208

PROVIDED TO:

Community Hospital Anderson
1515 North Madison Avenue
Anderson, IN 46011

This SERVICES AGREEMENT for blood services, blood product services, and/or related testing services is entered into this 1st day of July, 2013 ("Effective Date") by and between INDIANA BLOOD CENTER (hereinafter "Blood Center") and COMMUNITY HOSPITAL ANDERSON (hereinafter "Client").

In consideration of the mutual covenants and agreements contained in this Agreement, the parties agree as follows:

I. APPENDICES, EXHIBITS AND RESOURCE MANUAL

- A. All Appendices and Exhibits and Addenda attached hereto are hereby incorporated into this agreement.
- B. The Customer Resource Manual for Laboratory Testing Services ("Customer Resource Manual"), which may be amended by the Blood center from time to time, referred to in this agreement, is hereby incorporated into this agreement.

II. SERVICES

- A. The Blood Center agrees to provide to the Client one or more of the services set forth in Appendices and the Client agrees to pay to the Blood Center the service fees provided for therein as selected below.
 - Blood Services and Blood Products Services and service as described and selected on Appendix A and Exhibits thereto
 - Testing Services and Testing Service Fees as described and selected on Appendix B and Exhibits thereto.
 - Appendix X Committed Volume
 - Addendum A to Services Agreement
- B. The Blood Center agrees to provide to the Client consultative services for all tests performed for the Client upon the request of a Client pathologist, or a staff member of the referring physician.
- C. Use of Third Party Laboratories
 - 1. The Blood Center may, in its reasonable discretion, use the services of other

qualified and licensed blood and blood products testing laboratories (individually referred to as "Third Party Laboratory" and collectively referred to as "Third Party Laboratories") to perform any or all of the blood testing services contemplated by this Agreement and as more specifically identified in the Customer Resource Manual.

2. The Blood Center shall maintain or cause its Third Party Laboratories to maintain, as applicable, current and valid government licenses, permits and approvals as required to perform the blood testing services identified in Section III(A).
3. The Blood Center shall ensure that, prior to performing any work, the Third Party Laboratory agrees in writing to be bound by all the terms and conditions of this Agreement to the same extent as if such Third Party Laboratory were the Blood Center. The Client shall be a third party beneficiary of any such agreement.

D. Billing and Payment:

1. The Blood Center shall give the Client thirty (30) calendar days written notice prior to effecting any change in the price/rate schedules for blood products, blood products services, and testing products and services.
2. The Blood Center shall invoice the Client at least monthly for all services rendered under this Agreement. All laboratory invoices shall identify the laboratory services rendered by patient name and/or identification code, and testing date.
3. The Client shall make the payment within thirty (30) calendar days of the invoice date.
4. The Client shall remit payments to:

**Indiana Blood Center
3848 Solutions Center
Chicago, IL 60677-3008**

This address should be used for all First Class Mail routed through the US Postal System. No courier mail should be sent to this address.

5. The Blood Center may assess the Client a late payment charge on any amount which remains unpaid after it is due, computed at the rate of one and one-half percent (1-1/2%) per month on the balance which remains unpaid or at the maximum rate permitted by law, whichever is less; provided, however, the Client shall not be assessed the late payment charge on amounts disputed in good faith if the Client provides the Blood Center with a detailed written description of any disputed amounts within ten (10) calendar days of the date of the invoice and pays undisputed amounts in a timely manner.

6. The Client shall reimburse the Blood Center its reasonable costs of collection, including attorney fees, in the event the Client defaults in the payment of any amounts due under this Agreement.
7. The Blood Center may assess additional service fees for additional testing of blood products required by standard of care, standard industry practice, and the FDA. All new FDA mandated tests will be invoiced to the Client with thirty (30) days notice.

III. COVENANTS

A. The Blood Center shall:

1. Fully comply with the terms and conditions of this Agreement.
 2. Fully comply with all provisions of law applicable to the Blood Center;
 3. Provide standard requisition and report forms, upon request, to the Client;
 4. Pay the surcharge required under Indiana's Medical Malpractice Act of 1975, as amended, to the Department of Insurance and remain qualified as a Health Care Provider under said Act;
 5. Keep in force at all times, during the performance of this Agreement, a policy or policies of insurance in an amount not less than that required of it as a qualified Health Care Provider by Indiana's Medical Malpractice Act of 1975, as amended;
 6. Maintain professional liability insurance in the minimum amount of Five Million Dollars (\$5,000,000.00), in any combination of primary and excess amounts, for each occurrence;
 7. Upon request, provide the Client with a certificate of insurance evidencing that the coverage described in sub-sections 4 and 5 has been obtained;
 8. At all times, be licensed by the Food and Drug Administration (FDA), the State of Indiana, and applicable state health care agencies;
 9. At all times, be accredited by the AABB (American Association of Blood Banks) and the American Society for Histocompatibility and Immunogenetics (ASHI);
 10. Perform all services provided hereunder in conformity with the Customer Resource Manual, standard of care, and standard industry practices as set forth by the FDA, AABB, ASHI, and the Clinical Laboratory Improvement Amendments (CLIA); and
 11. Upon request, make available to the Client during an on-site audit, quality control information and proficiency testing or manufacturing processes or practices
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results pertaining to any testing done by the Blood Center.

B. The Client shall:

1. Fully comply with the terms and conditions of this Agreement.
2. Fully comply with all applicable provisions of law relating to the licensing and regulation of like health care organizations, blood services and laboratories;
3. Upon request, provide the Blood Center with a certificate of insurance evidencing a policy or policies of insurance, in an amount not less than that required of it under applicable law; and
4. Fully comply with all provisions of law applicable to the Client.

IV. TERM

- A. Except as otherwise provided in this Agreement, the initial term of this Agreement shall be for a period of three (3) years commencing on the Effective Date. Pricing will remain firm for the first one (1) year of this Agreement. The pricing for the subsequent years may be increased by a maximum of 3% each year. The Blood Center will notify the client thirty (30) days prior of any price increase(s) for any product, panel or individual test(s) listed in Exhibit A-1 and Appendix X.
- B. Except as otherwise provided in this Agreement, either party may terminate this agreement by providing one-hundred eighty (180) calendar days written notice to the other party.
- C. Either party may terminate this agreement upon an event of default by the other party by giving ten (10) calendar days written notice to the defaulting party, and provided such event of default is not cured within the ten (10) calendar day notice period.
- D. Either party may terminate this Agreement, effective immediately upon giving written notice, if the other party is the subject of a criminal investigation by the FDA or any other governmental or regulatory agency.

V. EVENTS OF DEFAULT

- A. If any one or more of the following events shall occur and be continuing, it is here defined as and declared to constitute an "event of default" or "default" under this agreement:
 1. failure of the Client to make any payments when due;
 2. failure to perform any Covenant in this agreement;
 3. material breach of any covenant, representation or warranty provided by the
-

defaulting party under this agreement;

4. either party files a petition in bankruptcy, is adjudicated bankrupt or takes advantage of the insolvency laws of any jurisdiction, makes an assignment for the benefit of its creditors, is voluntarily or involuntarily dissolved or has a receiver, trustee or other court officer appointed with respect to its property; or
5. either party is the subject of a criminal investigation by the FDA or any other governmental or regulatory agency.

VI. MISCELLANEOUS PROVISIONS

- A. Limitation of Liability. The Client acknowledges that the results of immunological and serological tests, even when properly performed by the Blood Center or its Third Party Laboratories, cannot be guaranteed or warranted by the Blood Center because of the occurrences of false positives or false negatives. The Blood Center does not, therefore, guarantee or warrant such tests.
- B. Independent Contractor. It is understood by the parties that each party is an independent contractor with respect to the other party, and that each party and its employees are not an employee, agent, partner of, or joint venturer of the other party. This Agreement is not intended to constitute an agreement of hiring under the provisions of any Workers Compensation or unemployment compensation law, any local, state or federal employment law or any similar law, and it shall not be so construed. Each party agrees to accept full and exclusive liability for the payment of contributions or taxes including, without limitation, unemployment compensation contributions and local, state and federal withholding taxes, imposed under such laws by the federal and state government which are measured by remuneration which paid to such party's employees.
- C. Force Majeure. The Blood Center shall use its best efforts to provide the blood services, blood product services, and blood testing services requested by Client, but the Blood Center shall not be liable for non-performance or delays or damages arising from such if caused by events beyond the Blood Center's control including, but not limited to, a shortage of supply of raw materials, manufacturing, delivery, acts of regulatory agencies, discontinuance of necessary products or unavailability of a service, war, riot, acts of God, or acts of public enemies.
- D. Non-Discrimination. The Blood Center and the Client both agree not to discriminate in any way on the basis of race, color, sex, religion, national origin, or disability and that each of them otherwise uphold the laws of their state.
- E. Omnibus Reconciliation Act of 1980 (P.L. 96-499) codified at 42 U.S.C. § 1395x(v)(I). In the event compensation payable hereunder shall exceed Ten Thousand Dollars (\$10,000.00) per annum, the Blood Center hereby agrees to make available to the Secretary of Health and Human Services (HHS), the Comptroller General of the US General Accounting Office (GAO), or their authorized

representatives, all contracts, books, documents, and records relating to the nature and extent of the costs hereunder for a period of four (4) years after the furnishing of services hereunder. In addition, the Blood Center hereby agrees, if services are to be provided by subcontract with a related organization, to require by contract that such subcontractor make available to the HHS and GAO, or their authorized representatives, all contracts, books, documents, and records relating to the nature and extent of the costs thereunder for a period of four (4) years after the furnishing of services thereunder.

- F. Health Insurance Portability and Accountability Act (HIPAA) Compliance. Blood Center agrees that any products or services provided under this Agreement will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to the Blood Center with respect to the services to Client under this Agreement, including but not limited to regulations promulgated under Title II Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-91) ("HIPAA"). Furthermore, Blood Center and Client shall promptly amend the Agreement to conform with any new or revised legislation, rules and regulations to which Blood Center is subject now or in the future including, without limitation, the Standards for Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Laws") in order to ensure that Blood Center is, at all times, in conformance with all Laws with respect to Client. If within 90 calendar days of either party first providing notice to the other party of the need to amend the Agreement to comply with Laws, the parties, acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate this Agreement upon 30 calendar days prior written notice to the other party. Blood Center shall mandate Blood Center's subcontractor, if any, comply with the requirements of this section.
- G. Legislative Limitations. In the event federal, state or local laws, rules or regulations at any time during the term of this Agreement prohibit, restrict, or in any way substantially change the method of reimbursement for services under this Agreement, then this Agreement shall, in good faith, be amended by the parties to provide for payment or compensation in a manner consistent with any such prohibition, restriction, or limitation. However, such legislative limitations shall not affect the standard price/rate schedule for services under this Agreement. If this Agreement is not amended prior to the effective date of such rule, regulation or interpretation, this Agreement shall terminate as of such effective date.
- H. Confidentiality. Neither party shall knowingly disclose any information developed or generated pursuant to performance under this Agreement without the other party's prior written consent, including the terms of the Agreement itself, except when compelled to do so by law. Further, the Blood Center shall not knowingly communicate directly with any Client customer or consignee. This confidentiality and non-disclosure provision shall survive termination of this Agreement.

- I. Severability. If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.
- J. Waiver. None of the terms of this Agreement shall be deemed to be waived by either party, unless such waiver be in writing and duly executed on behalf of the party to be charged with such waiver by its authorized officer and unless such waiver recites specifically that it is a waiver of the terms of this Agreement. The failure of either party to insist strictly on any of the terms or provisions of this Agreement shall not be deemed a waiver of any subsequent breach or default of its terms or provisions.
- K. Applicable Law. This Agreement shall be governed by and interpreted and enforced in accordance with the internal laws of the State of Indiana. The parties hereby irrevocably and unconditionally consent to the exclusive jurisdiction of the courts of the State of Indiana and of the United States of America located in Marion County, Indiana (the "Indiana Courts") for any litigation arising out of or relating to this Agreement (and agree not to commence any litigation relating to this Agreement except in such Indiana Courts) and waive any objection to venue of any such litigation in the Indiana Courts.
- L. Assignment. Except as otherwise provided herein, any assignments of this Agreement or the rights or obligations hereunder shall be invalid without the specific written consent of the other party.
- M. Notice. Any notice required or permitted by this Agreement shall be in writing and shall be deemed delivered three (3) days after it is deposited in the United States Mail, postage prepaid, certified or registered mail, return receipt requested, addressed to the party to whom it is to be given as follows:
- BLOOD CENTER:** Indiana Blood Center
Byron B Buhner, President and CEO
3450 North Meridian Street
Indianapolis, IN 46208
- cc: Mike Parejko, Executive VP/COO
- CLIENT:** Community Hospital Anderson
Beth Tharp, RN, MBA, President and CEO
1515 North Madison Avenue
Anderson, IN 46011
- N. Entire Agreement. This agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings whether written or otherwise between the parties relating to the subject matter hereof. There exists no

other understandings, terms or conditions, written or oral, related to the rights and obligations established by this Agreement, and neither Party has relied on any representation, express or implied, not contained herein.

- O. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.
- P. Amendments. This Agreement may only be modified or amended if the amendment or modification is made in writing and is signed by both parties.

[SIGNATURE PAGE TO FOLLOW]

Services Agreement 2013
Community Hospital Anderson

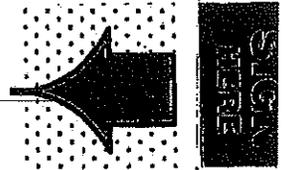
IN WITNESS WHEREOF, the Client and the Blood Center have duly executed this Agreement on the date first written above.

"Blood Center"
Indiana Blood Center

By: Byron B. Buhner
Byron B. Buhner, President and CEO
6-27-13
Date

"Client"
Community Hospital Anderson

By: Beth Tharp
Beth Tharp, RN, MBA, President and CEO
7/2/13
Date



160

APPENDIX A
BLOOD AND BLOOD PRODUCT SERVICES
Community Hospital Anderson

I. AGREEMENT

- A. Except as otherwise provided in this Agreement, the Blood Center shall provide to the Client one or more of the blood and blood product services as described on Exhibit A-1 and the Client shall pay the Blood Center the service fees set forth in Exhibit A-1.
- B. Transportation:
1. Unless otherwise agreed, the Blood Center shall provide to the Client routine delivery service for blood and blood product services.
 2. The Blood Center shall provide to the Client emergency delivery service for the emergency delivery service fee set forth in Appendix X.
 3. The Blood Center shall provide and retain ownership of transportation containers and equipment for use in providing the routine delivery service for blood and blood product services.

II. RECALLS/MARKET WITHDRAWALS

- A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Consignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

**Indiana Blood Center
EXHIBIT A-1
BLOOD PRODUCTS/SERVICES
Community Hospital Anderson**

<u>DESCRIPTION</u>	<u>SUGGESTED P-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
LRBC/RBC	P9016	1100, 1105, 2205	275.00
LRBC/RBC - Autologous (Administrative fee is additional)		1100, 1105, 2205	275.00
LRBC/RBC - Irradiated	P9040	1103, 1108	350.00
LRBC/RBC - Deglycerolized	P9054	1400, 1405, 2405	350.00
LRBC/RBC - Frozen	P9057	1300, 1310, 2310	350.00
LRBC/RBC - Washed	P9054	1200, 1201, 2210	350.00
Whole Blood	P9010	1000	400.00
Cryoprecipitate	P9012	3000	75.00
Cryoprecipitate - Pooled	P9012 X 5	3010	450.00
Apheresis Platelets, Leuko Reduced, Bacterial Detected	P9035	2100	650.00
Apheresis Platelets-Irradiated, Leuko reduced, Bacterial Detected	P9037	2103	705.00
- HLA Typed Surcharge		9105	150.00
AFFP (400 ml)	P9017 X 2	2001	131.00
AFFP Pediatric pack (per individual pack)		2003	32.00
Frozen Plasma < 24 hours (250 ml)	P9017	2000, 3050, 3070	54.00
Frozen Plasma - Cryo Poor	P9044	3055	70.00
CMV Neg charge	86644	5061	18.00
Irradiation fee for one to five platelet concentrates	B9006	9106	55.00
Neonatal Pack Surcharge			
- Neo 3		9120	30.00
- Neo 4		9121	35.00
- Neo 6		N/A	40.00
- Neo 8		9123	50.00
Imported Product Surcharge Fees:			
- Import fee (one fee per imported unit, per patient)		9159, 9160, 9170	150.00
- Excess fees above the Blood Center charges will be passed onto the hospital			*

Legend: LRBC - Leukoreduced Red Blood Cell
RBC - Red Blood Cell

AFFP - Apheresis Fresh Frozen Plasma
FFP - Fresh Frozen Plasma

<u>DESCRIPTION</u>	<u>SUGGESTED P-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
Source Leukocyte	85009	3106	40.00
Segments for Crossmatching (each group of 20)		9442	20.00
Packing Whole Blood (up to 4 units)		9168	30.00
Washing Platelet (per unit) (additional fee for one FFB used in processing)	B9064	9165	75.00
One Liter Wash (per unit)	B9064	N/A	75.00
Glycerolizing & Freezing	B4001	9158	75.00
Deglycerolizing	B4001	9163	85.00
Apheresis Special Draws		N/A	*
Donor / Patient Services			
Autologous Donation Fee (per unit)	86890	9102	300.00
Autologous Apheresis Donation Fee (per donation)	86890	9102	300.00
Directed Donation Fee (per unit)		9103	300.00
Additional Handling Fees - after hours, without appointment (per unit)		N/A	200.00
Annual Storage Fee for Autologous Frozen Cells		N/A	150.00
Off-site Draw Fee (per unit)		N/A	*
After Hours Charge - Apheresis		9150	350.00
Blood Derivatives			
Rho Gam (per package)	J27790		**
V-Zig Immune Globulin (comes in volume 125 & 625)			**
Factor 8	J7190, J7191, J7192		**
Non-Blood Products			
Platelet Leukocyte Removal Filters			
- PLX8C	PLX8C		***
- PLX12C	PLX12C		***
Red Cell Leukocyte Removal Filters			
- RCXL1C	RCXL1C		***

Regular hours are Monday – Friday, 5:30a.m.–6:30p.m.; Saturday, 6:30a.m –12:00noon (excluding holidays)
Services outside of these hours may incur additional charges

* Price based on order

** Fees are subject to change

*** Price based on the manufacturer's charge

TESTING – Outpatient

Confidential

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
Complete Donor Profile and NAT HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH, HIV 1/ HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5502	89.00
Complete Donor Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5503	68.50
BMR Panel HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592	5151	67.50
Infectious Disease Profile Only HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, HIV 1/HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592	5120	74.25
Tissue Bank Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86644	5091	64.00
Fertility Donor Profile HBSAG, HCV, HIV 1/2, HBC, (STS) Syphilis	87340, 86704, 86703, 86803, 86592	5552	58.25
ABO Group & Rh Type (donor)	86900, 86901	5030	10.50
ABO Group & Rh Type (cord)	86900, 86901	5031	12.60
Antibody Screen	86850	5200	10.50
Antibody to CMV	N/A	5060	5.50
Antibody to HB Core (EIA)	86704	5040	17.00
Antibody to HCV (EIA)	86803	5105	18.00
Antibody to HIV 1/2 (EIA)	86703	5110	17.00
Antibody to HTLV-I/II (EIA)	86687, 86688	5082	17.00
Cholesterol	82465	5220	5.50
HCV/HIV1 NAT (pool)	donor only	5007	19.25
HCV/HIV1 NAT (individual)	donor only	5011	31.00
WNV NAT (pool)	donor only	5008	11.00
WNV NAT (individual)	donor only	5012	19.25
Hepatitis B Surface Antigen (EIA)	87340	5010	17.00
Syphilis (STS)	86592	5086	5.25
Antibody to HBs (EIA)	86706	5020	15.75

<u>DESCRIPTION</u>	<u>SUGGESTED CPT-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
Syphilis Confirmatory	86781	5090	48.75
RPR Titer		5088	11.00
RPR Titer w/FTA if ind		5089	44.00
HBsAg Confirmatory Neutralization	86382	5005	157.50
HCV Immunoblot Assay	86804	5095	152.25
HIV1 Western Blot and HIV2 Antibody Confirmation	86689	5125/5127	126.00
HIV2 Western Blot	86689	5124	156.50
HTLV Antibody by WB	86689	5096	111.50
HTLV I/II Antibody w/WB if ind	86687	5129	21.25
HIV-1 Whole Viral Lysate	Donor only	5126	124.50
CMV IgG/IgM	86644/86645	5161	54.50
GC/Chlamydia	87490, 87491, 87590, 87591	5128	64.50
Chagas	87449	5021	20.00
Chagas RIPA	86753	5121	500.00
Leishmania IFA	86717	5101	131.25
Complete Blood Count			7.50

The laboratory can be reached at 317-916-5190, Monday-Saturday. If no answer, call 317-916-5279 to have the staff paged.

* Panel prices are for pooled pricing. Individual WNV NAT is an additional \$7.60

TESTING – Reference Lab

Confidential

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
ABO & Rh	86900, 86901	4000 RC	35.70
Allogeneic Adsorption	86971, 86978	4210	204.00
Antibody Identification	86870	4020 RC	97.00
Autoadsorption	86971, 86978	4220	153.00
Chloroquine/EGA Treatment of RBC's	86860	4270	142.75
Compatability Screening	86922	4070	40.75
Direct Antiglobulin Test	86880	4060	46.00
Donor Antigen Test, confirmed per antigen			
- CEceK	86903	4041 UPH	49.00
- AHG	86903	4042 UPH	72.50
- Direct	86903	4043 UPH	79.50
- Rare Low Frequency	86903	4044 UPH	79.50
- Rare High Frequency	86903	4045 UPH	118.25
Saline Replacement	86977	4320	20.50
DTT Treatment of RBC's	86970	4271	71.50
Eluate	86860	4290	132.50
Enzyme Treatment of Panel	86971	4250	66.25
Hemoglobin Screening	85660	4082 UPH	46.00
Microhematocrit/Hypotonic Cell Separation	86972	4280	86.75
Neutralization (HPC/Plasma/ Lewis/ P)	86977	4260	102.00
Patient Antigen Test			
- Rh Phenotype	86906	4031 RC	128.50
- CEceK (individual antigen)	86905	4032 RC	49.00
- AHG	86905	4033 RC	72.50
- Direct	86905	4034 RC	79.50
- Rare Low Frequency	86905	4035 RC	79.50
- Rare High Frequency	86905	4036 RC	118.25
Pre-warm	86940	4230	51.00
Titration	86886	4240	66.25
Triple Adsorbing Cells	86971	4084	61.25
RBC Molecular typing (patient)	83891, 83900, 83901x22, 83892x2, 83912, 83914x22	4115 P	510.00
RBC Molecular typing (donor)		4115 U	153.00
ARDP Fee (per unit)	86999	4105	204.00
Export Fee for Rare units (per unit)	86999	9171	127.50
Import Fee for Rare units (per unit)	86999	9170	127.50
Coordination/Consultation Fee	86999	4120	81.50
STAT Fee, For immediate provision of services Mon -Thur evenings and overnight and Fri evening	86999	4130	255.00
STAT Fee, For immediate provision of services during holidays, Fri overnight, Sat and Sun	86999	4130 N	510.00

The Blood Center Reference Laboratory is available on-site or on-call 24/7 by calling 317-916-5188.

TESTING – HLA-DNA Lab

Confidential

<u>DESCRIPTION</u>	<u>SUGGESTED CPT CODES</u>	<u>PRICE (\$)</u>
ROUTINE ITEMIZED TESTING		
1. HLA Typing (ABC)	83891, 83896x224, 83898x3, 83912	400.00
2. HLA Typing (ABCDRDQ)	83891, 83896x224, 83898x3, 83912	500.00
3. ABO	86900	15.00
4. Autocrossmatch T-Cell Flow	86805 X 6	212.50
5. Autocrossmatch B-Cell Flow	86805 X 6	212.50
6. Crossmatch (Donor T-Cell) Flow	86805X6	212.50
7. Crossmatch (Donor B-Cell) Flow	86805 X 6	212.50
8. Flow Antibody Screen Class I PRA	88184, 88185, 88187	158.00
9. Flow Antibody Screen Class II PRA	88184, 88185, 88187	158.00
10. Antibody Identification Class I	88184, 88185, 88187	350.00
11. Antibody Identification Class II	88184, 88185, 88187	325.00
12. Donor Specific Antibody DSA Class I	88184, 88185, 88187	350.00
13. Donor Specific Antibody DSA Class II	88184, 88185, 88187	325.00
14. SPRCA Crossmatch (HLA or Single Donor) Platelet	86806	165.00
15. Platelet Antibody Screen	86022	200.00
ROUTINE PANELS for Ease of Ordering (See itemized listing for tests included in panel)	TEST NUMBER (Routine itemized Testing List)	
Platelet Support Services		
Hematology Profile		1, 3, 10, 15
HLA Class I PRA and Antibody Identification Class I (Flow)		8, 15
SPRCA Crossmatch (HLA or Single donor) Platelet		14
Cardiac/Renal Services		
Transplant Candidate Profile		2, 3, 4, 5, 8, 9, 10, 11
Cadaveric Transplant Donor		3
Living (renal)Transplant Donor Profile		2, 3
Cardiac/Renal Transplant Recipient (day of transplant)		6, 7, 8, 9, 10, 11
Bone Marrow Transplant		
Bone Marrow Transplant Profile		2, 3, 8, 9
Bone Marrow Donor		2
Neonatal Alloimmune Thrombocytopenia (NATP) Panel		10, 14, 15
TRALI Investigation	No Charge for the Blood Center Units	

<u>DESCRIPTION</u>	<u>SUGGESTED CPT CODES</u>	<u>PRICE (\$)</u>
Other Services		
Platelet Antigen Typing		
Full Platelet Antigen Typing (HPA-1,2,3,4,5,6,15)	83896 x 2,83912	360.00
PLA1	83896 x 2,83912	175.00
Disease Association Profile		
HLATyping (AB/DR/DQ) per antigen	83891,83896x224,8 3898x3,83912	200.00
Parathyroid Tissue Cryopreservation	60500	850.00
Parathyroid Freezing Solution Sterility Check	87070, 87102	150.00
Parathyroid Tissue Release/Transportation Charges		varies with shipping
Parentage Testing		
Trio (Domestic)		490.00
Trio (International)		550.00
Single Parent Testing (Domestic)		550.00
Single Parent Testing (International)		585.00
Siblingship Testing (each person tested)		300.00
Each additional client		200.00
Specimen Collection Fee (out of state)		37.00

Regular hours are Monday – Friday, 8:00a.m.–4:30p.m. (excluding holidays)
 Services outside of these hours will incur an additional STAT charge of \$250.00 per order

RECALLS/MARKET WITHDRAWALS

- A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Cosignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Blood Center:

Initial BLB Date 6-27-13

Client:

Initial BT Date 7/2/13



Exhibit A-1

168

EXHIBIT A-2
CONSIGNEE/RECIPIENT NOTIFICATION
OF RECALLS/MARKET WITHDRAWALS

The Blood Center shall notify the Client of recalls and market withdrawals of blood products as soon as possible after discovery of a reactive screening test or other reason for product unsuitability.

- I. The Blood Center shall notify the Client as soon as possible, and no later than 72 hours of test completion of any potentially infectious disease marker or other reason for product unsuitability for blood products the Client has received from the Blood Center. For products intended for transfusion, the scope of review will include all of the donor's units collected within the past five (5) years. For products intended for further manufacture into injectable products, the scope of review will include all of the donor's units collected within the past six (6) months.
- A. Current positive tests for HIV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
 - HIV ABY repeat reactive lookback extends back 5 years or 1 year prior to the last negative test of record, whichever time is shorter.
 - HIV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
 - Available components are to be returned to IBC for credit.
 - Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
 - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).
- B. Current positive tests for HCV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
 - HCV ABY repeat reactive lookback extends back 10 years or 1 year prior to the last negative test of record, whichever time is shorter.
 - HCV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
 - Available components are to be returned to IBC for credit.
 - Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
 - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

C. Other lookbacks, recalls, or reasons for Post Donation Information:

- Notifications and recalls will be made similarly as above and in accordance with applicable guidance; however, for recalled products that are no longer potentially available (post-expiration date), written notification using IBC forms (e.g. Post Donation Information Consignee Notification form, Recipient Data Sheet, etc.) will be sent to the transfusion service. If requested, such forms should be returned as soon as possible, and within 15 days to allow for meeting FDA BPDR reporting timeframes.

II. The Client shall have a clearly defined and written policy that ensures recall notifications from IBC are appropriately received and managed per applicable guidance, and that recalled products are not inadvertently distributed for transfusion. The policy shall include identification of the person responsible for performing this activity, how the units are identified as "in quarantine", and how the units are physically separated from the regular blood inventory. The Client shall, upon request, provide the Blood Center with a copy of the written policy.

References:

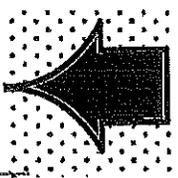
- 21 CFR §§ 610.46-610.48
- *Guidance for Industry: Nucleic Acid Testing (NAT) for Human Immunodeficiency Virus Type 1 (HIV-1) and Hepatitis C Virus (HCV): Testing Product Disposition, and Donor Deferral and Reentry.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, May 2010.
- *Guidance for Industry: "Lookback" for Hepatitis C Virus (HCV): Product Quarantine, Consignee Notification, Further Testing, Product Disposition, and Notification of Transfusion Recipients Based on Donor Test Results Indicating Infection with HCV.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, December 2010.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial BT Date 7/2/13



**APPENDIX B
TESTING SERVICES**

I. AGREEMENT

- A. The Blood Center shall provide to the Client one or more of the Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services set forth in Exhibit A, attached hereto and incorporated herein, upon submission of the appropriate testing request form by the Client and the Client shall pay the Blood Center the service fees set forth in Exhibit A,

II. TESTING PROTOCOL

A. Testing Request Process

1. The Client shall comply with the applicable testing request processes described in the Customer Resource Manual when the Client requests Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services.

B. Sample Requirements

1. The Client shall collect, label, store, pack, transport and ship all blood samples in accordance with applicable federal, state and local laws and in accordance with the Customer Resource Manual.
2. The Blood Center shall provide packing materials to the Client upon request.

C. Sample Transport

1. The Client shall transport all blood samples in accordance with the Customer Resource Manual.
2. The Client shall pack samples in accordance with federal, state or local regulations and shipping container manufacturers' specifications and requirements for clinical/diagnostic specimens.
3. The Client shall transport samples at refrigerated temperature to the testing laboratory located at Central Indiana Regional Blood Center, Inc., d/b/a Indiana Blood Center, 3450 North Meridian Street, Indianapolis, Indiana 46208.
4. The Client shall pay for all costs for transporting and shipping to the Blood Center or Third Party Laboratories and reimburse the Blood Center for any freight costs incurred by the Blood Center.

D. Sample Integrity

1. The parties agree that that the integrity of the specimen received by the Blood Center dictates the integrity of the results obtained. The parties agree that the Client must properly collect, store, identify, pack, and ship samples to ensure accurate and efficient processing of the samples.

2. The parties agree that the Blood Center shall not be responsible for any delay in processing under the following circumstances:
 - a) The sample and supporting documentation accompanying the shipment is incomplete or in a condition not reasonably satisfactory to the Blood Center (or its Third Party Laboratory) in accordance with the guidelines specified in the Customer Resource Manual;
 - b) The sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
 - c) The specimen contains incorrect information for sample shipment reconciliation;
 - d) Any aspect of sample identification is incorrect or illegible;
 - e) The specimen is not the appropriate quantity, type, or age; or
 - f) The Blood Center determines, in its sole judgment, that the specimen has not been properly stored.

E. Sample Receipt and Turn-Around Time

1. Upon receipt of a sample from the Client, the Blood Center shall:
 - a) Notify the Client of any damaged samples or any inadequate documentation relating thereto promptly after the arrival of a shipment at the Blood Center or its Third Party Laboratory; and
 - b) Handle the samples with all due care for as long as the samples are within the Blood Center's control.
2. Upon receipt of a sample from the Client, the Blood Center may, in its sole discretion:
 - a) Refuse to perform services hereunder in any instance in which the Blood Center deems that the samples or related documentation are not in reasonably satisfactory condition; or
 - b) Refuse to perform services hereunder in any instance in which the Blood Center deems that the sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
3. The Blood Center shall complete testing, review and reconciliation of records and transmit test results to the Client in accordance with the testing schedules set forth in the Customer Resource Manual for Testing Laboratory Services, Immunohematology Reference Laboratory Services, and Histocompatibility Laboratory Services.
4. The Blood Center shall immediately convey results from any specimen that registers a critical value to the appropriate Client personnel by telephone, facsimile or other electronic means.
5. The Blood Center shall provide the Client with the following technical information for all tests:
 - a) Normal values;
 - b) Technical method of analysis; and
 - c) Specimen requirements, including special handling instructions.
6. The Blood Center shall notify the Client a minimum of 30 days in advance of significant changes in the test protocols, reagents sample volumes or sample types set forth in the Customer Resource Manual.
7. The Blood Center shall not provide STAT testing unless the parties agree in writing upon the terms, conditions, and fees for STAT testing.

F. Test Performance and Procedures:

1. The Blood Center shall perform and cause its Third Party Laboratories to perform the blood testing services and interpret blood test results in accordance with applicable laws, regulations, manufacturer's package insert instructions (except where otherwise approved by the United States Food and Drug Administration (FDA), and use testing procedures at least as stringent as those recommended by the American Association of Blood Banks (collectively the Regulations).
2. The Blood Center shall perform blood testing services with licensed screening and confirmatory tests or, in the absence of licensed confirmatory tests, by a confirmatory test recognized as appropriate by standard of care and standard industry practices.
3. The Blood Center shall use FDA licensed reagents whenever available.
4. The Blood Center shall provide to the Client copies of the package inserts of each of the assays that the Blood Center and any Third Party Laboratories will perform.
5. The Blood Center shall implement any new immunohematology and viral marker tests approved for use in blood banking/screening by the FDA or applicable standards upon written agreement by the parties of the service fees for such new immunohematology and viral marker tests.
6. The Blood Center and the Client shall comply with applicable state reporting requirements with regard to infectious disease markers.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial ST Date 7/2/13



**APPENDIX X
SERVICES AGREEMENT – COMMITTED VOLUMES
COMMUNITY HOSPITAL ANDERSON**

I. PURCHASE COMMITMENT

A. Client and the Blood Center shall agree upon Annual Unit Quantity or percent of amount to be purchased under this agreement, which shall be as follows:

<u>Product Unit</u>	<u>Price per Unit (\$)</u>	<u>Annual Unit Quantity or % of Annual Purchased Amount</u>
LRC	215.00	2,029
APLT	500.00	98
FP24	50.00	236
CRYO	43.00	0
POOLED CRYO	300.00	0

B. Pricing for the Committed Volume shall be determined on an annual basis, provided, however, the Blood Center may adjust the price if, in any 3-month calendar quarter (i.e., January-March, April-June, etc.), the quarterly purchases by Client are not within five percent (5%) of the quarterly volume as set forth below for the quarter just completed, in which case, pricing shall default to Blood Center list pricing set forth on Exhibit A-1.

	<u>Jul-Sep</u>	<u>Oct-Dec</u>	<u>Jan-Mar</u>	<u>Apr-Jun</u>	<u>Total</u>
LRC	514	509	497	509	2,029
APLT	25	25	24	24	98
FP24	60	59	58	59	236
CRYO	0	0	0	0	0
POOLED CRYO	0	0	0	0	0

II. DELIVERY AND TRANSPORTATION

A. Delivery. The Blood Center shall provide delivery services as requested which will be made the most cost-effective way, one way or round trip, depending on the customer need and ability to schedule the delivery for a fee of:

One-way fee	\$62.00
Round-trip fee	\$84.00

B. Emergency Delivery. Emergency delivery fee will be added to the delivery for those orders which require immediate delivery at the then-current emergency rates charged by third-party delivery services plus a reasonable administrative fee.

C. Transfers. Products transferred from the Client will be credited to Client's account at the service fee in effect at the time the product was shipped to the Client. Products transferred to the Client will be invoiced at the Client's current service fee in effect.

III. RETURNS

Red Cells received with 10 days or more remaining before expiration will be given full credit for the Leukoreduced Red Cell product, excluding any additional special services provided for that unit, in the amount of the service fee in effect at the time the product was shipped to the Client. Apheresis Platelets received with 24 hours or more remaining before expiration and resold, will be given full credit in the amount of the service fee paid in effect at the time the products were shipped to the Client in the month following the calendar quarter end. Special order Apheresis Platelets including Irradiated, HLA matched and cross-matched are not eligible for credit.

IV. STANDING ORDERS

Client may establish a written standing order for blood and blood product services. Standing orders submitted to the Blood Center by any client will be filled ahead of additional orders submitted by the Client. Changes in Client's standing order require seven (7) days written notification, provided, however, such changes may only be made one time per calendar month. Client is to submit a standing order to Blood Center within seven (7) days of contract execution.

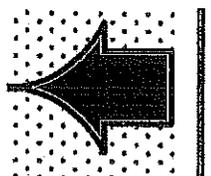
To assist both client and Blood Center with utilization review, installation of the AIM software is to be included as part of this process.

Blood Center:

Initial BBB Date 10-27-13

Client:

Initial RST Date 7/2/13



Appendix X

175

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 16

24 hour Laboratory Services

"16. **Laboratory services.** There must be laboratory services available 24 hours per day."

NARRATIVE RESPONSE AND DISCUSSION

Our Laboratory Administrative Director has provided a letter affirming compliance with all ACS lab requirements twenty-four hours per day. The Community Hospital Anderson (CHA) laboratory performs all standard analyses for blood, urine, and other bodily fluids including micro sampling when appropriate. Additional services include coagulation studies, blood gasses and microbiology. The CHA Lab recently achieved continued accreditation by completing its biennial College of American Pathologist (CAP) inspection.



**Community
Hospital Anderson**

Community Hospital Anderson
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T 765.298.4242
eCommunity.com

February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT:Community Hospital - Anderson's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Laboratory Administrative Director. I am pleased to support Community Hospital – Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that laboratory services are available twenty-four hours per day at Community Hospital – Anderson. This includes the standard analyses for blood, urine and other bodily fluids, including micro sampling when appropriate. Our lab services also include coagulation studies, blood gasses and microbiology.

Respectfully,

Dan H. Yates
Lab Administrative Director

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 17

Post-anesthesia Care Unit (PACU)

"17. Post-anesthesia care unit. The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment 24 hours per day. Documentation for this requirement must include a list of available equipment in the PACU."

RESPONSE

The requirements of section 17 are met with the following;

1. Letter from David Tharp M.D. affirming compliance with requirements
2. Perioperative Clinical Manager commitment letter
3. Twenty-four hour call policy
4. Staffing policy
5. PACU Quality Management Plan
6. PACU general policy
7. Perioperative services general policy
8. Staff qualifications list
9. PACU equipment list



Community Hospital Anderson

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February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "In the ACS Verification Process"
for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as Anesthesiology Section Representative. I am pleased to support Community Hospital - Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I confirm that qualified Nurses and all necessary equipment are available twenty-four hours per day in the Community Hospital - Anderson Post Anesthesia Care Unit.

Respectfully,

David Tharp, M.D.
Anesthesia Section Rep.

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director



Community Hospital Anderson

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February 12, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital - Anderson's Application for "In the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Clinical Manager of the Post Anesthesia Care Unit. I am pleased to support Community Hospital -- Anderson's effort to complete the "in the process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that qualified Nurses and all necessary equipment are available twenty-four hours per day.

Respectfully,

Joy F. Knotts, R.N.
Clinical Manager – Perioperative Svcs

Dwight B. McCurdy, M.D., FACS
Trauma Medical Director

COMMUNITY HOSPITAL ANDERSON
NURSING DEPARTMENT POLICY MANUAL
SDS/PACU Policy manual

SUBJECT:	SAMEDAY SURGERY AND PACU ON CALL POLICY
Originator:	Clinical Manager Sameday Surgery/PACU
Approved By:	<i>Sue Noble MSN, RN</i> Director Surgical Services
Policy Coordinator:	Cheryl Arnold
Effective:	2/2014
Revised:	
Reviewed:	
New Policy	2/2014
References:	2012-14 ASPAN Perianesthesia Nursing Standards and Practice Recommendations, 2014 Standards, Recommended Practices & Guidelines AORN, Inc.

PURPOSE: To establish a mechanism to provide adequate staffing for hours outside of the scheduled operating hours.

POLICY STATEMENT: Only staff members who have successfully completed orientation and demonstrated competence will be assigned call independently.

ACTION STEPS:

1. One PACU trained RN will be on call from hours of 1800 to 0700. A second PACU RN is scheduled as a backup call person on Friday, Saturday, and Sunday should circumstances prevent an OR RN from being available to stay in PACU as the second RN. The PACU RN is responsible for calling in the back up person when needed.
2. Personnel on call must be available to arrive at the hospital within 20 minutes of the initial call. Staff members living outside the 20 minute radius may obtain a hospital room for overnight accommodations by calling the Nursing Administrative Representative.
3. Staff members on call are responsible notifying Clinical Support Specialist of their cell &/or home phone numbers.
4. The on call staff is notified of a case either by the OR Coordinator or Nursing Administrative Representative.
5. On call staff may park in the physicians' parking lot for rapid access to the hospital.
6. Electronic key cards are to be used for entry.
7. Additional staff may be assigned call as deemed necessary by surgical services management.
8. If the on-call person call's in, an attempt will be made to cover that person's call voluntarily. If no one volunteers, the clinical manager will assign someone to cover.

Community Hospital of Anderson & Madison County

NURSING DEPARTMENT POLICY MANUAL
Same Day Surgery - PACU

SUBJECT:	Staffing Guidelines		
Originator:	SDS/PACU Clinical Manager		
Approved By:	Director Surgical Services <i>Lisa Noble MSN, RN</i>	Effective	4/06
		Revised	10/08; 4/11; 2/2014
References:	ASPAN Perianesthesia Nursing Standards and Practice Recommendations 2010-2012, 2012-2014	Reviewed	

PURPOSE: An appropriate number of professional nursing staff with demonstrated competence is available to meet the individual needs of patients and families in each level of perianesthesia care based on patient acuity, census, and physical facility. Staffing patterns reflect an adequate number of professional nursing staff with appropriate competencies to provide safe, quality nursing care.

POLICY STATEMENTS:

1. Nursing care in perianesthesia settings is directed toward provision of direct patient care, supervision of care given by others, health teaching, and patient advocacy. The expertise of professional perianesthesia nurses is necessary to provide safe, quality care to patients in this environment.
 - a. Staff functions within written job performance descriptions and receive regularly scheduled performance appraisals.
 - b. Staffing is based on patient acuity, census, patient flow processes, and physical facility.
 - c. A competent perianesthesia professional nurse is with the patient receiving care at all times to provide direct care and/or supervision.
 - d. Preanesthesia assessment is performed by an RN competent in perianesthesia nursing.
 - e. Two registered nurses, one of whom is an RN competent in Phase I postanesthesia nursing, are in the same room/unit where the patient is receiving Phase I level of care. An RN must be in the Phase II PACU at all times while a patient is present.
 - f. Two competent personnel, one of whom is an RN competent in Phase II postanesthesia nursing are in the same room/unit where the patient receiving Phase II level of care.

- g. Phase III (Extended Care) requires two competent personnel, one of whom is an RN possessing competence appropriate to the patient population are in the same room/unit where patient is receiving extended care level of care. The need for additional RN's and support staff is dependent on patient acuity, complexity of patient care, census, and the physical facility.
- h. Staffing patterns will reflect ASPAN's Patient Classification/Recommended Staffing guidelines

2. Sameday Surgery Staffing ratios preoperatively/postoperatively are determined but not limited to the following criteria:

- a. Patient safety
- b. Number and acuity (patient characteristics and requirements of care) of the patients
- c. Complexity and intensity of care
 - Examples include: average time in patient preparation, medication reconciliation, intravenous access,
 - Preoperative testing, completion of paperwork/electronic charting, medication administration,
 - Moderate sedation and subsequent monitoring for invasive procedures (e.g., invasive lines, regional blocks), need for additional monitoring

3. PACU: Phase I

Focus is on providing postanesthesia in the immediate postanesthesia period and transitioning patients to Phase II level of care, inpatient setting, or intensive care. Staffing in all phases should reflect patient acuity and complexity of care and allow for appropriate assessment, planning, and implementation of care and evaluation for discharge.

a. New admissions should be assigned so that nurse can devote their attention to that admission until critical elements are met. Critical Elements can be defined as:

- Report has been received from anesthesia care provider and any questions answered
- the transfer of care has taken place
- patient has a stable/secure airway
- initial assessment is complete
- patient is hemodynamically stable
- patient is free from agitation, restlessness, and combative behaviors

CLASS 1:2 ONE NURSE TO TWO PATIENTS

- a. One unconscious patient, hemodynamically stable, with stable airway, over 8 years and one conscious patient, stable and free of complications
- b. Two conscious patients, stable and free of complications not yet meeting discharge criteria

c. Two conscious patients stable, 8 years of age and under not yet meeting discharge criteria with family or competent support staff present.

CLASS 1:1 ONE NURSE TO ONE PATIENT

- a. On admission until critical elements are met.
- b. Airway and/or hemodynamic instability

Examples of unstable airway include but are not limited to the following;

Airway requiring active interventions to maintain patency such as manual chin lift, use of an artificial airway or any signs/symptoms of airway obstruction such as gasping, choking, crowing, or wheezing.

Symptoms of respiratory distress including dyspnea, tachypnea, panic, agitation, cyanosis

- c. Any unconscious patient 8 years of age and under
- d. A second nurse must be available to assist as necessary

CLASS 2:1 TWO NURSES TO ONE PATIENT

- a. One critically ill, unstable patient

4. Phase II: Recovery Continues in Sameday

Focus is on preparing patient, family/significant other for care in the home or extended care.

- a. New admissions should be assigned so that nurse can devote their attention as needed to discharge planning and teaching
- b. staffing can be adjusted based on changing acuity and nursing requirements, and as discharge criteria are met

CLASS 1:3 ONE NURSE TO THREE PATIENTS

- a. Over 8 years of age
- b. 8 years of age and under with family present

CLASS 1:2 ONE NURSE TO TWO PATIENTS

- a. 8 yrs of age and under without family or support staff present
- b. Initial admission of post op patient

CLASS 1:1 ONE NURSE TO ONE PATIENT

- a. Unstable patient of any age requiring transfer to higher level of care.

EXTENDED LEVEL OF CARE

Focus is on providing ongoing care for patients requiring extended observation/intervention after transfer or discharge from Phase I and Phase II levels of care.

CLASS 1:3/5 ONE NURSE TO THREE TO FIVE PATIENTS

- a. patients waiting for transport home
- b. patients with no caregiver

- c. patients having had procedures and/or symptoms requiring extended observation/interventions
- d. patients being held for an inpatient bed.

BLENDING LEVELS OF CARE

Phase I, Phase II and/ or Extended Care levels of care may be provided within the same environment. This may require blending of patients and staffing pattern. Staffing needs are determined by the perianesthesia registered nurse using clinical judgment and critical thinking based on patient acuity, nursing observations, and required interventions. Staffing requirements should be determined to prioritize the safe, competent care for the immediate postanesthesia patient or the patient with the highest level of care needs in addition to the care of the blended patient population with patient safety being the highest priority.

**.COMMUNITY HOSPITAL
OF ANDERSON, INDIANA**

**QUALITY MANAGEMENT PLAN
SCOPE OF SERVICE
SAME DAY SURGERY/PACU/ ENDOSCOPY
SPECIAL PROCEDURES**

SCOPE OF SERVICE

The emphasis of care is on the inpatient, outpatient, adult and pediatric patients requiring therapeutic and diagnostic procedures within the surgical services department. The PACU/SDS department provides perioperative nursing care and activities. The Endoscopy Unit is a specialty unit whose purpose is to provide safe and effective care to patients undergoing gastrointestinal or pulmonary endoscopic procedures. The Special Procedure nursing provided by the Special Procedures Nurses is the pre and post procedure care required for the safe and effective patient outcome from invasive or other radiology procedures that require sedation for patient comfort and ease of procedure.

The PACU/SDS/ENDO environment includes; assessment, diagnosis, treatment, and evaluation of perceived, actual, or potential, physical or psychosocial problems that may result from the intrusion of anesthetic agents and techniques.

The PACU/SDS/ENDO area includes; preadmission assessment, preop admission, post anesthesia recovery, post op discharge to home, post op discharge to nursing unit, or extended care facility, pain management services, and nursing care for the invasive radiology patient that requires sedation. Second stage recovery is provided in the SDS area for any SDS/ENDO patient and at times post procedure radiology patients. The PACU/SDS area has hours of operation from 6A.M. until 10P.M. The PACU has call hours from 6 P.M. until 7A.M. The ENDO area has hours of operation from 7:30 A.M until 6 P.M. The ENDO call hours are from 3:30 P.M. until 7 A.M.

The SDS's primary goal is to care for the surgical services patient preoperatively and postoperatively. There are 19 patient care areas and all are equipped with oxygen, suction; drapes for patient privacy; TV's as a means to reduce anxiety, and a nurse call light system; one room has reverse airflow if needed for the isolation patient. Four of the patient rooms have private bathrooms, which have emergency call systems. There are three other patient accessible bathrooms with emergency call system. The nursing station is centrally located. The exits to the waiting area have fire alarm pull boxes, and outside of room number 15 there is a fire extinguisher. Oxygen and suction shut off valves are outside of room #4 beside the chart rack. There is a door that separates SDS from the Endoscopy area, which will allow utilization of rooms for either SDS or Endoscopy with an increase in patient census. SDS area is equipped with a Code Blue cart. The code blue

cart in SDS is also utilized for the Endoscopy area. The Code Blue carts in SDS and PACU are kept locked when not in use. Pharmacy is responsible for outdating drugs on all crash carts. The defibrillator is checked daily for voltage integrity and appropriate documentation is maintained.

The PACU's primary goal is to restore physiological stability, prevent complications and achieve optimal patient outcomes following general anesthesia, monitored anesthesia care, intravenous sedation, and regional anesthesia. There are eight recovery stations that are supplied with capabilities to monitor cardiac rhythm, blood pressure, temperature, and oxygen saturation. The recovery stations are equipped to accommodate the pain management service's patient with needed supplies and equipment to assist with regional anesthesia, pain procedures, and bone marrow biopsies. In emergent situations where the interventional radiology room is unavailable cardioversions may be done in PACU. The PACU has its own Code Blue cart and defibrillator. The Code Blue cart is kept locked except when in use and is checked monthly or after use for supply update. The defibrillator is checked each day for voltage integrity and appropriate documentation is maintained. There is a fire extinguisher inside the door to the PACU, and a shut off valve to the suction and oxygen outside of the door to the PACU.

The Endoscopy Unit provides pre and post procedure patient care as well as assisting the physicians with the gastrointestinal or pulmonary endoscopic procedures. The Endoscopy area has two procedure rooms, four private preparation/recovery rooms. There is a door that separates SDS from the Endoscopy area that will allow utilization of rooms for either SDS or Endoscopy with an increase in patient census that may occur in either area. The Endoscopy Unit's primary focus is on the medical/surgical patient undergoing diagnostic and/or therapeutic endoscopic intervention. Endoscopy serves patients between the ages of ten years old through and including the geriatric patient. The Propaq bedside monitoring system includes one channel: Three lead ECG, noninvasive blood pressure, pulse oximetry, and optional temperature. Two patient rooms have a private bathroom and two patient rooms share a bathroom. All three bathrooms are equipped with emergency call system. Each room in the Endoscopy unit has medical vacuum and oxygen. The Endoscopy area has one fluoroscopy chair that is utilized for Bronchoscopy's. The procedure rooms are equipped with oxygen two medical vacuums, endoscopic tower (computer, light source, monitor, and ERBEcautery units), and an x-ray view box in Procedure Room A. Endoscopy room B is equipped with an Argon plasma coagulator. The Endoscopy area has hours of operation from 7-3:30pm and call hours from 3:30pm- 7am

The PACU/SDS/ENDO unit is supplied with Fax machines that allow communication inter and intra hospital; computer and printer terminals that allow processing Physician orders, patient charging, nursing documentation and information retrieval.

The PACU/SDS/ENDO area works in a cooperative manner with other hospital departments on a daily basis to keep patient care needs as top priority.

The PACU/SDS/ENDO is supplied with stock medicines per PYXIS, IV supplies and narcotics. Stock medicines are maintained in the Pyxis unit. R.N.'s and M.L.P.N.'s are responsible for the monitoring and distribution of medication. The PYXIS units in SDS and Endoscopy maintain narcotic counts automatically. Pharmacy is responsible for

filling and maintaining the PYXIS units. Narcotics are wasted with a witness at the PYXIS unit. If there is a narcotic discrepancy, it is reported to pharmacy immediately and the discrepancy is documented in the PYXIS unit. Medications are charged to the patient when they are signed out of the PYXIS unit. Any medications not contained in the PYXIS are ordered directly from pharmacy and charged by pharmacy.

Stock medicines and medicines on the code cart are outdated and restocked by pharmacy quarterly.

The SDS/PACU/ENDO area refers patients and their families to the Business Office should any financial problems or questions arise.

The SDS/PACU/ENDO area interchanges with the Dietary Department for patient post op snacks, and diet instructions.

The Admitting Office and the Assessment Nurses confirm and update any patient data during their contacts with the patient.

Outpatient Registration and the SDS/PACU/ENDO area confirm physician orders for the patient's preop testing.

Cardiopulmonary Service does diagnostic testing for the SDS/PACU/ENDO, as well as, stocking the department with oxygen masks, and providing clinical expertise for the ventilator patient. SPD supplies oxygen tanks.

The SDS/PACU/ENDO areas maintain stock supplies of chargeable and non-chargeable items through Materials Management. The SDS/PACU/ENDO personnel monitor inventory and order directly from SPD, Storeroom, or directly from suppliers on an as needed basis. Soiled linen, trash, and supplies are placed in the dirty hold areas, or returned to SPD/OR for disposal or resterilization

Linen Services delivers linen to the SDS/PACU/ENDO area at least once a day and as needed. Linen hampers are located throughout the SDS/PACU/ENDO area and soiled linens are handled with Standard Precautions and are returned to Linen Service thru the surgical services decontamination area.

The Case Management Department assists the SDS/PACU/ENDO Department with any patient and/or family care needs Pre-op and Post op, the SDS/PACU/ENDO Assessment Nurses or the SDS/PACU/ENDO staff nurses or the Patient Representative can accomplish referrals.

The SDS/PACU/ENDO can notify Maintenance/Biomedical Engineering by work order for any required services or repairs needed in the area.

The Environmental Services department maintains a clean and safe environment for the SDS/PACU/ENDO department.

Security is available to the department thru security officers or by the hospital's Code 7 Policy. Access to the Surgical Services department is limited by code access or entry badges.

Blood is collected by the lab personnel or qualified nursing personnel for the SDS/PACU/ENDO patients; staff processes lab orders by use of the Meditech computer system. Nursing service receives blood and blood products from the blood bank.

The SDS/PACU/ENDO department interfaces with the Radiology Department with computer order entry.

The SDS/PACU/ENDO department utilizes the Emergency Department for patient family or visitor injury or illness. The E.D. responds to any Code Blue situation within the SDS/PACU/ENDO department.

The SDS/PACU/ENDO area and the Medical/Surgical area receive and give Surgical Services patient report and updates to the nursing staff, surgeons, and anesthesiologist to maintain a consistent level of care.

Previous patient records are available to the SDS/PACU/ENDO department by accessing the Medical Records department and the EMR.

ORGANIZATION

The SDS/PACU/ENDO department organizational plan interfaces with the Nursing Department's organizational plan and is as follows:

The SDS/PACU Clinical Manager is a qualified Registered Nurse who provides managerial support on a twenty-four hour basis, with indirect responsibility when not on duty. The reporting accountability is to the Director of Surgical Services. The SDS/PACU Clinical Manager has line authority over staff Registered Nurses, Medication Licensed Practical Nurses, Nursing Technicians and other ancillary staff of SDS/PACU. The SDS/PACU Clinical Manager is responsible for directing, assessing, planning, implementing, and evaluating the delivery of services in the SDS/PACU department and directing provision of nursing care for radiology patients requiring sedation for anesthesia.

The Endoscopy Coordinator is a qualified Registered Nurse who provides managerial support, with indirect responsibility when not on duty. The reporting accountability is to the Director of Surgical Services. The Endoscopy Coordinator has line authority over staff Registered Nurses, Medication Licensed Practical Nurses, Nursing Technicians and other ancillary staff of Endoscopy. The Endoscopy Coordinator is responsible for directing, assessing, planning, implementing, and evaluating the delivery of services in the Endoscopy department and directing provision of nursing care for patients undergoing endoscopic procedures.

The Registered Nurses report to the SDS/PACU/ENDO Clinical Manager. The Registered Nurse is responsible for patient care, may direct and evaluate the activities of other ancillary personnel, and will attend and assist the physician as needed and according to policy for procedures performed in the SDS/PACU/ENDO area. The SDS/PACU Charge Registered Nurse is responsible for the day to day operations of the department in terms of staffing on a continuous basis throughout the day; assuring coverage is adequate for shifts in census or staff, assists with the maintenance of evaluations of performance, assesses the ongoing equipment up keep and needs.

The Special Procedures Nurse reports to the SDS/PACU Clinical Manager. The Special Procedures Nurse is responsible for patient care, may direct and evaluate the activities of other ancillary staff and will attend and assist the physician/anesthesiologist as needed and according to policy for the procedures performed in the surgical and radiology departments.

The Licensed Practical Nurse reports to the SDS/PACU Registered Nurses, and the Clinical Manager. The Medication Licensed Practical Nurses are responsible for patient care, may direct and evaluate the activities of other ancillary personnel, and will attend and assist the physician as needed and according to policy for procedures performed in the SDS/PACU area.

The Nursing Tech/OR Assist reports to the SDS/PACU nursing staff and the Clinical Manager. The Nursing Tech/OR Assist is responsible for assisting with the patient care and for providing some clerical support as directed by the Clinical Manager.

The SDS/PACU/ENDO Secretary reports to the SDS/PACU nursing staff and Clinical Manager. The SDS/PACU Secretary assists with the charts, phone calls, order transcription, Meeting minutes transcription and assist with the entry of the continuing education credits for staff.

Nursing is the art and science that:

Assist persons in maintaining or regaining optimal wellness.

Is comprised of specialized and dynamic knowledge, skills and techniques.

Holds the care of persons paramount in its focus.

Has a concern for the holistic care of people,

Nursing care is delivered to persons in a way that we:

Recognize the person's unique strengths and needs;

Respect the person's rights.

Accept each person as important and worthy;

Involve the person, family, and community in the care activities.

Utilize the nursing process as a framework for our actions.

BUDGET

The SDS/PACU Clinical Manager is responsible for preparing and maintaining the capital equipment expense and salary budget for the SDS/PACU area. Consideration of the staffing needs, patient/procedure volume, findings from Performance Improvement activities, and strategic plans for the improvement activities, and strategic plans for the improvement and innovations in nursing practice are the basis for the budget process. Biweekly and monthly operating reports are prepared for and analyzed by the Director of Surgical Services. Revisions to the plan are made as indicated.

COMMITTEES AND MEETINGS

The SDS/PACU Clinical Manager and the Endoscopy Coordinator attends the monthly CHA Nursing Professional Practice Council. The Surgical Services department managers have weekly meetings with the Director of Surgical Services.

Unit meetings are conducted monthly or as needed with all Surgical Services Department staff to maintain open channels of communication, to exchange ideas, to review performance improvement/Quality improvement activities, to participate in educational programs, and to resolve problems within the Surgical Services Department.

STAFFING AND SCHEDULING

Staffing is based on patient acuity, census and physical facility. Two Registered Nurses, one competent in Phase I post anesthesia nursing, is present whenever a patient is recovering in Phase I (PACU). Two competent personnel, one of who is an R.N competent in Phase II postanesthesia nursing, are in the same room/unit, where patient is receiving Phase II level of care. An RN must be in the Phase II PACU at all times when a patient is present; staffing is adjusted to maintain the minimum 1:3 ratio.

The SDS/PACU/ENDO Clinical Manager/Charge Registered Nurse reviews scheduled cases on a day-to-day basis; staff assignments are made throughout the workday in order to assure patient's needs are met. The SDS/PACU staff rotates thru the Phase I, and Phase II recovery and the pre procedure phase, allowing for ease in transition of areas if patient census increases in any one area. The SDS/PACU /ENDO staff is also cross-trained to utilize skills needed for admission, discharge and assessment of these patients. Call hours are covered by the SDS/PACU/ENDO RNs, MLPN's and Surgical Technologists. Staff can be utilized in other areas on days the census may be low in the SDS/PACU area. The American Society of Post Anesthesia Nursing standards are followed in the SDS/PACU area.

In the event of high volume or acuity that does not allow the department to meet its standard for nurse to patient ratio, the SDS/PACU/ENDO Clinical Manager or Administrative Rep is contacted. This person decides how to best meet departmental standards, either by re-assigning staff or calling in off-duty staff member(s).

In the event the Special Procedures Nurse is not available nursing care will be provided by SDS/PACU staff cross trained for this role.

COMPETENCY VALIDATION

Each member of the SDS/PACU/ENDO staff is assigned clinical and/or managerial responsibilities based on educational preparation and assessment of the current competence. A nursing orientation program is designated to assess each individual's current level of competency through the development of skills inventory. The RN will complete competency evaluation and completion in medication administration, IV therapy, blood therapy, arrhythmia interpretation, and cardiopulmonary resuscitation. Other SDS/PACU/ENDO staff is expected to demonstrate competency in areas relative to performance expectations.

Once general orientation is successfully completed, unit specific orientation begins. Unit specific information is shared. A unit specific orientation check list is instituted for each person being oriented into the SDS/PACU/ENDO area and updated as skills are acquired.

Unit specific competencies include current certification in ACLS and PALS for SDS/PACU/ENDO/SPECIAL PROCEDURE RNs (exception are Assessment Nurses who are required to stay BLS certified.) and current certification in BLS for SDS/PACU MLPNs, Nurse Techs and/or OR Assists. SDS, PACU, and SPECIAL PROCEDURES RN also maintain PALS certification. Other competencies are designed to comply with quarterly performance indicators, Surgical Clinical Core Group suggestions, and patient and staff concerns. Competencies are accomplished by the use of educational tools, e.g., inservices, assigned readings; computer based learning modules, actual demonstration and ongoing supervision.

STANDARDS OF PRACTICE

Each associate is responsible to provide nursing care based on policy and procedure, and standards of practice and care. The SDS/PACU Clinical Manager and Endoscopy Coordinator are responsible for the provision of appropriate educational and policy manuals to assist the staff. If problems or questions should arise, the established chain of reporting is followed. The SDS/PACU Clinical Manager, Endoscopy Coordinator and RNs assist in development of unit specific standards. The American Society of Post Anesthesia Nursing standards are followed in the SDS/PACU area. The Society of Gastroenterology Nurses and Associates standards are followed in the Endoscopy area.

PERFORMANCE IMPROVEMENT

Aside from the specific Performance Improvement/Quality improvement activities of the PACU/SDS/ENDO unit, each patient care unit has representation on the Nursing Practice council that is responsible for monitoring effects of care delivery and patient outcomes. Examples of monitored outcome indicators are nursing documentation, medication administration, restraints, patient satisfaction, and infection control and pain management. Nursing representation is also present on chartered QIC and reengineering teams and Clinical Core Groups.

SDS/PACU/ Clinical Manager

Endoscopy Coordinator

Director of Surgical Services

Sisa Noble MSW, RN

Medical Director Surgical Services

June, 1993

September, 2002(revised)

November 2008 (revised)

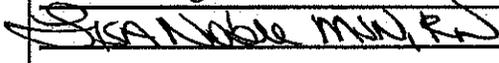
January, 1997(revised)

October, 2006(revised)

Feb. 2014 (revised)

Community Hospital of Anderson & Madison County

**NURSING DEPARTMENT POLICY MANUAL
SURGICAL SERVICES NURSING**

SUBJECT:	POLICIES POST ANESTHESIA CARE UNIT	Ref #	
		Page(s):	4
Originator:	Clinical Manager PACU/SDS		
Approved By:	Director Surgical Services	Effective	7/87
			
	Medical Director Perioperative Services		
		Revised	5/95; 1/98; 1/99; 9/02; 10/04;12/08,9/2011
References:	ASPAN Resource Manual Standards, Practice Recommendations 2012-14	Reviewed	4/96; 4/97;12/05, 7/12;2/14

POLICY STATEMENTS:

The Post- Anesthesia Care Unit is in daily operation from 7 am to 6 pm, 5 days a week except for holidays. On call coverage provides the operation of PACU 24 hours a day and 7 days a week.

The recovery of all patients within the SDS/PACU area who utilize the services of the Anesthesia Department is at the discretion of the attending anesthesiologist.

Any patient requiring Anesthesia services will be recovered by SDS/PACU oriented RN.

Two Registered Nurses, one competent in Phase 1 post anesthesia nursing, will be in the same room/unit where the patient is receiving Phase 1 level of care.

General anesthesia patients will recover in PACU until PACU discharge criteria is met as determined by the anesthesia department and in accordance with ASPAN and ASA standards for Phase I recovery.

Monitored Anesthesia Care patients, e.g. those who have had eye surgery, may return directly to the SDS area and be observed for a minimum of one hour, and/or until discharge criteria is met. Patient assessment with vital signs should occur on admission to the SDS area, then again in 30 minutes, and one hour.

The patient who has received Monitored Anesthesia Care and or Regional anesthesia care may require observation in the PACU. This is at the discretion of the attending Anesthesia provider. The recovery time period should be until discharge criteria are met.

The patient who has received IV moderate sedation may require observation in the PACU at the discretion of the surgeon or circulating RN. The recovery time period should be until discharge criteria are met.

The patient who has received IV moderate sedation may return to the SDS area at the discretion of surgeon or circulating RN. The patient should be observed for one hour after last dose of IV sedation medication has been administered. Patient assessment and vital signs should be checked on admission to SDS, again in 15 minutes and 30 minutes, as well as PRN.

Patients with known contagious infectious process will be recovered in the operating suite.

Patients needing the ventilator will be recovered in the ICU by the SDS/PACU oriented RN

All eight patient care areas will be ready for patient use at all times, with any possibly needed equipment and supplies clean and ready.

A PACU/SDS oriented RN must be at the bedside of any patient that has an airway adjunct in place or needs assistance in maintaining an airway.

A PACU/SDS oriented RN must be at the bedside of pediatric patients 8yrs old and under without family or support staff present.

All physician orders must be on the patient chart or in the EMR before discharging the patient to an acute care unit or to SDS. Any chart with medication orders that need to be stocked on the nursing unit should be faxed to the pharmacy.

The on call PACU/SDS RN will be available to assist the on call surgical team for on call surgery cases done in the OB C-Section room or if there is more than 1 surgical procedure scheduled at any one time. This requires the on call PACU/SDS RN to be called at the beginning of the surgical procedure. The PACU RN can assist the surgery team by helping with anesthesia needs, retrieving needed supplies, and setting up lines. The PACU RN is not to scrub in.

The Aldrete scoring system is used on admission to PACU and every 30 minutes until discharge from PACU.

The post op patient will have vital signs checked every 5 minutes for the first 15 minutes on admission to the PACU. After the first 15 minutes in PACU, the patient's vital signs will be monitored every 15 minutes, or as needed until discharge criteria are met.

ASPAN patient classification/recommended staffing guidelines for PHASE I (PACU). The nursing roles during PHASE I focus on providing a transition from a totally anesthetized state to one requiring less acute interventions. When the patient census increases to greater than the following ratios, the RN staff to patient ratio must be increased to maintain the ASPAN guidelines.

CLASS 1:2 ONE NURSE TO TWO PATIENTS WHO ARE

- a. one unconscious patient, hemodynamically stable without artificial airway over the age of 8 years; and one conscious patient, stable and free of complications
- b. Two conscious patients, stable and free of complications but not yet meeting discharge criteria.
- c. Two conscious patients, stable, 8 years of age and under; with family or competent support staff present but not yet meeting discharge criteria.

CLASS 1:1 ONE NURSE TO ONE PATIENT

- a. Any patient at the time of admission until airway is patent without assist, initial assessment is complete, patient is hemodynamically stable, report has been received and transfer of care has taken place.
- b. Any patient with unstable airway requiring jaw or chin lift, showing evidence of obstruction by gasping, choking, crowing. Showing symptoms of respiratory distress such as dyspnea panic, agitation, cyanosis, etc.
- c. Any unconscious patient 8 years of age and under
- d. A second nurse must be available to assist as necessary

CLASS 2:1 TWO NURSES TO ONE PATIENT

- a. One critically ill, unstable patient

DISCHARGE FROM PACU

Discharge of the patient from the PACU follows discharge criteria established by the anesthesia department. The Aldrete scoring system is utilized and the patient should have a final score of 10 before discharge from PACU. The Aldrete scoring system is used on admission to PACU and every 30 minutes until discharge from PACU.

The only exceptions are:

- a.) The patient was unable to score 10 on the Aldrete prior to surgery or
- b.) the attending anesthesiologist or his qualified designee gives a verbal or written order that the patient may be discharged from the PACU area.

Before the patient is discharged from the PACU to an inpatient nursing unit, the receiving unit and the Surgical Services volunteer is called by phone and notified of the transfer.

Report of the patient's condition is given to the Sameday Surgery nurse upon arrival to Sameday Surgery.

Report of the patient's condition is called to the ICU nurse prior to transfer of the patient.

Report of patient's condition is given to the unit nurse upon arrival to Medical Surgical or OB units.

Report of the patient's condition includes but may not be limited to;

Procedure done

Anesthesia type

IV fluids, blood/blood products given intraoperative and postoperative

All medications given postoperatively

Any outstanding orders to be done

Estimated blood loss

Any diagnostic test done postoperatively

Any need for supplemental oxygen

Any special equipment or monitors needed

Condition of dressings, drains, tubes, etc.

Time preop antibiotic given

Patients who have had general anesthesia are to be transported with surgical services RN(s), and/or assistance as needed from transport department.

**COMMUNITY HOSPITAL OF ANDERSON & MADISON COUNTY NURSING DEPARTMENT
SDS/PACU/ENDO POLICY MANUAL**

SUBJECT:	SCOPE OF ASSESSMENT; GENERAL INFORMATION AND POLICYS OF THE PATIENT INITIAL/ONGOING/DISHARGE ASSESSMENT	Ref #	
		Page(s):	4
Originator:	Clinical Manager SDS/PACU _____		
Approved By:	Director Surgical Services <i>[Signature]</i> MSW, RN	Effective	11/92
		Revised	7/95; 4/96; 10/02; 12/05; 4/09,4/12
		Reviewed	5/99;10/08
References:	STANDARDS OF PERIANESTHESIA NURSING PRACTICE ASPAN RESOURCE MANUAL 2012-14 GASTROENTEROLOGY CORE CURRICULUM PERIANESTHESIA CORE CIRRICULUM		

POLICY STATEMENTS;

1. Perianesthesia nursing practice includes the systematic and continuous assessment of the patient's condition. The nurse assures that the data are collected, documented, and communicated. The professional nurse analyzes the data to determine appropriate nursing intervention.
2. The SDS assessment office is a means to obtain preoperative patient medical history, medication used, and history of health problems and/or physical restrictions, previous surgery, any complications and the obtaining of preop testing from the hospital/other healthcare providers. At the time of the assessment, preoperative patient instructions are to be given to the patient and/or family member. Instructions include but may not be limited to time to report to the hospital, what medications to take or not to take, when the patient is to not eat or drink. Each patient's assessment includes consideration of biophysical, psychological, environmental, self care, educational and discharge planning factors. When appropriate, data from the patient's significant other (s) are included in the assessment.
3. The SDS assessment office is staffed with an SDS/PACU oriented RN from 6:30am-6: 00pm Monday through Friday.
 - a. Assessment will be done by an RN.
 - b. If Assessment RN is unable to reach the patient prior to the day of surgery the Sameday Surgery admitting RN will complete the pre admission/pre-op assessment at time of admission.

C. The SDS/PACU/ENDO/SPECIAL PROCEDURE'S RNs may also complete any patient assessments

4. The professional nurse (RN) performs the initial assessments and assures a systematic and pertinent collection of data. (See action steps)
5. The nurse reviews available patient care documentation, revises the data as appropriate and shares information with the other health care team members.

ACTION STEPS

- a. By the use of the surgical information computer system, scheduling data and patient information screen can be accessed for the assessment record.
 - a1. The Special Procedure's RNs collect and review any assessment data needed for the radiology patients
 - b. Completes phone or personal interview with client so that assessment record can be completed one to three days before the scheduled surgery/procedure date. Should the patient not be contacted one day prior to surgery/procedure then the Sameday Surgery/Endoscopy/Special Procedure admitting RN will complete the assessment when patient is admitted for surgery / procedure.
 - c. This information is shared with anesthesia provider, surgical staff, and ENDO/SDS/PACU staff through chart review or direct communication.
 - d. The assessment nurse will notify the anesthesia provider by various methods of the patient data (pt. data can be faxed to the attending anesthesia provider, put in their mailbox, notified by phone call or personal communication. Anesthesia providers may also access the EMR for information.
 - e. All charts with necessary individual patient information are reviewed and organized for the next day surgeries and taken to the admitting unit.
 - f. Any abnormal pre-operative testing values are communicated to the patient's primary care doctor, as well as the anesthesia provider prior to the day of surgery.
6. Assessment factors include but may not be limited to:
 - a. Relevant pre admission patient data such as; patient health history, previous surgeries, medication use including "over the counter medications" or "herbal preparations", allergies, physical and communication limitations, prostheses, age specific patient data, cognitive ability of patient and/or family, cultural diversity issues, psychosocial family status, alcohol/tobacco/recreational drug use, previous anesthetic history, pain history and current pain level. Use of non-invasive positive pressure ventilation devices e.g., CPAP/BIPAP machines.
 - b. Pre admission discharge planning such as; availability of responsible adult, safe transport home, post operative/post procedural physical/mental limitations, appropriate referrals and procurement of supplies and/or equipment as needed.
 - c. Pre admission patient/family teaching such as; NPO status, take/hold daily medications/ "OTC" medications, arrival time and place, post op care preparations, pain management techniques, advance directives review, and Patient's Bill of Rights.

- d. Day of surgery/procedure patient data such as; review of pre admission patient data and patient/ family understanding and follow through of teaching/instructions, preop patient diagnostic values (labs, EKG, Chest X-ray vital signs, O2 sat, emotional needs, safety needs.)
7. Postoperative Assessment factors include but may not be limited to:
 - a. Phase I recovery patient data such as; 1.) Review of pre operative patient status, anesthesia technique/preop medications, anesthetic agents used, surgical procedure, estimated fluid/blood loss and replacement, any intra-op complications. 2.) Aldrete scoring on admission to PACU and every 30 minutes and PRN until discharge, monitoring of patient vital signs on admission and every 5 minutes for 15 minutes then every 15 minutes and PRN until discharge. 3.) Airway assessment and maintenance, cardiac monitoring throughout PACU stay/rhythm, documented patient temperature on admission, PRN and discharge. 4.) Patient safety needs, condition of any dressings, type and patency of any drains, IV sites, fluid therapy, location and type and condition of any lines. 5.) Pain level on admission, with VS checks, PRN, and at discharge utilizing 0-10 pain scale. Documentation and communication of all interventions and outcomes, notification and communication of patient care and equipment needs to Acute Care/SDS/ENDO nursing units. Patient readiness for discharge (Aldrete score at 10 &/ or matching pre op patient status &/or per anesthesia order.)
 - b. Phase II recovery patient data such as: 1.) Integration of patient data at transfer of care. 2.) General anesthesia, IV sedation, monitored anesthesia care patients will have vital signs checked within 30 minutes of discharge from the PACU and PRN in the SDS area. 3.) Recovery after the first 30 minutes continues in 30 minute increments to total one hour and PRN; 4.) Every one-hour to total two hours and PRN. 5.) Any patient requiring greater than three hours of stage II (stage III) recovery will have vital sign checks every four hours and PRN until discharge to home or admitted to acute care unit.
 8. All SDS/ENDO patients must meet the discharge criteria approved by the anesthesia department: The patient will be discharged from the SDS/ENDO area according to the discharge criteria, patient status (Preop and Postop), and per physician order.
 9. If the SDS/ENDO patient does not meet the discharge criteria the attending surgeon/endoscopists or the anesthesia provider is notified for the order of patient to become an extended recovery patient due to, e.g., pain, or nausea or vomiting. Patient will then be admitted to an acute care unit until the discharge criteria are met.

Discharge Criteria: ongoing and discharge assessment factors

- a. Respiration's are regular and easy, without effort, or as preoperatively; respirations maintain oxygen saturation of 92% or better, or return to patient preoperatively level. Patient is able to cough and deep breathe.
- b. Blood Pressure is within plus or minus 20% of preoperative values unless systolic B/P is less than 90 or greater than 200 (outside of parameters physician must be notified)

- c. Heart rate, rhythm, and quality are within normal limits of patient preop status unless heart rate is less than 40 or greater than 110.
- d. Skin is warm and dry, and is without signs of cyanosis.
- e. Patient is alert and oriented, responds appropriately to verbal stimuli, reflexes have returned; swallow, cough, and gag.
- f. Dressing dry, clean and intact or the incision is clean and dry
- g. Pain is at a level 4 or less (according to 0-10 pain scale) at time of patient discharge to that will allow the patient periods of rest.
- h. Patient will be able to tolerate fluids without vomiting. Patient may have mild nausea that can be controlled by position and/or antiemetic medication.
- i. Patient is able to ambulate unassisted and the gait is steady.
- j. Written discharge and medication reconciliation instructions will be given and explained to the patient and family. The discharge instruction sheet will address:
 - Written or verbal orders from the attending surgeon
 - Wound care instructions (if applicable)
 - When to return for follow-up visit
 - What activity /diet is permitted or restricted
 - Potential problems that could occur and what to do; phone numbers to contact the Emergency Department, Same Day Surgery; or the physicians office
 - Medication instructions (if applicable)
- k.. The discharge instruction sheet should be kept with the permanent chart and a copy given to the patient and family. The discharge instruction sheet should be signed by person(s) as acknowledging receipt and understanding of the instructions.
- l. Any identified post discharge nursing care needs of the patients will be addressed by referral to the appropriate discipline and will be reflected in the nursing notes.

PACU RN'S QUALIFICATIONS

	BLS	ACLS	PALS	TNCC
ALDER HEATHER RN	X	X	X	
BERTRAM JODI RN	X	X	X	
BOTT, BRITTNEY RN	X	X	X	
DAVIS, PAMELA S RN	X	X	X	
ELSTON, LAUREN RN	X	X	X	
FINELY, WHITNEY RN	X	X	X	
FULLER, ANGELA RN	X	X	X	
FUTRELL, VALERIE RN	X	X	X	
HALSELL, BETH RN	X	X	X	
HAVENS, TINA RN	X	X	X	
HORTON, ANNIE RN	X	X	X	
HUNT, TERRA RN	X	X	X	
KNOTTS, JOY RN CAPA	X	X	X	
MORRIS, JENNIFER RN	X	X	X	X
SMITH, CYNTHIA RN	X	X	X	
SMITH, KRYSTAL RN	X	X	X	
THOMAS, LAURA LEE RN	X	X	X	
WEATHERLY-BROWN RN	X	X	X	
WOOD, NANCY	X	X	X	
WRIGHT-MIMS, HARVETTA	X	X	X	

Post Anesthesia Equipment Available for Trauma

At each stall:

Monitoring for basic and invasive vital signs, capnography

Portable monitors for basic and invasive vital signs, and capnography

O2, medical air, suction

Ambu bag

Within PACU

Adult crash cart

Broselow Pediatric emergency bag

IV pumps

Fluid warmers

Bair huggers

Doppler

Synapse for x-ray viewing on computers

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 18

Relationship with IOPO

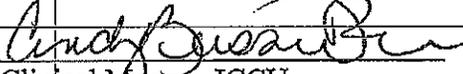
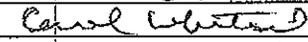
"18. Relationship with an organ procurement organization (OPO).

There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 18 are met with a signed copy of the Community Hospital - Anderson (CHA) Organ Donation policy. There is a copy of the current contract with the Indiana Organ Procurement Organization, Inc. (IOPO)

**NURSING DEPARTMENT POLICY MANUAL
INTENSIVE/CRITICAL CARE UNIT**

SUBJECT:	Protocol for Donation After Cardiac Death (DCD)
Originator:	 Clinical Manager, ICCU
Approved By:	 V.P. Patient Care Services/CNO
Policy Coordinator:	Cheryl Arnold
Scope:	All CHA personnel involved in the process of retrieving organs from a non-heart beating donor
Effective:	2/1/06
Revised:	1/13; 3/14
Reviewed:	2/09; 8/10
References:	Anatomical Gift Donation (Policy H8 – 7110.11); CHA Death Dismissal Policy; Kennedy Institute of Ethics Journal, Volume 3, No. 2, June 1993; The Institute of Medicine: Non-Heart –Beating Organ Transplantation: Medical and Ethical Issues in Procurement, 1997; The Institute of Medicine Non-Heart-Beating Organ Transplantation: Scientific and Ethical Basis for Practice and Procurement; Indiana Uniform Anatomical Gift Act; Indiana Uniform Determination of Death Act

PURPOSE: To provide the option of organ donation to families of patients who have made the decision to withdraw life support (controlled non-heart beating donation). For the last 20 years, the great majority of organ donors have been persons declared dead by brain death criteria. However, donation by persons who have died by cardiac and respiratory criteria was a commonly accepted practice before brain death criteria was established. This policy is intended to serve as a guideline for the donation of organs after cardiac death (DCD).

DEFINITIONS:

1. Donation after cardiac death (DCD) (i.e., non-heart beating organ donation or NHBD): organ recovery from patients who are pronounced dead on the basis of irreversible cessation of circulatory and respiratory function, not on the basis of brain death

POLICY STATEMENTS:

1. This protocol outlines the procedure for donation after cardiac death (DCD) (i.e., non-heart beating organ donations or NHBD), which has been defined as organ recovery from patients who are pronounced dead on the basis of irreversible cessation of circulatory and respiratory function.

ACTION STEPS:

1. A multi-disciplinary team approach will be utilized to provide appropriate support for the donor family:
 - a. If a request is made by the family to be present at the time of death, the appropriate hospital staff will make every attempt to accomplish this request.
 - b. The family will be offered the opportunity to be with their loved one after the recovery surgery.

2. Donation Discussion – The discussion about the option of donation will take place *after* the decision to remove life support has been made. The decision to withdraw life support must be made independent of, separate from, and predating any discussion about non-heart beating organ donation.
3. Referral – The hospital will make a referral to the Indiana organ Procurement organization when:
 - a. The consideration of and the discussion between the responsible physician and the family regarding the termination of life support has taken place prior to the referral. The physician will not be associated with IOPO nor shall he/she be affiliated with hepatic or renal transplant programs.
 - b. The patient meets the established criteria.
 - c. The responsible physician, according to hospital policy, has written a “Do Not Resuscitate” order with documentation in the progress notes.
4. Donor Suitability Evaluation – The IOPO coordinator, with the full knowledge and assistance of the attending physician, will conduct the following:
 - a. A review of the hospital medical record.
 - b. An initial physical assessment.
 - c. Verify the documentation of the family discussion and decision to withdraw support. The documentation must include the following information:
 1. Date and time of discussion.
 2. Name of legal next-of-kin or other legally designated surrogate.
 3. Next-of-kin’s decision.
 4. Responsible physician’s signature.
 - d. Should the patient be deemed medically unsuitable for donation:
 1. The attending physician will be informed of the rationale for unsuitability.
 2. The IOPO coordinator will document in the patient’s medical record the rationale for declining the patient for DCD.
 3. The IOPO coordinator will inform the Administrative Representative on call of the rationale for declining the patient.
5. Consent
 - a. The IOPO coordinator will approach the next-of-kin to initiate the consent process. The following information will be provided as part of securing consent.
 1. Organs and tissues that can be donated.
 2. A complete explanation of the NHBD process and organ recovery process.
 3. The location of death is expected to be in the operating room suite.
 4. Organ recovery will take place immediately after the physician has pronounced the patient dead.
 5. There is no cost for organ evaluation, allocation, or recovery.
 6. The family will be given the option to see their loved one after organ recovery has been completed.
 7. In the event that the patient does not expire within sixty (60) minutes after discontinuation of support and does not demonstrate a significant progression towards death the organ donation process will cease. In this instance, the family resumes financial obligations associated with terminal care.
 - b. Should the next-of-kin agree to donation, the IOPO personnel will:
 1. Complete the Consent for Organ and Tissue Donation after Cardiac Death form.

2. Conduct and document a thorough medical/behavioral history interview.
 3. Contact the Coroner to obtain permission to proceed with donation.
 4. Provide time for the family to be with the patient.
 5. Notify the appropriate Administrative Representative who will notify ICU and Surgery.
 6. The ICU bed will be held empty until they receive a call from the OR regarding the disposition of the patient.
 7. Inform the recovery surgeon and the perfusionist.
 8. The Operating personnel will notify the ICU when the patient expires or moves to an inpatient bed.
- c. Should the next-of-kin decline donation, the IOPO coordinator personnel will:
1. Support the family's decision.
 2. Document in the patient's hospital medical record the decision not to donate.
 3. Notify the attending physician.
 4. Thank the staff for their assistance.
6. Donor Maintenance
- a. The responsible physician will retain full responsibility for the patient until such time as the patient's death is pronounced.
 - b. The responsible physician for the patient will make a clinical judgment on the advisability of administering medications for comfort measures. The administration of clinically appropriate medications in appropriate doses to provide comfort is acceptable and encouraged. The use of paralytics is prohibited. Interventions to preserve organ function but which may cause patient discomfort or hasten death are prohibited. If not already in place, an arterial line will be inserted.
7. Withdraw of Support
- a. Withdraw of support will only occur in the operating room suite. The organ recovery team will be in the donor hospital and available prior to withdrawing support. The organ recovery team *will not* be in the patient's room during the withdrawal of support or the certification of death. The following procedure will be utilized:
 1. The patient will be surgically prepped and draped with hands left uncovered.
 2. The ICU RN will administer Heparin 300 units/kg IV push.
 3. The RN, RT will withdraw ventilator support and will discontinue all intravenous infusions excluding medications for comfort measures. Cardiac monitoring and invasive blood pressure monitoring will be maintained.
 4. Family may be with the patient after prepped and draped and support has been withdrawn until RHC takes place (maximum of two (2) family members).
8. Certification of Death
- a. For certification of death, the prompt and accurate diagnosis of cardiac arrest is extremely important. Recovery of organs cannot take place until the patient meets the cardiopulmonary criteria for death. Because of the obvious concerns regarding conflict of interest, the criteria in this protocol is more stringent than the standard clinical practice for declaring death in patients who are designated "comfort measures only" but who are not candidates for organ donation. A

206

responsible licensed physician will certify death. The physician will be present at the time of death.

- b. Under no circumstances will an incision, for the purpose of organ recovery, be made until death is pronounced. Under no circumstances will cold perfusion catheters be inserted until after death has been pronounced.
 - c. For the purposes of pronouncing death prior to organ recovery, the following will be confirmed:
 1. Correct cardiac electrode placement.
 2. Absence of pulse waveform on arterial line and absence of palpable pulse by physician exam or Doppler flow.
 3. Apnea via auscultation of breath sounds.
 4. completely unresponsive to stimuli.
 5. Five (5) minutes of any of the following electrocardiographic rhythms, confirmed in two (2) different leads:
 - Electrical asystole
 - Ventricular fibrillation
 - Pulseless electrical activity
 6. Pulselessness via auscultation of heart sounds.
 7. Pupils fixed and dilated.
 - d. Under no circumstances will chest compressions be performed after the declaration of death.
 - e. The physician declaring death will document the date and time of death in the patient's hospital medical record and will complete the certificate of death. The family will be informed and support will be provided. Immediately after certification of death, organ recovery will proceed. If the patient does not deteriorate to death within the designated time of one (1) hour and does not demonstrate a significant deterioration towards death, the donation process will cease and comfort measure will be maintained.
9. Recovery of Organs
- a. Recovery of organs will proceed after the certification of death.
 - b. The recovery surgeon will be informed of the warm ischemic time. For the purpose of this protocol, warm ischemic time will be defined as the time from pulselessness until the organs have been initially cooled and flushed.

10. Post-Donation Conference

- a. Initially, every DCD case will be reviewed by a committee composed of:
 1. Medical Director of Critical Care
 2. Medical Director of IOPO
 3. Director, Clinical Services of IOPO
 4. Supervisor, Organ Recovery of IOPO
 5. IOPO Coordinator
 6. IOPO Family Support Coordinator
 7. Attending Physician
 8. ICU Primary Care Nurse
 9. ICU Clinical Director
 10. Chaplain (Ethics)
 11. Clinical Director, Surgical Services
 12. Director of Quality Resources
- b. The purpose of this review is to:
 1. Assure compliance with the protocol procedures.
 2. Identify problems and complications, potential or actual, and recommend changes toward their solution.

207

3. Protect the interests of the donor, donor families, recipients, donor hospital, health care providers, and IOPO.
 4. Assess the effect of these procedures on the family's grief process and determine whether changes should be instituted to improve the process for them.
- c. This case review will take place within seventy-two (72) hours after the donation.

HOSPITAL PROCUREMENT AGREEMENT
(ORGAN)

This Hospital Procurement Agreement (Organ) ("Agreement") is made this 15th day of February, 2007, between Community Health Network - Anderson and Madison County ("Hospital") and Indiana Organ Procurement Organization, Inc. ("IOPO").

RECITALS

A. IOPO is an Indiana nonprofit corporation and is a freestanding Organ procurement organization (within the meaning of 42 C.F.R. § 413.200 and § 486.302) which is the federally qualified Organ procurement organization designated for the donation service area within the State of Indiana in accordance with Section 371 of the Public Health Service Act (42 U.S.C. § 273) ("Donation Service Area");

B. IOPO is a member of the Organ Procurement and Transplantation Network ("OPTN") established under Section 372 of the Public Health Service Act (42 U.S.C. § 274), the nonprofit corporation composed of transplant centers, organ procurement organizations, and histocompatibility laboratories, with the purpose of increasing the availability and access to donor organs;

C. OPTN is administered by the United Network for Organ Sharing ("UNOS"), a nonprofit corporation, which, as the OPTN contractor, manages the national Organ transplant waiting list, manages clinical data in a secure environment, works to improve the quality processes of OPTN, and facilitates the Organ allocation, matching and placement process for human Organ transplants;

D. The purposes of IOPO are to perform and coordinate the identification of donors, the retrieval, procurement, preservation and transportation of Organs for transplantation to work with the OPTN and UNOS in the allocation and placement of Organs available for transplant, and to educate medical personnel and the general public regarding donation and transplantation issues;

E. Hospital participates in the Medicare and Medicaid program and desires to be in compliance with Section 1138 of the Social Security Act (42 U.S.C. § 1329b-8) and the rules of the Centers For Medicare and Medicaid Services ("CMS") for hospital conditions of participation in Medicare and Medicaid programs (42 CFR Part 482.45);

F. Hospital is located within the Donation Service Area of IOPO;

G. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs donated, providing Timely Referral to IOPO of Imminent Deaths and deaths which occur in Hospital; allowing families of Potential Donors to be informed of the potential for Organ, Tissue, or Eye donation; and maintaining Potential Donors under the direction and guidance of IOPO while necessary determinations of medical suitability, testing and placement of Organs can take place. Hospital agrees to cooperate with IOPO in supporting a patient's right to donate Organs, Tissue and Eyes when an appropriate declaration of gift has been made by the patient, even if that declaration of gift is contrary to the wishes of the next of kin, and, allowing IOPO to appropriately approach all families of medically suitable Potential Donors in order to obtain the consent to donate Organs, Tissue and Eyes, when appropriate, for suitable Potential Donors under eighteen years of age or where no declaration of gift can be found. Hospital hereby requests that IOPO recover all Organs from Donors who die within Hospital that are determined to meet the requirements of medical suitability; and

H. In situations where organs, tissue and eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consents, procurement may proceed for medical or dental education, research, the advancement of medical or dental science, or therapy.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual covenants contained herein and for other good and valuable consideration, the parties hereby agree as follows:

1. Definitions. For purposes of this Agreement, the following words shall have the meanings indicated herein:

a) "Brain Death" shall mean the condition of death occurring when increased intracranial pressure is sufficient to impede the flow of blood into the brain causing cellular death of the brain tissue and/or herniation; characterized by the absence of electrical activity in the brain, blood flow to the brain, and brain function as determined by the clinical assessment of responses therefor, resulting in complete, irreversible cessation of all functions of the entire brain, including the brain stem.

b) "Clinical Indicators" shall mean the following criteria for a patient with severe, acute brain injury and (i) who requires mechanical ventilation; (ii) is in an intensive care unit, critical care unit or emergency department; (iii) has clinical findings consistent with a Glasgow Coma Score that is less than a threshold of 5, absent central nervous system depressants or an induced coma, or for whom the attending physicians are evaluating a diagnosis of brain death, or for whom a physician has ordered that life-sustaining therapies be withdrawn, pursuant to the family's or guardian's decision.

c) "Conversion Rate" shall mean the number of Potential Donors meeting the medical suitability requirements of IOPO, who actually donate Organs compared to all eligible Organ Donors who die in Hospital, including those for whom consent to donate is not obtained, expressed as a percentage.

d) "Designated Requestor" shall mean an individual designated by the Hospital or IOPO and trained to handle or participate in the donation consent process, who has completed a course offered or approved by IOPO or, in conjunction with a local Tissue and Eye bank, regarding the methodology for approaching the family or person responsible for a Potential Donor and requesting Organ, Tissue or Eye donation.

e) "Donation after Cardiac Death" ("DCD") shall mean an Organ donation process with a patient who has suffered a non-survivable brain injury or cardiac event such that patient death would be imminent subsequent to the removal of mechanical support for circulatory and respiratory functions. A Donor after Cardiac Death means an individual who donates Organs after his or her heart has irreversibly stopped beating and may be termed a non-heart beating systolic Donor.

f) "Donor" or "Potential Donor" shall mean any person who dies in circumstances (causes and conditions of death, and age at death) that are generally acceptable for donation of at least one vascularized Organ, Tissue or Eye; the Potential Donor can be identified in a timely manner; and where proof of the patient's declaration to donate an anatomical gift can be obtained; or, absent such a declaration to donate, permission for donation can be obtained from the family or other legal guardian.

g) "Eye" or "Eyes" shall mean the whole eye or portions of the human eye, including the cornea, corneal tissue, sclera, and vitreous.

h) "Family Services Coordinator" shall mean an employee of IOPO trained in obtaining consent for Organ, Tissue and Eye donations.

i) "Imminent Death" shall mean the time when an individual's death is reasonably expected utilizing the criteria enumerated for Clinical Indicators.

j) "Organ" shall mean a human kidney, heart, lung, pancreas, liver, or intestine (or multivisceral Organs when transplanted at the same time as an intestine).

k) "Procurement Transplant Coordinator" or "PTC" shall mean an employee of IOPO trained in coordinating the process of Organ donation and procurement.

l) "Timely Referral" shall mean a telephone call by Hospital notifying IOPO of an Imminent Death, in sufficient time to give IOPO an adequate opportunity to begin assessment of a Potential Donor prior to the withdrawal of, or discussion with family or guardian regarding, any life-sustaining therapies (i.e., medical or pharmacological support) and as soon as it is anticipated a patient will meet the criteria for Imminent Death agreed by the OPO and Hospital or as soon as possible after a patient meets the criteria for Imminent Death agreed to by the OPO and Hospital.

m) "Tissue" shall mean other transplantable and non-transplantable tissues of the human body, excluding Organs, and including but not limited to whole heart for heart valves, vascular tissue, connective tissues, skin and bones.

2. Notice of Donor Availability and Consent. Hospital shall, consistent with applicable laws and regulations, cooperate with IOPO in the recovery of Organs donated from patients who die in the Hospital. Hospital shall cooperate with IOPO to prepare and implement appropriate policies that support the mechanism of the donation of Organs.

a) Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to or at the time Brain Death is declared), in the Hospital. In addition, Hospital shall provide Timely Referral to IOPO or the named donee, if any, when Hospital becomes aware that a person in transit to Hospital is identified as a Potential Donor. IOPO shall preliminarily determine, based upon medical and patient information provided by Hospital, the medical suitability of each Potential Donor for Organ, Tissue and Eye donation according to requirements utilized by IOPO, and the appropriate tissue and eye banks serving Hospital.

b) The determination of death for a Potential Donor shall be made by the Donor's attending physician or by the physician responsible for certifying death at the Hospital. Such physician shall not participate in any procedure relating to removal or transplantation of any Organs, Tissues, or Eyes. IOPO shall not participate in the determination of death of any potential Organ, Tissue or Eye Donor. Notification of a determination of death shall be written into the patient's chart upon pronouncement. IOPO shall verify the determination of death according to applicable State and federal laws prior to proceeding with any anatomical recovery.

c) Hospital shall allow IOPO to determine the medical suitability of any Potential Donor and to use such portable laboratory equipment as may be necessary to facilitate such determination.

d) Hospital shall ensure, in collaboration with IOPO and consistent with federal and state laws, rules and regulations, that a patient's right to donate Organs, Tissues, and Eyes is fulfilled when appropriate declaration of gift is noted, or that the family of each Potential Donor, or person legally responsible for a Potential Donor, is informed of the potential to donate Organs, Tissues, and Eyes, or to decline to donate when the appropriate declaration of gift cannot be found. When a family member or person legally responsible for a Potential Donor is informed about the procedures for making a gift of Organs, Tissue or Eyes, the fact that the family member or representative was so informed shall be noted in the Potential Donor's medical chart. Hospital and IOPO shall encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of Potential Donors.

e) IOPO and Hospital shall act in good faith to support a patient's right to donate, and fulfill a patient's wishes to donate anatomical gifts in accordance with the Indiana Uniform Anatomical Gift Act, Indiana Code 29-2-16-2 et seq. (the "Act"). The Act prevents a patient's family from altering a gift declared in writing by an individual under the provisions of the Act. Under the provision of the Act, IOPO shall attempt to obtain any documentation of patient's declared decision to donate, including applicable designations on an individual's driver's license, which may be determined from the Bureau of Motor Vehicles registry or the Donate Life Indiana registry and honor such request in accordance with applicable requirements of law.

f) IOPO shall determine whether a Potential Donor has made a written anatomical gift, and, if so, whether the Potential Donor has subsequently revoked the anatomical gift in writing, in consultation with the family or guardian of the Potential Donor and with any other sources that are reasonably available, and any information received by IOPO shall be provided by IOPO to Hospital, the attending physician, and the physician who certified the Potential Donor's death if there is not an attending physician, and must be documented in the Donor's medical chart.

g) Designated Requestor shall work cooperatively with a Family Services Coordinator in requesting consent for any potential anatomical donation from a Potential Donor's family, when no declared intent by the Potential Donor can be found. If Hospital has actual notice of contrary intent in writing by a Potential Donor, or that the potential donation is opposed by a member of the Potential Donor's family or guardian, which member is of the same or prior class under Indiana law as the family member or guardian granting the consent, Hospital shall notify IOPO of such contrary intent. This shall not prevent IOPO from presenting options for donation to a Potential Donor's family members or guardian.

h) In the event that Organs, Tissue or Eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consent, procurement and all examinations necessary to assure suitability may proceed for donation for medical or dental research or education, the advancement of medical or dental science, or therapy.

3. Organ Procurement. The procedures undertaken to procure donated Organs shall be supervised by PTC, or other professional procurement personnel, provided by and or contracted by IOPO, with specialized training in transplantation, Donor evaluation and management and Organ preservation, to coordinate Organ procurement activities at Hospital, or, to serve as consultants to the Hospital physicians on the staff of Hospital, or when other qualified Organ procurement personnel perform such activities. Hospital agrees to grant access, on an emergency basis in accordance with its Medical Staff rules and regulations, to physicians and other Organ procurement personnel participating in the procurement procedures, case management, and all ancillary activities. Hospital and IOPO agree to cooperate in complying with reasonable requirements of other health care providers and payors in connection with Organ procurement pursuant to the terms of this Agreement.

4. IOPO Obligations. IOPO, consistent with its purposes of performing and coordinating the retrieval, preservation and transportation of Organs will follow the system of locating prospective recipients pursuant to the rules of the OPTN for available Organs, and educating medical personnel regarding donation issues, shall:

- a) provide twenty-four (24) hour availability of a qualified IOPO staff member or PTC to evaluate and determine the medical suitability for Organs from Potential Donors; assist in the clinical management of the Donor, coordinate the procurement teams for Organ recovery, provide technical assistance during recovery and initiate Organ preservation and recovery;
- b) provide a Family Services Coordinator or other qualified IOPO staff member to appropriately inform the family of a Potential Donor of the right to donate or to decline to donate, to seek to obtain consent for donation from the family or person legally responsible in accordance with applicable law, and with discretion and sensitivity to the family or legal guardian.
- c) provide in-service training for Hospital personnel involved in Organ donations;
- d) educate Hospital personnel regarding donation and transplantation issues;
- e) if requested, approve or provide on at least an annual basis a course in the methodology for approaching Potential Donor families and requesting Organ donation for the purposes of training Hospital personnel to become Designated Requestors, which training shall also be designed in conjunction with the tissue and eye bank community, if Hospital chooses to use Hospital personnel to perform such tasks;

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- f) provide a physician or other qualified and trained personnel to assist in the medical management of the Potential Donor during the time of actual procurement of Organs and provide assistance to physicians who are members of the Medical Staff of Hospital to provide such services, and IOPO's Medical Director shall provide oversight and assistance in the clinical management of a Potential Donor when the Hospital physician on call is unavailable;
- g) ensure that IOPO personnel and IOPO contractors providing services under this Agreement are trained in the proper methods necessary for Donor screening, determining medical suitability, requesting consent for donation, procurement, transportation and preservation of Organs, efficient placement of Organs, and oversight of Organ recovery;
- h) determine whether there are conditions that may influence or affect the medical suitability and acceptance of a Potential Donor;
- i) to the extent reasonably practical, obtain the medical and social history of a Potential Donor;
- j) review the medical chart of a Potential Donor and perform a physical examination of a Potential Donor;
- k) using the protocols and procedures developed and adopted by Hospital, in consultation with Hospital's designated Tissue recovery agency and Eye recovery agency, determine whether a Potential Donor whose death is imminent or who has died, is medically suitable for Tissue or Eye donation;
- l) obtain the vital signs of a Potential Donor and perform all pertinent tests, including blood typing using two separate samples from each Potential Donor;
- m) document each Potential Donor's medical chart with all test results, including blood type, before beginning Organ recovery;
- n) if IOPO recovers Organs from a DCD Donor, IOPO shall maintain and follow protocols for evaluating DCD Donors; for withdrawal of support, including the relationship between the time of consent to donation and the withdrawal of support; the use of medications and interventions not related to the withdrawal of support; the involvement of family members prior to Organ recovery; and criteria for the declaration of death and time period that must elapse prior to Organ recovery;
- o) provide qualified and trained personnel, materials, certain pharmaceuticals and equipment for recovery and preservation of Organs after their procurement;

- p) utilize Organs procured at Hospital in accordance with the rules and requirements of OPTN and UNOS, and requirements of law, to recipients deemed suitable in accordance with sound medical practice;
- q) if requested by Hospital, provide Hospital with information as to the eventual disposition of all Organs procured at the Hospital;
- r) reimburse Hospital at a rate consistent with national Organ procurement standards that are reasonable and customary for the Indiana region as determined by American Medical Bill Review ("AMBR"), for all costs associated with procurement of Organs from Donors preliminarily approved as medically suitable from and after the time of death of the Donor is determined and proper consent is obtained, in accordance with existing applicable CMS regulations;
- s) pay private physicians not otherwise compensated through Hospital for reasonable and customary procurement fees for services related to procurement activities, unless IOPO and a physician have entered into a separately negotiated agreement for charges related to procurement activities;
- t) make arrangements for histocompatibility tissue testing and testing for potentially transmittable diseases according to the current standards of practice to determine the medical acceptability of the donated Organs for the purposes intended, which shall be performed by a laboratory that is certified in the appropriate specialty or subspecialty of service and meeting the requirements specified by UNOS, in accordance with the guidelines specified by the Center for Disease Control and other applicable laws and regulations;
- u) send complete documentation of Donor information including Donor's blood type and other vital data necessary to determine compatibility for purposes of transportation, the complete record of Donor's management, documentation of consent, documentation of the pronouncement of death, and documentation regarding determining Organ quality to the Transplant Center that will utilize each Organ; and two individuals, one of whom must be an IOPO employee, must verify that the documentation that accompanies an Organ is correct;
- v) conduct reviews, on at least a monthly basis, of death records in every Medicare and Medicaid participating hospital in its Donation Services Area that has a Level I or Level II trauma center or 150 or more beds, a ventilator and an intensive care unit (unless the hospital has a waiver to work with an Organ procurement organization other than IOPO), with the exception of psychiatric and rehabilitation hospitals; to make an assessment of the medical charts of deceased patients to evaluate the potential for Organ donation; and in the event that missed opportunities for donation are identified, IOPO, working with Hospital, shall implement actions reasonably necessary to improve performance in identifying such opportunities;

w) establish written policies to address the process for identifying, reporting, thoroughly analyzing and preventing adverse events that may occur during the Organ donation process, and use the analysis to affect changes in IOPO's policies and procedures to prevent the repetition of adverse events during Organ donation;

x) maintain a toll-free telephone number (800-356-7757) to facilitate the central referral of Organ, Tissue and Eye donations within the IOPO Donation Service Area; and

y) either directly or through a contract with an answering service, shall cause Organ donation referrals to be referred to IOPO and its on-call staff, shall cause referrals for Tissue and Eye donation to be referred to the appropriate agency having an agreement with Hospital for handling such donations; and shall cooperate with the tissue banks with which Hospital has an agreement to ensure that referrals are screened for Tissue and Eye donation potential and to cooperate in obtaining consent for Tissue and Eye donations.

5. Additional Hospital Obligations. In addition to those obligations set forth in Section 2 of this Agreement, Hospital shall:

a) comply with the requirements of Section 1138 of the Social Security Act (42 U.S.C. § 1320b-8) and the regulations of the Centers for Medicare and Medicaid Services; all anatomical gift legislation of the State of Indiana; and other legal requirements applicable to Organ donation;

b) allow IOPO to use ancillary laboratory facilities, other than any available at Hospital, for tests of Organ function, blood typing, and other indicated clinical studies of Potential Donors as directed or requested by IOPO;

c) maintain certification of Hospital laboratory testing under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") and regulations of the Centers for Medicare and Medicaid Services, 42 C.F.R. Part 493.

d) in a timely manner provide intensive care or other clinical support for optimum maintenance of Potential Donors prior to Organ procurement, to follow procedures and protocols as specified by IOPO for Organ procurement; and work cooperatively with IOPO in the optimum maintenance of Potential Donors while necessary testing and placement of potential donated Organs takes place;

e) shall adopt a protocol for DCD Donors, and notify IOPO of Hospital's DCD protocol, and to take all steps required under such protocol for determinations of death as provided in subsection 5. (f) below;

- f) in a timely manner provide physicians to determine the death of Potential Organ Donors in compliance with applicable state law and in accordance with standard medical practice;
- g) work cooperatively with IOPO on providing access to Potential Donor medical records, in providing appropriate access to Hospital's information system;
- h) provide IOPO with wired or wireless secure high-speed internet connection within the Hospital, at no charge to IOPO, for the purpose of facilitating the evaluation, maintenance, recovery, placement, and medical charting of Donors, in order for IOPO to provide Donor information to UNOS, and, if Hospital cannot provide a high speed Internet connection, Hospital agrees to work with IOPO to make the best alternative Internet connection available, which could include wireless Internet access cards or a dial-up connection;
- i) provide an operating room with staff if needed (including surgical, anesthesia, and nursing) and materials deemed appropriate by IOPO for performing cadaveric Organ recovery, and assistance in performing all reasonably necessary tests and examinations, and if Hospital does not have appropriate operating room facilities, to follow procedures and protocols as specified by IOPO until such time as a potential Donor can be transported to another medical facility with appropriate facilities;
- j) provide an itemized bill of all services for each Organ Donor for which Hospital seeks reimbursement, and ensure that the family of an Organ Donor, or person financially responsible for payment of the expenses for medical and surgical care for the Donor, is not charged or billed for expenses related to Organ donation; and to furnish to IOPO, upon request, an itemized statement of expenses billed to the Donor family or other responsible party, relating to the Donor's medical and surgical care and treatment to confirm that no such charges or bills were remitted;
- k) work cooperatively with IOPO in the education of Hospital staff and the community regarding donation issues;
- l) enter a notation in a patient's chart when Timely Referral is provided to IOPO;
- m) cooperate with IOPO and provide the assistance of at least one qualified Hospital employee to assist in verifying that documentation, including Donor blood type and other vital data necessary to determine compatibility for purposes of transplantation, specified in subsection 4. (u) of this Agreement that accompanies an Organ to a Transplant Center is correct;

n) cooperate with IOPO in performing death record reviews as specified in subsection 4. (v) of this Agreement; and, if required, to cooperate with IOPO in implementing actions deemed reasonably necessary to improve the opportunities for identifying Potential Donors;

o) cooperate with IOPO in identifying, reporting, analyzing and preventing adverse events that may occur during Organ donation at Hospital, as specified in subsection 4(u) of this Agreement, and cooperate with IOPO in taking all steps deemed reasonably necessary to prevent the repetition of adverse events during Organ donation at Hospital; and

p) prepare and implement written policies supporting a program for monitoring the effectiveness of its Organ donation and procurement program by collecting and analyzing records regarding Potential Donors and referrals to IOPO, and Hospital's Conversion Rate data, and, where possible, taking steps to improve the Conversion Rate

6. Retention and Access to Records. In accordance with the Omnibus Reconciliation Act of 1980, 42 U.S.C. § 1395x(v)(I) and regulations thereunder, IOPO and Hospital agree that each shall retain and for four years after services are furnished by either hereunder, shall allow the Comptroller General of the United States and the United States Department of Health and Human Services, and their duly authorized representatives, access to this Agreement and to such of the books, documents and records of each as are necessary to verify the costs of services performed hereunder, provided that the said access is required by the cited law and regulations and further provided that the request for access complies with the procedural requirements of those regulations.

7. Independent Contractors. In the performance of all obligations hereunder, the relationship of Hospital and IOPO shall be that of independent contractors, and neither shall be deemed to be the partner or agent of the other, and no party shall withhold or in any way be responsible for the payment of any federal, state, or local income or occupational taxes, F.I.C.A. taxes, unemployment compensation or workers compensation contributions, or any other payments for or on behalf of any other party or any person on the payroll of any other party.

8. Professional Liability. IOPO and Hospital shall each, at all times, qualify and comply with the procedures to be and remain qualified health care providers pursuant to the Indiana Medical Malpractice Act, as amended, Indiana Code § 34-18-1-1 et seq. and shall maintain professional malpractice liability insurance coverage or other qualifying financial responsibility in accordance with the applicable liability limits or securities as specified therein, and pay the annual surcharges levied by the Indiana Department of Insurance.

9. Indemnification. Hospital and IOPO shall protect, defend, indemnify and hold harmless the other party from and against all claims, losses, demands, damages and causes of action, including reasonable attorney fees arising or in any way resulting from the indemnifying party's willful or negligent acts or omissions or the acts of the indemnifying party's agents or employees, in providing services pursuant to this Agreement. Said indemnification shall be limited to the maximum exposure permitted under Indiana Code § 34-18-1-1 et seq., unless insurance coverage in a greater amount is possessed by the indemnifying party.

10. Governing Law. This Agreement shall be controlled by and construed under, the laws and regulations of the State of Indiana and applicable federal laws and regulations.

11. Compliance with Social Security Act. The parties agree that all provisions of this Agreement shall be interpreted in such a manner as to comply with the requirements of Section 1138 of the Social Security Act, as added by Section 9318 of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. § 1320b-8), and rules or regulations adopted pursuant to that law relating to Organ procurement.

12. Confidentiality of Patient Records. The parties agree to maintain the confidentiality of patient records pursuant to state and federal laws and regulations. However, to the extent permissible, the parties agree to cooperate in the exchange of information and records as may be necessary to carry out the terms of this Agreement, including obtaining information for inclusion in any IOPO originated donation chart as required by federal law. IOPO may disclose Donor medical and patient information to physicians providing treatment for Organ recipients, to Transplant Centers receiving Organs, Tissue and Eyes, to the local coroner, and as may otherwise be required by applicable laws or regulations. IOPO may disclose medical and billing information to institutions providing reimbursement of expenses related to Organ donation and procurement.

13. Termination. This Agreement shall remain in effect until terminated by either party. Termination may be made by either party upon 90 days prior written notice to the other.

14. Waiver. The failure of any one party hereto to enforce any breach or to enforce any lack of performance of any covenants or obligations contained herein shall not constitute the waiver of that breach or of any similar subsequent breach of this Agreement.

15. Amendment. This Agreement represents the entire agreement between the parties hereto, and supersedes any prior stipulation, agreement, or understanding of the parties, whether oral or written. Any modification of this Agreement shall be invalid unless stated in writing and signed by both parties hereto.

16. Notice. All communications, notices and demands of any kind which either party may be required or desires to give or serve upon the other party shall be made in writing and sent by registered or certified mail, postage prepaid, return receipt requested, to the following addresses:

Hospital:

William C. VanNess II, M.D., President/CEO
Community Health Network - Anderson and Madison County
1515 North Madison Avenue
Anderson, IN 46016

IOPO:

Lynn Driver, President/CEO
Indiana Organ Procurement Organization, Inc.
429 N. Pennsylvania St., Suite 201
Indianapolis, IN 46204-1816

Either party hereto may change its address specified for notices herein by designating a new address in accordance with this paragraph.

17. Separable Provisions. If any provisions hereof shall be, or shall be adjudged to be, unlawful or contrary to public policy, then that provision shall be deemed to be null and separable from the remaining provisions hereof, and shall in no way affect the validity of this Agreement.

18. Discrimination. The parties hereby warrant that each party is and shall continue to be in compliance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973. No person shall, on account of race, color, religious creed, national origin, ancestry, sex, handicap or age be unlawfully excluded from participation in any program sponsored by either of the parties of this Agreement.

19. Debarment. IOPO and Hospital each represents and warrants to the other, that neither it nor any of its affiliates, officers, directors, subcontractors, or employees, is barred from participating in federal or state health care programs, or has been convicted of a criminal offense with respect to health care reimbursement. IOPO and Hospital shall notify the other immediately if the foregoing representation becomes untrue, or if it is notified by the Office of the Inspector General of the Department of Health and Human Services or other enforcement agencies that an investigation of IOPO or Hospital has begun which could lead to a sanction, debarment, or conviction.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

Community Health Network - Anderson and
Madison County

INDIANA ORGAN PROCUREMENT
ORGANIZATION, INC.

By: *William C. Van Noss II* / CEO

By: *Lynn Driver*

Printed: William C. Van Noss II

Printed: Lynn Driver

Its: President / CEO

Its: President / CEO

Date: 2/20/07

Date: 2-5-07

“HOSPITAL”

“IOPO”

Indiana Organ Procurement Organization Inc.

February 1, 2007

429 North Pennsylvania Street
Suite 201
Indianapolis, IN 46204-1816
317.685.0389
Fax 317.685.1687
www.ioipo.org

Mr. William C. VanNess
President/CEO
Community Health Network - Anderson and Madison County
1515 North Madison Avenue
Anderson, IN 46016

Re: Organ Procurement Agreement with
Indiana Organ Procurement Organization, Inc.

Dear Mr. VanNess:

Enclosed is a revised Organ Procurement Agreement prepared by Indiana Organ Procurement Organization, Inc. ("IOPO") to be consistent with the newly-revised rules of the Centers for Medicare & Medicaid Services ("CMS"), 42 CFR §486.301 et seq., issued on May 31, 2006. The CMS Rules covering hospital participation in improving organ and tissue donation have been anticipated for the last two years. The new Rules include new outcome and process performance measures based on organ donor potential and other related factors in each service area for qualified Organ Procurement Organizations ("OPOs"). The goal of the new Rules is to increase the number of organs available for donation. The donation efforts of each of the hospitals within IOPO's donation service area are crucial to insure that the supply of transplantable human organs continues to increase.

Indiana Donation Hotline

800.356.7757

Public Information Line

888.ASK.IOPO

IOPO and each of the hospitals are responsible for identifying potential organ donors and obtaining for transplant as many organs as possible from those medically suitable donors. IOPO is responsible in its service area to ensure that the organs are properly obtained and preserved and quickly delivered to a suitable recipient selected pursuant to the policies and procedures of the Organ Procurement and Transplantation Network. In order for a hospital to maintain its Medicare certification, a hospital must have in place an organ procurement agreement with its designated and certified OPO. We ask that you review the enclosed agreement carefully, sign both copies, and return one copy to IOPO by February 15, 2007. You should retain one signed copy in the hospital's files.

This letter summarizes the changes and additions in the new Agreement compared to prior versions of the Organ Procurement Agreement.

Regional Offices

Fort Wayne

South Bend

Evansville

223

In accordance with the new CMS Rules, revised and additional definitions are contained in the "Definitions" section of the Agreement, including "Brain Death," "Clinical Triggers," "Donation After Cardiac Death ("DCD"), "Family Services Coordinator," "Imminent Death," "Timely Notification," and "Conversion Rate" found in Section 5 (q). These new definitions are consistent with terms contained in the new CMS Rules.

In Section 2 of the Agreement, emphasis has been made on jointly establishing a "timely referral" procedure whereby hospitals are to notify IOPO of a patients' donor potential in order to facilitate obtaining family consent, where necessary, and to make preliminary determinations of medical suitability of organs and tissues for transplantation. Early notification to IOPO and early intervention by IOPO are the best ways to increase the availability of medically suitable organs for transplantation. Additional obligations are imposed on IOPO in Section 4 of the agreement, including the requirement for IOPO to follow each hospital's DCD protocols. Additional obligations include conducting death record reviews on at least a quarterly basis in each hospital with a Level 1 or Level 2 trauma center, 150 or more beds, or a ventilator and intensive care unit. It is incumbent upon IOPO to establish written policies to identify, report, analyze and prevent adverse events, and work to prevent the repetition of any adverse events in future organ donation procedures.

As we previously notified the Hospital, additional requirements are imposed on all OPOs that, effective January 1, 2007, all data and information pertinent to organ donations must be transmitted electronically over the Internet to UNOS. Accordingly, this Agreement contains new provisions requesting that each hospital provide Internet access to IOPO during the course of the organ procurement activities.

IOPO agrees to offer to provide designated requestor training on at least an annual basis for hospital and critical access hospital staff. IOPO will continue to have arrangements to cooperate with tissue banks and eye banks that have agreements with each contracted hospital, and will cooperate in the screening and referral of potential tissue and eye donors, assist in obtaining informed consent from families, support as applicable the retrieval, processing and distribution of tissues.

The CMS Rules encourage hospitals to develop and implement protocols for donation after cardiac death (DCD.) As a potential source for additional organs suitable for transplantation, IOPO will provide whatever assistance is required in working with you to develop and implement DCD protocols.

In its efforts to increase the number of transplantable organs obtained from each service area, CMS is requiring that OPOs maintain records regarding outcome measures and provide data reports to the Organ Procurement and Transplant Network (OPTN,) a contractor to the U.S. Department of Health and Human Services. To that end, IOPO will work with each hospital in its service area in continuing to develop data regarding the number of hospital deaths, the results of death record reviews, the timeliness of referral calls from hospitals with potential donors, the numbers of eligible donors, the number of organs recovered by type of organ, and the number of organs transplanted by type of organ.

IOPO has developed and implemented a quality assessment and performance improvement program, including objective measurements to evaluate and demonstrate improved performance in such areas as hospital development, timeliness and on-site response to hospital referrals, donor management, consent practices, as well as organ recovery and placement. As part of those ongoing efforts, IOPO will conduct death record reviews in cooperation with each hospital.

The changes contained in this organ procurement agreement are intended to comply with the spirit and intent of the new CMS rules to try to increase the availability of this limited resource, transplantable human organs. IOPO looks forward to working with your hospital's staff to continue to implement effective organ and tissue donation services in Indiana.

Please call either one of the undersigned to discuss the enclosed agreements or receive answers to any questions. We look forward to receiving a signed copy of the agreement by February 15, 2007.

Thank you for your assistance and cooperation. We look forward to continuing to work together to increase the availability of medically suitable organs.

Sincerely,



Lynn Driver, President/CEO
Indiana Organ Procurement Organization, Inc.
429 N. Pennsylvania St., Suite 201
Indianapolis, IN 46204-1816

DJB/ss
Enclosure
G:\IOPO\Djb\L\HospitalAgmtLtr

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 19

Diversion Policy

19. "**Diversion policy**. The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time. The hospital's documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 19 are met with a signed copy of the Community Hospital – Anderson (CHA) diversion policy. The Emergency Department Director has executed the included letter affirming that the hospital will not be on diversion status more than 5% of the time. The letter further attests that the CHA ER has not been on diversion in the previous year. Therefore, there is no existing record.



**Community
Hospital Anderson**

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011
T 765.298.4242
eCommunity.com

March 1, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

**SUBJECT: AFFIRMATION OF DIVERSION STANDARDS FOR LEVEL III
TRAUMA CENTER "IN THE PROCESS" APPLICATION REQUIREMENT
NUMBER 19**

Dear Dr. VanNess:

The purpose of this correspondence is to affirm that Community Hospital Anderson has a Diversion Policy and absolutely will not be on diversion status more than 5% of the time.

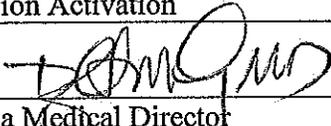
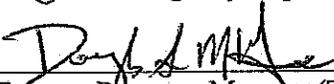
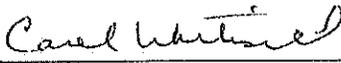
I further affirm that there has not been a diversion event at Community Hospital Anderson in the previous year.

Sincerely,

Joni Brinkman, MSN, RN
Director, Emergency Department
Community Hospital, Anderson
1515 North Madison Avenue
Anderson, IN 46011

 **Community Hospital Anderson**

Trauma Services Policy and Procedure Manual

Subject:	Diversion Activation
Originator:	 Trauma Medical Director
Approved By:	 Director Emergency Department  Trauma Program Manager (TPM)  Vice President Patient Care Services/CNO
Scope:	Emergency Department
Policy Coordinator:	Cheryl Arnold
Effective:	2/1/2014
Revised:	3/20/2014
Reviewed:	
References:	
Attachments:	

PURPOSE:

To provide the safest and most optimal care for the patient population that we serve.

GENERAL INFORMATION:

Ambulance diversion from Community Hospital Anderson Emergency Department will only occur under extreme situations that would not allow the patient access to the service or specialty required.

PERSONNEL: Emergency Department Physician
 Trauma Medical Director
 Administrative Representative
 Emergency Director or designee
 Emergency Department Charge Nurse

EQUIPMENT: None

PROCEDURE:

a. The ED Physician (or designee) or Trauma Medical Director (or designee) will contact the Administrative Representative and the ED Director (or designee) and advise of the extreme situation that requires the ED to go on diversion.

b. The ED Physician in consultation with the Trauma medical Director will make the final diversion implementation decision.

c. The Administrative Representative will notify the CNO.

d. The CNO will make appropriate executive administrative notification(s).

e. The Emergency Department staff will:

1. Notify EMS and the St. Vincent Anderson Regional Hospital House Supervisor that the CHA ED is on diversion.

2. Initiate the diversion log.

2. Releasing Diversion Status

a. When the extreme situation has been resolved or corrected, the Emergency Department physician (or designee), Trauma Medical Director (or designee) or Director of the Emergency Department (or designee), in consultation with the Administrative Representative will authorize removing the diversion status.

b. The Emergency Department staff will:

1. Notify appropriate EMS and St. Vincent Anderson Regional Hospital that the CHA ED is off diversion.

2. Complete the diversion log.

3. A copy of the log will be made available to:

i. Director of Emergency Department

ii. Trauma Program Manager

iii. Executive Administration Staff

3. Diversion Review

a. All diversion activations will be reviewed by the Trauma Program Operational Process Performance Committee or appropriate Standards Committee.

Community Hospital Anderson

DIVERSION EVENT RECORD

TYPE OF EVENT: _____

Date of Diversion: _____ Time: _____ Administrative Rep: _____
 OFF Diversion: Time: _____ ED Physician: _____

Explanation of Diversion and Mitigation actions:	ON Diversion (person contacted)	Time	Initials	OFF Diversion (person contacted)	Time	Initials
St. Vincents Regional House Supervisor 649-2511						
Anderson City Dispatch 648-6775						
Madison County Dispatch 642-0221						
EMAS Ambulance 644-1717						
SEALS Ambulance 641-9890						
Rural Metro Ambulance 644-2800						
Delaware County/Salem Township 747-7878						

231

COMMUNITY HOSPITAL ANDERSON

Diverted Patient Tracking Log

Date _____

No patients diverted

Time _____

Date/Time: _____

Ambulance Service: _____

Chief Complaint: _____

Diversion destination: _____

Date/Time: _____

Ambulance Service: _____

Chief Complaint: _____

Diversion destination: _____

Date/Time: _____

Ambulance Service: _____

Chief Complaint: _____

Diversion destination: _____

Date/Time: _____

Ambulance Service: _____

Chief Complaint: _____

Diversion destination: _____

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 20

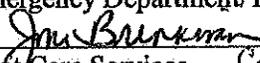
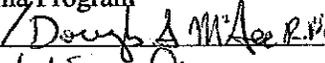
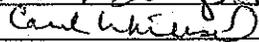
Operational Process Performance Improvement Committee

20. "Operational process performance improvement committee. There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 20 are met with a signed copy of the Community Hospital - Anderson (CHA) Trauma Program Operational Process Performance (TPOPP) Committee policy. A signed copy of the CHA Performance Plan is attached. Various sub-committees of the TPOPP Committee have been meeting to evaluate and improve our Trauma Service since the fall of 2013. A representative sample of meeting times and minutes is attached.


Community Hospital Anderson
Trauma Services Policy and Procedure Manual

Subject:	Trauma Program Operational Process Performance Committee (TPOPP)
Originator:	 Trauma Medical Director
Approved By:	Clinical Director Emergency Department/Trauma Program Manager (TPM)  /  Vice President Patient Care Services  Chief Executive Officer 
Scope:	Emergency Department
Policy Coordinator:	Cheryl Arnold
Effective:	1/3/14
Revised:	
Reviewed:	
References:	
Attachments:	

PURPOSE:

1. Review the performance of the trauma program
2. Review the safety of the trauma program
3. Provide focused education
4. Address trauma service operational issues
5. Ensure that the appropriate trauma patient population is identified

PROCEDURE:

The TPOPP Committee hereby created shall meet at least quarterly. Members shall be subject to the minimum attendance requirements as specified by the American College of Surgeons. Additional meetings may be called at the discretion of the Trauma Medical Director.

- A. Membership of the Trauma Program Operational Process Performance Committee
 1. Trauma Medical Director (Surgeon)
 2. ED Medical Director
 3. EMS Co-Medical Director
 4. Anesthesiologist
 5. Orthopedic Surgeon
 6. Neurosurgeon

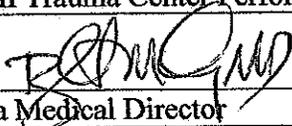
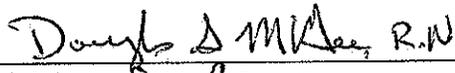
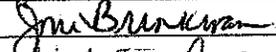
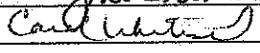
7. Radiologist
8. ICU Medical Director
9. CEO
10. CNO
11. Trauma Program Manager
12. Trauma Registrar
13. ED Director
14. ED Clinical Manager / EMS liaison
15. Surgery Clinical Director
16. ICU Clinical Director
17. Quality Management Director
18. Radiology Administrative Director
19. Lab Administrative Director
20. Rehab Services Admin Director
21. Administrative Assistant

END



Community Hospital Anderson

Emergency Department Policy and Procedure Manual

Subject:	Level III Trauma Center Performance Improvement Plan
Originator:	 Trauma Medical Director
Approved By:	Trauma Program Manager  R.W. Clinical Director Emergency Department  Vice President Patient Care Services  Chief Executive Officer 
Scope:	Hospital – all departments and Medical Staff
Policy Coordinator:	Cheryl Arnold
Effective:	3/1/2014
Revised:	
Reviewed:	
References:	American College of Surgeons, Committee On Trauma. Resources For The Optimal Care Of The Injured Patient 2006. Chicago, IL. Society of Trauma Nurses. Trauma outcomes & Performance Improvement Course. 2013 Edition. Lexington, KY 40517
Attachments:	

PERSONNEL:

Applicable to all hospital staff and Medical Staff

PHILOSOPHY:

Services by the CHA Trauma Program are of the highest quality with a focus to provide superior value to our patients

MISSION:

The Trauma Program Performance Improvement and Patient Safety Plan is designed to ensure efficient, cost effective, quality patient care that is facilitated by continuous, systematic and objective data analysis and multidisciplinary peer review to identify opportunities to improve patient safety through all phases of trauma care. The ultimate goal is to reduce mortality and morbidity in the Trauma patient population. This policy establishes a formal, validated, internal performance improvement process that provides for a multidisciplinary approach to rapid problem identification, data-driven analysis and resolution of issues within the quality framework of our institution.

GOALS:

The Trauma Services Performance Improvement Patient Safety Plan is designed to provide an ongoing, comprehensive and systematic structure for monitoring the quality

and appropriateness of multidisciplinary care for the injured patient. The monitoring and evaluation of patient care is based upon predetermined standards.

These standards include the following:

1. Evidenced-based practice management guidelines (EBPMGs) and protocol/policies developed by the Trauma Performance Improvement (PIPS) committee.
2. Resources for Optimal Care of the Injured Patient: 2006 developed by the American College of Surgeons, Committee on Trauma
3. The State Rules and Regulations for Trauma Centers

The specific goals of the Trauma and PIPs Plan include:

1. Regular and systematic monitoring of the process of care and outcomes for the injured patient
2. Monitor and intervene to assure the appropriate and timely provision of care
3. Improve the knowledge and skills of the trauma care providers
4. Assure compliance with accrediting and regulating agencies governing the designation of trauma centers
5. Provide the institutional culture, structure and organization to promote quality improvement

AUTHORITY AND SCOPE:

The Trauma Performance Improvement Program is under the direction of the Trauma Medical Director (TMD). The TMD has the express authority and duty to manage all aspects of Trauma care. The TMD has specific authority to correct trauma program and medical staff deficiencies.

CREDENTIALING:

All physicians who participate in the care of injured patients will be credentialed according to the medical staff bylaws. The Trauma Program Manager (TPM) in collaboration with nursing leadership is responsible for overseeing the credentialing and continuing education of nurses working with trauma patients.

PATIENT POPULATION:

As illustrated on the Indiana Trauma Registry Inclusion Map in **Appendix A**, the trauma patient is defined as any patient with ICD9-CM discharge diagnosis of 800.00 - 959.9 (ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9); excluding 905 - 909.9, 910 - 924.9 and 930 - 939.9.(ICD-10-CM S00, S10, S20, S30, S40, S50, S60, S70, S80, S90). The patient record must also include **one** of the following:

1. Hospital admission
2. Patient transfer via emergency medical services transport (including air ambulance) from Community Hospital - Anderson ("CHA") to another hospital.

3. Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)

DATA COLLECTION:

Quality review is dependent upon both concurrent and retrospective data abstraction. The data will be abstracted by the Trauma Registrar or designee from patient records meeting the patient population definition. The Trauma Program Manager will abstract ten percent of the patient population to ensure the inter-rater reliability. The data sources include but are not limited to the following:

1. Pre-hospital reports
2. Computerized hospital medical records
3. Hand-written hospital records
4. Trauma registry analysis
5. Audit filters
6. Medical examiner report review
7. Sentinel event report
8. Internal special studies conducted by the TPM
9. Special studies conducted by other disciplines or departments
10. System analysis referrals
11. Direct observation and reporting by trauma service providers or other care providers

AUDIT FILTERS:

A. The following selected outcomes will be evaluated by the Trauma Peer Review Committee.

1. Mortality
2. Patient with gunshot wound or stab wound which penetrates the abdominal wall which does not receive an exploratory lap if not transferred.
3. Patient requiring laparotomy which is not performed within two hours
4. Negative exploratory laparotomy unplanned abdominal, thoracic, vascular or intracranial complications that occur greater than 24 hours after arrival
5. Thoracotomy procedure performed in the ER if patient is not transferred
6. Readmission: Patient previously an inpatient on the trauma service - discharged and is readmitted as an inpatient within 7 days of initial discharge
7. Delay of diagnosis
8. Patients with an interval of greater than 8 hours between arrival and treatment of open fracture or laceration into the joint if patient not transferred
9. Missed activation with serious or potentially serious detriment to patient care
10. Sentinel events

11. Major complications which significantly increase length of stay or impact positive patient outcomes
12. Significant deviation from brain trauma Foundation guidelines

B. The following outcomes will be tracked for general nursing or multidisciplinary review

1. Under or over triage
2. Major nursing documentation deficits or errors
3. Fracture identified after 24 hours
4. Glasgow Coma Scale ("GCS") 8 or less left ER without an advanced airway
5. GCS < 13 receives Head CT > two hours after arrival
6. Massive transfusion protocol initiated
7. Complicated intubation
8. System issues (misplaced imaging reports, misplaced blood specimens, communication equipment failure)
9. Activation not implemented correctly
10. Delays in rehab disposition
11. Patient evaluated in ER and discharged with return to hospital within 72 hours with subsequent admission
12. Apparent Inappropriate pre-hospital treatment or omission
13. NG inserted in patient with contraindications (mid facial fractures, etc.)
14. No nutritional support within 72 hours of arrival
15. No rehab consult prior to day of DC when needed

C. Specific audit filters

1. No documentation of c-spine clearance
2. Delayed or absent Venous Thromboembolism ("VTE") prophylaxis when indicated.
3. Inter-facility transfers
4. GCS not documented
5. Missing hourly VS for trauma level one activations
6. Missing sequential GCS on head injured patients
7. Trauma surgeon response time greater than 30 minutes of pt. arrival
8. Re-intubation within 48 hour of extubation
9. Trauma Level One remained in ER greater than two hours
10. Trauma Level One activations discharged home from ER
11. Transfer to Level I or II Trauma Center greater than one hour from transfer decision.
12. Transfer decision made greater that one hour from patient arrival
13. EMS scene time greater than 20 minutes
14. Absence of EMS Patient Care Report
15. All trauma deaths
16. All neurosurgical trauma cases
17. All delays in identification of injuries

18. Indiana Blood Center response to emergency request when product delivery to CHA is greater than three (3) hours

D. The following focused audits will be reported as follows

1. Nursing education compliance (annually)
2. Physician credential compliance (annually)
3. Trauma Peer Review Committee Physician attendance (quarterly)
4. Surgeon response time (quarterly)
5. Data integrity validation audit (quarterly)
6. Over and Under triage (quarterly)
7. Indiana Blood Center response (annually)
8. Compliance with the Brain Trauma Foundation guidelines (quarterly)

PERFORMANCE IMPROVEMENT PROCESS:

Performance improvement consists of ongoing evaluation of all facets of trauma care provided to the trauma patient. The process is illustrated in Trauma PI Flowchart in **Appendix B**. The Trauma Medical Director and Trauma Program Manager provide ongoing and systematic monitoring of care provided by medical, nursing, and ancillary personnel. Performance Improvement review consists of the utilization of pre-selected quality indicators and additional hospital and regional focused audits. In addition, a process of tracking complications, systems issues, provider issues, and adverse events is determined. The Trauma Program Manager will report all issues and opportunities for improvement to the Trauma Medical Director for determination of the need for further review via the *Trauma Peer Review Committee*, *Trauma Program Operational Process Performance Committee*, or *Quality of Care Committee*. Documentation of resolution of identified issues (loop closure) is the responsibility of the Trauma Medical Director and the Trauma Program Manager.

The use of quality indicators to measure, evaluate, and improve performance is an important component of the Trauma Performance Improvement Plan.

A. First Level of Review

The Trauma Program Manager or designee will do the initial case review of all trauma patients. Appropriate clinical care without provider or system issues identified will need no further review.

B. Second Level of Review

Opportunities for improvement in the system or provider and sentinel events are referred to the Trauma Medical Director (TMD). The Trauma Medical Director and the Trauma Program Manager will perform the second level of review. Further analysis of the case and issue(s) identified will occur. Those cases in which a simple action plan, such as trending of the issue, targeted education, provider counseling or discussion is the only corrective action identified need not proceed to the next level of review. Deaths,

significant adverse events and cases involving more than one service or provider with opportunities for improvement should be elevated to the Third Level of Review. Trauma PI issues will be documented on the "Event Tracking Form" in **Appendix C**. This form tracks all patient care issues, serves as a reference for all PI activity, and assures proper documentation and loop closure by tracking all aspects of the case review to include:

1. Clinical summary,
2. Trauma Medical Director review,
3. Determinations of committee,
4. Corrective actions,
5. Re-evaluation and loop closure date.

C. Third Level of Review

Tertiary Review will occur with the Trauma Peer Review Committee or the Trauma Program Operational Process Performance Committee

D. Purpose of the Meetings

- a) Process Improvement-issues identified in the review that deal with the system of care in the facility are appropriate to discuss in this venue.

These include issues such as:

1. Creation of Trauma Activation Criteria
2. Creation of pathways and protocols
3. Process for utilizing a call team for OR cases
4. Determination of additional requirements for service on the trauma team

These issues deal more with the system of care and not an individual provider. It is important to have representation from all hospital and pre-hospital stakeholders (representatives) at this meeting

- b) Provider Peer Review-issues identified in the review that deal with specific cases and provider issues that arise. These include issues such as :

1. Timeliness of response to a high level activation
2. Appropriateness of evaluation and treatment
3. Appropriateness of admission or transfer
4. Trauma Death

- c) A judgment will be rendered by the committee with regards to the appropriateness of the issue referred for further review.

At the conclusion of an incident review the Trauma Peer Review Committee may take any of the following actions:

1. Determine that care was appropriate and close the case
2. Determine the need for intervention or corrective action and support the TMD during intervention implementation.

3. Determine the need to track and trend

- d) All mortality will be reviewed according to the following metrics:
1. Survival with Opportunity for Improvement (OFI) in the care
 2. Unanticipated Mortality with Opportunity for Improvement (OFI)
 3. Anticipated Mortality with Opportunity for Improvement (OFI)
 4. Mortality without Opportunity for Improvement (OFI)

Further recommendations for performance improvement based on tertiary review will be made to the relevant hospital committees who with the trauma program are responsible for loop closure.

E. Performance Improvement Action Plan

All corrective action planning and implementation will be overseen by the Trauma Medical Director and Trauma Program Manager. Possible corrective actions may include:

1. Education
2. Trending of issue
3. Policy or Guideline Development/Revision
4. Counseling
5. Referral (Management, Quality etc.)
6. Peer Review
7. Focused Audit
8. Resource Enhancement

F. Loop Closure and Re-Evaluation

An essential component in Performance Improvement is demonstrating that a corrective action has the desired effect. The outcome of any action plan will be monitored for expected change and re-evaluated accordingly so that the PI loop can be closed. No issue will be considered as "closed" until the re-evaluation process has been complete and it demonstrates a measure of performance and sustainability that has been deemed acceptable. This evaluation usually occurs within three to six months of the corrective action. Documentation should include the following aspects of follow-up and re-evaluation:

1. Time Frame for Re-evaluation
2. Documentation of Findings
3. Results of Re-monitoring

G. Integration into the Hospital Performance Improvement Reporting Structure

Any organizational improvement activity performed by the Trauma Program Performance Improvement Committee is eligible for submission to Quality Resources for inclusion in specific reports to the Leadership, Clinical Core Groups (CCG) and/or the Quality of Care Committee of the Board. The Quality Resources staff is available for

assistance in data collection, aggregation, analysis and overall data management; comparison to internal and/or external databases, and presentation of the resulting information to applicable groups.

It is preferable to use a combination of outcome and process measures of performance, to fully evaluate the care/service of delivery systems. When rates of performance or outcome vary significantly from the expected, or when the process appears stable but an opportunity to improve the care or service is identified, the Trauma Program Manager/Trauma Medical Director may exercise various options.

Confidentiality

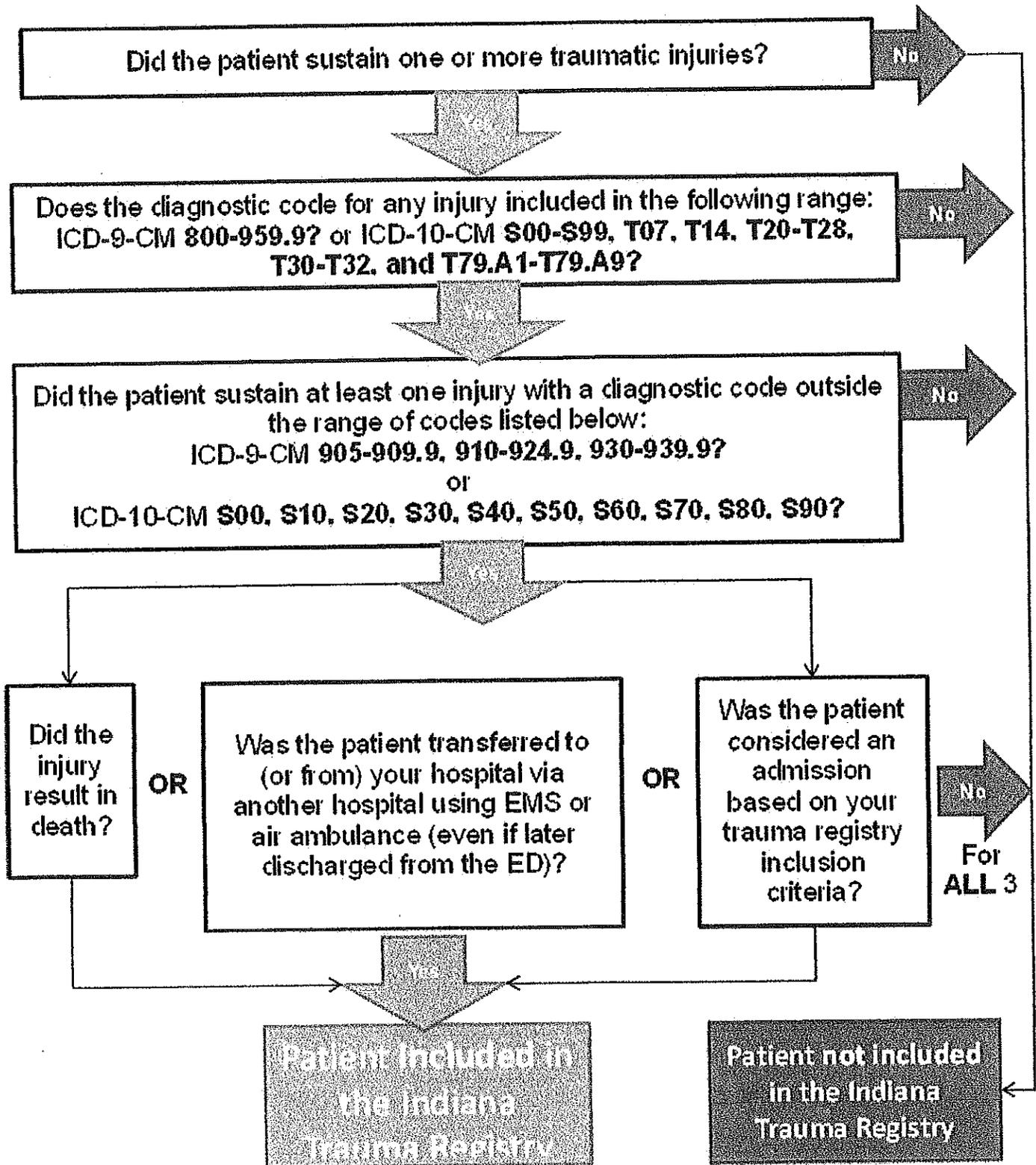
All performance improvement activities that are a component of the Trauma Performance Improvement Peer Review Committee, or that are related to the treatment of specific patients are confidential. Separate records and minutes are maintained in accordance with Federal and Indiana statutes.

END

243

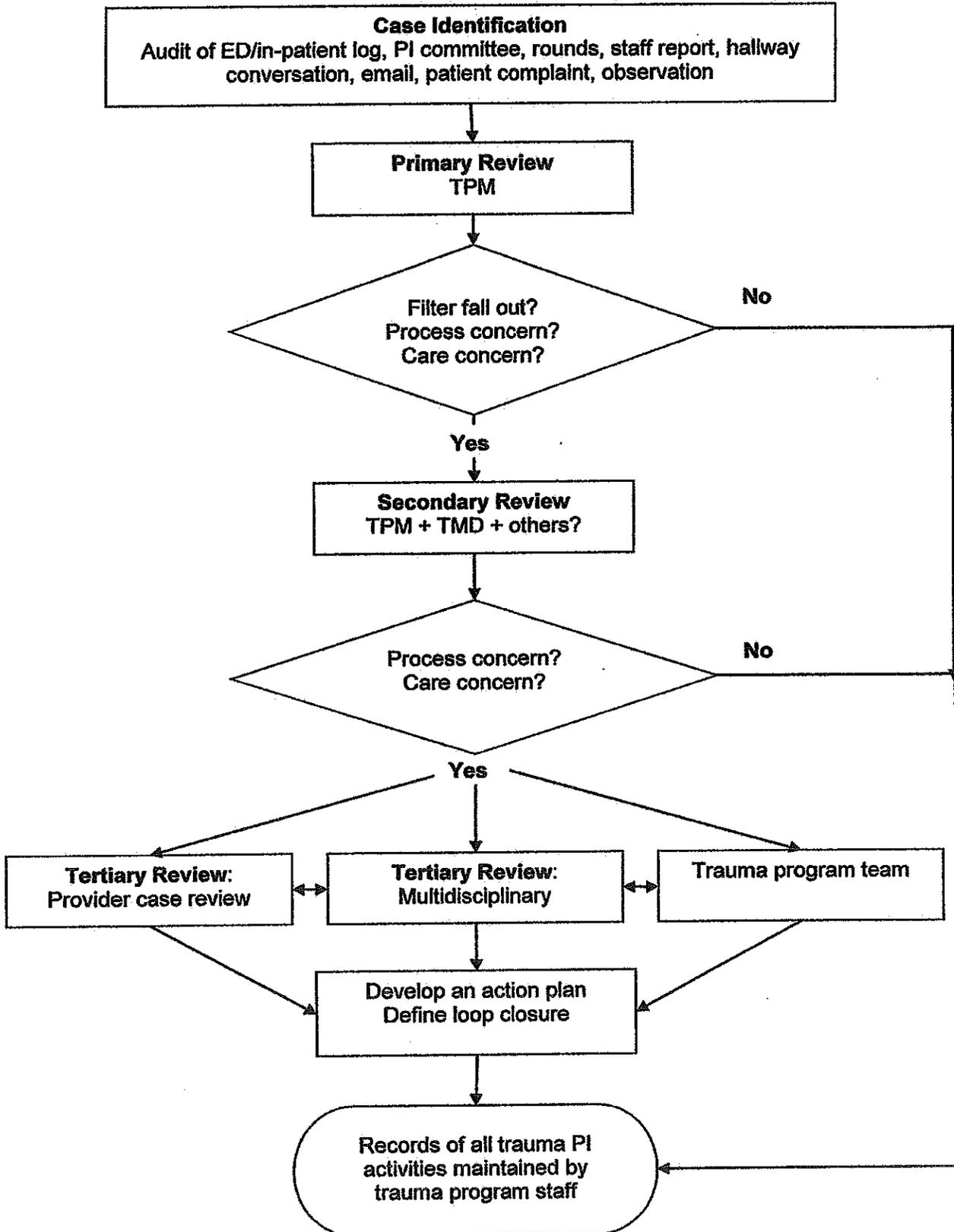
Indiana Trauma Registry Inclusion Criteria Map

APPENDIX A



APPENDIX B

Trauma PI Flowchart



Event Tracking Form

APPENDIX C

Demographics

Date of report: _____ Medical record No: _____ Admit Date: _____ Date: _____ Time: _____

Nature of event: _____ Patient Name: _____ Age: _____ Gender: _____

Diagnosis: _____ Level of Activation: _____

Other Pertinent Information: _____ Report completed by: _____

Source of information (N) _____

Trauma nurse coordinators
 PPS coordinator
 Physician
 Rounds
 Other

Impact (N) _____

Physical: _____ Psychological: _____ Legal: _____

No harm
 No detectable harm
 Mild temporary harm
 Mild permanent harm
 Moderate temporary harm
 Moderate permanent harm
 Severe temporary harm
 Severe permanent harm
 Death

No harm
 No detectable harm
 Mild temporary harm
 Mild permanent harm
 Moderate temporary harm
 Moderate permanent harm
 Severe temporary harm
 Severe permanent harm
 Profound mental harm

Risk management contacted
 Complaint registered
 Suit filed
 Case dropped
 Case dismissed
 Settled
 Defense Verdict
 Plaintiff Verdict

Plaintiff Verdict
 Not employable

Employment:
 Employed
 Seeking employment
 Part-time employment
 Unemployed
 Not employable

Social:
 Unable to socialize
 Homebound, able to socialize
 No social impediments, not socially active
 Socially active

Patient/family satisfaction:
 Extremely satisfied
 Satisfied
 Neutral
 Dissatisfied
 Extremely dissatisfied

Costs of Hospital Care: _____ Total Collections _____

Type (N) _____

Patient Management:
 Airway
 Breathing
 Circulation
 Neurologic
 Gastrointestinal

Nutritional
 Urologic
 Orthopedic
 Delegation of care or tasks
 Patient care flow/tracking
 Patient follow-up

Consultation or referral
 Resource utilization
 Resuscitation
 Intensive care
 Wound care

Communication:
 Inaccurate or incomplete information
 Questionable advice & Interpretation
 Questionable consent process
 Questionable disclosure process
 Questionable documentation

Communication:
 Airway
 Breathing
 Circulation
 Neurologic
 Gastrointestinal

Nutritional
 Urologic
 Orthopedic
 Delegation of care or tasks
 Patient care flow/tracking
 Patient follow-up

Consultation or referral
 Resource utilization
 Resuscitation
 Intensive care
 Wound care

Inaccurate or incomplete information
 Questionable advice & Interpretation
 Questionable consent process
 Questionable disclosure process
 Questionable documentation

Inaccurate or incomplete information
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 Questionable consent process
 Questionable disclosure process
 Questionable documentation

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 Questionable disclosure process
 Questionable documentation

Inaccurate or incomplete information
 Questionable advice & Interpretation
 Questionable consent process
 Questionable disclosure process
 Questionable documentation

246

Event Tracking Form

APPENDIX C

Clinical Performance

- Pre-Interventional:
- Correct diagnosis questionable intervention
 - Inaccurate diagnosis
 - Incomplete diagnosis
 - Questionable diagnosis
- Interventional:
- Correct procedure with complications
 - Correct procedure, incorrectly performed
 - Correct procedure but untimely
 - Omission of essential procedure
 - Procedure contraindicated
 - Procedure not indicated
 - Questionable procedure
 - Wrong patient
- Post-Interventional:
- Correct prognosis
 - Inaccurate prognosis
 - Incomplete prognosis
 - Questionable prognosis

Domain (A)

Settings:		
<p>Hospital</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ambulatory care <input type="checkbox"/> Catheterization laboratory <input type="checkbox"/> Clinical ward <input type="checkbox"/> Diagnostic procedures <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospice <input type="checkbox"/> Inpatient Mental Health <input type="checkbox"/> Inpatient Rehabilitation <input type="checkbox"/> Intensive Care Unit <input type="checkbox"/> Interventional Radiology <input type="checkbox"/> Operating Room <input type="checkbox"/> Outpatient Behavioral Health <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Psychiatric Unit <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Other 	<p>Non-Hospital</p> <ul style="list-style-type: none"> <input type="checkbox"/> EMS Aeromedical Transport vehicle <input type="checkbox"/> EMS Ground Transport vehicle <input type="checkbox"/> Home <input type="checkbox"/> Hospice <input type="checkbox"/> Long-Term Care facility <input type="checkbox"/> Mental Health Facility <input type="checkbox"/> Nursing home <input type="checkbox"/> Practitioner's office <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other facility <input type="checkbox"/> Scene 	<p>Phase:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Evaluation <input type="checkbox"/> Resuscitation <input type="checkbox"/> Operative <input type="checkbox"/> Critical Care <input type="checkbox"/> Recovery <input type="checkbox"/> Rehabilitation <p>Target:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cosmetic <input type="checkbox"/> Diagnostic <input type="checkbox"/> Other <input type="checkbox"/> Palliative <input type="checkbox"/> Preventative <input type="checkbox"/> Reconstructive <input type="checkbox"/> Rehabilitative <input type="checkbox"/> Research <input type="checkbox"/> Therapeutic

247

<p>Staff:</p> <p><input type="checkbox"/> Physicians</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Intern <input checked="" type="checkbox"/> Resident <input checked="" type="checkbox"/> Attending <input checked="" type="checkbox"/> Dentist <input checked="" type="checkbox"/> Podiatrist <input checked="" type="checkbox"/> Physician assistant 		<p><input type="checkbox"/> Nurses</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Nurse's aid <input checked="" type="checkbox"/> Licensed practical nurse <input checked="" type="checkbox"/> Registered nurse <input checked="" type="checkbox"/> Nurse Practitioner 		<p><input type="checkbox"/> Therapists</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Physical therapist <input checked="" type="checkbox"/> Occupational therapist <input checked="" type="checkbox"/> Speech therapist 		<p><input type="checkbox"/> Others</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Health professional student <input checked="" type="checkbox"/> Pharmacist <input checked="" type="checkbox"/> Pharmacy technician <input checked="" type="checkbox"/> Radiation technician <input checked="" type="checkbox"/> Optometrist <input checked="" type="checkbox"/> Other 	
<p>System Factors (N)</p>							
<ul style="list-style-type: none"> <input type="checkbox"/> Chain of command <input type="checkbox"/> Communication channels <input type="checkbox"/> Culture of safety <input type="checkbox"/> Delegation of authority and responsibility <input type="checkbox"/> Documentation <input type="checkbox"/> Equipment or materials availability <input type="checkbox"/> Equipment or materials design <input type="checkbox"/> Equipment or materials malfunction <input type="checkbox"/> Equipment or materials obsolescence <input type="checkbox"/> Establishment and use of safety programs <input type="checkbox"/> Formal accountability <input type="checkbox"/> Incentive systems <input type="checkbox"/> Instructions about procedure 				<ul style="list-style-type: none"> <input type="checkbox"/> Monetary safety budgets <input type="checkbox"/> Objectives <input type="checkbox"/> Organizational failures beyond the control of the organization <input type="checkbox"/> Performance standards <input type="checkbox"/> Risk management <input type="checkbox"/> Schedules <input type="checkbox"/> Selection of organizational resources <input type="checkbox"/> Staffing of organizational resources <input type="checkbox"/> Supervision <input type="checkbox"/> Technical failures beyond the control of the organization <input type="checkbox"/> Time pressures <input type="checkbox"/> Training <input type="checkbox"/> Training of organizational resources 			
<p>Human Factors (N)</p>							
<ul style="list-style-type: none"> <input type="checkbox"/> Patient factor <input type="checkbox"/> Practitioner skill-based <input type="checkbox"/> Practitioner rule-based <input type="checkbox"/> Practitioner knowledge-based <input type="checkbox"/> Practitioner unclassifiable 				<ul style="list-style-type: none"> <input type="checkbox"/> External <input type="checkbox"/> Negligence <input type="checkbox"/> Recklessness <input type="checkbox"/> Internal rule violations <input type="checkbox"/> Do not resuscitate order <input type="checkbox"/> Withdrawal of support 			
<p>Prevention & Mitigation Activities</p>							
<p>Universal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improve the accuracy of patient identification (P) <input type="checkbox"/> Improve the effectiveness of communication and caregivers (P) 				<ul style="list-style-type: none"> <input type="checkbox"/> Improve the effectiveness of clinical alarm systems (P) <input type="checkbox"/> Reduce the risk of healthcare-acquired infections (M) 			
<p>Indicated:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improve the safety of using high-alert medications (P) <input type="checkbox"/> Improve the safety of using infusion pumps (P) 				<p>Selective:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eliminate wrong-side, wrong site, wrong procedure surgery (M) 			

248

Action Plan and Loop Closure:

APPENDIX C

Signature:

Date:

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 12/12/2013 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	A
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	P
Tharp, Beth	CEO	CHA	CHA	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 11:30 a.m.
Beth Tharp Report	<ul style="list-style-type: none"> ❖ B. Tharp reported that Dr. Ben McCurdy is ready to talk about our certification. ❖ Beth will talk about this at the board meeting tonight. ❖ Will need a letter from the board to receive this certification.
Discussion	<ul style="list-style-type: none"> ❖ D. McGee has not heard from St. Francis Lafayette about a site visit. Need to talk to Eskenazi, also, to get forms and information. ❖ Gap Analysis – Need to put policies in place. Need a collection tool for trauma, a diversion policy and a trauma overview policy. ❖ Get bylaws and policies ready for Dr. McCurdy to look at when he comes to the meeting. ❖ C. Arnold to order 10 books” <i>Resources for Optimal</i>

MINUTES OF:

	<p><i>Care of the Injured Patient</i>” newest edition. ACTION: C. Arnold contacted M. Meckel and reported that only the current edition is available. M. Meckel will look for newest edition and let C. Arnold know where to locate it.</p> <ul style="list-style-type: none"> ❖ Need to collect objective data from the above book. ❖ Need to get al information on PIPS. ❖ Along with the trauma tool, need to create a flow for everyone involved in the trauma Level III center. ❖ Dan Yates, Laboratory, is working on a Mass Transfusion policy. D. McGee will send his information to Dan. ❖ Dr. Malik is now the Medical Director of ICU. Beth has not discussed the Trauma Directorship role. ❖ The group agreed that a policy should be presented to Dr. Malik so he will know his role in the trauma certification process.
Peer Review Committee	<ul style="list-style-type: none"> ❖ The Trauma Center Peer Review Committee should consist of a general surgeon, ortho surgeon, neuro surgeon, ED physician, anesthesia physician, and the trauma director. ❖ Trying to set the Peer Review Committee up for “Board Book” on line. They can look at a case before the meeting and review.
Next Steps	<ul style="list-style-type: none"> ❖ D. McGee to talk to Dr. McCurdy. ❖ Need to go to St. Elizabeth’s to talk about certification. ❖ Talk to Respiratory Therapy. Invite Susan Durbin and/or Cheryl Bennett to a trauma certification meeting. ❖ Ask B. Corbey to check policies when they are ready. ❖ Update Role Summary for each person involved in trauma. ❖ Ortho metrics need to be built into MediTech so it can be easily followed. ❖ PIP reviews each trauma case thoroughly and measures it against standards. ❖ Cost is \$16,000 to apply.
	<p>Meeting was adjourned at 12:40 p.m.</p>

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 12/19/2013 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	A
Tharp, Beth	CEO	CHA	CHA	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 3:00 p.m.
General Update	<ul style="list-style-type: none"> ❖ Working through the process and talking to Dr. McCurdy.
Lafayette Site Visit	<ul style="list-style-type: none"> ❖ Doug, Joni, Marsha, and Susie met with the Trauma Director at Franciscan Saint Elizabeth Health in Lafayette. ❖ This site has their application voted on by EMS on Friday, December 20. ❖ Had challenges with data gathering. The group agreed this would be a challenge for us, too. ❖ Have to track the discharge of Trauma I or II daily: <ul style="list-style-type: none"> - Helicopter - Inpatient - Other hospital ❖ They have a common area with a spreadsheet in the shared drive. ICU takes care of this.

MINUTES OF:

	<ul style="list-style-type: none"> ❖ They use a pre-assigned level of nurses. Level I, II, and III used in ICU at CHA. - Intake documentation – have acquired a 6 page tool from IU. They use it for Code FAST and STEMIs. Doug will send this to everyone. - Primary RN – She was the expert - Secondary – Did more procedures, IVs. - Novice - documentation ❖ Do not use handwritten record. They use epic. Use activation button to flip to correct screens.
<p>Discussion</p>	<ul style="list-style-type: none"> ❖ We need the same criteria as St. Vincent Regional (St. John's). ❖ Stipend to general, ortho and neuro physicians. ❖ Debriefing tool used for after the incident. ❖ Alcohol screening requirement?. Will discuss later. ❖ Neuro Surgeon – what if he/she is on vacation and the other one is in surgery? Need to set up a plan. ❖ Need to address availability of surgeon. (Surgeon can only be on call for either trauma or surgery, but not both at same time). If physician group doesn't want to take call – need to transfer patient. ❖ Need policy for surgeon on call. ❖ Only need one transfer agreement with a Level I and we need one with Riley for pediatric patients. ❖ Need signed copies of policies. ❖ Neuro map – Made a map of process for neuro surgeon: <ul style="list-style-type: none"> - Signature pages on policies - Nurse credentials for ED - TNCC current - 100% review of alert status ❖ Need inpatient database created. ❖ Doug is thinking about asking Dr. Gomez from Eskenazi to talk with our doctors. ❖ Peer Review committee must include surgeon, ortho and neuro surgeons. ❖ Need Bylaws for this committee. C. Arnold will send a set of Bylaws from the NPPC to Doug for review. ❖ Need a new folder for Trauma Services policies on the Intranet. C. Arnold will talk to Ben Graham. ❖ IOPA should be contacted to check on a trauma document from them. ❖ This group will need to meet weekly. ❖ Setting up alerts – people that will make decisions

MINUTES OF:

<p>Submission Timing</p>	<p>will meet to decide on alerts/ ❖ January 7, 2014 is the deadline for the 2/7 meeting. The group agreed that this is too soon. ❖ In order to get a 5/9 approval, must be submitted by 4/9. This group will target 3/1 to be ready for submission.</p>
<p>Trauma Program Operational Process Performance Committee Draft Roster for Discussion</p>	<p>❖ D. McGee submitted the following list of necessary people to be appointed by the CEO or designee for the OP Committee:</p> <ul style="list-style-type: none"> - Trauma Medical Director (Surgeon) - ED Medical Director - EMS Co-Medical Director - Anesthesiologist - Orthopedic Surgeon - Neurosurgeon - CEO - CNO - Trauma Program Manager - Trauma Registrar - ED Director - ED Clinical Manager/EMS Liaison - Surgery Director - ICU Clinical Director - Quality Management Director - Radiology Administrative Director - Lab Administrative Director - Administrative Assistant - Radiologist Section Chief - Cardiopulmonary Director - ICU Medical Director <p>More appointees can be added as needed. This list needs to be in the Bylaws.</p>
	<p>Meeting was adjourned at 4:00 p.m.</p>

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 1/2/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	A
Tharp, Beth	CEO	CHA	CHA	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	A

Agenda Items	Discussion/Action/Next Steps
Agenda Review	❖ D. McGee opened the meeting at 8:15 a.m.
Protocol Update	❖ D. McGee is working on the protocols and policies. He will get them to the committee this week.
Activation Update	❖ D. McGee will get them to the next meeting.
Trauma Services Update	<ul style="list-style-type: none"> ❖ D. McGee will contact Wendy St. John at the Eskenazi Trauma Center for guidance. ❖ Trauma Services and processes need to be explained to the Administrative Representatives. They will be a vital part of this process. ❖ Who should be a first responder to the Trauma call? <ul style="list-style-type: none"> - Administrative Representative - Cardiopulmonary - Radiology - Transporters ❖ Who should be ready to respond after they hear the overhead activation? <ul style="list-style-type: none"> - Lab – may be asked to bring blood to the ED within 30 minutes. D. Yates is working on a

MINUTES OF:

	<p>Mass Transfusion Policy. - Security – may be needed for crowd control.</p>
<p>Trauma Surgeon Update</p>	<ul style="list-style-type: none"> ❖ D. McGee sent an e-mail to Dr. Ben McCurdy regarding the Trauma Services program, but has not received a response. ❖ The committee agreed that a small group should meet with Dr. McCurdy the first time to explain the process and show him the documents, goals and steps and how to get there. <p>ACTION: The meeting is set for January 16 at 9 am in the Board Room. Dr. McCurdy, D. McGee, L. Noble, M. Meckel and C. Whitesel have been invited to the meeting.</p>
<p>Discussion</p>	<ul style="list-style-type: none"> ❖ D. McGee reported that two more IU facilities have filed for certification. ❖ Sharper Coding for Trauma with ICD-10-CM and ICD – 10 – PCS – D. McGee and R. Mourey will attend this class. J. Brinkman will purchase one set of books for them. ❖ Need to be collecting complete data now. Need to be able to pull information into a database. Must have collection started 1/1/14. There were a couple to review from December. <ol style="list-style-type: none"> 1. Create form to complete when patient comes in. Will probably adopt IU's. 2. Date record of each time ED doctor leaves the ED for emergent situations (codes, etc.) The form should show: <ul style="list-style-type: none"> - Date and time out of ED - time returned to ED - Trauma during that time? If yes, get patient's name. 3. Need 2 tiered activation protocol put into place. Doug to review. 4. Need to invite departments involved to a meeting and let them know that Trauma Services is in place. 5. Need to have Administrative Representative to scribe for trauma cases. 6. Need to get a trauma tab for Meditech. 7. Bypass policy is needed – D. McGee to look for this. 8. Need folder for Trauma Services in ED and for the Administrative Representatives. ❖ C. Arnold to set up weekly meetings through the end of February. ❖ C. Arnold to talk with Administrative Representatives to find out if they document the time

MINUTES OF:

	<p>surgery team is called in.</p> <p>ACTION: Administrative Representatives do not document the time OR is called in.</p> <ul style="list-style-type: none">❖ Letters need to go out to doctors soon. Letters must be signed. <p>ACTION: C. Arnold will type letters and get to Tammy Utterback for signatures.</p> <ul style="list-style-type: none">❖ M. Meckel needs this entire process for a Process Improvement for The Joint Commission.❖ ICU and OR information needed:<ul style="list-style-type: none">- List of employees names- Trauma training? (PALS< ACLS)- Equipment in area that could be used for trauma patients.
	<p>Meeting was adjourned at 9:20 a.m.</p> <p>Next meeting will be held in the Board Room on January 9, 2014 at 8:30 a.m. Calendar of the next meetings will be brought to the next meeting and sent via e-mail.</p>

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 1/9/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	P
Tharp, Beth	CEO	CHA	CHA	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 8:40 a.m.
TM Update	<ul style="list-style-type: none"> ❖ D. McGee reported that Wendy St. John from Eskenazi is working on getting a form for our transfer agreement. This will go to our legal department when it is complete. Will need a form for each facility we might/will transfer a patient: IU, Riley, St. Vincent, Eskenazi, etc. Doug will check with contacts next week at the TNCC meeting and will compare our form with their form. ❖ Network Committee met last week and discussed trauma certification: <ul style="list-style-type: none"> - Share point site - Consistent messages sent out - Project management team – Trauma Retreat? - Contacting coding team regarding upcoming coding meeting - Suggested data bases to review <p>They are working on the certification, but are behind us. They are trying to get financial support from administration.</p>

MINUTES OF:

	<ul style="list-style-type: none"> ❖ C. Whitesel is on the Network Trauma Committee. J. Brinkman will give information from out trauma committee to take to that meeting.
Trauma Services Update	<ul style="list-style-type: none"> ❖ D. McGee brought a questionnaire from the ACS. We need to know everything in this before they make a visit. ❖ Need job description for Trauma Registrar. ❖ Need comprehensive transfer criteria – Doug will have this at the next meeting. ❖ Final committee policy and diversion policy ready to be signed. ❖ Need to look at tiered policy and get it ready to sign. ❖ Tammy Utterback has letters of approval ready. These will go to MEC next week.
Trauma Surgeon Update	<ul style="list-style-type: none"> ❖ Dr. McCurdy need to provide credentials and training to show he is certified to do this job. Doug will meet with Tammy Utterback and his office manager for this information. ❖ The certification committee needs a ½ hour of Dr. McCurdy's time to explain what the trauma team is about. L. Noble will let him know that a meeting will be set up.
Discussion	<ul style="list-style-type: none"> ❖ Need a trauma services folder on the Intranet for policies. Need to put them on the shared drive, also. ❖ Need a call schedule for Trauma Surgeon. ❖ Need to start collecting data and putting things together now (forms, policies, etc.) ❖ Need to look into the state downloading the trauma database automatically for the federal trauma database. ❖ Bloomington and Arnett in Lafayette are applying for certification now. ❖ Need to look at IOPO policy to add trauma services.
	Meeting was adjourned at 9:25 a.m.

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 1/23/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	A
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	P
Tharp, Beth	CEO	CHA	CHA	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 8:30 a.m.
TM Update	<ul style="list-style-type: none"> ❖ D. McGee reported that the agreement is at Eskenazi. ❖ Doug talked to the Program Manager at Eskenazi and asked about data manipulation software. ❖ Ready to start Trauma Activations. Need to meet with the Administrative Representatives and those that respond to Code FAST. Those employees should respond to Trauma Alert. ❖ Doug will get on the agenda for the management meeting to describe the process for Trauma Activation. ❖ Log in ED will be kept so admits don't fall through.
Trauma Services Update	<ul style="list-style-type: none"> ❖ J. Brinkman had a meeting with St. Vincent's Regional in Anderson. They are ok with us using their EMS protocols. ❖ Goal is still April 7th for application. Doug says we will be ready. ❖ Diversion policy and Diversion log has been completed. Dough will send final policy to Cheryl to

MINUTES OF:

	put on the Intranet.
Discussion	<ul style="list-style-type: none">❖ C. Arnold distributed trauma meeting calendar.❖ Dr. Callahan discussed with L. Noble the collection of times he went through this in Duluth. Dr. Callahan will be involved with this group at some point.❖ C. Arnold to continuing searching for new books.❖ L. Noble is working on the Surgery Scope of Service that will include trauma information. C. Beisser to get ICU information to her for referencing.❖ C. Whitesel to send out a memo to Administrative Representatives regarding writing down the time that surgery team is called in on the report sheet. They will be reminded to look at the computer time and not watch/clock time.
	Meeting was adjourned at 9:20 a.m.

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 1/30/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
Hayes, Lisa		CHA	Neuroscience Services	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	P
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 2 p.m.
Trauma Services Update	<ul style="list-style-type: none"> ❖ Committee agreed that education on Trauma Activation needs to begin soon. ❖ Committee agreed that the activation process cannot begin on 2/1/14 due to the need for education. Departments needing training are: ED, Patient Access, Laboratory, Radiology, and Administrative Representatives. R. Mourey will make a 7 step process flowsheet for the education. ❖ The Medical Director agreement needs to be signed. ❖ Eskenazi patient transfer agreement has been sent to them to sign. ❖ Dr. Short, J. Brinkman, and S. Cleaver are working on the transfer criteria document at this time. ❖ Trauma information only being sent to state database at this time. ❖ Need to be sure that the correct billing codes are used for trauma cases. ❖ The Administrative Representatives role is to start the trauma documentation sheet. They will be kept in the COC on a clipboard.
Trauma Surgeon Update	<ul style="list-style-type: none"> ❖ Need to set up a meeting with Dr. McCurdy regarding the call schedule and contracts. ❖ Need agenda for Dr. McCurdy meeting.
	Meeting was adjourned at 3:30 p.m.

262

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 1/30/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
Hayes, Lisa	Clinical Coord.	CHA	Neuroscience Services	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Ad Hoc Members:

Kinsey Jutte, Administrative Representative

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 2 p.m.
Trauma Program Manager Update	<ul style="list-style-type: none"> ❖ D. McGee will be attending the trauma meetings held by the Indiana State Board of Health in Indianapolis on Friday, February 7, 2014. ❖ Doug discussed that we have to put together a precise policy adequate for CHA's needs.
Trauma Services Update	<ul style="list-style-type: none"> ❖ The committee agreed that the ready date will be moved to May or later since we do not have the trauma surgeon signed in time for the first projected date of February 7, 2014. ❖ Discussion was held on keeping a log showing why patients are transferred out of the CHA Emergency Department (ED). <p>ACTION: J. Brinkman will send that information to J. Rogers at the Network.</p> <ul style="list-style-type: none"> ❖ Discussion was held on how much data will be available for the application for in process. Doug told the committee that the PIPS process shows we gather the data, evaluate the trauma, set it against the standards, and close the loop. ❖ J. Brinkman reported on the Network trauma application process: <ul style="list-style-type: none"> - They are looking at a software program to upload our data. The software would be

263

MINUTES OF:

	<p>either DI or Image Trend. Image Trend is being used now and it is free. We may have to pay to send information to the national data base.</p> <ul style="list-style-type: none"> - The Blue Sky project for the State Board of Health pulls information from Meditech to report. We are the pilot hospital for reporting to the state. M. Meckel requested to see a list of data points that it pulls. Quality may need to make is discreet data and they need to get ready for the report. Joey Hobbs and Jerry Elam are working on this in IT. ❖ M. Meckel suggested a flow chart process for staff education. Need to get a list of steps for the staff to follow when trauma activation is called. ❖ Discussion was held on how the Administrative Representatives will log call-in times for surgery process to have consistent time documentation. The committee agreed to: <ul style="list-style-type: none"> - The Administrative Representatives will log all surgery call-ins on their report sheet. - C. Arnold will create a spreadsheet to log these times and the times that the Surgery personnel arrive. She will send this spreadsheet to D. McGee monthly. This will start immediately. ❖ Administrative Representatives need to be TNCC certified.
Trauma Surgeon Update	<ul style="list-style-type: none"> ❖ J. Brinkman reported that CHA is still waiting on information from Cat Zapper on fair market value of having a trauma surgeon. We can't go forward without this. ❖ Need to get Dr. McCurdy's credentialing from Tammy Utterback. Doug spoke with her about this. ❖ Ortho and Neuro piece of this process needs to receive guidance from Dr. McCurdy ❖ The Trauma Surgeon has the authority to handle problems between meetings. It is in the job description.
Discussion	<ul style="list-style-type: none"> ❖ Need to set another deadline. ❖ If anyone has something to add to the agenda, please contact C. Arnold.
	Meeting was adjourned at 3:20 p.m.

264

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 2/13/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
Hayes, Lisa	Clinical Coord.	CHA	Neuroscience Services	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	A
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	A

Ad Hoc Members:

Kinsey Jutte, Administrative Representative

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 2 p.m.
Trauma Program Manager Update	<ul style="list-style-type: none"> ❖ D. McGee attended the State Trauma meeting last Friday in Indianapolis. He found the meeting to very interesting and will be attending quarterly. Doug shared the following highlights of the meeting: <ul style="list-style-type: none"> - Average from time of pager to door of Level I Trauma Centers was reported as 5 hrs. 47 mins. - Discussed washing out fractures. Doug spoke with Ron Lewis after the meeting. The Indy committee is talking about a consultation visit for the American College of Surgeons (ACS). - Doug spoke with the Trauma Program Managers from Methodist and Riley. They are sending a draft to Doug and he will forward it to Carol Whitesel and Beth Tharp.
Trauma Services Update	<ul style="list-style-type: none"> ❖ C. Beisser gave D. McGee an equipment list from ICU. She also brought the admission prioritization and staffing and scheduling policies. She will update the Scope of Service and give that to him at a later date. ❖ D. McGee sent an e-mail to Brian Carnes regarding

MINUTES OF:

	<p>stocking platelets. He is waiting on a response. C. Beisser noted that we have two products that can be used in place of platelets. K-Centra is one of them.</p> <ul style="list-style-type: none"> ❖ C. Beisser just purchased ECCO for ICU staff trauma training. ❖ Presently, ED has 40% of RNs current in TNCC. All ED nurses have taken the course within one year of their hire date. ❖ The committee needs to put together a list of what Level I traumas we will keep at CHA. Will probably be just neurosurgery. Multiple system traumas will most likely be shipped. ❖ D. McGee has requested a letter from Virtual Reality through Bob Reed in Radiology that states they are aware of this process at CHA. Doug will also talk to Andrew Shuck and Betty Godbey about this letter.
<p>Trauma Surgeon Update</p>	<ul style="list-style-type: none"> ❖ J. Brinkman reported that Dr. McCurdy should be signed and final on February 26.
<p>Discussion</p>	<ul style="list-style-type: none"> ❖ Brandy Robertson is sending information to the state registry. ❖ J. Brinkman asked about the ICD coding diagnoses. D. McGee said that activation, DOAs, transfers and trauma on admissions should be entered. ❖ J. Brinkman reported a Webinar on Trauma Reporting to the National Trauma Database will be held on 2/14. She will invite Robin Mourey and Doug McGee to listen in. ❖ PIPS – Performance Improvement Safety Outcomes is the last big piece to put together. M. Meckel told the group that we can get a lot out of Power Health data repository (DR). She needs to know what data points we want so it can be built with what we want. She also noted that we have MediSolv which is more clinically based DR. It takes its information out of Meditech. ❖ D. McGee reported that the new Trauma Resource book (The Orange Book) will not be available until the end of 2014/
<p>Meeting was adjourned at 3:15 p.m.</p>	

266

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 3/06/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	A
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	A
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
Hayes, Lisa	Clinical Coord.	CHA	Neuroscience Services	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, Robin	Inf. Control	CHA	Quality Resources	P
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	A

Agenda Items	Discussion/Action/Next Steps
Agenda Review	<ul style="list-style-type: none"> ❖ D. McGee opened the meeting at 2 p.m.
Trauma Program Manager Update	<ul style="list-style-type: none"> ❖ D. McGee reported that he and R. Mourey attended the ICD-10 Coding class. Jeannette from coding was also there. It was helpful to have her there to ask questions. <ul style="list-style-type: none"> - Coders code for reimbursement - TR may have to dig deeper into ICD-10 codes to get to trauma severity. - Coders currently doing dual coding with ICD-9 and 10 to get ahead of the process. ❖ Mandatory education for physicians coming. ❖ Contacted Kathi Wasilewski at St. Vincent Anderson Regional Hospital regarding Peer Review quarterly. Can possibly coordinate meetings between hospitals. ❖ Looking at Trauma Database Software on 3/11/14. Will invite IT for input. ❖ Trauma Level 1 contracts to IU Health and Eskenazi are expected back anytime.
Trauma Services Update	<ul style="list-style-type: none"> ❖ Going to start Trauma Level 1 activations on 3/18/14 at 11:00 a.m. ❖ Want all inclusive trauma information on Meditech in Trauma Section under Clinical Section. ❖ Since we will be keeping more trauma patients at CHA, specific criteria is needed to meet the standards of the Brain Trauma Foundation.
Trauma Surgeon Update	<ul style="list-style-type: none"> ❖ Met with Dr. McCurdy on Wednesday, March 5, 2014. Reviewed trauma information. He had a

267

MINUTES OF:

	couple of minor questions about the PI plan.
Discussion	<ul style="list-style-type: none">❖ L. Noble reported that she going to get with Dr. Kay regarding signing of the support letter.❖ E-mails out to responding departments/staff/ED staff/ED physicians informing them of 3/8/14 start date of Trauma Level I activation.
	Meeting was adjourned at 4:00 p.m.

MINUTES OF:

CHA TRAUMA CERTIFICATION TEAM MEETING

Date/Time: 3/20/2014 Chairperson: Doug McGee Recorder(s): C. Arnold

Voting Members Attending/Titles:

Name	Title	Site	Unit(s)	Present/Absent
Arnold, Cheryl	Secretary	CHA	Patient Care Services	P
Beisser, Cindy	Clinical Mgr.	CHA	Intensive Care	P
Brinkman, Joni	Director	CHA	Emergency Department	P
Cleaver, Susie	Clinical Mgr.	CHA	Emergency Department	P
Hayes, Lisa	Clinical Coord.	CHA	Neuroscience Services	P
McGee, Doug	Director	CHA	Trauma Team	P
Meckel, Marsha	Director	CHA	Quality Resources	P
Mourey, R.	Inf. Control	CHA	Quality Resources	A
Noble, Lisa	Clinical Dir.	CHA	Surgical Services	P
Whitesel, Carol	VP/CNO	CHA	Patient Care Services	P

Agenda Items	Discussion/Action/Next Steps
Agenda Review	❖ D. McGee opened the meeting at 2 p.m.
Trauma Program Manager Update	<ul style="list-style-type: none"> ❖ D. McGee reported that he is planning on having everything finalized by next Thursday. ❖ Doug gave policies to each person responsible to sign. Will meet with Dr. McCurdy on Monday morning at 7am for is signing.
Trauma Services Update	❖ Discussed the ICU Scope of Service and made necessary changes. C. Arnold will update the scope and send to Doug.
Trauma Surgeon Update	❖ Discussion was held on how the doctors need to be notified of a trauma. Right now, they are being notified the way they have been in the past.
Discussion	<ul style="list-style-type: none"> ❖ L. Hayes reported the tubes being sent to Lab STAT for STEMIs, trauma, stroke, and code blue will have an orange sticker on top. This sticker will show up in the centrifuge and let the lab personnel know that it needs to be checked now. This will be used as a Process Improvement for trauma. ❖ Level I Activation was called on Saturday. Joni shared the chart with the group to show it was completed correctly. ❖ M. Meckel will review the organ donation policy. ❖ Peer Review to set up a meeting. ❖ J. Brinkman discussed her visit with Kathi W. from St. Vincent Anderson Regional.
	Meeting was adjourned at 3:00 p.m.

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"
LEVEL III TRAUMA CENTER STATUS

SECTION 21

RN Credentialing

"21. Nurse credentialing requirements. Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU"

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 21 are met with a signed copy of the Community Hospital-Anderson (CHA) RN credentialing requirements covering ICU and ER nurses. The Emergency Department has additional requirements which are delineated in an ER-specific policy as attached. A spreadsheet illustrating the training level of each ER RN is attached.


Community Hospital Anderson
**Hospital Policy Manual
Educational Services Section**

Subject:	Core Competency (Performance Checklist) Registered Nurse (RN), New Graduate (NG), Medication Licensed Practical Nurse (MLPN) and NGP
Originator:	Educational Services Director
Approved By:	<i>Carl W. [Signature]</i> Vice President, Patient Care Services, CNO
Policy Coordinator:	Vicki Salyer
Scope:	CHA Nursing Staff
Effective:	8/93
Revised:	05/94, 08/96, 08/99, 03/02, 04/02, 03/05, 03/08, 08/11
Reviewed:	N/A
Reference(s):	N/A
Previous Number:	7620.09
Attachment(s):	N/A

PURPOSE: To outline the core competencies nursing personnel will be exposed to prior to release from Educational Services. The competent performance of the core competencies will begin with clinical education and be completed during the unit-specific orientation under the supervision of a preceptor.

POLICY STATEMENT: Realizing nurses will have various levels of past experience and that core competencies vary in the level of complexity, some core competency evaluations will need to begin in clinical education week with initial exposure to the skill. Then the competency evaluation will be completed during the nursing personnel's unit-specific orientation under the supervision of a preceptor. To begin the core competency evaluation process any nursing personnel whose job title requires attendance to Clinical Education Orientation will meet the following criteria before being released from Educational Services.

ACTION STEPS:
A. Performance Checklist: Intravenous

1. Nursing personnel required to attend Clinical Education Orientation will complete the Clinical Education IV Start Module/Checklist, designed to introduce the nursing individual to CHA-used devices, related policies and procedures and to allow for return demonstration practice. The completion of the core competency will occur under the supervision of the nursing individual's preceptor during unit-specific orientation.

2. Nursing personnel required to attend Clinical Education Orientation will complete the Clinical Education IV Pump Module/Checklist, designed to introduce the nursing individual to CHA-used devices, related policies and procedures and to allow for return demonstration practice. The completion of the core competency will occur under the supervision of the nursing individual's preceptor during unit-specific orientation.

B. Performance Checklist: Blood & Blood Components

1. All NGs and RNs required to attend Clinical Education Orientation will complete the Clinical Education Blood & Blood Components Module/Checklist, designed to introduce the nursing individual to CHA-used devices, related policies and procedures and to allow for return demonstration practice. The final completion of the core competency will occur under the supervision of the nursing individual's preceptor during unit-specific orientation.

C. Basic Proficiency In Medication Administration

1. All RNs, NGs, MLPNs and NGPs required to attend Clinical Education Orientation will demonstrate the following:
 - a) Evidence of general knowledge of medications and administration and meet the standard for safe practice of medication administration by:
 - Completion of the standardized computerized NLN "Basic Proficiency in Medication Administration Exam." The exam results will be used by the unit-specific director/managers to assess level of competency in medication knowledge and administration and to plan for and implement any remediation needed by the individual RN, NG, MLPN or NGP.
 - Completion of the medication administration modules, designed to introduce the nursing individual to CHA-used devices, related policies and procedures.
 - Completion of the PYXIS tutorial.
 - Completion of the electronic bedside medication verification training.

D. Competency Verification Checklist: Basic Physical Assessment – Adult

1. All NGs and RNs required to attend Clinical Education Orientation will complete the Clinical Education Basic Physical Assessment Module/Checklist (if applicable). The module is designed to introduce the nursing individual to CHA-used devices, related policies and procedures and to allow for return demonstration practice. The completion of the core competency will occur under the supervision of either the clinical educator (or designee) or under the supervision of the nursing individual's preceptor(s) during unit-specific orientation.
2. All nurses will meet at least 80 % efficiency in each section.

E. Performance Checklist: Restraints

1. All nurses required to attend Clinical Education Orientation will complete the Clinical Education Restraint Module/Checklist, designed to introduce the nursing individual to CHA-used devices, related policies and procedures and to allow for

return demonstration practice. The completion of the core competency will occur under the supervision of either the clinical educator (or designee) and/or the nursing individual's preceptor(s) during unit-specific orientation.

2. All nurses required to attend Clinical Education Orientation will apply wrist and vest restraints correctly.

G. Department Orientation/Competency Inventory (DOCI) Is To Be Signed By The Employee And The Educational Services RN

1. Staff will not be released for patient care until all of the above criteria are met.
2. Completion of the core competencies will occur under the supervision of either the clinical educator (or designee) or under the supervision of the nursing individual's preceptor(s) during unit-specific orientation.
3. If the orientee does not meet the standard, the unit-specific director/manager will be responsible for determining and planning for remediation of the individual and subsequent performance evaluations.



Community Hospital Anderson

NURSING DEPARTMENT POLICY MANUAL INTENSIVE/CRITICAL CARE UNIT

Subject:	Staffing Guidelines – Changes in Census
Originator:	<u><i>Carol Deems</i></u> Clinical Manager, ICCU
Approved By:	<u><i>Carol Whitson</i></u> Vice President Patient Care Services/CNO
Policy Coordinator:	Cheryl Arnold
Scope:	ICCU
Effective:	12/95
Revised:	5/09; 5/10, 08/12; 3/20/14
Reviewed:	12/98; 12/01; 12/04; 12/07
References:	

PURPOSE: To facilitate safe and effective patient care through recognition of various levels of skills held by staff who may work in ICCU. The unit is routinely staffed by nurses who have the special skills required to work in Intensive Care.

Statement: A Level 1 ICU nurse will always be scheduled for the ICU. From time to time, the census may increase, requiring more help than was planned for. During times of high census, staff will be asked to work additional hours. Staff who routinely work in other areas of the hospital may assist in ICCU. They will be assigned to an ICCU staff member and will function under their supervision.

Objectives:

1. To clarify what is expected of each associate, by defining levels of expertise related to ICCU.
2. To facilitate competent patient care by providing information to the individual floated to ICCU.
3. To encourage individuals to expand their knowledge base.

ACTION STEPS:

Levels of Expertise Related to ICCU:

Level I: This staff member has completed the ICCU orientation and is currently ACLS certified. This nurse can competently care for a critical “one-on-one” ICU patient, or for multiple ICU patients skillfully.

Level II: This staff member is competent in working with the intubated patient, administering critical drugs, and interpreting EKG abnormalities. (Examples of this staff member would include those staff currently working in the Recovery Room and the

274

Emergency Department). They are currently ACLS certified or are seeking to become ACLS certified.

Level III: This staff member is competent in working with patients who require cardiac monitoring. They are familiar with some medications not routinely used on Med/Surg units. (Refer to the current pharmacy list).

Level IV: This staff member is competent in delivery of patient care. They are not familiar with procedures or medications used normally only in ICCU.

Responsibility/Accountability:

1. The ICCU staff is ultimately accountable for patient care.
2. The ICCU staff member is responsible for ascertaining the level of expertise of those individuals who are "floated" to work in ICCU.
3. The ICCU staff is accountable for communicating, orienting, and collaborating with these other staff members.

In the event that the acuity level requires more assistance than has been planned, a staff member may be floated to ICCU where they will work alongside an intensive care nurse. This individual may not assume direct patient care, but will assist the intensive care staff in their care delivery. Under no circumstances will a staff member be asked or expected to do more than their capabilities.

The individual floated to ICCU is responsible for communicating their current level of expertise and for collaborating with the ICCU staff to provide safe and effective patient care.

Patient Care Assignments will be determined at the beginning of each shift. "ICU staffing" [acuity] will be done on the computer once during each 12 hour shift--round 0600 and 1800 to serve as a guide for the needs of the next shift. All patients in Class 3 or Class 4 will be cared for by the ICCU staff. Some stable patients in Class 2 may be cared for by other levels of staff in collaboration of the ICCU staff. For example, if a nurse floated to ICCU is competent to care for surgical patients, but is not familiar with EKG monitoring, the ICCU nurse would assume all responsibility for the EKG monitoring of that patient, while the floated nurse would be the care provider.

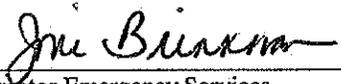
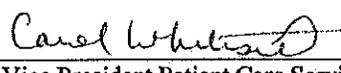
The staffing Rolodex provides a listing of nurses who are ICCU staff or have been floated to the unit. The level of expertise for each associate is noted on the card by their name.

Low Census:

1. During time of decreased census, PRN, Resource and those who may have signed up for extra hours (or who would be paid overtime) will be called off first.
2. Staff may volunteer to take a low census day, but will normally remain PRN.
3. If there are no volunteers, staff will rotate taking time off so that all staff loose as close to an equal amount of hours as possible.

4. Staff may split shifts of time off.
5. Vacation time off (requested time off) does not count as low census time.

 **Community Hospital Anderson****Emergency Department Policy and Procedure Manual**

Subject:	Skills for Nursing Personnel in the Emergency Department
Originator:	 Director Emergency Services
Approved By:	 Vice President Patient Care Services/CNO
Scope:	Emergency Department
Effective:	
Revised:	3/16/98;7/3/03; 3/20/2014
Reviewed:	5/25/06; 5/09;12/28/10
References:	
Attachments:	

PURPOSE

To establish minimal skill guidelines for nursing staff working in the Emergency Department.

POLICY STATEMENT

1. Registered Nurse's scheduled in the ED shall have a minimum of the following:
 - a. Current CPR certification.
 - b. Successful completion of Medication Administration competency.
 - c. Completion of IV Therapy and Blood Administration competency.
 - d. Current ACLS certification or must be trained within 1 year from completion of orientation.
 - e. Successful completion of TNCC within 1 year from end of orientation.
 - f. Completion of Arrhythmia Interpretation class or Challenge Test.
 - g. RN Orientation packet completed with a preceptor.
2. All of the above criteria will be documented in the nurse's personnel file.

ED EMPLOYEE	ACLS	PALS	TNCC	ATCN	PHTLS
Tammy Alvarez RN	x		x		
Jennifer Anderson RN	x		x		
Samantha Barnes RN	x	x	X		
Nancy Bitner RN	x		x		
Robert Bonecutter RN	x		x		
Daniel Butler RN	x	x	X		
Joy Butler RN	x	x	x		
Justin Chase EMT-P	x		NA		
Susie Cleaver RN	x		x		
Brandi Crum RN	x	x	x		
Rachel Ferguson RN	x	x	x		
Karin Fix RN	x		x		
Heather Hall RN	x		x		
Jacob Harris EMT-P	x	x	NA		
Rachael Hartley RN	x	x	x		
Chad Horning EMT-P	x	x	NA		
Kristen Howard RN	x	x	x		
Kia Lutz RN	x	x	x		
Anthony Malon EMTP	x	x	NA		x
Jane Mathavich RN	x	x	x		
Megan Matson RN	x	x	x		
Douglas McGee RN	x	x	x	x	
Kathy Mendoza RN	x		x		
Kayla Newby RN	x	x	x		
Kari Nodine RN	x	x	x		
Kendall Osborn RN	x		x	x	
Ashley Patton RN	x	x	x		
Jane Patz RN	x		x		
James Pitts EMT-P	x	x	NA		
Audra Porter EMT-P	x		NA		
Kylie Rector RN	x		x		
Sara Robinson RN	x	x	x		
Nancy Saulmon RN	x		x		
Lea Solid RN	x	x	x		
Erica Stultz RN	x	x	x		
Mikki Surguy RN	x	x	x		
Denna Thompson RN	x	x	x		
Tara Wales RN	x	x	x		
Hugo Wans EMT-P	x	x	NA		
Allison Wilson RN	x		x		
Lori Wilson RN	x		x		

Community Hospital

Anderson, Indiana

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 22

Governing Body and Medical Staff Commitment

"22. **Commitment by the governing body and medical staff.** There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within 1 year of this application and to achieve ACS verification within 2 years of the granting of "in the process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one year of this application and/or does not achieve ACS verification within 2 years of the granting of "in the process" status that the hospital's "in the process" status will immediately be revoked, become null and void and have no effect whatsoever."

NARRATIVE RESPONSE AND DISCUSSION

This requirement is met with the attached separately written commitments by the Community Hospital- Anderson Board of Directors and medical staff to establish a Level III Trauma Center and to pursue verification by American College of Surgeons within 1 year of application to achieve 2 years granting of "in the ACS verification process" status.

These letters includes recognition by the hospital that if it does not pursue verification within 1 year of application and/or does not achieve ACS verification within 2 years of the granting of "in the ACS verification process" status then Community Hospital- Anderson's "In the ACS verification process" status will be revoked, become null and void and have no effect whatsoever.

A copy of the meeting minutes memorializing the Board trauma discussion is included.



**Community
Hospital Anderson**

Community Hospital Anderson Foundation
1515 North Madison Avenue
Anderson, Indiana 46011-3453
T 765.298.5133
eCommunity.com

March 4, 2014

William C. VanNess II, M.D., Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Application for hospital to be designated "In the ACS Verification Process"

Indiana State Trauma Care Committee:

The Community Hospital of Anderson & Madison County, Inc. Board of Directors endorses the establishment of a Level III trauma center at Community Hospital of Anderson. It is our understanding that a favorable approval recommendation from the EMS Commission will allow any EMS Provider to take trauma patients to this facility, thus, providing Community Hospital of Anderson the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Board of Directors understands that if the hospital does not pursue verification within one (1) year of the application and/or does not achieve ACS verification within two (2) years of the granting of "In the ACS Verification Process" status that the hospital's "In the ACS Verification Process" status will immediately be revoked, become null and void and have no effect whatsoever.

We will provide the leadership and corporate culture to continue to deliver excellent patient care and more specifically demonstrate an exemplary trauma care system to achieve and maintain American College of Surgeons verification as a Level III Trauma Center. Thank you for the consideration of this application.

Respectfully

Charles Staley
Chairman, Board of Directors
Community Hospital Anderson

CS/lrw



Attending:

- Chuck Staley
- Jay Ricker – via phone conference
- Mary Jamerson
- John Kane
- Dennis Carroll
- David Shapiro, MD

Staff Present:

- Beth Tharp
- Linda West

❖ **Trauma Certification**

As previously discussed, we are now undergoing the process to submit the Trauma Center certification and need Board approval to proceed.

Action: John Kane made a motion to approve the submission of the trauma certification to the State Department of Health and endorse the establishment of a trauma center at CHA. Second by Jay Ricker, motion passed.

ADJOURNMENT	1:20 p.m.
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Respectfully submitted,

Jay Ricker, Secretary



**Community
Hospital Anderson**

Community Hospital Anderson
1515 North Madison Avenue
Anderson, Indiana 46011
T 765.298.4242
eCommunity.com

January 16th, 2014

William C. VanNess II, M.D. - Indiana State Health Commissioner Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Indiana State Trauma Care Committee:

SUBJECT: Application for hospital to be designated "In the ACS Verification Process"

The Medical Staff Executive Committee of Community Hospital Anderson supports the establishment of a Level III trauma center. It is our understanding that a favorable approval recommendation from the EMS Commission will allow any EMS Provider to take trauma patients to this facility, thus providing Community Hospital Anderson the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Medical Staff Executive Committee, understands that if the hospital does not pursue verification within one (1) year of the application and/or does not achieve ACS certification within (2) years of the granting of "In the ACS Verification Process" status, that the hospital's "In the ACS Verification Process" status will immediately be revoked, become null and void and have no effect whatsoever.

The statement acknowledges the commitment to provide specialty care as required to support optimal care of trauma patients. Thank you for your consideration of this application,

Respectfully,

Carol P. Magee, M.D.

Medical Staff President

Community Hospital Anderson

282



Indiana State
Department of Health
An Equal Opportunity Employer

Michael R. Pence
Governor

William C. VanNess II, MD
State Health Commissioner

March 3, 2014

Daniel A. Nafziger, M.D., Health Officer
Elkhart County Health Department
608 Oakland Avenue
Elkhart, Indiana 46516

Dear Dr. Nafziger:

Indiana WIC Program state staff, Stephanie Thomas, will conduct a WIC Nutrition and Clinic Services Comprehensive Review and Clinic Visit(s) of your agency from Wednesday, April 2nd to Friday, April 4th, 2014. During the review, Indiana WIC Program staff will assess compliance with United States Department of Agriculture (USDA) Regulations and Indiana WIC policies and procedures.

Advance preparation is required for the review. The following items have been emailed to the Coordinator, and should be completed and returned to the State WIC office no later than **10 days prior** to the scheduled review:

- Title VI Civil Rights Review Form
- Voter Registration Review Form
- WIC Clinic Hours and Staffing Pattern Form
- Indiana WIC Pre-Review Questionnaire.

The Coordinator has also been sent the following via email:

- Review Preparation List
- Local Agency Review Form, Sections A & B

The Review Preparation List will assist the Coordinator in gathering files and documents for the review. The remaining forms are samples of the forms completed by the State WIC staff during the review.

We look forward to visiting your agency and value your presence at the initial meeting on Wednesday, April 2nd, 2014 from 10:00 a.m. to 10:30 a.m.. The visit will conclude with an exit conference scheduled for Friday, April 4th at 11:00 a.m. to discuss findings, answer questions, and address concerns. Working together, we can deliver quality services to our WIC participants.

Sincerely,

Karen Thomas, R.D.
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Indiana WIC Program
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Enclosures

cc: Katherine Wright, Elkhart County WIC Coordinator
Jenny Schrock, Elkhart County WIC Manager
Stephanie Thomas, Nutrition Consultant
File: Elkhart County Biennial Review



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283